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Substance Abuse and Mental Health Services Administration

Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose

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Executive Summary

This report presents summary information on Medicaid coverage and financing of medications to treat alcohol and opioid use disorders. Medicaid serves over 72 million adult and child beneficiaries annually (Centers for Medicare & Medicaid Services [CMS], 2017a). An estimated 12 percent of adults over 18 years of age and 6 percent of adolescents aged 12 to 17 years in Medicaid have a substance use disorder (SUD)[1] (CMS, 2014, 2015). Given the important role that medications can play in treating these disorders, it is critical that Medicaid programs develop clinically effective and cost-effective delivery and financing approaches to providing these medications to beneficiaries. The present report is intended to serve as a resource guide for those efforts.

Background

Excessive alcohol consumption and/or the use of illicit drugs have been clearly linked to adverse health and social outcomes (Bouchery, Harwood, Sacks, Simon, & Brewer, 2011; Devlin & Henry, 2008; National Institute on Drug Abuse, 2012a). There are an estimated 88,000 deaths each year due to the use of alcohol (Centers for Disease Control and Prevention, 2013), and drug overdose is the leading cause of accidental death in the United States, with more than 72,000 lethal drug overdoses estimated in 2017 and 63,632 in 2016 (National Institute on Drug Abuse, 2018). Of the 63,632 drug overdoses in 2016, 42,249 deaths involved an opioid and, out of those, 15,469 involved heroin (Seth, Scholl, Rudd, & Bacon, CDC MMWR, 2018).

Fortunately, the U.S. Food and Drug Administration (FDA) has approved effective medications for treating alcohol and opioid use disorders. These medications include:

- disulfiram and acamprosate for treatment of alcohol dependence;
- methadone, buprenorphine (including oral, subdermal and injectable extended-release formulations), and buprenorphine-naloxone (including oral, buccal, and sublingual) for treatment of opioid dependence; and
- naltrexone (oral and an injectable extended-release formulation) for treatment of alcohol or opioid dependence.

In addition, naloxone is an effective medication used to reverse opioid overdose.

Study Methods

The research team retrieved the most recent pharmacy and behavioral health documents from state Medicaid agency websites during the second and third quarters of 2018. Searches were conducted for information related to Medicaid pharmaceutical coverage of and benefit design for medication-assisted treatment (MAT), including selected Medicaid managed care plans, if

[1] According to the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (DSM-5), an SUD is characterized by a problematic pattern of using a substance that results in impairment in daily life or noticeable stress.

available. Internet queries sought documents providing information on formularies, Preferred Drug Lists (PDLs), prior authorization, psychosocial treatment requirements, quantity limits, and other pharmacy benefit limitations. Where ambiguity remained, the research team accessed online drug search tools such as Epocrates® (https://online.epocrates.com/rxmain), which provided additional information that allowed us to pursue the subject further using other documents. Medications may be covered by state Medicaid programs without being listed on an easily accessible formulary; therefore, when no other evidence of coverage was found in the Medicaid or other documents, a final determination of whether Medicaid coverage existed was made by searching the 2018 Medicaid State Drug Utilization Data (CMS, n.d.).

Key Findings

State Medicaid Program Reimbursement for and Limitations on MAT and Naloxone

All states reimburse for some form of medications for MAT. A review of Medicaid policies and data revealed that all states reimburse some form of buprenorphine, buprenorphine-naloxone, oral naltrexone, and extended-release naltrexone and that most states cover disulfiram and acamprosate. All states also reimburse for some form of naloxone, the opioid overdose reversal medication. Only 42 state Medicaid programs, however, reimburse for methadone as MAT (in contrast to reimbursing for the use of methadone to treat pain and other conditions), and fewer than 70 percent of states reimburse for implanted or extended-release injectable buprenorphine.

Even if state Medicaid agencies reimburse for specific medications, they may impose certain constraints, or benefit design limits, on obtaining the medication. State Medicaid agencies typically rely on a Pharmacy and Therapeutics Committee or equivalent entity to determine whether to reimburse for a medication and whether it will be assigned preferred or nonpreferred status, a subject addressed in greater detail below and in Section I of this report. These committees establish PDLs, which typically list the first-choice medication(s) preferred for a given condition for Medicaid patients. State Medicaid agencies also may establish other benefit design limits that must be satisfied in order to obtain reimbursement for the medication. These limits may include quantity or dosing limits, prior authorization, requirements for psychosocial treatment, and step therapy, the latter three of which are known as "nonquantitative treatment limitations," or NQTLs. Each of these benefit design features are addressed in greater detail below and in Section I of this report.

Reimbursement of medications as MAT does not mean that they all have preferred status within state Medicaid programs. Reimbursement may be available for a medication even if the medication does not have preferred status; however, if a medication does not have preferred status, the prescriber usually must obtain permission from the member's pharmacy benefit plan

Coverage Versus Preferred Status of MAT and Overdose Reversal Drugs

(number of states and territories)

Drug	Coverage	Preferred Status
• Acamprosate	40	27
• Buprenorphine	52	29
• Buprenorphine implant	37	2
• Buprenorphine injection extended-release (ER)	33	7
• Buprenorphine-naloxone	52	51
• Disulfiram	49	32
• Methadone	42	—
• Naloxone	51	43
• Naltrexone (oral)	51	44
• Naltrexone ER	51	34

- Includes the 50 states, District of Columbia, Puerto Rico and the US Virgin Islands

before the product can be reimbursed. In some instances, a drug still may require authorization even if it has a preferred status. Preferred status of a drug also can vary between fee-for-service and managed care plans within a state's Medicaid program. The majority of state Medicaid programs assign preferred status to all of the MAT medications and naloxone, with the exceptions of the extended-release versions of buprenorphine. In addition, we concluded that at least one formulation of naloxone, which is used to reverse opioid overdose, was covered with preferred status in 43 state Medicaid programs.

State Medicaid programs routinely use pharmacy benefit management requirements, such as prior authorization, to contain expenditures and encourage the proper use of medications, including for the treatment of alcohol and opioid disorders. Research on the use of prior authorization requirements with psychiatric medications has revealed that prior authorization can reduce medication expenditures. However, these requirements also can have the unintended consequence of preventing timely access to treatment. Potential barriers to access may be reduced as payers and providers move from a paper-based prior authorization process to an electronic, real-time, standardized process. An electronic process may integrate better into providers' workflow and may reduce the time that providers and patients must wait to secure authorization. Among the medications reviewed, prior authorization was required most commonly for buprenorphine and buprenorphine-naloxone, in 40 and 31 states, respectively. Most prior authorization requirements for buprenorphine monotherapy exist because of its potential for abuse, and many include restrictions limiting it to use by pregnant women and in other limited applications. Prior authorization for extended-release injectable naltrexone is required in 19 states, likely because it is not available in generic form, making it more expensive, and because patients must abstain from opioids for a minimum of 7 days prior to receiving the injection. Extended-release forms of buprenorphine also require prior authorization in approximately half of all states; they also are brand drugs and require that the patient be stabilized on other medication before their use. Relatively few states require authorization for the

other MAT drugs. However, one state requires prior authorization for all drugs in the opioid dependence treatment class.

As part of the authorization process, several states require evidence that the patient was being referred or was concurrently receiving psychosocial treatment with their medications. This requirement is most often applied to medications for opioid use disorders, particularly buprenorphine and buprenorphine-naloxone.

Step therapy is another drug utilization management strategy that requires patients to try a first-line medication, such as a generic medication, before they can receive a second-line treatment, such as a brand name medication. This requirement is relatively common. However, some states also impose step therapy requirements across medications types, in which a drug may not be used unless one or more other specific drugs are tried unsuccessfully first. One example might include requirements to try naltrexone before disulfiram or acamprosate.

Quantity or dosing limits often are used by Medicaid programs to avoid potential abuse or misuse of a medication, promoting safe and appropriate medication use. Such limits are used by 45 and 46 states for buprenorphine and buprenorphine-naloxone, respectively. In addition to quantity limits, some states historically have established lifetime treatment limits, most commonly applied to buprenorphine and buprenorphine-naloxone. However, lifetime limits are disappearing, which is consistent with clinical evidence and best practices, given that addiction is a chronic disease.

Key Findings on Innovative Approaches to Financing and Delivering MAT

States are using a variety of innovative approaches to finance and deliver medications for alcohol and opioid use disorders. For example, Massachusetts is addressing the opioid addiction epidemic by expanding medication access through a nurse care manager model. This model allows physicians to treat more patients with buprenorphine and has proven to be cost-effective. Another example is Missouri, which has begun the process of integrating MAT into all SUD treatment in the state. Missouri currently is requiring any SUD treatment provider that contracts with the state to offer MAT either directly or by referral. To ensure that providers are fairly compensated for the provision of MAT, the state has taken steps to establish an equitable reimbursement model that covers medications, the act of administration, laboratory services, other MAT-related activities, and overhead costs. The state of Washington has implemented a pilot involving a telemedicine project, Flex Care, at the Grays Harbor Clinic in the township of Hoquiam (about 2 hours southeast of Seattle). Approximately 200 patients in rural coastal Washington who previously had no access to MAT for their opioid dependence disorder now receive MAT under the Flex Care treatment model.

I. Introduction

Addiction is a chronic, relapsing brain disease that is characterized by compulsive drug or alcohol seeking and use, despite harmful consequences (National Institute on Drug Abuse [NIDA], 2016a). Drug-induced deaths have become a leading public health concern in the United States, with opioid overdose and mortality rising at an especially alarming rate. It is estimated that more than 72,000 Americans died from drug overdoses in 2017 and more than 63,000 in 2016 (NIDA, 2018). In 2016, more than 6 out of 10 of these deaths involved an opioid (Seth et al., CDC MMWR, 2018). Opioid overdose deaths (including both opioid pain relievers and heroin) reached record levels in 2016, with an age-adjusted 27.9 percent increase in just 1 year (Seth et al., CDC MMWR, 2018). The use of illicit drugs, including opioids, also is linked to a variety of adverse health events (Devlin & Henry, 2008; NIDA, 2012a).

Substance Use-Related Deaths

There were over 63,000 drug overdose deaths in 2016. Six out of 10 involved an opioid.

An estimated 88,000 deaths are attributed to alcohol use annually.

Alcohol-related morbidity and mortality also present serious public health concerns. Each year in the United States, an estimated 88,000 deaths are attributed to the use of alcohol (Centers for Disease Control and Prevention, 2013). Excessive alcohol consumption is associated with adverse health and social consequences, including liver cirrhosis, certain cancers, fetal alcohol spectrum disorder, unintentional injuries, and violent behaviors (Bouchery, Harwood, Sacks, Simon, & Brewer, 2011). Substance use disorder (SUD) also is associated with high costs to both individuals and society (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014a).

Addiction, like many other chronic diseases, is a treatable condition. According to NIDA, "treatment enables individuals to counteract addiction's powerful effects on the brain and behavior and allows them to regain control of their lives. According to research that tracks individuals in treatment over extended periods, most people who get into and remain in treatment stop using drugs, decrease their criminal activity, and improve their occupational, social, and psychological functioning" (NIDA, 2012b). There are a variety of evidence-based approaches to treating addiction. For alcohol and opioid use disorders, treatment can include psychosocial treatments (such as cognitive-behavioral therapy or contingency management), medications, or a combination of approaches. Although reliance on medication alone is not uncommon, a combination of psychosocial treatment and medication generally is recommended for the treatment of alcohol or opioid use disorders. Treatment that incorporates medication is referred to as medication-assisted treatment or MAT. MAT for opioid use disorders using buprenorphine or methadone is associated with substantial reductions in the risk for all cause and overdose mortality (Sordo et al., 2017).

Medications can help individuals with SUDs re-establish normal brain functioning, prevent relapse, and reduce cravings (NIDA, 2016b). The following medications have been approved by the FDA for treatment of alcohol and opioid use disorders:[2]

***Alcohol use disorders*—**

- Acamprosate
- Disulfiram
- Naltrexone (oral)
- Naltrexone extended release (injectable)

***Opioid use disorders*—**

- Buprenorphine
- Buprenorphine extended release (subdermal and injectable)
- Buprenorphine-naloxone
- Methadone
- Naltrexone (oral)
- Naltrexone extended release (injectable)

In 2016, an estimated 21.0 million people aged 12 years or older in the United States needed treatment for an illicit drug or alcohol use disorder (SAMHSA, 2017). SAMHSA found that only 10.6 percent of individuals (2.2 million people) who needed substance use treatment for illicit drug or alcohol use had received it at a specialty facility in the past year. Among individuals who recognized a need for treatment and tried to obtain it, lack of health coverage was the most frequently reported reason (reported by 37.9 percent of those individuals) for not receiving treatment (SAMHSA, 2017). Health insurance significantly increases access to SUD treatment by making it more affordable. Medicaid is a critical payment source and is one of the largest single payers of medications for treating SUDs. Medicaid was responsible for 25 percent of SUD-related spending in 2014, and that share is projected to increase to 28 percent by 2020 (SAMHSA, 2014b). The primary purpose of this report is to present information about Medicaid coverage of medications used to treat alcohol and opioid use disorders.[3] This report serves as an update to the SAMHSA report *Medicaid Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders* (SAMHSA, 2014c).

In addition to describing the treatment and cost-effectiveness of these medications, the first section of this report reviews policies and regulations that affect coverage of and access to them. The second section describes Medicaid coverage of these medications for all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands in the second and third quarters of 2018, and it explains the different benefit design elements most commonly used for each medication. The third section provides examples of the way that states are using innovative financing and delivery models to achieve positive outcomes and addresses some cross-cutting best practices that may help increase access to SUD medications.

[2] In addition, the Food and Drug Administration has approved the use of naloxone for the reversal of opioid overdose.

[3] Medications intended for the treatment of nicotine or tobacco use are excluded.

II. State Considerations for Covering Medications for Alcohol and Opioid Use Disorders

State Medicaid agencies typically use a Pharmacy and Therapeutics Committee or equivalent body to (1) determine whether to provide reimbursement for new medications, (2) determine whether to provide preferred or nonpreferred status for those medications, and (3) reconsider the status of coverage of existing medications. Sometimes a separate drug utilization review committee may contribute to the process. Usually, a new medication requires prior authorization until a preferred or nonpreferred status is designated for the drug. Although priority reviews can be enacted when appropriate, preferred or nonpreferred status and other coverage decisions can generally take up to 6 months. The committee approval process often includes literature and evidence review, efficacy determination, proposed protocol provisions, and safety and cost considerations (American Society of Addiction Medicine, 2013).

This section presents topics that members of Pharmacy and Therapeutics Committees may consider as they determine whether medications for alcohol or opioid use disorders will be available as indicated on the Medicaid formulary or Preferred Drug List (PDL). These topics include evidence regarding the treatment efficacy of these medications, their cost-effectiveness and cost offset, and policies and regulations that may affect their coverage in Medicaid.

A. Efficacy of Medications Used to Treat Alcohol and Opioid Use Disorders

Before determining whether to provide coverage for a drug or whether to include it on a PDL, state Medicaid agencies examine evidence of efficacy. These drugs are ones that the Food and Drug Administration (FDA) already has approved for prescribing. It is important to note, however, that, although the FDA approves drugs for certain indications, it does not decide how doctors use these drugs or whether and to what extent Medicare, Medicaid, and private insurers will cover drug costs. Those are independent decisions made once the FDA has approved the drug for release on the market.

Brand Versus Generic

Brand-name drugs are patented and marketed by the manufacturer after undergoing extensive research and subsequent FDA approval. Once the patent expires, other manufacturers can produce *generic equivalents*, or *generics*, that are required by the FDA to be therapeutically equivalent to the branded version. Generic equivalents are typically priced much lower than existing brand medications.

The FDA evaluates a product's safety and efficacy but does not formally consider cost as part of the drug approval process. The FDA approves drugs for certain conditions or indications that then are reflected on product labels. However, once these medications are approved by the FDA, health care professionals also may prescribe them "off-label" for other uses. After receiving initial approval for treating one or more given conditions, the manufacturer also may subsequently seek FDA approval for use of the

product for other indications or for a new route of administration or form (e.g., tablet or liquid) of the medication (FDA, 2017a, 2017b). All the medications reviewed in this section are ones that have met the FDA requirements for substantial evidence of safety and efficacy and were approved by the FDA for the treatment of alcohol or opioid use disorders. After a brand-name drug's patents and other exclusivity have expired, a generic drug product may become available. The FDA describes generic drugs as "copies of brand-name drugs and are the same as those brand name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use" (FDA, 2017c). Although not always the case, generic drug product prices may be up to 85 percent lower than their brand-name counterparts (FDA, 2017d). For this reason, many PDLs will list generic drugs if one has been approved by FDA.

Medications for Alcohol Use Disorders

The medications currently approved by the FDA for treatment of alcohol use disorders are acamprosate (also available as Campral®), disulfiram (also available as Antabuse®), oral naltrexone, and extended-release injectable naltrexone (only available as Vivitrol®) (Table 1). Extended-release injectable naltrexone and acamprosate were developed more recently than the other medications; extended-release injectable naltrexone is not yet available in generic form. In general, scientific research has found that these medications for alcohol use disorders help maintain abstinence, reduce the risk of relapse, and reduce heavy drinking (Laaksonen, Koski-Jannes, Salaspuro, Ahtinen, & Alho, 2008; Maisel, Blodgett, Wilbourne, Humphreys, & Finney, 2013; Mason & Lehert, 2012; Specka, Heilmann, Lieb, & Scherbaum, 2014). Each is discussed briefly below.

Table 1. Medications Used to Treat Alcohol Use Disorders

Medication	Year of First FDA Approval[a]	Mechanism of Action	Is a Generic Version Available?
Acamprosate calcium (oral) (Campral)	2004	Possible glutamate antagonist and gamma-aminobutyric acid (GABA) agonist (not fully known)—reduces symptoms of withdrawal and craving	Yes
Disulfiram (oral) (Antabuse)	1951	Alcohol antagonist—disulfiram plus alcohol will produce flushing, throbbing in head and neck, headache, nausea, vomiting, and other highly unpleasant symptoms	Yes
Naltrexone (oral)	1994 (for alcohol use disorders)	Opioid antagonist—blocks opioid receptors that are involved in alcohol and opioid cravings	Yes
Naltrexone (extended-release injectable) (Vivitrol)	2006	Opioid antagonist—blocks opioid receptors that are involved in alcohol and opioid cravings	No

Abbreviations: FDA, Food and Drug Administration.

[a] For more information on FDA approval of drugs, see U.S. Food and Drug Administration. Drugs@FDA: FDA Approved Drug Products. Retrieved from http://www.accessdata.fda.gov/scripts/cder/daf/

Acamprosate. Acamprosate is an oral medication that is used for postwithdrawal maintenance of alcohol abstinence. Short-term and long-term studies provide evidence of the efficacy of acamprosate. For example, acamprosate is effective at increasing the cumulative days of abstinence among individuals with alcohol use disorders (Bouza, Angeles, Ana, & María, 2004; Donoghue et al., 2015; Maisel et al., 2013; Mann, Lehert, & Morgan, 2004; Rösner et al, 2011; SAMHSA, 2009). This medication is associated with significantly higher rates of treatment completion and medication compliance and has a significant effect compared with placebo in improving rates of abstinence and no heavy drinking in people with alcohol use disorders (Mason & Lehert, 2012). Acamprosate may be most effective among individuals who are motivated for complete abstinence from alcohol and when provided over a long period of time.

*Disulfiram***.** Disulfiram is the oldest medication used in the treatment of alcohol use disorder. The medication, administered orally as a tablet, does not prevent alcohol craving; instead, it deters subsequent alcohol consumption by causing unpleasant effects such as flushing, throbbing headache, nausea, vomiting, and other unpleasant symptoms for 24–30 hours after taking the medication. Research shows that, when taken consistently and under supervision, disulfiram increases abstinence, prevents relapse, and decreases the frequency of alcohol consumption (Brewer, Meyers, & Johnsen, 2000; SAMHSA, 2009; Specka, Heilmann, Lieb, & Scherbaum, 2014). The mechanism of action for disulfiram, an aversive reaction upon drinking alcohol, may, however, lead to poor adherence. Consequently, expert consensus recommends using disulfiram only with reliable and highly motivated individuals in monitored situations (in which another person administers the medication) or in circumstances in which it is necessary to deter an anticipated high-risk situation (Garbutt, 2009; Jorgensen, Pedersen, & Tonnesen, 2011; Mann, 2004; Suh, Pettinati, Kampman, & O'Brien, 2006).

*Naltrexone (oral and injectable)***.** Naltrexone is an opioid antagonist that is used to prevent the reinforcing effects of alcohol and opioids. It has the advantages of not being addictive and not reacting aversively with alcohol (Leavitt, 2002; National Institute on Alcohol Abuse and Alcoholism, 2008). The FDA initially approved oral naltrexone for treating alcohol use disorders in 1994.

In 2006, the FDA approved the injectable, extended-release formulation of naltrexone (known by its trade name, Vivitrol) for the treatment of alcohol use disorder. This formulation is more expensive than the oral form and is given once every 4 weeks rather than taken daily. Monthly intramuscular injection has a clear advantage over the daily oral formulation because it is clinically well-tolerated (occasional side effects in some patients may include pain and tenderness at the injection site) and is more effective for patients who do not adhere well to a daily oral regimen of naltrexone. Consistent bioavailability of the long-acting formulation

contributes to an improved adverse effect profile compared with its oral counterpart (Clapp, 2012; Mannelli, Peindl, Masand, & Patkar, 2007).[4]

Many literature reviews and meta-analyses of randomized controlled trials have found that the use of naltrexone for alcohol use disorders is effective at reducing the number of heavy drinking days, alcohol-related mortality, and alcohol craving (Bouza et al., 2004; Garbutt et al., 2005; Harris et al., 2015; Helstrom et al., 2016; Jonas et al., 2014; Lobmaier, Kunøe, Gossop, & Waal, 2011; Maisel et al., 2013; Pettinati et al., 2006; SAMHSA, 2009). Studies also have shown less frequent relapses. It is commonly reported that naltrexone is most effective at significantly improving drinking outcomes when the drug therapy is used in conjunction with psychosocial support. In addition, its benefits are more pronounced for patients who stopped drinking alcohol prior to entering treatment (lead-in abstinence). Genetic factors and adherence play a significant role in the effectiveness of naltrexone (Chamorro et al., 2012; Volpicelli et al., 1997).

Medications for Opioid Use Disorders

Scientific research has established that treatment of opioid addiction with medication (1) increases patient retention in treatment; (2) improves social functioning; and (3) decreases drug use, infectious disease transmission, criminal activities, and the risk of overdose and death (Connock et al., 2007; Gowing, Farrell, Bornemann, Sullivan, & Ali, 2011; Johnson et al., 2000; Kinlock et al., 2007; Schwartz et al., 2013; Soyka, Zingg, Koller, & Kuefner, 2008; Thomas et al., 2014; Woody et al., 2015; Zaric, Brandeau, & Barnett, 2000).

Medications currently approved for the management of opioid use disorders include buprenorphine (available as Probuphine® [extended-release subdermal {implant}]), Sublocade® [extended-release injectable], and in a sublingual formulation); buprenorphine-naloxone (sublingual) (also available as Bunavail® [buccal], Suboxone® [sublingual], or Zubsolv® [sublingual]); methadone (generally dispensed orally for MAT) (also available as Dolophine®) oral naltrexone; and extended-release injectable naltrexone (only available as Vivitrol) (Table 2). Generic versions of buprenorphine and buprenorphine-naloxone were made available in 2009 and 2013, respectively. Extended-release injectable naltrexone and the extended-release subdermal and injectable forms of buprenorphine are the only medications for the treatment of opioid use disorders that are not available in at least one generic form. Each of these medications is discussed briefly below.

[4] More information about extended-release injectable naltrexone is available on the FDA drug label (https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&ApplNo=021897).

Table 2. Medications Used to Treat Opioid Use Disorders

Medication	Year of First FDA Approval[a]	Mechanism of Action	Is a Generic Version Available?
Buprenorphine (sublingual)	2002	Partial-opioid agonist—attaches to opioid receptors but produces only a limited opioid-like effect while competitively inhibiting other opioids from attaching to and fully activating the receptor. These properties allow it to relieve withdrawal and reduce cravings while blocking other opioids.	Yes
Buprenorphine (subdermal/implant) (Probuphine)	2016	Partial-opioid agonist—attaches to opioid receptors but produces only a limited opioid-like effect while competitively inhibiting other opioids from attaching to and fully activating the receptor. These properties allow it to relieve withdrawal and reduce cravings while blocking other opioids for up to 6 months.	No
Buprenorphine (extended-release injectable) (Sublocade)	2017	Partial-opioid agonist—attaches to opioid receptors but produces only a limited opioid-like effect while competitively inhibiting other opioids from attaching to and fully activating the receptor. These properties allow it to relieve withdrawal and reduce cravings while blocking other opioids for up to a month.	No
Buprenorphine/ naloxone (oral, Bunavail [buccal], Suboxone [sublingual], Zubsolv [sublingual])	2002	Opioid antagonist (naloxone) added to buprenorphine to deter misuse by injection. If buprenorphine/naloxone is injected, the user can experience acute withdrawal.	Yes
Methadone (oral) (Dolophine)	1947	Full-opioid agonist—attaches to opioid receptors and produces a full range of opioid effects. Full agonists differ from partial agonists in that, the higher the dose, the greater the effect they produce. Methadone is extremely long acting. When taken daily at an effective dose, it relieves withdrawal and reduces cravings. It also saturates the available opioid receptors and inhibits the effects of other opioids that may be ingested.	Yes
Naltrexone (oral)	1984 (for opioid use disorders)	Opioid antagonist— attaches to opioid receptors but produces no opioid-like effect and prevents opioids acting at the receptor.	Yes
Naltrexone (extended-release injectable) (Vivitrol)	2010	Opioid antagonist— attaches to opioid receptors but produces no opioid-like effect and prevents opioids acting at the receptor for up to a month.	No

Abbreviation: FDA, Food and Drug Administration.

[a] For more information on FDA approval of drugs, see U.S. Food & Drug Administration. Drugs@FDA: FDA Approved Drug Products. Retrieved from http://www.accessdata.fda.gov/scripts/cder/daf/

Buprenorphine, buprenorphine extended-release, and buprenorphine-naloxone. Buprenorphine[5] is a partial opioid agonist. Buprenorphine alone, when administered sublingually, is indicated for the induction phase of opioid use disorder treatment (National Library of Medicine, 2017) or for maintenance therapy during pregnancy (SAMHSA, 2016a). A recently approved implantable form of buprenorphine (Probuphine) is available for maintenance pharmacotherapy for opioid use disorder for patients who have been stabilized at a low or moderate dose (FDA, 2016a).[6] An extended-release injectable formulation (Sublocade) is available for treatment of moderate to severe opioid use disorder in patients who have initiated treatment with a transmucosal buprenorphine-containing product, and who have been on a stable dose for at least 7 days (FDA, 2017e).[7]

Buprenorphine combined with naloxone[8] can be used for withdrawal and induction as well as for the maintenance phase of treatment. FDA approved the oral generic form in 2013 (Formulary Watch, 2013), but the medication also is marketed under the brand names of Bunavail (buccal), Suboxone (sublingual), and Zubsolv (sublingual). Naloxone is an opioid antagonist widely used as the antidote to opioid poisoning. It is combined with buprenorphine to reduce the risk of buprenorphine being misused by injection. Naloxone is addressed in greater detail separately regarding its use in managing opioid overdose.

Several comprehensive reviews have concluded that there is a high level of evidence from many randomized clinical trials indicating that buprenorphine is a safe and effective treatment for opioid use disorders (Amass et al, 2012; Mattick, Breen, Kimber, & Davoli, 2014; Thomas et al., 2014). The American Society of Addiction Medicine (ASAM) *National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use* (ASAM, 2015) provides concrete guidance on the use of buprenorphine for induction and maintenance as well as for use with special populations such as pregnant women.

Two recent studies provide information on the potential effects of insurer dose limits for buprenorphine-naloxone use. The first study investigated the effect of dose limits paired with prior authorization within the Massachusetts Medicaid program, in which the requirements for prior authorization increased in frequency as dose limits increased (Clark et al., 2014). The

[5] More information about buprenorphine is available on the FDA drug label (https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&ApplNo=078633).

[6] More information about implantable buprenorphine is available on the FDA drug label (https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/204442s006lbl.pdf).

[7] More information about extended-release injectable buprenorphine is available on the FDA drug label (https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/209819s001lbl.pdf).

[8] More information about buprenorphine-naloxone is available on the FDA drug label (https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&ApplNo=091149).

results showed that the change effectively reduced the number of enrollees receiving high doses but did not affect total health care cost for those patients. There was, however, a short-term increase in relapses among individuals who were switched to lower doses, suggesting that the change was initially difficult for certain patients. The second study conducted elsewhere found that those with higher buprenorphine-naloxone doses had fewer aberrant drug tests and greater retention in treatment than those required by a payer to reduce their dosage to 16 mg/day or lower (Accurso & Rastegar, 2016).

Methadone. Maintenance treatment with methadone[9] has been used for many decades in the United States. Pharmacologically, methadone is a full-opioid agonist in that it attaches to opioid receptors and produces a full range of opioid effects, with greater effects at higher doses. Methadone is extremely long acting (24–30 hours). When taken daily at an effective dose, it relieves withdrawal and reduces cravings. It also saturates the available opioid receptors and inhibits the effects of other opioids that may be ingested. Because the medication is taken orally and has a slow and very long period of metabolism, it does not generate the extreme euphoria of short-acting, injectable opioids (e.g., heroin or many pharmaceutical opioids) in properly prescribed doses (Rettig & Yarmolinsky, 1995). Because methadone is an opioid and produces opioid effects, however, its use for treatment is sometimes controversial.

A high level of evidence from multiple randomized controlled trials over the past 4 decades supports methadone maintenance treatment (MMT) as an effective method to reduce craving, use of opioids, and mortality. Additionally, MMT usually improves health and social functioning (Faggiano, Vigna-Taglianti, Versino, & Lemma, 2003; Fullerton et al., 2014; Mattick, Breen, Kimber, & Davoli, 2014; SAMHSA, 2012; Sordo et al., 2017; Soyka et al., 2008).

Naltrexone (oral and injectable). The FDA first approved naltrexone in 1984 as an oral agent for treating opioid use disorders. Naltrexone is a long-acting opioid antagonist that works by tightly binding to opioid receptors for 24–30

Diversion Potential of Buprenorphine

Policymakers have expressed concern about the potential for abuse of buprenorphine. In making decisions about coverage, it is important to weigh the potential harm from diversion against the consequences of limiting access to effective treatment. Poison control centers and emergency departments have reported that, among adults, fewer emergency visits related to buprenorphine reflect life-threatening situations and result in hospital admission than visits related to the use of heroin, methadone, or oxycodone (Bronstein et al., 2009). Buprenorphine-naloxone also has been reformulated to an individually packaged sublingual film version in efforts to reduce its potential for diversion as well as its accidental use by children (Clark & Baxter, 2013).

[9] More information about methadone is available on the FDA drug label (https://www.accessdata.fda.gov/drugsatfda_docs/label/2008/017116s021lbl.pdf).

hours (oral) or up to 30 days (extended-release injection). This makes the opioid receptors unavailable for activation should the individual subsequently take any opioid. Studies have found that naltrexone[10] can be effective at decreasing relapse to illicit opioid use (SAMHSA, 2012); however, this result is dependent on adherence to treatment, which often is low for oral naltrexone (Johansson, Berglund, & Lindgren, 2006; Swift, Oslin, Alexander, & Forman, 2011) because those being treated must be abstinent to use the medication (O'Connor & Fiellin, 2000).

In 2010, FDA approved the extended-release injectable formulation of naltrexone[11] (Vivitrol) for treating opioid use disorders. Studies have found that it produces significantly better retention in treatment and lower rates of opioid relapse (Brooks et al., 2010; Lee et al., 2016) as well as significantly lower opioid-related mortality compared with no treatment (Harris et al., 2015). However, to prevent severe iatrogenic opioid withdrawal, patients must abstain from opioids for a minimum of 7 days before beginning the naltrexone treatment; thus, it is effective when used following medical detoxification from opioids or after a period of abstinence such as during incarceration. Some literature suggests that counseling or other supports may be beneficial to encourage continuation in treatment among some individuals receiving extended-release injectable naltrexone (Brooks et al., 2010). Barriers to the use of extended-release injectable naltrexone may include complexity of ordering and using the medication, cost, health plan reimbursement policies, and lack of knowledge about the drug (Alanis-Hirsch et al., 2016). Recent studies have shown that, although extended-release injectable naltrexone is effective for preventing relapse to opioid use, its use is not as widespread compared with other pharmacotherapies, in part because of cost and its more limited inclusion in payer formularies (Lee, Kresina, Campopiano, Lubran, & Clark, 2015).

A recent randomized, multistate controlled clinical trial with criminal justice offenders demonstrated effective results using extended-release injectable naltrexone to prevent opioid relapse, with the use of this drug resulting in a longer median time to relapse compared with usual treatment (Lee et al., 2016; NYU Langone Medical Center, 2016). It is important to provide viable assistance to this population, which has a high potential for relapse, high risk of mortality from drug overdose, and risk of repeated interactions with the criminal justice system. These patients also are less likely to have access to other medications such as buprenorphine or methadone, so extended-release injectable naltrexone may be the most effective treatment for them.

Medications for Opioid Overdose

Naloxone. Naloxone is a short-acting opioid antagonist that has been demonstrated to be safe and effective at reversing opioid-induced respiratory depression from opioid overdose (FDA,

[10] More information about oral naltrexone is available on the FDA drug label (https://www.accessdata.fda.gov/drugsatfda_docs/label/2013/018932s017lbl.pdf).

[11] More information about extended-release injectable naltrexone is available on the FDA drug label (https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=BasicSearch.process).

2015; Hawk, Vaca, & D'Onofrio, 2015; van Dorp, Yassen, & Dahan, 2007). Naloxone currently requires a prescription but has no abuse potential; it is not a controlled substance.

Over the past 40 years, naloxone has been used with good outcomes in the emergency department and in hospital settings for opioid overdose reversal; it has an excellent safety profile, and reported side effects have been rare (Burris, Norland, & Edlin, 2001; Davis, Ruiz, Glynn, Picariello, & Walley, 2014). It initially was administered intravenously and later became available intramuscularly (Evzio®). In 2015, the FDA approved the marketing of intranasally administered naloxone (Narcan®). Increasingly, naloxone is being administered by nonprofessionals in its intramuscular and intranasal forms (FDA, 2015), allowing administration outside the hospital and emergency department by bystanders and professional first responders (Mueller, Walley, Calcaterra, Glanz, & Binswanger, 2015; Wickramatilake et al., 2017). The reader is referred to the SAMHSA *Opioid Overdose Prevention Toolkit* for more information about naloxone (SAMHSA, 2016b).

Cost Offset and Cost Effectiveness of Medications for Alcohol and Opioid Use Disorders

State Medicaid programs also examine the cost offset and cost-effectiveness of medications used for alcohol and opioid use disorders to determine whether to reimburse for them and whether to place them on a PDL. In doing so, states will take account of the high costs associated with alcohol and opioid misuse and use disorders.

> ***Cost offset*** is defined as the economic savings from an intervention after accounting for the economic costs of that intervention.
>
> ***Cost-effectiveness*** is defined as the comparison between the relative costs and outcomes of an intervention that is typically quantified in an individual's quality-adjusted life years.

Alcohol Use Disorder Costs

In 2010, excessive drinking costs the United States were estimated at almost $250 billion annually (Sacks, Gonzales, Bouchery, Tomedi, & Brewer, 2010). Studies of the comparative effectiveness of different treatments for alcohol use disorders have found greater savings from use of MAT than from use of psychosocial treatment alone. The following are findings from studies examining alcohol treatment, which relied on retrospective claims data and did not distinguish those who received MAT alone from those who received it in conjunction with counseling:

- Total health care costs were 30 percent less for those who received MAT than for those who did not (Baser, Chalk, Fiellin, & Gastfriend, 2011). This study compared costs for those who received MAT with those who received only psychosocial therapy. Health care costs were 34 percent greater for those receiving acamprosate than for those receiving disulfiram, oral naltrexone, or extended-release injectable naltrexone.

- Individuals treated with MAT compared with those who did not receive MAT incurred less expense related to alcoholism-related inpatient hospitalizations and detoxification, with extended-release injectable naltrexone reducing those costs the most (Mark, Montejano, Kranzler, Chalk, & Gastfriend, 2010).
- Use of extended-release injectable naltrexone resulted in the largest reduction in nonpharmacy health care spending, compared with disulfiram, oral naltrexone, acamprosate, or psychosocial therapy only (Bryson, McConnell, Korthuis, & McCarty, 2011).
- Treatment with implanted naltrexone was associated with reduced health care events and reduced costs of hospital admission and emergency department visits in patients treated for alcohol use disorders in the first 6 months following treatment compared with those who did not receive implanted naltrexone (Kelty et al., 2014).
- A meta-analysis of studies indicated that health care utilization and costs were generally equivalent to or lower for patients receiving extended-release injectable naltrexone relative to patients receiving other alcohol use disorder agents (Hartung et al., 2014).

Opioid Use Disorder Costs

The economic consequences of opioid use disorders also are substantial. Annual health care expenditures for individuals with an opioid use disorder are estimated to be almost nine times higher than annual expenditures for those without such a disorder (White et al., 2005). The total economic burden associated with fatal overdose, misuse, and use disorder attributable to prescription opioid misuse in 2013 was estimated to be $78.5 billion, of which $28.9 billion was associated with increased health care and SUD treatment costs and one-quarter was associated with public sector health care, treatment, and criminal justice costs (Florence, Zhou, Luo, & Xu, 2016). A recent analysis in Australia also revealed substantial crime-related costs in that country associated with heroin disorders (Dunlop et al., 2017).

As discussed below, cost-effectiveness and comparative effectiveness studies regarding opioid treatment found greater savings from use of MAT than from use of psychosocial treatment alone. Most of these studies, however, do not address whether those in the groups receiving MAT also received counseling, although a study of the cost-effectiveness of adherence to buprenorphine treatment did consider, among other things, the impact on outpatient treatment costs. These studies relied primarily on claims data and one used predictive modeling but excluded the cost of counseling. These studies are summarized below:

- The odds and costs of hospitalizations, emergency department visits, and detoxification admissions were greatest for those without treatment, followed by those treated without medication, followed by those treated with buprenorphine, and finally followed by those treated with methadone. In contrast, annual cost per patient was lower for those taking buprenorphine than for those taking methadone largely because of longer hospitalizations for those receiving methadone (Clark, Samnaliev, Baxter, & Leung, 2011).

- Patients who did not receive pharmacotherapy had higher costs for detoxification, rehabilitation, and both opioid-related and non-opioid-related hospitalizations. Among those treated with medication, the highest drug costs were for extended-release injectable naltrexone, whereas the highest overall costs were for methadone, apparently because of a far higher number of non-opioid-related hospitalizations (Baser et al., 2011).
- A meta-analysis of opioid dependent extended-release injectable naltrexone patients found they had lower inpatient substance abuse-related utilization than patients treated with other agents and lower total cost than patients treated with methadone (Hartung et al., 2014).
- A study of the cost-effectiveness of buprenorphine, which compared individuals who were treatment adherent with those who were not, found that, although use of buprenorphine resulted in increased pharmacy costs ($6,156 vs. $3,581), other costs—including outpatient ($9,288 vs. $14,570), inpatient ($10,982 vs. $26,470), emergency department ($1,891 vs. $4,439), and total health care costs ($28,458 vs. $49,051)—were less (Tkacz, Volpicelli, Un, & Ruetsch, 2014).
- A study that modeled the incremental cost-effectiveness of extended-release injectable naltrexone, methadone, and buprenorphine for adult males with opioid dependence from the perspective of state addiction treatment payers found that the expected per patient cost of a 24-week treatment period was $1,390.98 for methadone, $1,837.40 for buprenorphine, and $4,287.73 for extended-release injectable naltrexone (Jackson, Mandell, Johnson, Chatterjee, & Vanness, 2015).

Controlled Substance Schedules

Substances deemed to be "controlled" under the Controlled Substances Act are divided into five schedules. Substances are placed in their respective schedule on the basis of whether they have a currently accepted medical use in the United States, their relative abuse potential, and their likelihood of causing dependence when abused. Controlled substances are overseen by the Drug Enforcement Administration (DEA). Drugs are scheduled by DEA in coordination with the FDA.

Schedule I substances have no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse.

Schedule II substances, which include methadone and most opioid pain relievers, have high potential for abuse and may lead to severe psychological or physical dependence.

Schedule III substances, which include buprenorphine, have less abuse potential than those in Schedules I or II. Abuse may lead to moderate or low physical dependence or high psychological dependence.

Schedule IV substances have lower abuse potential relative to those listed in Schedule III.

Schedule V substances have low abuse potential relative to those listed in Schedule IV, and they have preparations containing limited quantities of certain narcotics.

State and Federal Regulations and Policies Affecting the Prescription and Dispensing of Medications for Alcohol and Opioid Use Disorders

In addition to considerations related to efficacy and cost-effectiveness, federal and state laws and other policies may affect the prescribing and dispensing of medications for alcohol and opioid use disorders. In this section, we address some of the most important statutes, regulations, and other policies.

Federal Laws Governing Methadone and Buprenorphine

Medications for treatment of alcohol and opioid use disorders must be prescribed or dispensed by individuals who are licensed to perform these activities in their respective states; however, additional rules and regulations apply to methadone and buprenorphine because of their status as controlled substances under the Comprehensive Drug Abuse Prevention and Control Act (Controlled Substances Act, 1970). The rules and regulations affect access to these medications regardless of insurance coverage.

Methadone is a Schedule II drug that is used for the treatment of both pain and opioid addiction (U.S. Department of Justice, n.d.). When prescribed for pain, it may be dispensed by a pharmacy. For treating opioid addiction, however, methadone may be dispensed only through an opioid treatment program (OTP) that has been certified by SAMHSA and registered as a narcotic treatment program by the U.S. Drug Enforcement Agency (DEA) (SAMHSA, 2015).

Buprenorphine is a Schedule III drug (U.S. Department of Justice, n.d.), indicating its lower potential for abuse or misuse than Schedule II substances. Pursuant to the Drug Addiction Treatment Act of 2000 (DATA 2000), qualified physicians can prescribe buprenorphine to patients for the treatment of opioid use disorder after completing a required training and submitting to SAMHSA a notification of intent to prescribe. This permitted the physician to treat up to 30 patients at a time in the first year and, if requested, 100 patients at a time after that (SAMHSA, 2016c). In July 2016, a regulation was finalized that created the possibility for some physicians with added qualification or in specific practice settings to treat up to 275 patients at a time. Later in 2016, the Comprehensive Addiction and Recovery Act of 2016 (CARA) amended the Controlled Substances Act to allow qualifying nurse practitioners and physician assistants to receive a DATA 2000 waiver and prescribe buprenorphine at the original 30 and 100 patient limits. As discussed in the section on state laws and policies, several states have scope of practice laws that limit the effect of this federal law. In October 2018, President Trump signed into law the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act. This law contains provisions intended to increase access to and use of MAT.

Table 3 summarizes federal prescribing restrictions that apply to alcohol and opioid use disorder treatment. Relevant state laws or regulations are discussed in the section on state laws and policies.

Table 3. Federal Prescribing Regulations for Medications Used to Treat Alcohol and Opioid Use Disorders or to Reverse Opioid Overdose

Medication	Federal Restrictions
Acamprosate	Can be prescribed by a licensed health care professional or practitioner
Disulfiram	Can be prescribed by a licensed health care professional or practitioner
Buprenorphine/ buprenorphine-naloxone	Can be prescribed by a physician, nurse practitioner, or physician assistant to up to 30 or 100 patients at a time after completing required training. Some physicians with added qualification or in specific practices may treat up to 275 patients at a time.
Methadone	Can be administered only by a SAMHSA-certified opioid treatment program that has been registered with DEA as a narcotic treatment program
Naloxone	Can be prescribed by a licensed health care professional or practitioner
Naltrexone (oral and injectable)	Can be prescribed by a licensed health care professional or practitioner

Abbreviations: DEA, Drug Enforcement Administration; SAMHSA, Substance Abuse and Mental Health Services Administration.

Requirements of Parity

Additional laws and policies affect access to medications for alcohol and opioid use disorders. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires that the cost sharing and treatment limitations for medications used to treat SUDs, if covered by a health plan, must be comparable to and no more restrictive than medications for other medical or surgical needs (Center for Consumer Information and Insurance Oversight, 2013). These requirements apply to both quantitative and nonquantitative treatment limits (NQTLs), which include some of the utilization management techniques commonly applied to MAT medications (e.g., prior authorization and step therapy). Federal parity law prohibits the use of any NQTLs for mental health or SUD benefits unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTLs to the behavioral health benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTLs to medical benefits in the same benefit classification (e.g., the prescription drug benefit classification). Thus, for example, this MHPAEA requirement is satisfied if health plans use a tiered formulary, in which different financial requirements and treatment limits are imposed uniformly for different tiers of drugs on the basis of factors unrelated to diagnosis, such as the cost and efficacy of the drug (Department of the Treasury, 2013). In March 2016, the Centers for Medicare & Medicaid Services (CMS) released a Final Rule implementing the MHPAEA requirements for the Children's Health Insurance Program, the Medicaid benchmark benefit plans, and Medicaid managed care plans (Department of Health and Human Services, 2016). Separate but parallel regulations implement MHPAEA for nonfederal government plans with more than 100 employees and group health plans of private employers with more than 50 employees (Center for Consumer Information and Insurance Oversight, 2013).

States also have implemented parity laws that vary greatly regarding required coverage. As movement occurs toward enforcement of the federal parity laws, states also are enacting statutes and promulgating regulations designed to meet the federal requirements (National Conference of State Legislatures, 2015; ParityTrack, n.d.).

State Laws and Policies

In addition to the state parity laws, state laws and policies may affect access to or reimbursement of high-quality MAT in other ways. State laws fall into several categories. In a recent report on the integration of physical and behavioral health services, with particular focus on Medicaid, Bachrach and colleagues (2014) identified four types of statutes or regulations that may impede the provision of integrated care, including behavioral health. These requirements included ones related to (1) professional licensure and certification, (2) facility licensing and certification, (3) billing requirements, and (4) data exchange (Bachrach, Anthony, & Detty, 2014). Each of these categories of regulation may affect the provision of integrated care that includes MAT, and some may influence the ability to provide MAT per se. Each of these requirements as well as other state policies that may affect the provision of MAT or naloxone are addressed briefly below.

Professional Licensure and Certification

Given the shortage of physicians and, particularly, physicians approved to prescribe buprenorphine in some areas, it is expected that treatment facilities will take advantage of the 2016 statutory and regulatory changes and turn to physician assistants or nurse practitioners to fill the void. Individual state laws, however, may restrict whether and when a physician assistant or nurse practitioner may prescribe medication within the scope of his or her license and the level and type of nursing license required. State regulations may limit further whether a nurse practitioner may prescribe controlled substances and may limit such drugs to certain schedules, may limit the age of patients for which prescribing is allowed, may place time limits on the prescription (e.g., 7 days), may limit prescribing setting (e.g., only inpatient), or may impose other prescribing restrictions specifically applicable to nonphysician prescribers (American Association of Nurse Practitioners, 2017; Stowkowski, 2016). Such limits have particularly profound effects on the prescribing of buprenorphine, which has strict federal prescribing restrictions that limit the availability of approved prescribers.

As discussed above, in its July 8, 2016, rulemaking, SAMHSA expanded the number of patients to whom a waivered provider may prescribe buprenorphine (Medication Assisted Treatment for Opioid Use Disorders, 2016). Subsequently, Congress amended the enabling statute to permit both physician assistants and nurse practitioners to become waivered to prescribe buprenorphine upon completion of additional instruction as part of certification (Comprehensive Addiction and Recovery Act of 2016, 2016). As of April 2017, however, 28 states had scope of practice laws that prohibit nurse practitioners from prescribing buprenorphine without a waivered physician's supervision. These restrictions may preclude certain states from taking full advantage of the 2016 changes to the federal laws governing buprenorphine prescribing by nonphysicians.

Additionally, as of April 2017, three states explicitly prohibited nurse practitioners from prescribing buprenorphine, even when working with a waivered physician, and an additional state prohibited physician assistants from prescribing buprenorphine (Vestal, 2017). These state requirements mean that the extent of nonphysician prescribing of buprenorphine will vary by state.

Facility Licensing and Certification

Facility licensing or certification regulations in some states historically have required facilities providing SUD treatment and any other physical or mental health treatment to be separate—for example, requiring separate entrances, waiting rooms, or bathrooms. In addition, county or municipal laws may restrict siting of opioid treatment facilities. Some states recently have taken steps to eliminate some of these requirements (e.g., Arizona [Bachrach et al., 2014]), to clarify that such requirements do not apply (e.g., Texas [Texas Health and Human Services, 2016]), or to allow for waivers of such requirements (e.g., Massachusetts [Bachrach et al., 2014; Behavioral Health Integration Task Force, 2013]). To the extent that such requirements exist, however, they may impede comprehensive care, care coordination, warm hand-offs, and other aspects of integration that can be integral to the provision of SUD treatment, including the provision of MAT in conjunction with other services addressing physical or mental health. Such restrictions also may reinforce discrimination in that they separate SUD treatment, identifying both the disorder and its treatment as distinct from other conditions, including other chronic illnesses.

Billing Requirements

Billing procedures and requirements can affect access to MAT. For example, in the context of integrated care, some states restrict whether a provider may bill for both a physical and a behavioral health visit in 1 day, limiting the ability to provide convenient integrated care for those with comorbid conditions (Bachrach et al., 2014; Brolin et al., 2012). Such billing restrictions also may affect the provision of MAT integrated with other services. For example, a primary care physician providing buprenorphine for an opioid use disorder diagnosis may be prohibited from providing accompanying physical health care, requiring separate appointments on separate days. Requiring separate appointments may discourage the patient from obtaining complete care and may increase the cost of care to both the patient and the Medicaid program.

Some states also limit the types of providers who may bill for behavioral health services or the types of procedures for which they may bill. They also may limit diagnosis codes for which primary care providers may receive reimbursement under Medicaid (Bachrach et al., 2014; Mauch, Kautz, & Smith, 2008). This may lead providers to record a physical health diagnosis rather than a nonreimbursable behavioral health diagnosis, resulting in inaccurate records and confusion for providers seeking to provide coordinated care (Bachrach et al., 2014). Partial information in patient records may substantially impede coordination of care with other providers and may produce questionable data for quality improvement, performance measurement, and research.

Data Exchange

Bachrach et al. (2014) identified a regulatory impediment to data exchange that may adversely affect integrated care, potentially including the provision of MAT. This impediment involves requirements for privacy and confidentiality regarding SUDs, particularly as exemplified by federal regulations at 42 CFR Part 2 (Bachrach et al., 2014). Although 42 CFR Part 2 was amended in 2016 to relax somewhat the prior restrictions, it is too early to determine what practical effect this amendment will have. Under the earlier version of the regulation, however, states interpreted the restrictions differently, with greater and lesser degrees of caution; some states also have separate privacy restrictions that may differ from and be stricter than the federal regulation. It remains to be seen how state laws and varied state interpretations of the amended federal regulation will affect data exchange and related care integration and coordination, including those involving MAT.

Other Policies That May Affect Delivery of MAT

Adequacy and timeliness of provider reimbursement. Adequacy and timeliness of provider reimbursement are factors that affect whether providers accept Medicaid patients (Cunningham & Malley, 2009). State Medicaid reimbursement rates for MAT vary greatly, and although many states are working to increase delivery of MAT, others have cut reimbursement rates, which some believe has made access more difficult (Terkel & Cherkis, 2015). Anecdotal evidence suggests that Medicaid reimbursement for some MAT medications is below cost in certain states, which may discourage the provision of services to Medicaid beneficiaries, undermining access to MAT and other treatment.

Laws and policies affecting naloxone availability. Of the medications discussed in this report, naloxone is unique. It is not MAT per se but is used to reverse opioid overdoses. The branded versions of naloxone can be expensive, and price increases have made access difficult (Gupta, Shaw, & Ross, 2016), including for agencies that must plan, budget, and pay for supplies of the medication. States are implementing creative approaches both to make naloxone readily available to those who need it and to provide ways to pay for it. The following are some approaches that states and municipalities around the country are taking to disseminate naloxone as broadly as possible:

- Making naloxone or a naloxone prescription available in OTPs for individuals receiving methadone or buprenorphine from the OTP. States also are increasingly reaching out at other locations where those at risk of overdose are likely to be found, such as needle exchange programs (Addiction Treatment Forum, 2014; Drug Policy Alignment, n.d.; Oregon Health and Science University, 2015).
- Distributing naloxone through Opioid Overdose Prevention Programs, emergency responders, SUD treatment providers, community pharmacists, local health department offices, recovery homes, sober houses, assertive community treatment teams, mobile crisis teams, case managers, recovery support specialists, school personnel, and staff

within the criminal justice system (e.g., Drug Policy Alignment, n.d.; New York State Department of Health, n.d.; U.S. News and World Report, 2016).

Federal agencies also have taken steps to facilitate naloxone access. Two examples include the SAMHSA Opioid Overdose Prevention Toolkit and the FDA Naloxone App Competition (FDA, 2016b; SAMHSA, 2016b). The SAMHSA Opioid Overdose Prevention Toolkit provides valuable information on some of the key approaches being undertaken to date, including coprescribing naloxone to people who receive opioids for pain or opioid use disorder treatment, dispensing naloxone to persons completing detox and rehab or being released from jail, furnishing professional first responders such as law enforcement officers and emergency medical technicians with naloxone, and implementing standing orders for pharmacies to dispense naloxone to people at risk of an overdose (SAMHSA, 2016b). The FDA Naloxone App Competition was created to promote creative technological approaches to making naloxone accessible, with a prize awarded to the team designing the selected app (FDA, 2016b).

States also have passed laws, promulgated regulations, and taken other administrative or executive actions allowing or encouraging necessary naloxone use, such as by (1) enacting legislation establishing statewide "standing orders" for naloxone dispensing or providing authority for more limited standing orders (e.g., California Legislative Information, n.d.; Justia, n.d.); (2) taking executive action to issue statewide standing orders (e.g., Commonwealth of Pennsylvania, 2015); (3) granting prescribing privileges to pharmacists (e.g., North Dakota Department of Human Services, 2016; Oregon State Legislature, 2016); (4) depending on the state, allowing different categories of professionals to administer naloxone pursuant to a standing order (e.g., law enforcement personnel, fire department personnel, and emergency medical personnel [State of Delaware, 2014; State of South Dakota, 2015]); and (5) allowing third parties such as families or caregivers to be dispensed naloxone and granting "Good Samaritan" status to those who administer it in the event of an overdose (e.g., CMS, 2017a; Harm Reduction Coalition, n.d.; Legal Systems, LLC, 2016; Muller, 2016; National Conference of State Legislatures, 2017; Policy Surveillance Program, 2016).

State Medicaid programs have taken steps to reimburse for naloxone, as do some but not all other payers (Appendix A, Table A-10). In addition to insurance reimbursement, states use alternate funding sources and approaches to pay for naloxone, such as the following:

- SAMHSA-funded Prescription Drug Overdose discretionary grants
- SAMHSA-funded State Targeted Response Opioid Crisis Grants
- SAMHSA-funded Substance Abuse Block Grants
- State funding of local health departments
- State mental health and SUD agency funding
- State general funds
- Funding through municipality or other community budgets
- Pharmaceutical company funding and pharmaceutical company settlement funds

- Naloxone manufacturer rebates to health departments, emergency personnel, and other entities
- The use of bulk purchases to lower cost

When Medicaid does pay for naloxone, the process typically works like any other covered medication. An enrollee is directly dispensed prescribed medication covered by the plan, or another individual picks up the medication on the enrollee's behalf, with the prescription having been filled for the enrollee and paid for by his or her Medicaid account. The promulgation of laws permitting dispensing of naloxone without a traditional prescription (under standing orders) or permitting dispensing to someone other than the end user (e.g., family or friends) introduces the question of how the naloxone is reimbursed if the traditional link between prescriber, dispenser, and end user is altered in some way. Nearly all state Medicaid programs still envision that the end user of naloxone will be the Medicaid beneficiary under whose Medicaid account payment is made. This approach, in concert with laws that facilitate the use of naloxone by Good Samaritans, may have an unintended consequence whereby Medicaid beneficiaries use the naloxone that they purchased with Medicaid benefits to revive others who may or may not be Medicaid beneficiaries.

As of October 2016, however, two state Medicaid programs appear to have modified the standard reimbursement process and were reimbursing third parties for naloxone purchases without any active involvement by the beneficiary (Smith et al., 2016). Our team identified one of these states is New York, which reimburses as part of its fee-for-service (FFS) Medicaid program. New York law defines an "opioid antagonist recipient" as "a person at risk of experiencing an opioid-related overdose, or a family member, friend or other person in a position to assist a person experiencing or at risk of experiencing an opioid-related overdose, or an organization registered as an opioid overdose prevention program pursuant to this section or a [series of school entities]" and allows the dispensing of naloxone to such persons or entities (New York State Public Health Law, Article 33 [Justia, 2016]). Pharmacists operating under a standing order may bill FFS Medicaid for that medication, if the intended user is not dually-eligible for Medicare and Medicaid and is a Medicaid fee-for-service enrollee (New York Department of Health, 2016). This suggests that any of the individuals or entities enumerated in the definition of an "opioid antagonist recipient" actually may purchase the naloxone and have it billed to Medicaid. In contrast to the approach that New York has taken as part of its FFS Medicaid program, what is more likely to happen in other states is that the opioid user who is a Medicaid beneficiary will be prescribed and dispensed the medication to take home, where it later may be administered by others if the need arises.

On January 17, 2017, CMS issued an informational bulletin that highlighted some of the options that states have for the improved use of pharmacists to expand timely access to certain drugs in the interest of public health, specifically including naloxone. These options included expanding the scope of practices and range of services that pharmacists can provide, "including dispensing drugs based on their own independently initiated prescriptions, collaborative practice agreements

(CPA) with other licensed prescribing healthcare providers like physicians, ‘standing orders’ issued by the state [health authority], or other predetermined protocols” (CMS, 2017b, p. 1).

Most states use one or more of these approaches to increase access to a variety of medications such as naloxone, nicotine replacement therapy, emergency contraception, or flu shots. The CMS bulletin discusses the value of using these approaches for time-sensitive medication dosing, such as naloxone, and encourages states to consider how they might use these methods for addressing public health emergencies (CMS, 2017b). CMS did not, however, address the issue of Medicaid coverage as it might apply to dispensing to third parties. It seems that this is to be left to each state to consider and possibly implement if it is considered useful by the state in stemming the tide of opioid overdose fatalities.

III. Medicaid Coverage of Medications for Alcohol and Opioid Use Disorders

This section summarizes state Medicaid coverage policies for medications used to treat alcohol and opioid use disorders in the 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Information is presented about whether a medication is reimbursed and whether it has an identifiable preferred status. Requirements for prior authorization, quantity limits, treatment duration limits, step therapy, and concurrent behavioral therapy also are described. Detailed results of the analyses are outlined by drug and state in Appendix A.

A. Data Sources and Methodology

Medications specifically researched include the following:

- Acamprosate
- Buprenorphine
- Buprenorphine, implantable
- Buprenorphine, extended-release injectable
- Buprenorphine/naloxone
- Disulfiram
- Methadone
- Naloxone
- Naltrexone, oral
- Naltrexone, extended-release injectable

Rules for Determining Coverage

The research team used multiple data sources to obtain information on Medicaid coverage of MAT.[12] During the second and third quarters of 2018, the most recent pharmacy and behavioral health documents were retrieved from state Medicaid agency websites. Documents were reviewed to identify information related to Medicaid pharmaceutical coverage of and benefit design for MAT, including, where available, selected Medicaid managed care plans. Internet queries sought documents providing information on formularies, PDLs, prior authorization, behavioral therapy requirements, quantity limits, and other pharmacy benefit limitations. Where ambiguity remained, online drug search tools such as Epocrates® (https://online.epocrates.com/rxmain) were accessed, which provided additional information that allowed us to pursue the subject further using other documents. Medications may be covered by state Medicaid programs without being listed on an easily accessible formulary; therefore, when there was no clear evidence of coverage in the Medicaid or other documents, a determination of

[12] Our methods for determining state coverage of methadone for SUD treatment are discussed separately below.

coverage was made by searching the 2018 Medicaid State Drug Utilization Data (CMS, n.d.). These data identify medications for alcohol and opioid use disorders that are paid by Medicaid during one quarter for each year. If the Medicaid programs paid for an alcohol or opioid use disorder medication during the reported quarter of 2018, then the state was classified as covering the drug. Puerto Rico and the U.S. Virgin Islands are not included in this dataset, so coverage for those two territories could not be verified. Additionally, for extended-release naltrexone (Vivitrol), implantable buprenorphine (Probuphine), and extended-release buprenorphine (Sublocade), which are not consumed orally, if a determination of coverage could not be made from any of the above sources, we searched state provider fee codes to determine whether the drug was available only as a medical benefit. The codes used were as follows:

- Buprenorphine, implantable: J0570
- Buprenorphine, extended-release injectable: Q9991, Q9992
- Naltrexone, extended-release injectable: J2315

In all instances, whether regarding reimbursement, preferred status, or benefit limitations, if a definitive determination of a state's coverage policy could not be made for a particular medication, the coverage was treated as unknown. The list of documents used for this review can be found in Appendix A, Table A-1. Where necessary for clarity, additional details on benefit designs within specific states are outlined in the notes to the appendix tables.

Rules for Determining Preferred Status and Benefit Limitations

Inclusion in the Medicaid State Drug Utilization Data does not necessarily indicate that the drug is covered both by a state's FFS Medicaid plan *and* by Medicaid managed care organizations (MCOs). It also does not indicate whether the drug has preferred status or is on a state's PDL. Similarly, exclusion from a PDL does not necessarily mean that the drug is not covered or even not preferred. It is important to note that not all states have a PDL. Moreover, state PDLs have different designs. For that reason, drugs were identified as having a "preferred status" rather than as being on the state's PDL. Following are the issues observed in the data regarding PDL inclusion, along with how assigning preferred status to medications was addressed:

- A PDL may list a drug and indicate that it is either preferred or nonpreferred. The requirements for nonpreferred drugs typically include prior authorization and sometimes other requirements. Even preferred drugs may have these requirements. If a drug was identified as preferred on a PDL, it was treated as preferred. If a generic version was identified as preferred and the brand version as nonpreferred, the medication was treated as preferred.
- A PDL may list only certain categories or classes of drugs. In these instances, a specific drug may be—

- In a drug category that is not included on the PDL. If so, the PDL may state that such a drug requires prior authorization, may state that a drug does not require prior authorization, or may be ambiguous. If the PDL stated that those omitted categories do not require prior authorization, the drug was treated as preferred.
- In a drug category that is included and listed within that drug category. If so, inclusion on the PDL may mean that the drug is automatically preferred, or the PDL may state that certain drugs in the included categories are preferred or not, and typically include whether prior authorization is required. If a drug was identified as preferred, it was treated as such.
- In a drug category that is included but not listed within that category. If so, the PDL may indicate that prior authorization is required, or it may be ambiguous. In that instance, the drug was treated as nonpreferred.

- There may be a separate document related to specific categories of drugs (e.g., MAT medications) indicating exactly what benefits and limitations apply. If the drug was included without limitation, it was treated as preferred.
- There may be a separate computerized "look-up" that serves as the most current formulary, or even the current PDL, and that provides information on coverage and benefit limits. If the drug was included without limitation, it was treated as preferred unless there was any indication to the contrary on a PDL.
- A state's Medicaid formulary or PDL may apply only to FFS coverage or may apply to both FFS and MCO coverage. Some MCOs may have independent formularies or PDLs with their own requirements for preferred status, prior authorization, or other benefit limitations. There may be one or many MCOs in a state, each with different requirements. If the research team could locate at least one MCO where the drug fit the criteria set out above as preferred, the drug was identified as such for that state. No attempt was made to try to identify every Medicaid MCO in a state or to locate applicable formularies or PDLs for each MCO. Rather, one or more MCOs were arbitrarily selected, and the same process applied to those MCOs as was done for any information available for FFS coverage.
- Finally, for buprenorphine-naloxone, we compared the results we obtained from our review of Medicaid documents current as of 2018 against the CMS Medicaid Drug Utilization Review State Comparison/Summary Report FFY 2017 Annual Report on Prescription Drug Fee-For-Service Programs. That report includes information on whether any formulation of buprenorphine-naloxone was treated as preferred by each state's FFS Medicaid program during the fiscal year ending September 30, 2017. This resulted in us adding one state as giving preferred status to buprenorphine-naloxone where we had been unable to determine this from review of Medicaid documents in the state. All other inconsistencies were attributable to the fact that our review of state documents was more current than the information in the DUR report and we retained our original decisions in those instances. The DUR report was also used to determine

requirements for quantity limits for buprenorphine and buprenorphine-naloxone (excluding buprenorphine implantable or long-acting injectable formulations) in instances where our review of the state Medicaid documents publicly-available in 2018 did not provide certainty about those requirements (CMS, 2018).

The differences across states and between Medicaid payers within a state make it (1) challenging to determine the meaning of inclusion on (or exclusion from) any one PDL and (2) difficult to judge with high precision whether prior authorization is required or other limits are imposed. In determining prior authorization status, if at least one Medicaid insurer required prior authorization (other than for brand in contrast to generic drugs), the drug was treated as requiring prior authorization. Similarly, if at least one Medicaid insurer required counseling, step therapy, or quantity limits, it is indicated that the limit was required, even though it may not be true of all Medicaid payers in the state and does not indicate that this is the policy of that state's Medicaid program. If the status of prior authorization was unclear because the drug was not included on a limited PDL, the prior authorization status was treated as unknown. To make the decisions as clear as possible, notes were placed at the end of each appendix table where further clarification was needed. The status of benefits and limitations was delineated as clearly and accurately as possible, although there was uncertainty about the status in certain cases. Additionally, the status may change over time within a given state. **Readers are encouraged to consult recent documents applicable to the state and Medicaid payer of interest for the most current and clear statement of coverage and limitations.**

Some states limit the number of prescriptions for which a Medicaid enrollee may be reimbursed in a month. Those limits were not included as quantity limits because they apply to all medications, and they are not specific to the drugs being studied in this report. However, such limits also may affect access to MAT.

Approach to Analysis of Methadone Coverage

Because methadone for SUD treatment is not prescribed and dispensed in the same manner as all other MAT medications, it is difficult to ascertain whether it is covered by Medicaid for treatment of opioid use disorder in each state. This is further complicated by the fact that methadone also is prescribed for pain and that, when covered by a state Medicaid program, its inclusion on formulary, preferred drug, or prior authorization lists relates to its use for pain.[13] For that reason, the research team used a different approach to ascertain methadone coverage than was used for all other types of MAT. The following approach was used to determine whether the dispensing of methadone as MAT was included in a state's Medicaid reimbursement for SUD treatment and, if so, what limits might have applied.

[13] Please see discussion of results related to methadone for an explanation of the very limited circumstances in which prior authorization or quantity limits may apply to the administration of methadone as MAT.

Determination of coverage. To determine whether a state program covered methadone, the researchers followed the process listed below:

- *Step one.* First, state Medicaid documents were examined to determine whether any of the following billing codes were identified as reimbursed:
    - H0020: Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)
    - S0109: Methadone, oral, 5 mg

  If at least one of these codes was included in at least one state Medicaid FFS plan document, methadone was treated as reimbursed for SUD treatment.
- *Step two.* If not clear from step one, other state Medicaid documents were examined to determine whether methadone was reimbursed for SUD treatment. If other Medicaid documents were unambiguous about coverage, it was treated as clearly covered or not covered, depending on the document content. In some cases, the team relied on state Medicaid statutes or regulations and state Medicaid Section 1115 documents—the latter for states participating in Section 1115 demonstrations related to the provision of SUD treatment.
- *Step three.* The 2013 report sponsored by ASAM, on which researchers relied to ascertain coverage of methadone for the 2014 version of this report, also was revisited as a final check on coverage (ASAM, 2013). The 2013 ASAM report provided the results of ASAM's survey of Medicaid directors, which asked specifically about coverage of medications for opioid use disorder, including methadone. Results obtained from steps one and two above were verified against results from the ASAM report to ensure that no state Medicaid programs were incorrectly omitted that had been identified as providing coverage for methadone in 2013.
- *Step four*. The Kaiser Family Foundation (KFF) produces reports based on surveys of state Medicaid programs. We used their publicly available fiscal year (FY) 2017 survey information to verify our results on methadone. This information is summarized in their *State Health Facts* (KFF, 2018), and additional information is available in the report titled *Medicaid Moving Ahead in Uncertain Times* (KFF, 2017). If the KFF information indicated that methadone was not covered at the point of its survey but we located information to the contrary on the state program website, we included the state as covering methadone for MAT (Alabama, Indiana, and Iowa). If the KFF information indicated that methadone was covered, we counted it as covered, even if we found no evidence on the state Medicaid program website or elsewhere (Alaska, Kansas, Mississippi, Missouri, Montana, Oklahoma, and South Dakota).

Determination of preferred status and benefit limits. If it was determined that methadone was reimbursed as MAT, the process listed below was followed to ascertain applicable benefit design limits.

- *Step one.* If behavioral health or other materials clearly indicated that methadone benefit limits such as prior authorization applied to the administration of methadone for MAT, those materials were used to define status and limits.
- *Step two.* In all other instances, the status, prior authorization, quantity limits, or other benefit limits that applied to methadone were treated as *not applying* to methadone provided for MAT.
- *Step three.* The 2013 ASAM report utilized a blanket rule that prior authorization requirements do not apply to methadone. This approach was accepted unless it was very clear, pursuant to the research steps outlined above, that prior authorization was required by a state program for methadone maintenance and not for pain.[14]

In addition to any state requirements or benefit limits that precede or accompany methadone administration, providers also must comply with federal regulations that govern access to methadone. These regulations do not impose restrictions directly related to reimbursement but, instead, are designed to enhance safety and efficacy and to reduce the possibility of diversion. Although they are not reimbursement-related, the federal regulations arguably affect access to methadone as MAT in ways that are similar to some state Medicaid requirements for reimbursement of other MAT medications. One example includes a requirement that patients younger than 18 years of age have had two documented unsuccessful attempts at short-term detoxification or drug-free treatment within a 12-month period to be eligible for methadone maintenance treatment. Although it is not linked to reimbursement in any way, this universal federal requirement (42 CFR § 8.12(e)(2)) arguably has a similar effect on access, as does step therapy. Some other requirements found at 42 CFR § 8.12 (Federal Opioid Treatment Standards, 2002) include the following, which must be satisfied to allow methadone administration:

- Requirements for evaluation and assessment, including diagnostic requirements
- Additional age restrictions
- Requirements related to pregnancy
- Requirements related to number of detoxification attempts and length of dependency
- Requirements for provision of medical, counseling, vocational, educational, and other assessment and treatment services
- Requirements for drug testing
- Requirements that methadone be administered orally
- Requirements regarding take-home doses, including limitations on such dosing

[14] Please see discussion of results related to methadone for an explanation of the very limited circumstances in which prior authorization or quantity limits may apply to the administration of methadone in MAT.

These regulations are clarified further in SAMHSA's March 2015 *Federal Guidelines for Opioid Treatment Programs* (SAMHSA, 2015). Because these are not reimbursement-related, they are not included in our findings related to methadone in this report.

Moreover, although some states directly incorporate aspects of the federal regulations into their state Medicaid policies (e.g., Massachusetts regarding age [Massachusetts Department of Public Health,, 2016]) or specify that methadone treatment may occur only through a federally certified OTP (e.g., Vermont [Department of Vermont Health Access, 2017]), they also were not noted as state-specific requirements in the analysis because these state reimbursement-related restrictions do not differ from the federal treatment standards.

Methodology Limitations

Potential limitations to our approach for classifying drugs and state Medicaid benefit limitations include the following: (1) reliance on publicly accessible documents that did not include all Medicaid MCO documents, which means that there may be additional or inconsistent benefit restrictions placed by some MCOs that were not captured, and (2) the fact that some Medicaid Section 1115 waivers may limit coverage to parts of states, so certain areas may have more limited funding for some types of MAT. A further limitation of this study is that methadone is reimbursed by states in different ways depending on whether it is used for MAT or for pain, but this report only focuses on reimbursement for MAT. Methadone used as a treatment for pain is reimbursed similarly to other on-MAT pharmaceutical options. However, given that methadone is involved in one out of every three accidental overdose deaths, it has been suggested that the process for obtaining methadone to treat pain might also benefit from greater controls (Vestal, 2015). An expanded analysis of the financing policies for methadone could take into consideration the fact that adverse outcomes may be associated with its use for the treatment of pain in addition to MAT and expand the scope of the financing policies included in the analysis.

Medicaid Benefit Limits on Medications for Alcohol and Opioid Use Disorders

State Medicaid programs use various techniques in their benefit designs to try to constrain costs and encourage the proper use of medications for alcohol and opioid use disorders. In general, more management techniques were used for medications to treat opioid use disorders than those to treat alcohol use disorders. The findings for the different types of benefit limits for opioid and alcohol MAT are discussed below, as are separate findings for methadone and naloxone.[15] Detailed information regarding each drug may be found in the Appendix A tables.

[15] Our discussion here excludes the U.S. Virgin Islands because of a lack of pertinent Medicaid coverage information.

Benefit Design Elements

Common Medicaid benefit design elements and their respective definitions are listed below.

Preferred Drug List (PDL) is a list of the drugs that providers usually are permitted to prescribe without seeking prior authorization. If a drug is not included on the PDL, the provider may need to obtain approval from the state Medicaid agency before the drug can be dispensed. Not every state Medicaid agency has a PDL, and some drugs on a PDL may still require prior authorization.

Prior Authorization is a broad term that requires a prescriber to obtain permission from the pharmacy benefit plan prior to prescribing a product to a member. Without permission, the product will not be covered. Some prior authorization forms require the prescribing medical provider to have referred the patient to concurrent behavioral therapy, for the patient to have a negative urine drug screen or documented adherence to a treatment plan, or other requirements. Such requirements also may be imposed by payers through clinical edits. *Clinical (point-of-sale) edits* is a generic term for a variety of reviews that are conducted, often at the benefit plan and pharmacy levels, to help ensure the therapeutically prudent use of pharmaceutical products as well as the optimization of benefit program funds. With *drug utilization reviews*, claims processors match information on claims against a clinical database and a member's prior pharmacy history to assess clinical issues with prescriptions, duplication of therapy, and compatibility. These reviews can stop prescriptions from being filled until the prescriber corrects a discrepancy, or they will prompt a warning to the pharmacist before dispensing.

Psychosocial treatment includes counseling and other nonmedication interventions that may be required to obtain reimbursement for a medication as part of MAT.

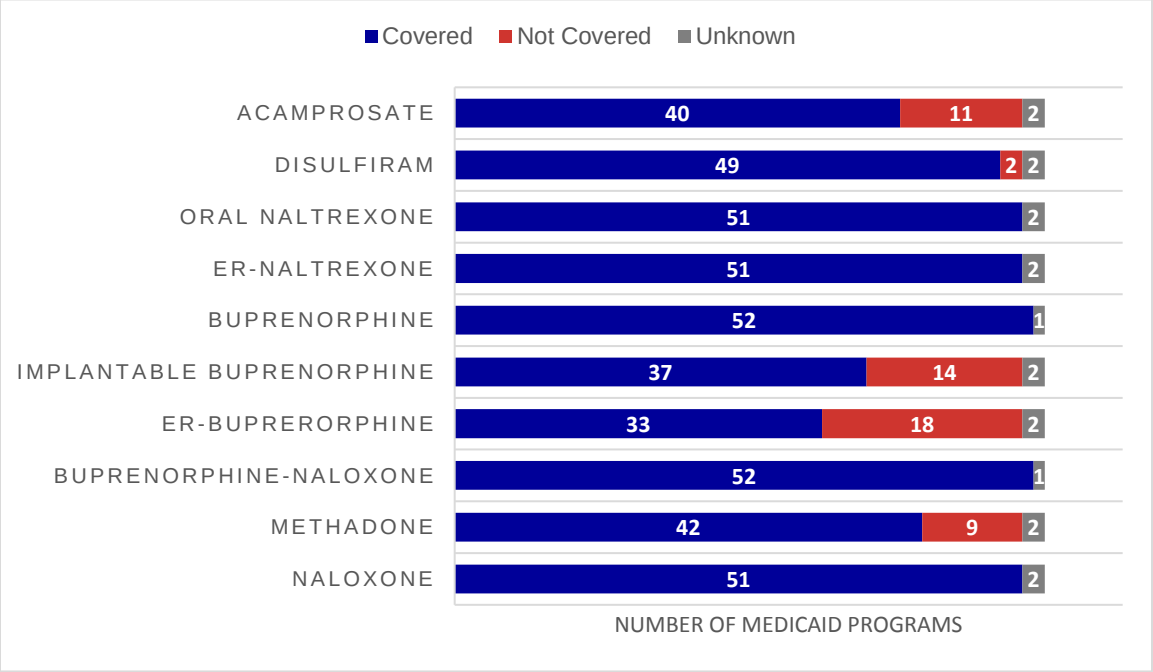
Quantity level limits define the maximum quantity of medication that is covered for one prescription or copayment. Typically, a prescription may be for only a 30-day supply or (in the case of mail-order prescription) a 90-day supply.

Step therapy occurs when a claims processor must verify that the patient first tried a more cost-effective medication before filling a more expensive alternative. If the first-line treatment was ineffective or not tolerated by the patient, the "next step up" may be authorized.

States may reimburse for medications regardless of preferred status. Examination of reimbursement showed that ***Medicaid coverage*** of alcohol and opioid use disorder medication treatments varies. As shown in Figure 1, some states show no evidence of covering disulfiram (2 states), acamprosate (11 states), implantable buprenorphine (14 states), or extended-release injectable buprenorphine (18 states). Other than these four drugs and methadone, which is not covered by Medicaid in nine states, state Medicaid plans cover all other SUD medications.[16] In every state, some form of naloxone is reimbursed—Evzio is least likely to be covered. Puerto Rico covers buprenorphine and buprenorphine-naloxone, but coverage for other alcohol or opioid treatments is uncertain.

[16] For additional information on Medicaid coverage of buprenorphine, please see the Medicaid Coverage of Effective Treatment for Opioid Use Disorder (Urban Institute, 2017).

Figure 1. Medicaid Coverage of Medications for Alcohol and Opioid Use Disorders or to Reverse Opioid Overdose, 2018[a]



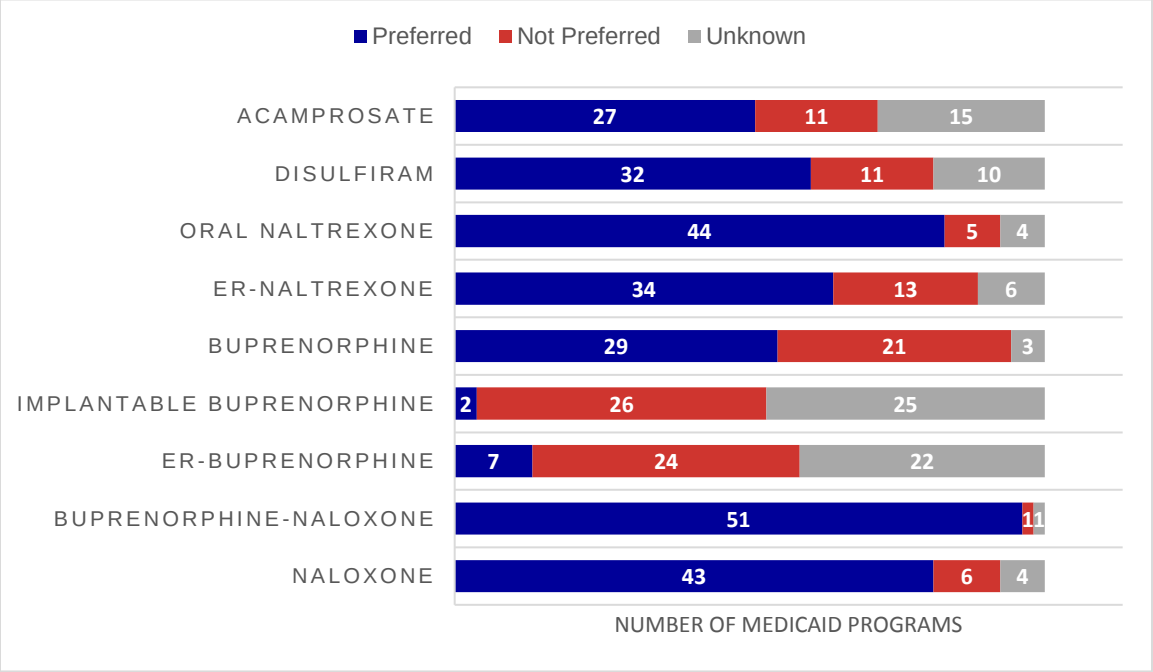
Abbreviation: ER, extended-release.

[a] Materials reviewed were those available in the second and third quarters of 2018.

Sources: State documents listed in Appendix A, Table A-1, the 2018 Medicaid State Drug Utilization data.

To ascertain ***preferred status,*** researchers assessed whether at least one version of each drug has preferred status by at least one Medicaid plan per state (Figure 2). For medications specific to alcohol use disorder treatment only, 32 states and 27 states afforded disulfiram and acamprosate preferred status, respectively. Oral naltrexone, which may be used for the treatment of either alcohol or opioid use disorder, has preferred status in 44 states, and extended-release injectable naltrexone is preferred in 34 states, perhaps indicating a decision on the basis of cost. Buprenorphine is preferred in only 29 states, and even those states typically limit its use with preferred status to pregnant women or other clinically limited situations. In contrast, buprenorphine-naloxone is preferred in 51 states. Preferred status varies considerably, however, for buprenorphine-naloxone by formulation across states, with preferred status sometimes given to the generic or to one or more of Suboxone, Suboxone film, Zubsolv, or Bunavail, depending on the state. Forty-three states treat some form of naloxone as preferred. Attributing preferred status to methadone as a form of MAT is not possible, given the different method of dispensing and strict restrictions on access governed by federal law.

Figure 2. Preferred Status of Medications for Alcohol and Opioid Use Disorders or to Reverse Opioid Overdose, 2018[a]



Abbreviation: ER, extended-release.

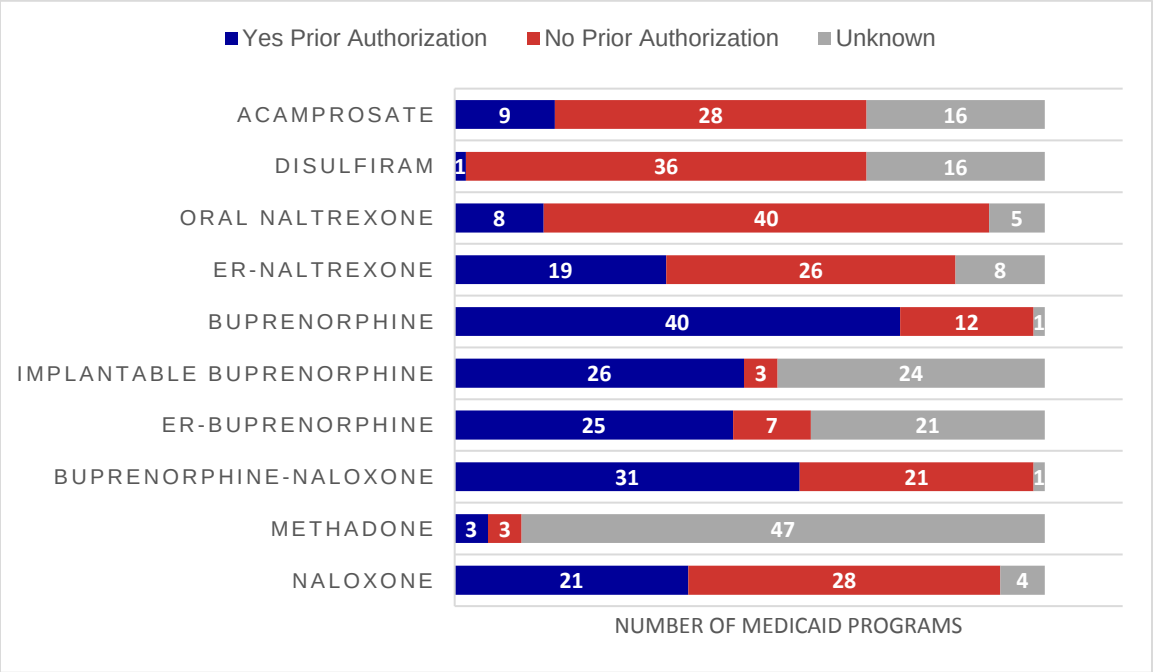
[a] Materials reviewed were those available in the second and third quarters of 2018.

Sources: State documents listed in Appendix A, Table A-1.

Prior authorization is frequently required in Medicaid programs for medications to treat opioid and alcohol use disorders, although recent policies have led to changes in this area. Examples include new Section 1115 waivers, such as in Virginia, where prior authorization for some drugs is explicitly being eliminated, and steps being taken by certain health plans to eliminate prior authorization requirements for some or all MAT. Because prior authorization requirements often are inconsistent across a state's Medicaid FFS plan and different Medicaid MCOs, in this report, a state was counted as having a prior authorization requirement for a medication if any one of the FFS or selected MCO plans required it for the generic version of the drug even though just because one plan has such a policy does not indicate that this is the policy of that state's Medicaid program. If only a brand medication is available in that state, our analysis of prior authorization only is applied to reimbursement for the brand drug. Among the Medicaid programs with available information on their pharmacy benefit management designs, prior authorization requirements for buprenorphine and buprenorphine-naloxone were most common (Figure 3), required by 40 and 31 Medicaid programs, respectively, with prior authorization requirements for buprenorphine-naloxone varying greatly by formulation across states. Authorization for use of buprenorphine is available most often for pregnant women and less so for those who are breastfeeding or who have a documented intolerance to naloxone that may interfere with use of the buprenorphine-naloxone combination. Clear prior authorization requirements for implantable buprenorphine and extended-release injectable buprenorphine were seen in 26 and 25 states, respectively, although many states do not include these medications in

their pharmacy benefits, treating them, instead, as medical benefits with different criteria. Among the naloxone formulations, Evzio is most likely to require a prior authorization.

Figure 3. Prior Authorization Requirements for Medications for Alcohol and Opioid Use Disorders or to Reverse Opioid Overdose, 2018[a]



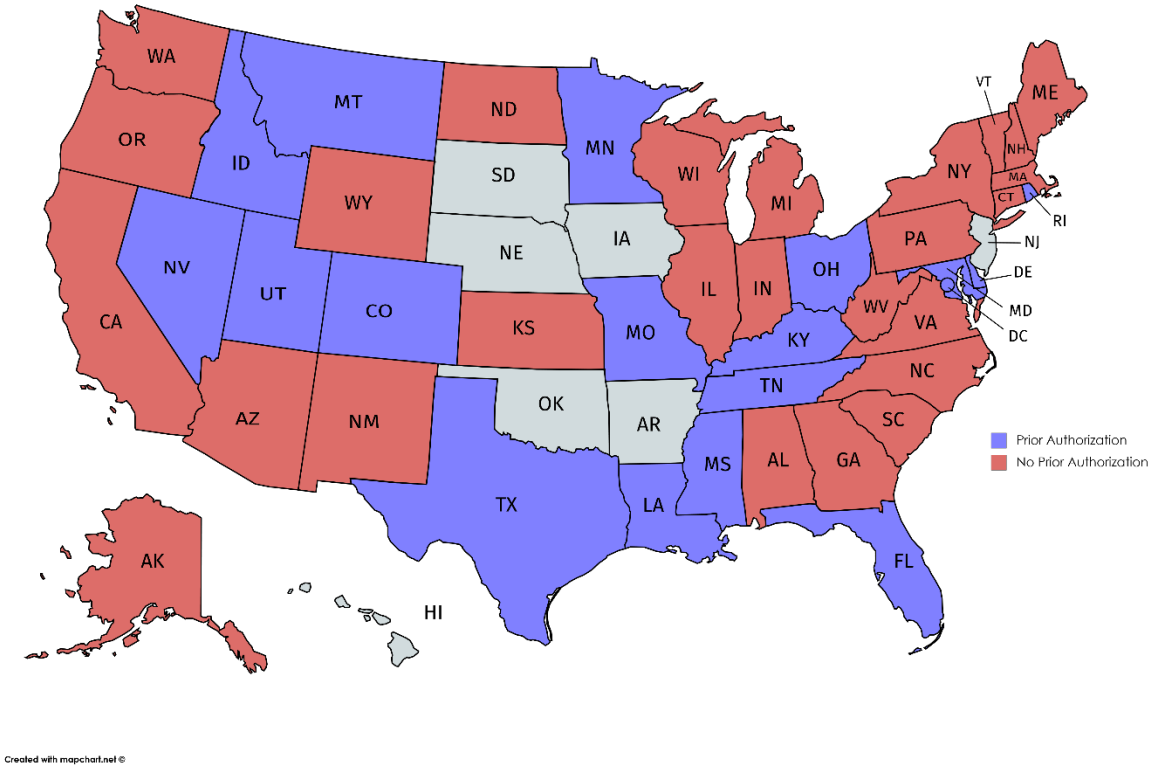
Abbreviation: ER, extended-release.

[a] Materials reviewed were those available in the second and third quarters of 2018.

Sources: State documents listed in Appendix A, Table A-1.

Prior authorization for oral naltrexone was required in 8 states and, for extended-release injectable naltrexone, in 19 states (see Figure 4). In general, fewer programs required prior authorization for disulfiram (one state) and acamprosate (nine states). In Figure 4, we illustrate the distribution of prior authorization requirements for extended-release injectable naltrexone across the U.S.

Figure 4. Prior Authorization Requirements for Extended-Release Injectable Naltrexone, 2018[a]

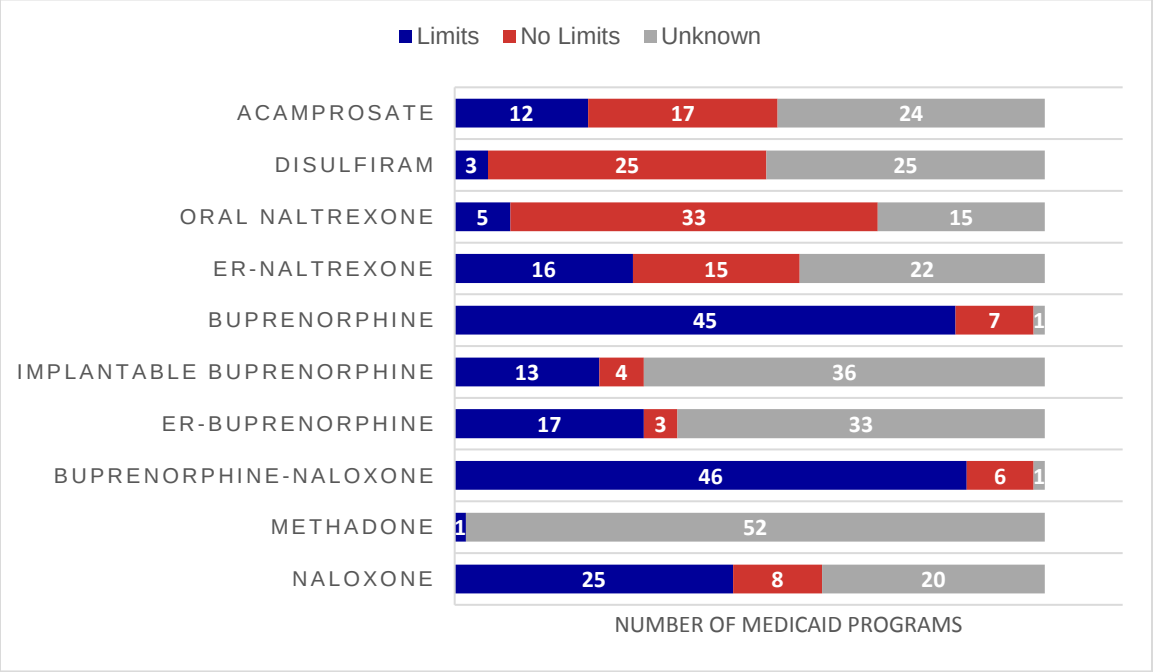


[a] Materials reviewed were those available in the third quarter of 2018.
Sources: State documents listed in Appendix A, Table A-1; Table A-6.

Several states also required evidence that the patient was being referred to or receiving ***psychosocial treatment*** with his or her medications. These requirements almost exclusively applied to medications for opioid use disorders. Documentation of psychosocial treatment was required by 16 programs for buprenorphine and for buprenorphine-naloxone, 10 programs for extended-release injectable buprenorphine, 5 programs for implantable buprenorphine and extended-release injectable naltrexone, 3 programs for acamprosate, 1 program for oral naltrexone, and no programs for disulfiram. Two states required receipt of psychosocial treatment to receive some forms of naloxone.

Quantity or dosing limits often are used by Medicaid programs (Figure 5). Quantity or dosing limits are least common for disulfiram (3 states), oral naltrexone (5 states), acamprosate (12 states), and extended-release injectable naltrexone (16 states). In contrast, quantity or dosing limits for buprenorphine and buprenorphine-naloxone were used by 45 and 46 states, respectively.

Figure 5. Quantity or Dosing Limit Requirements for Medications for Alcohol and Opioid Use Disorders or to Reverse Opioid Overdose, 2018[a]



[a] Materials reviewed were those available in the second and third quarters of 2018.
Sources: State documents listed in Appendix A, Table A-1.

In addition to quantity limits, some states have established ***lifetime treatment limits***, most commonly applied to buprenorphine and buprenorphine-naloxone. Along with other changes in response to the opioid crisis and, to some extent, possibly parity implementation, these limits have begun to disappear. This study found, in mid-2018, only one instance of a state imposing a lifetime limit. Specifically, New York regards any treatment using implantable buprenorphine for longer than 1 year as "investigational" and not medically necessary. A pharmacy benefit management strategy of imposing a lifetime limit is one that payers should consider carefully because it can impose significant challenges for individuals with opioid use disorders. Both opioid and alcohol addiction are chronic diseases; consequently, such limitations in MAT may increase the number of individuals who are at risk for relapse even after long periods of abstinence (McLellan, Lewis, O'Brien, & Kleber, 2000; NIDA, 2012c).

Step therapy also is required in some programs for certain medications. Often this is a requirement that the generic drug be tried unsuccessfully before a brand or that a preferred drug be tried unsuccessfully before a nonpreferred drug. Some indications of step therapy requirements are found in MCO documents without clear indication as to the nature of the progression required. Some sort of step therapy on disulfiram and acamprosate is imposed in

one state and four states, respectively. One state requires step therapy for oral naltrexone, and four impose it on extended-release injectable naltrexone. Step therapy for extended-release injectable naltrexone likely is required because it is a relatively expensive medication, and in some states, buprenorphine drugs are preferred for treatment of opioid use disorder. Step therapy requirements are more common for the buprenorphine drugs. Nine states require it for buprenorphine, and most require a showing of serious documented adverse reactions to naloxone. At least nine states require step therapy for implantable buprenorphine and three for extended-release injectable buprenorphine. Two states apply step therapy to buprenorphine-naloxone, although the formulations for which it is required (e.g., Bunavail, Zubsolv) vary by state. Two states require step therapy using other forms of naloxone before they will reimburse Evzio.

Substance Use Disorder Relapse

Substance abuse treatment, including medication therapy, enables people to counteract the disruptive effects of addiction on the brain and behavior and to regain control of their lives. However, the chronic nature of the disease means that relapse is likely. Studies have found that 1 year after discharge from treatment programs, 40 percent to 60 percent of individuals relapse in using alcohol or illicit drugs (McLellan, Lewis, O'Brien, & Kleber, 2000). This finding is similar to the 30 percent to 50 percent relapse rate for adults with diabetes and to the 50 percent to 70 percent relapse rate of adults being treated for hypertension or asthma (McLellan et al., 2000).

Methadone is covered for MAT by Medicaid in 42 of 53 states and territories.[17] Methadone as MAT, in contrast to pain treatment, is subject to a unique federal regulatory structure that governs administration of and access to the drug. The federal regulations impose restrictions such as required counseling, observed dosing requirements, and that those under 18 years of age have met certain criteria before methadone may be administered. Additionally, because methadone for MAT is not covered under pharmaceutical benefits but as a medical service, pharmaceutical benefit limitations generally do not apply. There are, however, a few states that clearly have Medicaid reimbursement limits that apply to the service of methadone maintenance and that, consequently, affect access to the medication. These state Medicaid limits include those in three states (Connecticut, Maine, and North Carolina) that require prior authorization for methadone maintenance.

Naloxone is not technically MAT but is an opioid overdose treatment that comes in three formulations. All 50 states and the District of Columbia cover at least one of those formulations, 23 cover all three, and 28 states do not cover Evzio (auto-injector). Forty-three states identify at least one formulation as preferred, with Evzio least likely to be preferred and most likely to require prior authorization. Two states require documentation of counseling, and that is only

[17] For Alaska, Kansas, Mississippi, Missouri, Montana, Oklahoma, and South Dakota, we found no evidence of methadone coverage in state Medicaid or MCO documents. We relied on KFF documents based on surveys of state Medicaid programs to identify methadone MAT coverage in these states (KFF, 2017, 2018).

when reimbursement is sought for Evzio (two states) or Narcan (one state). Quantity limits vary greatly by formulation and by state. Only two states require step therapy for naloxone—New York and South Carolina (both for Evzio)—which would require problematic use of the preferred version of the drug before the nonpreferred version may be reimbursed.

IV. Innovative MAT Provision, Coverage, and Financing Models

This section describes examples of innovative models across the states for achieving effective results in the provision of MAT and other treatment of opioid and alcohol use disorders. It also highlights some cross-cutting best practices that may help to increase access to SUD medications.

A. Innovative Models

Three approaches to the provision and financing of treatment that include MAT were identified for discussion.[18] These include the Massachusetts Nurse Care Management Model, a model that also was discussed in the first edition of this report published in 2014; statewide integration of MAT in state-contracted SUD treatment in Missouri; and innovative MAT approaches in Washington, including a telemedicine MAT pilot project. Potential approaches were identified through initial interviews with staff of the American Society of Addiction Medicine, the National Association of Medicaid Directors, the National Association of State Alcohol and Drug Abuse Directors, and the National Association of State Mental Health Program Directors. Based upon those interviews and on a review of public sources, the authors of this report also conducted semi-structured telephone interviews with state or program staff to obtain further information. Detailed notes were taken on those interviews, summaries were prepared in the form of case studies and the state and program staff were provided an opportunity to review the summaries for accuracy and completeness.

Nurse Care Management Model, Massachusetts

The Massachusetts Nurse Care Management Model of treatment for SUDs was developed to respond to a shortage of clinical support for outpatient buprenorphine treatment. Nurse care managers (NCMs) are an integral part of the Massachusetts Collaborative Care Model of office-based opioid treatment with buprenorphine (OBOT-B). The model allows waivered physicians more time to manage a larger group of patients by having NCMs work with program coordinators or medical assistants to perform much of the initial assessment, education management, referral to addiction treatment, adherence monitoring, admission paperwork, and communication with prescribing physicians, addiction counselors, and pharmacists. The program allows the NCMs to have daily interaction, either in person or by phone, with each patient receiving buprenorphine (Alford et al., 2011; LaBelle, Han, Bergerson, & Samet, 2016). The model, which adheres to recognized practice standards, includes four treatment stages: (1)

[18] For more comprehensive information about MAT treatment models that focuses on provision of MAT in primary care, the reader is pointed to the publication *Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings* (Agency for Healthcare Research and Quality, 2016).

screening and assessment of appropriateness for OBOT-B, (2) medication induction, (3) stabilization, and (4) maintenance (LaBelle et al., 2016).

The pilot project began in 2003 at the Boston Medical Center. After a successful demonstration in that setting, it was expanded to community health centers (CHCs) throughout the state. The project was initially funded for up to 7 years by the Commonwealth of Massachusetts, with block grant funding paying for nonbillable services, including the salary of a full-time registered nurse to allow the provision of nonbillable services, staff training, and technical support on implementation of protocols for each program. An initial cost study of 16 CHCs determined that the NCMs needed to manage a caseload of 100 patients to cover their salaries. This was achievable in most of the CHC participating programs, and the expectation subsequently was increased to 125 patients per NCM, with the assistance of a medical assistant (LaBelle et al., 2016).

OBAT is the New OBOT

The Office-Based Opioid Treatment (OBOT) model is now the Office-Based Addiction Treatment (OBAT) model. This change recognizes that—

- MAT and the office-based model address alcohol and other drug dependence besides opioid dependence
- The model does not rely only on medication but incorporates other treatments and patient supports

The state OBOT-B program director also provides training and technical assistance (TA) to the CHCs. For example, NCMs are provided with 8 hours of buprenorphine training that is modeled on the required waiver training for physicians while being modified to fit the needs of the program, with quarterly follow-up training (LaBelle et al., 2016). On-site and remote training, TA, and clinical supervision allow additional training for other CHC personnel involved in MAT. The provision of clinical support to physicians and the provision of training and TA to the NCMs are critical elements for the success of the program (LaBelle et al., 2016).

As the program matured, it went through some notable changes. First, the title of the program has changed from Office-Based Opioid Treatment (OBOT) to Office-Based Addiction Treatment (OBAT) to provide a better explanation of the scope of the model. This makes clear that the program addresses all SUDs rather than only opioid disorders and that is does not rely exclusively on medication but incorporates other treatments and supports for patients, including for those who may be in remission. Second, extended-release injectable naltrexone increasingly is used to treat both opioid and alcohol use disorders, supplementing buprenorphine and other older medications in the treatment arsenal. Third, the model incorporates risk reduction to keep patients engaged in treatment even when they are struggling. This recognizes the profound risk that accompanies nontreatment for those who may not be capable of abstinence. Fourth, Boston Medical Center is participating as faculty in the national Project Extension for Community Healthcare Outcomes (ECHO) Opioid Addiction Treatment, which provides training and technical assistance in addiction treatment to providers in clinics around the country, including rural and underserved communities (UNM School of Medicine, 2017).

Funding also has evolved as the Massachusetts NCM program has grown. Many of the CHCs are federally qualified health centers (FQHCs), which use a Medicaid prospective payment system model that is a capitated approach allowing flexibility for services rendered. More recent cost modeling data for the FQHCs show that, if an NCM manages a caseload of 40 patients and sees each of them 27 times a year, the prospective payment system will cover salary, administrative costs, and fringe benefits. NCMs working in the model presently manage 100 to 125 patients, far more than are needed to break even. Consequently, several CHCs have hired additional nurses to reduce the caseload. Not all CHCs can use this funding model, however, because they do not have the FQHC recognition. Other supplemental funding sources include general state funding, federal Health Resources and Services Administration funding, SAMHSA grants, and funding from a large Boston-area employer (LaBelle et al., 2016).

Provider Capacity Issues

Missouri has undertaken several approaches to addressing provider capacity issues:

- Telehealth
- Contracting with primary care providers for MAT
- Contracting with OTPs for prescribers
- Expanding OTP prescribing beyond methadone
- Relying on nurse practitioners to use naltrexone and acamprosate, leaving waivered physicians more time to prescribe buprenorphine

Statewide Integration of MAT into SUD Treatment, Missouri

The Missouri Division of Behavioral Health works to integrate MAT into all SUD treatment in the state, requiring any SUD treatment provider who contracts with the Division to offer MAT either directly or by formal arrangement. Prior to 2006, most MAT in Missouri involved methadone; nonmethadone treatment providers had not successfully integrated other forms of MAT such as naltrexone. Beginning in 2006, the state recruited a group of volunteer providers to participate as part of a Robert Wood Johnson Foundation Advancing Recovery grant, in part to identify barriers and opportunities to the use of oral naltrexone and acamprosate for alcohol use disorders. From this experience, the state developed an expectation that all contracted providers would integrate MAT into their service delivery starting in 2007. In 2008, Missouri was one of the earliest advocates for making Vivitrol available in treatment. The use of this medication expanded beyond the community in 2012 when the St. Louis City Drug court began using Vivitrol prior to participant release from jail. This idea was adapted to the state correctional system with a pilot program that offered Vivitrol to prison inmates nearing release, with continuing provision of MAT in the postrelease period. The successful integration of MAT into SUD and co-occurring disorders treatment led the state to require all Certified Community Behavioral Health Clinics in the Prospective Payment System demonstration provide all forms of MAT other than methadone.

Because Missouri state government has worked to implement MAT for at least a decade, it has been in the position to recognize and address several challenges:

- Expanding capacity to prescribe buprenorphine in Missouri has been slow because of a shortage of prescribers. Some interim solutions have included use of telehealth, first available in 2009, and contracting for prescribing services from local primary care providers and OTPs. Rather than relying solely on methadone, OTPs also are expanding their menu of medications to include buprenorphine, naltrexone, and other drugs. Although the state is working to expand access to waivered providers through training and education/awareness efforts, the new federal law that expanded buprenorphine prescribing privileges to nurse practitioners and physician assistants may be impeded by strict state licensing regulations. To circumvent that, nurse practitioners are sometimes used to administer Vivitrol, whereas waivered physicians manage buprenorphine clients.
- Like many other states, there is some controversy about treating SUDs with medications. Education and the growing scientific evidence that supports efficacy has helped change provider, prescriber, consumer, and family attitudes.
- Missouri has learned that establishing equitable reimbursement that covers medications, medication administration, laboratory services, other related activities, and administrative overhead is important to ensure that providers are fairly compensated for the provision of MAT.

Missouri also has been at the forefront of integrating behavioral health treatment, including MAT, into primary care. This has involved different strategies, including hiring physicians to staff the SUD agency, establishing relationships with FQHCs, co-locating SUD and FQHC services, and contracting with community providers. The use of telehealth has further facilitated the integration of SUD treatment, including MAT, into primary care. Challenges that the state has confronted include the need for primary care provider education related to the treatment of SUDs. Missouri also has found that addressing negative perceptions of SUD treatment, whether held by providers, patients, or patients' families, is critical to success.

Missouri has found ways to address barriers that often are encountered, whether MAT is provided by a specialty SUD provider or by a primary care physician. These include the following:

- Supporting champions at both the state and provider level, specifically individuals who can serve as leaders in moving forward with the delivery of MAT, including doctors who can serve as mentors and trainers for other providers.
- Monitoring prescribing patterns within organizations to ensure that prescribers are providing patient-centered care, rather than prescribing particular medications uniformly regardless of individual need. This has been facilitated by a robust health information and data system that is already well established.

- Continuing efforts to adopt prescribing protocols that make use of the existing evidence base in a way that makes sense within the Missouri system of treatment.

Flex Care Telemedicine-MAT Pilot Project and Other Innovative MAT Approaches, Washington

Using a 2015 SAMHSA Medication-Assisted-Treatment Prescription Drug and Opioid Addiction (MAT-PDOA)[19] grant to the state of Washington, Evergreen Treatment Services implemented a Flex Care pilot telemedicine project at the Grays Harbor Clinic in the township of Hoquiam. Hoquiam is located in a rural area on the central Washington coast about 2 hours southeast of Seattle, and many people in that part of the state were unable to access MAT prior to implementation of the Flex Care project. Although some patients still travel up to 3 hours to attend the Grays Harbor Clinic, the introduction of telemedicine has made a difference for many individuals struggling with opioid use disorder in isolated areas of the Washington coast. The success of this pilot will determine whether the state expands to other settings, like to Grays Harbor Clinic, that are not FQHCs.

Expanding Access to MAT via Telemedicine

Approximately 200 patients in rural coastal Washington state who had no access to medication assisted treatment for their opioid dependence disorder, now receive MAT as part of the Washington state Flex Care treatment model.

The Grays Harbor Clinic opened as an OTP in 2014. Upon receipt of the MAT-PDOA award, it was difficult to find a waivered physician to prescribe Suboxone because of the isolated location and stigma within the medical community related to the patient population. To resolve this problem, Evergreen implemented a practice incorporating MAT, telemedicine, and two proven models of care. The first model was the Massachusetts OBOT-B model, also known as the Nurse Care Manager model, in which an NCM provides most medical visits with a patient and coordinates and manages integrated treatment with other providers, as needed. The second model was The Johns Hopkins School of Medicine Collaborative Opioid Prescribing model of OTP/OBOT coordinated care, which provides flexibility as to the level of care at which the patient is treated on the basis of patient need. This hybrid approach has allowed the clinic to provide services to a larger group of patients, many of whom previously could not access care.

To implement telemedicine, Evergreen contracted with a physician in Portland, Oregon. The physician provides prescribing oversight while an on-site staff member is with the patient during the telemedicine session and assists with the telemedicine equipment. The project initially relied

[19] More information on the MAT-PDOA is available at Substance Abuse and Mental Health Services Administration. (2018). State grant programs. Retrieved from https://www.samhsa.gov/medication-assisted-treatment/mat-pdoa

on the NCM to manage the telemedicine equipment but has now moved to using medical assistants for that role. The NCM manages most of the rest of the patient's visits. Patients come in weekly for a check-in with the NCM and to receive a prescription for Suboxone. Depending on how a patient progresses, he or she transitions to biweekly then to monthly or quarterly visits with the NCM. The off-site physician will conduct a telemedicine session with the patient at least quarterly. Incorporation of the Collaborative Opioid Prescribing model allows for unstable patients to be admitted to the OTP and then to move into maintaining their care with the Flex Care team once they are stabilized on the medication regime. Because the model incorporates a continuum of care, however, it allows the patient to return to the OTP for treatment if he or she destabilizes, resuming treatment by the Flex Care medical staff once again after restabilization occurs. This model has provided motivation for other primary care providers in the area to participate in the program, prescribing and overseeing Suboxone once patients are stabilized, because there is a reliable back-up specialty provider to step in if a patient destabilizes or becomes too challenging for the community physician to manage.

Program staff report that the Flex Care program has encountered several challenges, some of which have been resolved and some of which are ongoing.

- **Volume**. The pilot program cannot see as many patients via telemedicine as originally anticipated because of the need to have a staff person in the room as well as the off-site physician in place. This is an on-going concern that affects the level of reimbursement available to the clinic.
- **Cost.** The telemedicine equipment costs approximately $30,000 per unit. Although the clinic's unit was paid for by the MAT-PDOA grant, this cost could deter other nonprofits from adopting telehealth absent supplemental grants or other funding. Reimbursement and staffing are other essential components of cost.
- **Equipment management.** The clinic had to hire additional staff to manage the telemedicine equipment during the sessions with the doctor. It is a task that can be performed by someone who is paid less than a nurse and is now performed by a medical assistant, but it was an unanticipated cost that contributes to the unsustainability of the program unless reimbursements are addressed.
- **Staffing.** In addition to hiring staff to manage the equipment, the clinic has had difficulty finding nursing staff in rural locations. There is a nursing shortage in the area, and the clinic lost the nurse care manager who started the program. The clinic currently is using a more expensive advanced nurse practitioner and is paying for additional physician time to compensate. The clinic is hoping to attract qualified personnel to replace the original nurse care manager.
- **Infrastructure.** Connectivity between the rural location and the remote physician was initially difficult and highlighted technical issues that had to be resolved, leading to improved information technology capabilities for the clinic.

- **Sustainability.** The grant will provide funding until July 2018. The clinic is exploring other avenues of reimbursement to cover costs when the grant ends. Historically, the agency had not used insurance contracts and began the process of contracting with payers to initiate that reimbursement opportunity. For Medicaid patients, the level of reimbursement alone may not cover the cost of operating the telemedicine program, possibly requiring additional funding sources.

Access to treatment for patients in rural coastal Washington has improved because of this innovative approach to the provision of MAT. Approximately 200 patients now receive MAT who could not access any care before this program was implemented. This is the only option available to obtain MAT for these patients. To continue availability for those patients, the Grays Harbor Clinic is exploring options to sustain the Flex Care program of treatment for those with opioid use disorders.

In addition to the Flex Care telemedicine model being implemented at Grays Harbor Clinic, there are several other innovative approaches to MAT in Washington. These include the following:

- Use of mobile methadone vans to reach patients
- A program in Port Angeles inducting county jail inmates with buprenorphine and transitioning them into a nearby community health center for follow-up (Port Angeles is located about 3 hours northwest of Seattle).
- A citywide emergency department multidisciplinary care-coordination program in Spokane in which all EDs in the area are connected to a web-based information exchange system (Murphy & Neven, 2014)
- A Seattle-based buprenorphine induction program affiliated with a needle exchange program, in which patients subsequently are transitioned to community providers.

B. Cross-Cutting Best Practices

Three factors that may affect access to MAT include lifetime limits, level of burden associated with prior authorization, and state licensure requirements. Each is addressed below.

Historically, a number of Medicaid programs imposed lifetime limits on the use of medications for alcohol or opioid use disorders. Eleven states had lifetime limits on buprenorphine-naloxone when the first edition of this report was published in 2014. Currently, however, only one state imposes such a limit on implantable buprenorphine, and that is on the grounds that longer use is considered "investigational." SUD is a chronic, relapsing disease similar to diabetes or asthma, and a lifetime limit for opioid treatment is inconsistent with evidence and best practices. For example, a randomized multisite study found that stopping buprenorphine-naloxone after a 12-week treatment course resulted in a rate of unsuccessful outcomes that exceeded 90 percent (Weiss et al., 2011). The decrease in lifetime limits may relate to parity

or reflect the realities of addressing the opioid crisis, but represents progress in assuring access to treatment.

Effects of Prior Authorization on Medication Use and Costs

Research is limited regarding the impact of prior authorization (PA) on medications for alcohol and opioid use disorders. However, studies have examined the effect of PA on medications to treat other chronic conditions. Research on the effect of PA on antipsychotics to treat schizophrenia or bipolar disorder shows that PA policies lead to higher rates of treatment discontinuation and hospitalization and may present barriers to access (Abouzaid et al., 2010; Brown, Barrett, Caffery, Hourihan, & Ireys, 2013; Lu et al., 2011; Zhang, Adams, Ross-Degnan, Zhang, & Soumerai, 2009). Formulary restrictions on atypical antipsychotics have also been associated with higher total medical expenditures and higher social costs among Medicaid patients with schizophrenia and bipolar disorder; these higher costs may offset any savings in pharmacy costs (Seabury et al., 2014).

Prior authorization is a common benefit design element, particularly for buprenorphine and buprenorphine-naloxone. The prior authorization and subsequent reauthorizations of buprenorphine and buprenorphine-naloxone may require various types of documentation. Some states require more extensive documentation than others. These requirements may include documentation of the patient's opioid addiction, drug screening tests, supplemental psychosocial treatment, tapering plans, or a specific plan for following up with the patient (e.g., frequency of office visits) (see Appendix A, additional specifications to Tables A-7, A-8, A-9, and A-10 for some of the prior authorization requirements). Although these requirements aim to ensure the proper use of buprenorphine and buprenorphine-naloxone, they may delay access to treatment and add significant provider burden. The end result is often that the patient does not receive any medication (ASAM, 2013). Standard operating rules concerning prior authorization for all medications, including buprenorphine, should improve access to medications used to treat alcohol and opioid use disorders. Increasingly, payers are moving toward a system of real-time, electronic prior authorization at the point of care that may reduce interruptions to patient flow or access to medications (covermymeds®, 2017). Providers and pharmacies such as CVS Caremark (http://www2.caremark.com/epa) also are moving toward this electronic system facilitating authorization.

State licensure requirements affect whether a nurse practitioner or other nonphysician provider may legally prescribe, including whether they may prescribe a controlled substance or, specifically, buprenorphine and buprenorphine-naloxone. Although qualifying nurse practitioners and physician assistants will now be allowed under federal law to receive a DATA 2000 waiver and prescribe buprenorphine, some states have explicit restrictions in place on prescribing buprenorphine by non-physicians. These restrictions may be artifacts of states

attempting to ensure that their providers did not run afoul of the previous federal buprenorphine restrictions. Failure to modify state licensure laws, however, to accommodate the prescribing permissions found in current federal law may impede the increased access to buprenorphine and buprenorphine-naloxone that the federal amendments sought to address. States face persistent problems of insufficient buprenorphine prescriber capacity. Adjusting legacy statutes and regulations to reflect the amended federal law could help alleviate that.

V. Conclusion

A large body of research increasingly emphasizes that medications used in MAT are effective for the treatment of alcohol and opioid use disorders and that naloxone is effective for addressing acute opioid overdose. Studies also have shown that these medications are cost effective and typically can pay for themselves. Given the scope of the opioid epidemic as well as the toll that alcohol use disorders take on the population of the United States, coverage and reimbursement policies that facilitate access to MAT are believed by many experts to be critical elements of assisting persons with SUDs. As Medicaid programs continue to assess the needs of individuals with alcohol and opioid use disorders in their states, this report can be a resource guide for developing beneficial medication coverage and financing policies. Ongoing assessment should include several different factors discussed below.

A. Coverage of Medications Used for MAT

Currently, the Medicaid programs in all states and the District of Columbia cover some form of naloxone, oral and extended-release injectable naltrexone, buprenorphine, and buprenorphine-naloxone, and disulfiram is covered in nearly all states.[20] In contrast, the Medicaid programs in 9 states still do not reimburse methadone, 11 do not reimburse acamprosate, 14 do not reimburse implantable buprenorphine, and 18 do not reimburse extended-release injectable buprenorphine. Careful examination of current coverage for medications, including methadone, is a critical step toward combatting the opioid epidemic in the United States.

B. Benefit Design

Many Medicaid programs use benefit design requirements, such as prior authorization, to contain expenditures and encourage the proper use of medications for the treatment of alcohol and opioid disorders. These requirements may reduce patients' access to treatment and result in poorer health and economic treatment outcomes. Research on the use of prior authorization with psychiatric medications has revealed that prior authorization may reduce medication expenditures but also may have the unintended consequence of reducing use of the medication and access to treatment.

Reconsideration of whether to require prior authorization or other benefit limitations is another step states may wish to take toward addressing treatment access. Most benefit design restrictions currently used by states are for medications to treat opioid use disorders. For example, prior authorization is required for reimbursement of some form of buprenorphine and buprenorphine-naloxone in 40 and 31 of the 51 Medicaid programs, respectively, and extended-release injectable naltrexone requires prior authorization in 19 Medicaid programs. One state imposes a

[20] We exclude Puerto Rico and the U.S. Virgin Islands from these numbers because of uncertainty about the status of most of the drugs.

blanket prior authorization requirement on all opioid use disorder treatments. However, state Medicaid programs, health plans, and states acting via statute or regulation are increasingly taking the step of removing prior authorization for MAT, particularly for treatment of opioid use disorders, to facilitate access to urgently needed treatment.

One area in which reconsideration of prior authorization and other benefit limits may be most important concerns extended-release injectable naltrexone. Because this medication remains on-patent and there is no available generic, it is more expensive than most other MAT medications. There is considerable evidence, however, that extended-release injectable naltrexone can be effective and that it offers opportunities for treatment in settings such as the criminal justice system or for populations such as the homeless, where access to or use of other MAT medications may be more problematic. Because both methadone and the buprenorphine drugs are so heavily regulated, oral naltrexone and extended-release injectable naltrexone offer a path to treatment when access to either methadone or buprenorphine is limited. For this reason, close examination of existing benefit limitations for extended-release injectable naltrexone is important if states wish to ensure access to treatment.

C. Other Considerations

The recent amendments to federal statutes and regulations regarding prescribing of buprenorphine were designed to open prescribing to include nurse practitioners and physician assistants and to increase the number of patients a specially qualified prescriber may serve at one time. Some state licensing laws, however, restrict scope of practice to preclude prescribing by nurse practitioners and physician assistants, whereas other states have adopted regulations related to buprenorphine prescribing that specifically refer only to physicians as buprenorphine prescribers. To the extent that state laws or regulations inhibit prescribing of buprenorphine by nurse practitioners or physician assistants, the intent of the federal changes will be unrealized. Although states have a legitimate interest in regulating the scope of practice of providers in their jurisdiction to keep their citizens safe and healthy and to regulate buprenorphine prescribing, with the change in federal law, some states may want to re-examine which providers should be permitted to prescribe MAT. These states with legacy scope of practice or buprenorphine restrictions may consider amendments to state statutes and regulations to reflect current federal law.

D. Lessons Learned from Innovative Approaches to Financing MAT.

The three innovative approaches to MAT from Massachusetts, Missouri, and Washington that are highlighted in this report are just some of many underway in the United States. These three represent several approaches and present a variety of opportunities and challenges that may be useful to consider as other states assess their own financing of MAT. Importantly, all three of the case study examples rely on multiple funding sources to support their innovative provision of MAT, including Medicaid, to finance SUD services and medications. It is clear from these case

studies that reliance on Medicaid alone was insufficient to get these innovations under way and, in some cases, will be insufficient to sustain them.

The Massachusetts model was built with a healthy boost of financing from the state in addition to Medicaid reimbursement. Both funding sources were necessary to get the model going and to facilitate sustainability. After initial development, however, at least the CHCs that are FQHCs have managed to rely on Medicaid to cover salaries, administrative costs, and fringe benefits for providers. The FQHCs, however, use a Medicaid prospective payment system that allows greater flexibility in funding of services. Facilities without that advantage will have greater difficulty in sustaining a Massachusetts-like model, suggesting that increased opportunities for alternative payment approaches are needed to expand use of the Nurse Care Manager model and that other states wishing to adopt this model also may need to find additional sources of money to pay for it.

The state of Missouri also has relied on additional funding streams to supplement Medicaid payments. Over the many years in which Missouri state government has worked to build and sustain a statewide network of MAT providers, however, it learned that careful planning regarding reimbursement rates was critical. Planning in advance for equitable reimbursement requires setting rates that cover many things, including medications, the act of administration, laboratory services, other MAT-related activities, and overhead to ensure that providers are fairly compensated for the provision of MAT.

The Washington state Flex Care telemedicine pilot had the advantage of being able to use grant funding to purchase its telehealth equipment and to fund other facets of the pilot. The pilot clinic also is moving toward accepting insurance to assist in sustaining the pilot once grant funding ends. Despite this, as a small rural clinic providing services to a large area, the pilot site still struggles with finding staff and expects continued difficulty paying the salaries of the multiple staff needed at both ends of the telemedicine encounter. This promising project, which now provides MAT to more than 200 individuals who could not access treatment in the past, needs the resources to sustain it. Other rural clinics and providers who may not have a grant to fund telehealth equipment may not even be able to begin such a project.

Viable Medicaid reimbursement is a critical component of success for providers of MAT. As Medicaid programs consider these and other innovative coverage and financing approaches, they also must put in place viable coverage and benefit design structures that effectively reduce costs but still improve access to necessary treatment and the quality of life for individuals with an opioid or alcohol use disorder.

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VII. Appendix A. Coverage of Medications for Alcohol and Opioid Use Disorders by State

Table A-1. State Medicaid Documents Used to Identify Medication Coverage for Alcohol and Opioid Use Disorders or to Reverse Opioid Overdose

State	Effective Date	Document Name	Link
Alabama	07/02/2018	Alabama PDL	Link
	Accessed 08/10/2018	Alabama Drug Look-up	Link
	08/01/2017	Alabama Rehabilitative Option Fee Schedule	Link
Alaska	03/15/2015	Alaska PDL	Link
	05/08/2013	Alaska Prior Authorization	Link
	09/29/2017	Alaska Interim Prior Authorization	Link
	Accessed 08/10/2018	Alaska Medication Prior Authorization Webpage	Link
	10/03/2016	Alaska Medicaid Prior Authorization—Evzio	Link
	03/19/2010	Alaska Medicaid Suboxone and Subutex (Buprenorphine)	Link
	Accessed 07/31/2018	Kaiser Family Foundation States Reporting Medicaid Coverage of MAT Drugs	Link
Arizona	Accessed 08/10/2018	Arizona Pharmacy Information	Link
	07/01/2018	Arizona Acute/Long Term Care PDL	Link
	07/01/2018	Arizona Buprenorphine Use in Pregnant and Nursing Women for Medication Assisted Therapy	Link
	07/01/2018	Arizona Behavioral Health Drug List	Link
	11/2017	Arizona Health Care Cost Containment System Covered Behavioral Health Services Guide	Link
Arkansas	08/10/2018	Arkansas PDL	Link
	07/10/2018	Arkansas Prior Authorization	Link
	Accessed 08/09/2018	Arkansas Drug Lookup	Link
	05/11/2017	Arkansas Office-Based Opioid Dependence Pharmacotherapy Statement of Medical Necessity	Link
	02/20/2017	Arkansas Medicaid Prior Authorization edits—buprenorphine-containing agents	Link
California	Accessed 08/09/2018	California PDL (contract drug list)	Link
	08/01/2018	California Health and Wellness PDL	Link
	Accessed 08/09/2018	California Online PDL	Link
	Amended 04/05/2018	California Special Terms and Conditions Section 1115 Waiver	Link
	04/2016	California Heroin Detoxification	Link
Colorado	07/01/2018	Colorado PDL	Link
	07/01/2018	Colorado Prior Authorization and Quantity Limits	Link
	06/01/2018	Colorado Access Child Health Plan+ Formulary	Link
	07/01/2018	Colorado Uniform Service Coding Standards Manual	Link

State	Effective Date	Document Name	Link
Connecticut	07/01/2018	Connecticut PDL	Link
	Accessed 07/16/2018	Connecticut Behavioral Health Partnership Services	Link
	10/2018	Medicaid Drug Utilization Review State Comparison/Summary Report FFY 2017 Annual Report Prescription Drug Fee-For-Service Programs	Link
Delaware	07/03/2018	Delaware PDL	Link
	Accessed 08/20/2018	Delaware Health Options Supplemental Formulary	Link
	12/23/2016	Delaware Medicaid and Medical Assistance Request for Prior Authorization Vivitrol	Link
	Accessed 07/12/2018	Delaware Procedure Codes	Link
District of Columbia	07/12/2018	Washington DC PDL	Link
	Accessed 07/28/2018	Washington DC Fee Schedule	Link
	Accessed 08/07/2018	Washington DC AmeriHealth Formulary	Link
	10/2018	Medicaid Drug Utilization Review State Comparison/Summary Report FFY 2017 Annual Report Prescription Drug Fee-For-Service Programs	Link
Florida	07/18/2018	Florida PDL	Link
	Accessed 08/06/2018	Florida Prior Authorization (Buprenorphine Products [05/24/2017])	Link
	03/2014	Florida Behavioral Health Overlay Services	Link
	10/2018	Medicaid Drug Utilization Review State Comparison/Summary Report FFY 2017 Annual Report Prescription Drug Fee-For-Service Programs	Link
Georgia	08/01/2018	Georgia Medicaid/PeachCare PDL	Link
	Accessed 08/08/2018	Georgia Prior Authorization Links	Link
	07/01/2018	Georgia Policies and Procedures for Pharmacy Services	Link
	08/01/2018	Georgia Amerigroup PDL	Link
	07/01/2018	Georgia Policies for Community Behavioral Health & Rehabilitation Services	Link
Hawaii	Accessed 08/08/2018	Hawaii Fee-for-Service Formulary Drug Search	Link
	07/01/2018	Hawaii PDL (Hawaii Medical Service Association Blue Cross Blue Shield)	Link
	Accessed 07/16/2018	Hawaii Quest Integration Medical Benefits	Link
Idaho	07/01/2018	Idaho PDL	Link
	07/01/2018	Idaho Prior Authorization Opioid Dependence Treatments	Link
Illinois	07/01/2018	Illinois PDL	Link
	Accessed 08/07/2018	Illinois Prior Authorization	Link
	08/03/2018	Illinois Formulary (Meridian)	Link
	03/2018	Illinois Drugs Billed Under Medical Benefit (Meridian)	Link
	01/01/2017	Illinois Fee Schedule for Medication Assisted Treatment	Link
	10/2018	Medicaid Drug Utilization Review State Comparison/Summary Report FFY 2017 Annual Report Prescription Drug Fee-For-Service Programs	Link

State	Effective Date	Document Name	Link
Indiana	07/01/2018	Indiana PDL	Link
	04/01/2018	Indiana Buprenorphine Products Prior Authorization Criteria	Link
	08/01/2018	Indiana MCO PDL (Anthem Healthy Indiana Basic)	Link
	Accessed 08/07/2018	Indiana MCO Formulary (Anthem Healthy Indiana Basic)	Link
	07/01/2018	Indiana Outpatient Fee Schedule	Link
	07/28/2018	Indiana Professional Fee Schedule	Link
	07/14/2018	Indiana Methadone Coverage Document	Link
Iowa	01/01/2017	Iowa PDL Alpha Drug List	Link
	06/01/2018	Iowa PDL	Link
	06/01/2018	Iowa Methadone Coverage Document	Link
	07/01/2018	Iowa Medicaid Prior Authorization Criteria	Link
Kansas	07/01/2018	Kansas PDL	Link
	10/12/2016	Kansas Probuphine Prior Authorization	Link
	Accessed 07/31/2018	KanCare Amerigroup PDL	Link
	07/09/2014	Kansas Criteria for Prior Authorization Opioid Dependence Agents	Link
	01/2017	Kansas Criteria for Non-Preferred Drugs That Require Prior Authorization	Link
	10/2018	Medicaid Drug Utilization Review State Comparison/Summary Report FFY 2017 Annual Report Prescription Drug Fee-For-Service Programs	Link
	Accessed 07/31/2018	Kaiser Family Foundation States Reporting Medicaid Coverage of Medication Assisted Treatment (MAT) Drugs	Link
Kentucky	07/09/2018	Kentucky PDL (Magellan)	Link
	07/01/2018	Kentucky PDL (WellCare)	Link
	02/01/2018	Kentucky Pharmacy Prior Authorization Guidelines (Aetna)	Link
	Accessed 07/31/2018	Kentucky Formulary (Passport)	Link
	07/21/2018	Kentucky Authorization Requirements (Humana)	Link
Louisiana	10/01/2017	Louisiana Fee-for-Service PDL and Prior Authorization	Link
	Accessed 08/01/2018	Louisiana Link to All Medicaid MCO PDLs	Link
	10/01/2017	Louisiana MCO Common PDL	Link
	08/01/2018	Louisiana PDL (Anthem)	Link
Maine	07/28/2018	Maine PDL	Link
	01/01/2013	Maine Revised Statutes, title 22-3, § 3174-VV	Link
	01/01/2013	Maine Revised Statutes, title 22-3, § 3174-SS	Link
Maryland	07/01/2018	Maryland PDL	Link
	07/2018	Maryland Maximum Quantity Listing	Link
	07/15/2018	Maryland Vivitrol/Campral Prior Authorization Form	Link
	01/01/2015, updated 10/04/2017	Maryland Clinical Criteria SUD Medications	Link
	Accessed 08/01/2018	Maryland Pharmacy Program Clinical Criteria Look-up	Link
	Accessed 08/01/2018	Maryland MCO Formulary (Amerigroup)	Link
	08/01/2017	Maryland Community-Based Substance Use Disorder Fee Schedule	Link

State	Effective Date	Document Name	Link
Massachusetts	Accessed 08/01/2018	Massachusetts Drug List	Link
	07/30/2018	Massachusetts PDL (Drug and Alcohol Agents)	Link
	01/2016	Massachusetts Buprenorphine-Naloxone Letter	Link
	05/2018	Massachusetts Opioid Dependence and Reversal Agents Prior Authorization Request	Link
	Accessed 07/16/2018	Massachusetts SUD Treatment Manual	Link
Michigan	Accessed 08/02/2018	Michigan Drug Carve Out	Link
	07/17/2018	Michigan PDL	Link
	07/17/2018	Michigan Quantity Limitations	Link
	06/01/2018	Michigan Opioid Abuse Treatments	Link
	07/2017	Michigan Prior Authorization for Office Based Opioid Addiction Treatment	Link
	07/01/2018	Michigan MCO Common Formulary	Link
	2018	Michigan MCO Services Requiring Authorization and Benefit Exclusions (Molina)	Link
	07/01/2018	Michigan Provider Manual (Methadone)	Link
Minnesota	Accessed 08/02/2018	Minnesota Magellan Formulary Look-up	Link
	07/18/2018	Minnesota Prior Authorization	Link
	02/09/2018	Minnesota Prior Authorization Buprenorphine and Buprenorphine-Naloxone	Link
	02/09/2018	Minnesota Prior Authorization Zubsolv	Link
	Accessed 08/02/2018	Minnesota Health Partners Formulary	Link
	07/10/2017	Minnesota Alcohol and Drug Abuse Services	Link
Mississippi	07/01/2018	Mississippi PDL	Link
	01/01/2017	Mississippi Buprenorphine-Naloxone & Buprenorphine Coverage	Link
	Accessed 08/01/2018	Mississippi United Healthcare Optum Prescription Drug List	Link
	Accessed 07/31/2018	Kaiser Family Foundation States Reporting Medicaid Coverage of MAT Drugs	Link
Missouri	07/01/2018	Missouri PDL	Link
	10/19/2017	Missouri Opioid Dependence Agents PDL	Link
	Accessed 08/02/2018	Missouri HealthNet Epocrates	Link
	Accessed 07/31/2018	Kaiser Family Foundation States Reporting Medicaid Coverage of MAT Drugs	Link
Montana	08/02/18	Montana PDL	Link
	11/2017	Montana Buprenorphine-Containing Products for Opioid Substance Use Disorder Prior Authorization	Link
	01/01/2018	Montana Fee Schedule Physician Services	Link
	Accessed 07/31/2018	Kaiser Family Foundation States Reporting Medicaid Coverage of MAT Drugs	Link
Nebraska	05/2018	Nebraska PDL	Link
	Accessed 08/03/2018	Nebraska Magellan Drug Look-up	Link
	07/01/2018	Nebraska Summary of Drug Limitations	Link
	11/2017	Nebraska Buprenorphine Products Prior Authorization	Link
	02/2014	Nebraska Buprenorphine Products Consent	Link
	07/01/2018	Nebraska Fee Schedule for Behavioral Health	Link

State	Effective Date	Document Name	Link
Nevada	02/05/2018	Nevada PDL	Link
	11/19/2013	Nevada Prior Authorization Suboxone and Subutex	Link
	11/03/2016	Nevada Medicaid Informational Bulletin on Medications and Services for Substance Use Disorders	Link
	08/01/2018	Nevada MCO Preferred Drug List (Anthem)	Link
	04/10/2018	Nevada Provider Type 17 Billing Guide	Link
New Hampshire	06/18/2018	New Hampshire PDL	Link
	10/08	New Hampshire Quantity Limit Program	Link
	Accessed 08/04/2018	New Hampshire WellSense Formulary	Link
	07/01/2017	WellSense Buprenorphine and Naloxone Products and Wellsense Sublocade and Wellsense Probuphine Pharmacy Policies (versions applicable to New Hampshire Medicaid)	Link
	Accessed 08/04/2018	New Hampshire Healthy Families Formulary	Link
	07/01/2016	New Hampshire SUD Benefit for Standard Medicaid Recipients	Link
New Jersey	07/01/2018	New Jersey PDL (UnitedHealthcare)	Link
	Accessed 08/05/2018	New Jersey UnitedHealthcare/Optum PDL Lookup	Link
	07/01/2018	New Jersey PDL (WellCare)	Link
	04/2018	New Jersey PDL (Horizon)	Link
	08/01/2018	New Jersey PDL (Amerigroup)	Link
	Accessed 07/16/2018	New Jersey Administrative Code 10:49-5.2(b)(18)	Link
New Mexico	07/01/2018	New Mexico Formulary (Blue Cross Blue Shield)	Link
	07/2018	New Mexico Formulary (Molina)	Link
	Accessed 08/03/2018	New Mexico Formulary (United Healthcare)	Link
	Accessed 07/16/2018	New Mexico Fee-for-Service MAT Reimbursement Plan	Link
New York	07/12/2018	New York PDL (Fee for Service)	Link
	Accessed 03/17/2017	New York Pharmacy Benefit Information Center	Link
	Accessed 03/17/2017	New York Formulary Drug Search (Amerigroup)	Link
	05/18/2017	New York State Health and Recovery Plan/Mainstream Behavioral Health Billing and Coding Manual	Link
North Carolina	08/01/2018	North Carolina PDL	Link
	Accessed 07/11/2017	North Carolina Clinical Edits Behavioral Health Adult	Link
	06/05/2018	North Carolina Prior Approval Buprenorphine & Buprenorphine/Naloxone	Link
	12/2016	North Carolina Medicaid Bulletin	Link
	04/01/2017	North Carolina Enhanced Mental Health and Substance Abuse Services	Link

State	Effective Date	Document Name	Link
North Dakota	07/01/2018	North Dakota PDL	Link
	Accessed 08/11/2018	North Dakota Prior Authorization	Link
	Accessed 08/11/2018	North Dakota Department of Human Services Drug Search	Link
	Accessed 08/11/2018	North Dakota Opioid Dependence Agents Prior Authorization Form	Link
	Accessed 08/11/2018	North Dakota Naloxone Rescue Agents Prior Authorization Form	Link
Ohio	07/01/2018	Ohio PDL (Fee for Service)	Link
	Accessed 03/17/2017	Ohio Drug Search	Link
	06/12/2016	Ohio Quantity Limits	Link
	05/2016	Ohio Prior Authorization Form Suboxone/Zubxolv	Link
	11/01/2017	OAC 5160-9-03 List of Drugs Covered Without Prior Authorization	Link
	08/01/2018	Ohio PDL (Molina)	Link
	01/01/2018	Ohio Medicaid Fee Schedule Medicine, Surgery, Radiology and Imaging, and Additional Procedures	Link
Oklahoma	Accessed 08/13/2018	Oklahoma Pharmacy Central Nervous System/Behavioral Health Substance Abuse Treatments	Link
	Accessed 08/13/2018	Oklahoma Maximum Quantity Limits	Link
	Accessed 08/13/2018	Oklahoma Prior Authorization WebAlerts	Link
	Accessed 07/31/2018	Kaiser Family Foundation States Reporting Medicaid Coverage of MAT Drugs	Link
Oregon	07/01/2018	Oregon PDL	Link and Link
	Accessed 08/13/2018	Oregon Health Plan Drug Formulary	Link
	11/06/2017	Oregon (Family Care) Formulary	Link
	02/20/2018	Oregon Health Plan Behavioral Health Fee Schedule	Link
	05/30/2018	Oregon Health Plan Fee-for-Service Fee Schedule	Link
Pennsylvania	07/23/2018	Pennsylvania PDL	Link
	05/01/2018	Pennsylvania Maximum Quantity Limits	Link
	Accessed 08/16/2018	GHS Pennsylvania Fee-for-Service Drug Search	Link
	04/10/2018	Pennsylvania Opiate Dependence Treatments Prior Authorization Form	Link
	04/10/2018	Pennsylvania Prior Authorization of Opiate Dependence Treatments	Link
	04/10/2018	Pennsylvania Prior Authorization Probuphine	Link
	Accessed 08/16/2018	Pennsylvania Fee-for-Service Billing Information for Naloxone	Link
	07/18/2016	Pennsylvania Prior Authorization of Opiate Overdose Agents	Link
	Accessed 07/27/2018	Pennsylvania Mental Health/Substance Abuse Outpatient Fee Schedule	Link
Puerto Rico	Accessed 08/06/2018	Puerto Rico Government Health Plan Provider Manual (Molina)	Link
	2018	Puerto Rico Salud Mental Formulario de Medicamentos en Cubierta del PSG	Link
	2018	Puerto Rico Salud Fisica Formulario de Medicamentos en Cubierta del PSG	Link

State	Effective Date	Document Name	Link
Rhode Island	07/10/2018	Rhode Island PDL	Link
	09/29/2017	Rhode Island MCO (Neighborhood Health Plan)	Link
	Accessed 07/16/2018	Rhode Island Rehabilitative Services Policy	Link
South Carolina	Accessed 08/16/2018	South Carolina Drug Lookup (Magellan)	Link
	08/01/2018	South Carolina PDL (Magellan)	Link
	08/01/2018	South Carolina PDL (Blue Cross Blue Shield)	Link and Link
	06/01/2017	South Carolina Clinical Criteria Buprenorphine Sublingual Tablets for Medication Assisted Treatment (Blue Cross Blue Shield)	Link
	01/09/2018	South Carolina Clinical Criteria Naloxone Agents (Blue Cross Blue Shield)	Link
	Accessed 08/16/2018	South Carolina Formulary Lookup (Blue Cross Blue Shield)	Link
South Dakota	Accessed 08/15/2018	South Dakota Prior Authorization Page	Link
	11/04/2014	South Dakota Medications Requiring Prior Authorization	Link
	08/02/2011	South Dakota Maximum Units List	Link
	Accessed 08/15/2018	South Dakota Evzio Prior Authorization Form	Link
	Accessed 08/15/2018	South Dakota Suboxone/Subutex Prior Authorization Form	Link
	Accessed 08/15/2018	South Dakota Evzio Prior Authorization Algorithm	Link
	Accessed 08/15/2018	South Dakota Suboxone/Subutex Prior Authorization Criteria	Link
	10/2018	Medicaid Drug Utilization Review State Comparison/Summary Report FFY 2017 Annual Report Prescription Drug Fee-For-Service Programs	Link
	Accessed 07/31/2018	Kaiser Family Foundation States Reporting Medicaid Coverage of MAT Drugs	Link
Tennessee	08/01/2018	Tennessee PDL (Magellan)	Link
	08/01/2018	Tennessee AutoExempt List	Link
	07/01/2018	Tennessee Prior Authorization Buprenorphine Products	Link
	08/01/2018	Tennessee Clinical Criteria, Step Therapy, and Quantity Limits (Magellan)	Link
	06/26/2018	Naltrexone MAT Program Description Division of TennCare	Link
	05/18/2018	Buprenorphine MAT Program Description Division of TennCare	Link
Texas	Accessed 08/15/2018	Texas Formulary Drug Search	Link
	07/26/2018	Texas Prior Authorization Criteria	Link
	05/2018	Texas Pharmacy Clinical Prior Authorization Assistance Chart	Link
	03/26/2018	Texas Prior Authorization Clinical Criteria Buprenorphine Agents	Link
	Accessed 07/16/2018	Texas Online Fee Lookup Search	Link
	10/2018	Medicaid Drug Utilization Review State Comparison/Summary Report FFY 2017 Annual Report Prescription Drug Fee-For-Service Programs	Link
U.S. Virgin Islands	N.D.	-	-

State	Effective Date	Document Name	Link
Utah	08/01/2018	Utah PDL	Link
	Accessed 08/14/2018	Utah Prior Authorization	Link
	08/01/2018	Utah Drug Quantity Limits	Link
	07/14/2018	Utah Coverage and Reimbursement Code Look-up	Link
	01/12/2018	Utah Prior Authorization Request Oral Buprenorphine and Buprenorphine/Naloxone Products	Link
	02/26/2018	Utah Prior Authorization Request Vivitrol and Sublocade	Link
	07/2018	Utah PDL (Molina)	Link
Vermont	07/06/2018	Vermont PDL	Link
Virginia	07/01/2018	Virginia PDL	Link
	Accessed 08/15/2018	Virginia Drug Lookup	Link
	05/31/2017	Virginia Service Authorization Form Oral Buprenorphine Products	Link
	Accessed 08/15/2018	Virginia Service Authorization Form Extended Release Buprenorphine (Sublocade)	Link
	12/29/2017	Virginia Addiction and Recovery Treatment Services Manual Supplement	Link
	07/2018	Magellan Virginia Medicaid/ Department of Medical Assistance Services Rates	Link
Washington	07/01/2018	Washington Apple Health PDL	Link
	07/01/2018	Washington MAT Coverage Limitation	Link
	04/01/2018	Washington Substance Use Disorder Billing Guide	Link
West Virginia	07/01/2018	West Virginia Substance Use Disorder Services	Link
	07/01/2018	West Virginia PDL	Link
	Accessed 08/14/2018	West Virginia Drug Limits	Link
	06/11/2018	West Virginia Drug Code List	Link
	Accessed 08/14/2018	West Virginia Prior Authorization	Link
	07/31/2017	West Virginia Policy for the Coverage of Suboxone Film (Buprenorphine/Naloxone) and Buprenorphine Tablets	Link
	06/01/2018	West Virginia Prior Authorization Criteria Sublocade (buprenorphine extended-release injection)	Link
Wisconsin	08/01/2018	Wisconsin Medicaid, BadgerCare Plus Standard, and SeniorCare Preferred Drug List—Quick Reference	Link
	08/01/2018	Wisconsin Quantity Limit Drugs	Link
	07/2018	Wisconsin Prior Authorization/Preferred Drug List for Opioid Dependency Agents—Buprenorphine	Link
	Accessed 08/12/2018	Wisconsin Drug Search	Link
Wyoming	07/17/2018	Wyoming PDL	Link
	07/17/2018	Wyoming Dosage Limitation List	Link
	07/17/2018	Wyoming Additional Therapeutic Classes with Clinical Criteria	Link
	Accessed 08/12/2018	Wyoming Oral Buprenorphine/Naloxone or Oral Buprenorphine Prior Authorization Request Form	Link

Abbreviations: MAT, medication-assisted treatment; MCO, managed care organization; PDL, Preferred Drug List; PSG, Plan de Salud del Gobierno de Puerto Rico; SUD, substance use disorder.

Note: Links were current as of August 20, 2018.

Table A-2. Preferred Status of Medications for Alcohol and Opioid Use Disorders or to Reverse Opioid Overdose Within Medicaid, by State, 2016–2017[a,b,c,d]

State	Acamprosate	Disulfiram	Oral Naltrexone	Extended-Release Injectable Naltrexone	Buprenorphine	Implantable Buprenorphine	Extended-Release Injectable Buprenorphine	Buprenorphine-Naloxone	Naloxone
Alabama	Yes	Yes	Yes	Yes	No	No	No	Yes	No
Alaska	-	No	Yes	Yes	No	No	-	Yes	No
Arizona	No	No	Yes	Yes	Yes	-	-	Yes	Yes
Arkansas	No	No	No	No	-	No	No	Yes	No
California	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Colorado	Yes	Yes	Yes	No	No	-	No	Yes	Yes
Connecticut	No	-	Yes	Yes	Yes	-	-	Yes	Yes
Delaware	-	No	Yes	Yes	Yes	-	Yes	Yes	Yes
District of Columbia	-	Yes	Yes	No	No	No	No	Yes	Yes
Florida	Yes	Yes	Yes	Yes	Yes	-	-	Yes	Yes
Georgia	Yes	Yes	Yes	Yes	Yes	-	-	Yes	Yes
Hawaii	No	Yes	Yes	No	Yes	-	-	Yes	Yes
Idaho	-	No	Yes	Yes	No	No	No	Yes	Yes
Illinois	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Indiana	Yes	Yes	Yes	No	Yes	-	No	Yes	Yes
Iowa	Yes	Yes	Yes	-	No	-	-	Yes	Yes
Kansas	No	No	No	No	No	No	-	No	No
Kentucky	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes
Louisiana	Yes	Yes	Yes	Yes	Yes	No	-	Yes	Yes
Maine	No	Yes	Yes	No	No	No	No	Yes	Yes
Maryland	No	-	Yes	Yes	Yes	-	No	Yes	Yes
Massachusetts	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes
Michigan	Yes	Yes	Yes	Yes	Yes	-	No	Yes	Yes
Minnesota	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes
Mississippi	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes
Missouri	-	No	Yes	Yes	No	No	No	Yes	Yes
Montana	No	No	Yes	No	Yes	-	-	Yes	Yes
Nebraska	No	No	Yes	-	No	-	-	Yes	Yes
Nevada	No	Yes	No	No	No	-	-	Yes	Yes
New Hampshire	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes
New Jersey	Yes	Yes	Yes	No	Yes	No	-	Yes	Yes
New Mexico	Yes	Yes	Yes	Yes	Yes	No	-	Yes	Yes
New York	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
North Carolina	Yes	Yes	Yes	Yes	No	-	Yes	Yes	Yes
North Dakota	Yes	Yes	No	Yes	No	No	No	Yes	Yes
Ohio	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Oklahoma	-	-	-	-	No	No	-	Yes	-
Oregon	Yes	Yes	Yes	Yes	Yes	-	-	Yes	Yes
Pennsylvania	-	-	Yes	Yes	Yes	No	No	Yes	Yes
Puerto Rico	-	-	-	-	Yes	-	-	Yes	-
Rhode Island	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes
South Carolina	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
South Dakota	-	-	-	-	-	-	-	Yes	No
Tennessee	-	-	Yes	Yes	Yes	-	-	Yes	Yes
Texas	Yes	Yes	Yes	No	Yes	-	-	Yes	Yes
U.S. Virgin Islands	-	-	-	-	-	-	-	-	-

State	Acamprosate	Disulfiram	Oral Naltrexone	Extended-Release Injectable Naltrexone	Buprenorphine	Implantable Buprenorphine	Extended-Release Injectable Buprenorphine	Buprenorphine-Naloxone	Naloxone
Utah	-	Yes	Yes	Yes	No	-	No	Yes	-
Vermont	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes
Virginia	-	-	Yes	Yes	Yes	No	No	Yes	Yes
Washington	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes
West Virginia	-	-	No	Yes	No	-	No	Yes	Yes
Wisconsin	No	No	Yes	Yes	No	-	No	Yes	Yes
Wyoming	-	No	Yes	Yes	No	-	-	Yes	No
Totals for All States									
Yes	27	32	44	34	29	2	7	51	43
No	11	11	5	13	21	26	24	1	6
Unknown	15	10	4	6	3	25	22	1	4

[a] As indicated in the methods section of this report, preferred status may vary between fee-for-service plans and managed care organizations (MCOs) or among MCOs. If the drug met the criteria for preferred status as laid out in the methods section of this report, it is identified as preferred in that state.

[b] Methadone is covered in Table A-9.

[c] Dashes indicate unknown or not applicable for each item.

[d] Materials reviewed were those available in the third quarter of 2018.

Table A-3. Medicaid Coverage of Acamprosate, by State, 2016–2017[a,b]

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psychosocial treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
Alabama	Yes	Yes	No	-	No	-	-
Alaska	No	-	-	-	-	-	-
Arizona	Yes	No	No	-	No	-	-
Arkansas	Yes	No	No	-	No	-	-
California	Yes	Yes	No	-	No	-	No
Colorado	Yes	Yes	No	-	No	-	No
Connecticut	No	No	-	-	-	-	-
Delaware	No	-	-	-	-	-	-
District of Columbia	No	-	-	-	-	-	-
Florida	Yes	Yes	No	-	-	-	-
Georgia	Yes	Yes	No	-	Yes	-	-
Hawaii	Yes	No	Yes	-	No	-	-
Idaho	No	-	-	-	-	-	-
Illinois	Yes	Yes	No	-	-	-	-
Indiana	Yes	Yes	No	-	Yes	-	-
Iowa	Yes	Yes	No	-	-	-	-
Kansas	Yes	No	No	-	-	-	-
Kentucky	Yes	Yes	Yes	Yes	Yes	-	Yes
Louisiana	Yes	Yes	No	-	Yes	-	-
Maine	Yes	No	Yes	Yes	-	-	Yes
Maryland	Yes	No	Yes	Yes	Yes	-	Yes
Massachusetts	Yes	Yes	No	-	-	-	-
Michigan	Yes	Yes	Yes	-	No	-	No
Minnesota	Yes	Yes	No	-	Yes	-	-
Mississippi	Yes	Yes	No	-	Yes	-	No
Missouri	Yes	-	-	-	-	-	-
Montana	Yes	No	-	-	-	-	-
Nebraska	Yes	No	-	-	No	-	-
Nevada	Yes	No	Yes	-	Yes	-	-
New Hampshire	Yes	Yes	No	-	No	-	-
New Jersey	Yes	Yes	No	-	Yes	-	-
New Mexico	Yes	Yes	No	-	No	-	No
New York	Yes	Yes	No	-	Yes	-	No
North Carolina	Yes	Yes	No	-	-	-	-
North Dakota	Yes	Yes	No	-	No	-	-
Ohio	Yes	Yes	Yes	-	No	-	-
Oklahoma	No	-	-	-	-	-	-
Oregon	Yes	Yes	Yes	-	Yes	-	No
Pennsylvania	No	-	-	-	-	-	-
Puerto Rico	-	-	Yes	-	-	-	Yes
Rhode Island	Yes	Yes	No	-	No	-	No
South Carolina	Yes	Yes	No	-	Yes	-	No
South Dakota	Yes	-	-	-	-	-	-
Tennessee	No	-	-	-	-	-	-
Texas	Yes	Yes	No	-	-	-	-

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psycho-social treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
U.S. Virgin Islands	-	-	-	-	-	-	-
Utah	No	-	-	-	-	-	-
Vermont	Yes	Yes	No	-	No	-	-
Virginia	Yes	-	No	-	No	-	-
Washington	Yes	Yes	No	-	No	-	-
West Virginia	No	-	-	-	-	-	-
Wisconsin	Yes	No	No	-	No	-	-
Wyoming	No	-	-	-	-	-	-
Totals for All States							
Yes	40	27	9	3	12	0	4
No	11	11	28	0	17	0	9
Unknown	2	15	16	50	24	53	40

Abbreviations: FFS, fee-for-service; MCO, managed care organization; PDL, Preferred Drug List.

[a] Dashes indicate unknown or not applicable for each item.

[b] Materials reviewed were those available in the third quarter of 2018.

Alabama: Only certain brand drugs are identified as preferred and most generics are available without prior authorization. The formulary identifies this drug as available without authorization or quantity limits.

Arizona: The behavioral health drug list identifies it as not preferred but does not require prior authorization or quantity limits.

Arkansas: The drug is available without limits on formulary. Preferred status is indicated as “N/A."

California: Acamprosate is preferred on the Health and Wellness PDL.

Colorado: The drug is not on the FFS drug list, but neither is this drug class. It is included as preferred on a selected MCO formulary without prior authorization or other limits.

Connecticut: The drug is not on the PDL, and there is no evidence of reimbursement in the CMS data.

Delaware: The drug is not on the FFS PDL and is nonformulary on MCO, with no evidence of any reimbursement in 2018.

District of Columbia: The drug is not on the FFS PDL or MCO formulary, and no reimbursement is found in 2018.

Hawaii: The drug is not on the FFS formulary. The generic is covered with prior authorization on a selected MCO formulary.

Illinois: Generic is preferred.

Indiana: Neutral drugs (including acamprosate) are not listed on the FFS PDL and are neither preferred nor nonpreferred. The drug is preferred with quantity limits for the selected MCO.

Iowa: Generic is preferred with no prior authorization.

Kentucky: The FFS PDL does not identify this as preferred, but at least one MCO does identify it as preferred, whereas another requires prior authorization and imposes quantity limits, step therapy, and participation in a treatment program or recovery plan.

Louisiana: The drug is not listed on the FFS PDL or the MCO common PDL. At least one MCO identifies it as preferred with quantity limits.

Maine: The drug is nonpreferred on the FFS PDL and prior authorization is required. It is required to be used as part of a “formal structured outpatient detoxification program,” and preferred drugs must be tried first.

Maryland: The drug class is not on the FFS PDL, but the program does impose quantity limits, requirements for prior authorization, counseling, and failure of preferred drugs required.

Michigan: FFS does not list the drug. It is preferred on the common MCO formulary without prior authorization. There are no quantity limits for FFS or the MCO formulary. The carve-out requires prior authorization.

Mississippi: The FFS PDL does not include the drug, but at least one MCO treats it as preferred.

Missouri: The state uses Epocrates for its formulary. Epocrates identifies it as covered. No other information is available.

Montana: The drug is not on the FFS PDL, and there is no indication regarding requirements for prior authorization.

Nebraska: The drug is listed on formulary as covered for some but not all doses. The drug class is not on the PDL and requirements for prior authorization are unclear.

Nevada: The general FFS PDL does not list the drug. Substance use specific information (dated in that MCOs have since changed) indicated prior authorization is required for some and that quantity limits are required for some.

New Hampshire: The drug class is not on the FFS PDL, and it is not listed in one MCO formulary. One MCO formulary lists it as generic preferred. It is not listed on the FFS quantity limits document (which is dated).

New Jersey: Generic is preferred by a selected MCO, with quantity limits.

New York: The drug class is not on the FFS PDL. It is preferred on most MCO formularies, and for the selected plan, there is no prior authorization, but quantity limits are imposed.

North Carolina: The state treats the drug as preferred as the class is not listed. Prior authorization is not required.

North Dakota: Only certain classes are on PDL; this class is not included. Drug look-up indicates it is covered without prior authorization or quantity limits; treating as preferred.

Ohio: The drug is on the state FFS formulary, but the drug class is not on the PDL; there is no prior authorization and no quantity limit under FFS for generic or brand. The selected MCO identifies it as preferred with prior authorization.

Oklahoma: There is no evidence of coverage.

Oregon: Generic is preferred without prior authorization for FFS. The Oregon Health Plan drug list requires prior authorization and quantity limits.

Pennsylvania: The class is not on the FFS PDL, and it is not included in the current FFS formulary and has not been reimbursed in 2018.

Puerto Rico: The drug class is not included in the mental health formulary, although detoxification medications are included. Use of any drug not in the formulary requires approval and a showing of failure or other reasons why formulary medications cannot be used.

Rhode Island: The drug class is not listed on the FFS PDL, but generic is included without prior authorization or other limits on one MCO formulary.

South Carolina: This drug class is not on the FFS PDL. The generic is on the FFS formulary without prior authorization or other limits. The selected MCO identifies it as preferred with quantity limits.

South Dakota: The state seemingly does not have a publicly available PDL. There is no evidence of coverage in other pharmacy documents nor evidence of reimbursement in the 2018 CMS data.

Tennessee: The class is not on the state PDL, there were no reimbursements in the CMS data, and there is no publicly available information indicating it is covered.

Utah: This class is not included on the PDL, and there were no reimbursements in the 2018 CMS data.

Virginia: This class is not covered by the PDL. The drug look-up does not include a service authorization or quantity limit requirement.

Washington: Generic is preferred without limits. There are clinical cautions for acamprosate.

West Virginia: This class is not managed under the PDL. Documents indicate nonmanaged classes are covered as they historically have been. There was no reimbursement in the CMS 2018 data.

Wisconsin: Generic is on the formulary (without prior authorization) but not the PDL. The drug class is included on the PDL, but acamprosate is not.

Wyoming: There is no evidence of coverage of this drug.

Table A-4. Medicaid Coverage of Disulfiram, by State, 2016–2017[a,b]

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psychosocial treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
Alabama	Yes	Yes	No	-	No	-	-
Alaska	Yes	No	-	-	-	-	-
Arizona	Yes	No	No	-	No	-	-
Arkansas	Yes	No	No	-	No	-	-
California	Yes	Yes	No	-	No	-	No
Colorado	Yes	Yes	No	-	No	-	No
Connecticut	Yes	-	-	-	-	-	-
Delaware	Yes	No	-	-	-	-	-
District of Columbia	Yes	Yes	No	-	-	-	-
Florida	Yes	Yes	No	-	-	-	-
Georgia	Yes	Yes	No	-	Yes	-	-
Hawaii	Yes	Yes	No	-	No	-	-
Idaho	Yes	No	-	-	-	-	-
Illinois	Yes	Yes	No	-	-	-	-
Indiana	Yes	Yes	No	-	No	-	-
Iowa	Yes	Yes	No	-	-	-	-
Kansas	No	No	No	-	-	-	-
Kentucky	Yes	Yes	-	-	-	-	-
Louisiana	Yes	Yes	No	-	No	-	-
Maine	Yes	Yes	No	No	-	-	No
Maryland	Yes	-	-	-	-	-	-
Massachusetts	Yes	Yes	No	-	-	-	-
Michigan	Yes	Yes	No	-	No	-	No
Minnesota	Yes	Yes	No	-	No	-	-
Mississippi	Yes	Yes	No	-	Yes	-	No
Missouri	Yes	No	-	-	-	-	-
Montana	Yes	No	-	-	-	-	-
Nebraska	Yes	No	-	-	No	-	-
Nevada	Yes	Yes	No	-	No	-	-
New Hampshire	Yes	Yes	No	-	No	-	-
New Jersey	Yes	Yes	No	-	No	-	No
New Mexico	Yes	Yes	No	-	No	-	No
New York	Yes	Yes	No	-	No	-	No
North Carolina	Yes	Yes	No	-	-	-	-
North Dakota	Yes	Yes	No	-	No	-	-
Ohio	Yes	Yes	No	-	Yes	-	-
Oklahoma	Yes	-	-	-	-	-	-
Oregon	Yes	Yes	No	-	No	-	No
Pennsylvania	Yes	-	-	-	-	-	-
Puerto Rico	-	-	Yes	-	-	-	Yes
Rhode Island	No	Yes	No	-	No	-	No
South Carolina	Yes	Yes	No	-	No	-	No
South Dakota	Yes	-	-	-	-	-	-
Tennessee	Yes	-	-	-	-	-	-
Texas	Yes	Yes	No	-	-	-	-

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psycho-social treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
U.S. Virgin Islands	-	-	-	-	-	-	-
Utah	Yes	Yes	No	-	No	-	-
Vermont	Yes	Yes	No	-	No	-	-
Virginia	Yes	-	No	-	No	-	-
Washington	Yes	Yes	No	-	No	-	-
West Virginia	Yes	-	-	-	-	-	-
Wisconsin	Yes	No	No	-	No	-	-
Wyoming	Yes	No	-	-	-	-	-
Totals for All States							
Yes	49	32	1	0	3	0	1
No	2	11	36	1	25	0	11
Unknown	2	10	16	52	25	53	41

Abbreviations: FFS, fee-for-service; MCO, managed care organization; PDL, Preferred Drug List.

[a] Dashes indicate unknown or not applicable for each item.

[b] Materials reviewed were those available in the third quarter of 2018.

Alabama: Only certain brand drugs are identified as preferred, and most generics are available without prior authorization. The formulary identifies this drug as available without authorization or quantity limits.

Arizona: The behavioral health drug list identifies it as not preferred but does not require prior authorization or quantity limits.

Arkansas: The drug is available without limits on formulary. Preferred status is indicated as “N/A."

California: The generic is preferred on the Health and Wellness PDL.

Colorado: The drug is not on the FFS drug list, but neither is this drug class. It is included as preferred on a selected MCO formulary without prior authorization or other limits.

Connecticut: The drug is not on the PDL but is shown as reimbursed in the CMS data.

Delaware: The drug is not on the FFS PDL; the generic drug is included on an MCO formulary as “supplemental.”

District of Columbia: The drug is not on the FFS PDL, but the generic is included on MCO formulary without restrictions.

Idaho: The drug is not listed in the PDL, but the CMS Medicaid drug data do indicate it has been reimbursed in 2018.

Illinois: The generic and brand are preferred on the FFS PDL.

Indiana: Neutral drugs (including disulfiram) are not listed on the FFS PDL and are neither preferred nor nonpreferred. The selected MCO treats the generic as preferred and does not require prior authorization.

Iowa: Generic is preferred; brand is not.

Kentucky: Identified as preferred by some plans and not by others.

Louisiana: This is not on the FFS or common MCO PDL, but at least one MCO identifies it as preferred without prior authorization or quantity limits.

Maine: Both generic and brand drugs are preferred.

Maryland: The FFS PDL is not applicable to this class. It is treated as preferred in that it is one of the two drugs that must be tried and failed before acamprosate can be reimbursed. At least one MCO includes it on its formulary and does not require prior authorization.

Minnesota: The generic is preferred without prior authorization or quantity limits.

Mississippi: The FFS PDL does not include the drug, but at least one MCO treats it as preferred.

Missouri: Missouri HealthNet uses Epocrates as its formulary, and it indicates the drug is not covered by Missouri Medicaid. It was, however, reimbursed by Missouri Medicaid in 2018.

Nebraska: The drug class is not on the PDL, but it is listed on formulary. Prior authorization requirements are unclear.

Nevada: The drug is not listed on the FFS PDL; however, it is included on the state Medicaid substance use treatment document as not requiring prior authorization.

New Hampshire: The generic is preferred on one MCO PDL. It is not on the FFS PDL or quantity limits list.

New Jersey: The drug is preferred by a selected MCO.

New York: The drug class is not on the FFS PDL. It is preferred on most MCO formularies, and for the selected plan, there is no prior authorization, but quantity limits are imposed.

North Carolina: The **s**tate treats the drug as preferred as the class is not listed. Prior authorization is not required.

North Dakota: Only certain classes are on the PDL; this class is not included. Drug look-up indicates that tablets are covered without prior authorization or quantity limits; treating as preferred.

Ohio: The drug class is not on the FFS PDL, but the generic is covered without prior authorization. Quantity limits apply. The selected MCO identifies it as preferred.

Oklahoma: Disulfiram was reimbursed in 2018.

Oregon: The drug is not on the FFS PDL. The Oregon Health Plan formulary preferred generic without prior authorization or quantity limits.

Pennsylvania: The drug class is not subject to the FFS PDL, but it is not included on the current formulary for the FFS program. It has, however, been reimbursed in 2018.

Puerto Rico: The drug class is not included in the mental health formulary, although detoxification medications are included. Use of any drug not in the formulary requires approval and a showing of failure or other reasons why formulary medications cannot be used.

Rhode Island: The drug class is not on the FFS PDL. A selected MCO prefers generic without prior authorization or other limits.

South Carolina: This drug class is not on the FFS PDL. The generic is on the FFS formulary without prior authorization or other limits. The selected MCO identifies it as preferred.

South Dakota: The state seemingly does not have a publicly available PDL. There is no evidence of coverage in other pharmacy documents, but there was reimbursement shown in the 2018 CMS data.

Tennessee: The class is not on the state PDL, but there were 2018 reimbursements in the CMS data.

Utah: This class is not on the FFS PDL, but disulfiram is included as preferred on the selected MCO PDL.

Vermont: Disulfiram is preferred without prior authorization. Brand is nonpreferred and requires prior authorization and proof of intolerance of generic.

Virginia: This class is not covered by the PDL. The drug look-up does not include a service authorization or quantity limit requirement.

Washington: Generic is preferred without limits.

West Virginia: This class is not managed under the PDL. Documents indicate nonmanaged classes are covered as they historically have been. There is evidence that the drug was reimbursed in 2018.

Wisconsin: Generic is on the formulary (without prior authorization) but not the PDL. The drug class is included on the PDL, but disulfiram is not.

Wyoming: Other drugs are identified as preferred or nonpreferred in chemical dependency class, including for alcohol dependence. Disulfiram and Antabuse are not mentioned. Disulfiram was reimbursed in 2018 in Wyoming.

Table A-5. Medicaid Coverage of Naltrexone, by State, 2016–2017[a,b]

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psychosocial treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
Alabama	Yes	Yes	No	-	No	-	-
Alaska	Yes	Yes	No	-	No	-	-
Arizona	Yes	Yes	No	-	No	-	-
Arkansas	Yes	No	Yes	-	Yes	-	-
California	Yes	Yes	No	-	No	-	No
Colorado	Yes	Yes	No	-	No	-	-
Connecticut	Yes	Yes	No	-	-	-	-
Delaware	Yes	Yes	No	-	No	-	No
District of Columbia	Yes	Yes	No	-	-	-	-
Florida	Yes	Yes	No	-	-	-	-
Georgia	Yes	Yes	No	-	No	-	-
Hawaii	Yes	Yes	No	-	No	-	-
Idaho	Yes	Yes	Yes	-	-	-	-
Illinois	Yes	Yes	No	-	-	-	-
Indiana	Yes	Yes	No	-	No	-	-
Iowa	Yes	Yes	No	-	-	-	-
Kansas	Yes	No	No	-	-	-	-
Kentucky	Yes	Yes	No	-	No	-	-
Louisiana	Yes	Yes	No	-	No	-	-
Maine	Yes	Yes	No	-	No	-	-
Maryland	Yes	Yes	No[c]	No	No	-	-
Massachusetts	Yes	Yes	No	-	-	-	-
Michigan	Yes	Yes	No	-	No	-	No
Minnesota	Yes	Yes	No	-	No	-	-
Mississippi	Yes	Yes	No	-	No	-	No
Missouri	Yes	Yes	Yes	-	Yes	-	-
Montana	Yes	Yes	-	-	-	-	-
Nebraska	Yes	Yes	No	-	No	-	-
Nevada	Yes	No	Yes	-	No	-	-
New Hampshire	Yes	Yes	Yes	-	No	-	-
New Jersey	Yes	Yes	No	-	No	-	No
New Mexico	Yes	Yes	No	-	No	-	No
New York	Yes	Yes	No	-	No	-	No
North Carolina	Yes	Yes	No	-	-	-	-
North Dakota	Yes	No	Yes	-	Yes	-	-
Ohio	Yes	Yes	No	-	No	-	No
Oklahoma	Yes	-	-	-	-	-	-
Oregon	Yes	Yes	No	-	No	-	No
Pennsylvania	Yes	Yes	No	-	No	-	-
Puerto Rico	-	-	Yes	-	-	-	Yes
Rhode Island	Yes	Yes	No	-	No	-	No
South Carolina	Yes	Yes	No	-	No	-	No
South Dakota	Yes	-	-	-	-	-	-
Tennessee	Yes	Yes	Yes	Yes	No	-	-

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psycho-social treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
Texas	Yes	Yes	No	-	-	-	-
U.S. Virgin Islands	-	-	-	-	-	-	-
Utah	Yes	Yes	No	-	Yes	-	No
Vermont	Yes	Yes	No	-	No	-	-
Virginia	Yes	Yes	No	-	No	-	No
Washington	Yes	Yes	No[c]	-	No	-	-
West Virginia	Yes	No	-	-	Yes	-	-
Wisconsin	Yes	Yes	No	-	No	-	-
Wyoming	Yes	Yes	No	-	No	-	-
Totals for All States							
Yes	51	44	8	1	5	0	1
No	0	5	40	1	33	0	13
Unknown	2	4	5	51	15	53	39

Abbreviations: FFS, fee-for-service; MCO, managed care organization; PDL, Preferred Drug List.

[a] Dashes indicate unknown or not applicable for each item.

[b] Materials reviewed were those available in the third quarter of 2018.

[c] See state information below.

Alabama: Only certain brand drugs are identified as preferred, and most generics are available without prior authorization. The formulary identifies this drug as available without authorization or quantity limits.

Arizona: The behavioral health drug list identifies it as preferred with no prior authorization or quantity limits.

Arkansas: The drug is available without limits on formulary. Preferred status is indicated as “N/A."

California: Naltrexone is preferred on the Health and Wellness PDL without limits.

Colorado: Generic and brand drugs are on the FFS prior authorization and quantity limits document without either prior authorization or quantity limits.

Georgia: The drug is not listed on the FFS PDL but is preferred without authorization by the selected PDL.

Hawaii: The drug is not listed on the FFS formulary but is preferred without prior authorization for the selected MCO.

Idaho: Generic is preferred with prior authorization.

Illinois: The drug is preferred without prior authorization.

Indiana: The drug is not on the FFS PDL, but it only has limited classes. The tablet formulation is preferred on at least one MCO formulary with no limits.

Kentucky: The drug is preferred for multiple state Medicaid plans.

Louisiana: FFS lists the generic drug as preferred for opioid dependence but does not list alcohol dependence treatments. At least one MCO identifies it as preferred for opioid dependence treatment.

Maine: Generic is preferred for both alcohol and opioid dependence treatment.

Maryland: Generic and brand drugs are preferred. Clinical criteria include a requirement for prior authorization if there was a paid claim within the previous 35 days for bupropion hydrochloride extended-release tablets or bupropion hydrochloride.

Massachusetts: Generic tablet does not require prior authorization.

Missouri: Naltrexone is preferred. Although it appears that prior authorization is not required by the general PDL, materials specific to treatment of opioid use disorder suggest otherwise.

Nebraska: Naltrexone is preferred on the PDL but is listed in the opioid reversal drug class.

Nevada: The drug is not on the FFS PDL, although the class is. The state Medicaid substance use specific document indicates clinical prior authorization is required for FFS. The MCO identified on that document as requiring quantity limits is no longer an MCO in the state.

New Hampshire: The FFS PDL does not list naltrexone in the opioid dependence treatment class, but it imposes a comprehensive prior authorization requirement on the entire class without regard to preferred status. A selected MCO prefers naltrexone without limit or prior authorization.

New Jersey: The drug is preferred by a selected MCO.

New York: The drug is preferred on the FFS PDL without limits. It is covered by the MCOs, and the selected MCO imposes no limits.

North Dakota: The drug is not on the PDL but is on the Department of Human Services drug look-up with prior authorization and quantity limit requirements; treating as nonpreferred.

Ohio: The drug is not on the FFS PDL, but it is listed on the drug look-up as being available without prior authorization, as well as being on the list of drugs, listed by statutory requirement, that do not require prior authorization. The selected MCO identifies it as preferred.

Oklahoma: The drug was reimbursed in 2018.

Puerto Rico: The drug is not included in the mental health formulary, although opioid treatment medications are included. Use of any drug not in the formulary requires approval and a showing of failure or other reasons why formulary medications cannot be used.

South Carolina: The drug is not on the FFS PDL, although Vivitrol is; however, the FFS formulary lists it as being available without limits. The selected MCO PDL identifies it as a preferred treatment.

South Dakota: The state seemingly does not have a publicly available PDL. There is no evidence of coverage in other pharmacy documents although it was reimbursed by Medicaid in 2018.

Tennessee: Naltrexone is preferred but requires prior authorization and counseling.

Utah: The drug is preferred on the FFS PDL and quantity limits are imposed. Molina includes it on formulary without prior authorization, quantity limits, or step therapy.

Washington: Generic is preferred without limits for patients older than 18 years. There are clinical cautions and restrictions (e.g., past 3 days for opioid withdrawal; if the patient is pregnant or has decompensated liver disease).

West Virginia: Naltrexone is not listed on the PDL, although Vivitrol is (see Table A-6). Injectable naltrexone, short and long-acting, is on the drug code list with quantity limits.

Wisconsin: Prior authorization is required only if diagnostic criteria are not met.

Wyoming: Clinical criteria apply if certain other medications are to be prescribed (narcotic, carisoprodol, benzodiazepines), and diagnostic criteria apply.

Table A-6. Medicaid Coverage of Extended Release Injectable Naltrexone, by State, 2016–2017[a,b]

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psychosocial treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
Alabama	Yes	Yes	No	-	No	-	-
Alaska	Yes	Yes	No	-	No	-	-
Arizona	Yes	Yes	No	-	No	-	-
Arkansas	Yes	No	-	-	-	-	-
California	Yes	Yes	No	-	No	-	No
Colorado	Yes	No	Yes	-	No	-	-
Connecticut	Yes	Yes	No	-	-	-	-
Delaware	Yes	Yes	Yes	Yes	Yes	-	Yes
District of Columbia	Yes	No	Yes	-	Yes	-	-
Florida	Yes	Yes	Yes	-	-	-	-
Georgia	Yes	Yes	No	-	Yes	-	-
Hawaii	Yes	No	-	-	-	-	-
Idaho	Yes	Yes	Yes	-	-	-	-
Illinois	Yes	Yes	No	-	-	-	-
Indiana	Yes	No	No	-	-	-	-
Iowa	Yes	-	-	-	-	-	-
Kansas	Yes	No	No	-	-	-	-
Kentucky	Yes	Yes	Yes	Yes	Yes	-	Yes
Louisiana	Yes	Yes	Yes	-	Yes	-	-
Maine	Yes	No	No	-	-	-	-
Maryland	Yes	Yes	Yes	Yes	Yes	-	-
Massachusetts	Yes	Yes	No	-	-	-	-
Michigan	Yes	Yes	No	-	No	-	No
Minnesota	Yes	Yes	Yes	-	Yes	-	-
Mississippi	Yes	No	Yes	-	Yes	-	-
Missouri	Yes	Yes	Yes	No	Yes	-	-
Montana	Yes	No	Yes	-	-	-	-
Nebraska	Yes[c]	-	-	-	-	-	-
Nevada	Yes	No	Yes	-	Yes	-	-
New Hampshire	Yes	Yes	No	-	No	-	-
New Jersey	Yes	No	-	-	-	-	-
New Mexico	Yes	Yes	No	-	Yes	-	No
New York	Yes	Yes	No	-	-	-	Yes
North Carolina	Yes	Yes	No	-	Yes	-	-
North Dakota	Yes	Yes	No	-	Yes	-	-
Ohio	Yes	Yes	Yes[c]	-	No	-	-
Oklahoma	Yes	-	-	-	-	-	-
Oregon	Yes	Yes[c]	No	-	No	-	-
Pennsylvania	Yes	Yes	No[c]	No[c]	Yes	-	-
Puerto Rico	-	-	Yes	-	-	-	Yes
Rhode Island	Yes	No	Yes	-	No	-	No
South Carolina	Yes	Yes	No[c]	-	No	-	-
South Dakota	Yes	-	-	-	-	-	-
Tennessee	Yes	Yes	Yes	Yes	-	-	-
Texas	Yes	No	Yes	-	-	-	-

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psycho-social treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
U.S. Virgin Islands	-	-	-	-	-	-	-
Utah	Yes	Yes	Yes	Yes	-	-	-
Vermont	Yes	Yes[c]	No	-	Yes	-	-
Virginia	Yes	Yes	No	-	No	-	No
Washington	Yes	Yes	No	-	No	-	-
West Virginia	Yes	Yes	No	-	Yes	-	-
Wisconsin	Yes	Yes	No	-	No	-	-
Wyoming	Yes	Yes	No	-	No	-	-
Totals for All States							
Yes	51	34	19	5	16	0	4
No	0	13	26	2	15	0	5
Unknown	2	6	8	46	22	53	44

Abbreviations: FFS, fee-for-service; MAT, medication-assisted treatment; MCO, managed care organization; PDL, Preferred Drug List.

[a] Dashes indicate unknown or not applicable for each item.

[b] Materials reviewed were those available in the third quarter of 2018.

[c] See state information below.

Alabama: The formulary identifies this drug as available without authorization or quantity limits.

Arizona: The behavioral health drug list identifies it as preferred with no prior authorization or quantity limits.

Arkansas: Vivitrol is listed on the PDL as neither preferred nor nonpreferred but, rather, as a medical benefit.

California: The drug is preferred without limit on the Health and Wellness PDL.

Colorado: The drug is not on the FFS PDL but is listed on the FFS quantity limits and prior authorization guidance, where it states that approval will be granted if administered in the patient's home or in a long-term care facility. Otherwise, it must be billed as a medical expense.

Delaware: The drug is preferred on the FFS PDL but requires prior authorization, counseling, quantity limits, and an "oral naltrexone challenge."

District of Columbia: The drug is identified as not preferred on the FFS PDL and requires prior authorization. A selected MCO includes it on its formulary with quantity limits.

Florida: The drug is preferred and, on the FFS PDL, has an "auto-PA" status, meaning that the system will automatically approve if certain criteria are clear at the point of entry.

Georgia: The drug is preferred with FFS without prior authorization but with quantity limits.

Hawaii: The drug is not listed on the FFS formulary or the selected MCO formulary, but a small quantity was reimbursed in 2018.

Idaho: The drug is preferred for treatment of both alcohol and opioid use disorders.

Illinois: The drug is preferred without prior authorization on the FFS PDL.

Indiana: The drug is not on the FFS PDL, but it only has limited classes, and classes not included are neutral regarding preference. It is listed as nonpreferred on at least one MCO with no prior authorization.

Iowa: Coverage of extended-release injectable naltrexone is not found in state Medicaid documents, but it was reimbursed in 2018 in the Medicaid drug utilization data.

Kentucky: The drug is preferred on some Medicaid plans but not others. For nonpreferred, prior authorization is required, and for at least one managed care plan, step therapy, treatment participation, and quantity limits are imposed.

Louisiana: The FFS PDL identifies it as not preferred and requires prior authorization. At least one MCO lists it on its PDL and imposes quantity limits but not prior authorization.

Maine: The drug is preferred without prior authorization.

Maryland: The drug is preferred, but prior authorization, counseling, and quantity limits are required, as well as satisfaction of additional clinical criteria.

Massachusetts: The drug has no requirement for prior authorization.

Michigan: On the common MCO PDL, the drug appears to be preferred only for alcohol treatment and not opioid treatment. No distinction is made on the carve-out formulary.

Minnesota: There are prior authorization and quantity limits on extended-release injectable naltrexone.

Missouri: Vivitrol is preferred, and the general PDL indicates no prior authorization is required for preferred drugs; however, the PDL specific to MAT suggests otherwise.

Montana: The drug is not on the FFS PDL, although generic naltrexone is.

Nebraska: The state formulary identifies the drug as not covered, but it is covered as a medical service.

Nevada: The drug is not on the FFS PDL. The state Medicaid substance use treatment reimbursement guide indicates that prior authorization and quantity limits apply.

New Hampshire: The FFS PDL does not list Vivitrol in the opioid dependence treatment class, but it imposes a comprehensive prior authorization requirement on the entire class without regard to preferred status. A selected MCO lists Vivitrol as Tier 2 (treated here as nonpreferred) without limit or prior authorization.

New Jersey: Three selected MCOs do not include the drug on their PDLs. A fourth MCO does include it on its formulary with ambiguous limitations that may include prior authorization.

New Mexico: The drug is not on either of two selected MCO PDLs. It is on the formulary of a third MCO without prior authorization or step therapy, although quantity limits are imposed (treated as preferred).

New York: The drug is preferred on the FFS PDL, and it is covered by all MCOs. The selected MCO does not require prior authorization of quantity limits but does impose step therapy.

Ohio: The drug is preferred in the FFS program without prior authorization, although there are quantity limits. The selected MCO does not include Vivitrol on its PDL, indicating that prior authorization would be required.

Oklahoma: The drug was reimbursed in 2018.

Oregon: The drug is preferred without authorization on the FFS PDL but is not on the Oregon Health Plan formulary, although it is included as a medical benefit for that plan.

Pennsylvania: The drug is preferred with quantity limits. The current FFS PDL indicates that prior authorization is required, but the April 2018 prior authorization guidance for opioid treatment indicates that is no longer true. Counseling participation is a prerequisite for prior authorization, if that were to be required.

Puerto Rico: The drug is not included in the mental health formulary, although opioid treatment medications are included. Use of any drug not in the formulary requires approval and a showing of failure or other reasons why formulary medications cannot be used.

South Carolina: The drug is preferred without limits on the FFS PDL and formulary. The selected MCO treats it as nonpreferred and a medical benefit.

South Dakota: The state seemingly does not have a publicly available PDL. There is no evidence of coverage in other pharmacy documents, although it was reimbursed by Medicaid in 2018.

Tennessee: The drug is not listed on the PDL, although generic and brand naltrexone are. There was reimbursement during 2018, and it is identified as preferred, with counseling required, by a TennCare document applicable to the three MCOs.

Utah: The drug is preferred on the FFS PDL but is not on the selected MCO PDL. In FFS, clinical prior authorization is required with documentation of psychosocial services.

Vermont: The drug is preferred, if clinical criteria are met, for treatment of alcohol dependence and for prevention of relapse in opioid dependence treatment. Quantity limits apply to both.

Virginia: Extended-release injectable naltrexone is preferred without either prior authorization or quantity limits.

Washington: Extended-release injectable naltrexone is preferred without limits. There are several clinical prescribing guidelines that explicitly are not requirements for authorization.

West Virginia: The drug is preferred on the PDL with no prior authorization quantity limits on the drug code list.

Wisconsin: Prior authorization is required only if diagnostic criteria are not met.

Wyoming: Clinical criteria apply if certain other medications are to be prescribed (narcotic, carisoprodol, benzodiazepines), and diagnostic criteria apply.

Table A-7. Medicaid Coverage of Buprenorphine, by State, 2016–2017[a,b]

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psycho-social treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
Alabama	Yes	No	Yes	-	Yes	-	-
Alaska	Yes	No	Yes	-	Yes	-	-
Arizona	Yes	Yes[c]	No[c]	-	No	-	-
Arkansas	Yes	-[c]	Yes	Yes	Yes	-	-
California	Yes	Yes	No	-	No	-	No
Colorado	Yes	No	Yes	-	Yes	-	-
Connecticut	Yes	Yes	No	-	Yes	-	-
Delaware	Yes	Yes	No	-	Yes	-	No
District of Columbia	Yes	No	Yes	-	Yes	-	-
Florida	Yes	Yes	Yes	Yes	Yes	-	-
Georgia	Yes	Yes	No	-	Yes	-	-
Hawaii	Yes	Yes	No	-	No	-	-
Idaho	Yes	No	Yes	-	Yes	-	Yes
Illinois	Yes	Yes	No	-	Yes	-	-
Indiana	Yes	Yes	Yes	Yes	Yes	-	-
Iowa	Yes	No	Yes	Yes	Yes	-	-
Kansas	Yes	No	Yes	Yes[c]	Yes	-	-
Kentucky	Yes	Yes	Yes	Yes	Yes	-	-
Louisiana	Yes	Yes	Yes	-	Yes	-	-
Maine	Yes	No	Yes	Yes	Yes	No[c]	Yes
Maryland	Yes	Yes	No	-	Yes	-	-
Massachusetts	Yes	No	Yes	-	No	-	-
Michigan	Yes	Yes	Yes	Yes	Yes	No	No
Minnesota	Yes	Yes	Yes	-	Yes	-	-
Mississippi	Yes	Yes	No	-	Yes	-	No
Missouri	Yes	No	Yes	-	Yes	-	-
Montana	Yes	Yes	Yes	Yes	Yes	-	-
Nebraska	Yes	No	Yes	Yes	Yes	-	Yes[c]
Nevada	Yes	No	Yes	Yes	Yes	-	-
New Hampshire	Yes	Yes	Yes	Yes	Yes	-	-
New Jersey	Yes	Yes	No	-	Yes	-	No
New Mexico	Yes	Yes	Yes	-	Yes	-	No
New York	Yes	Yes	Yes	-	Yes	-	-
North Carolina	Yes	No	Yes	-	Yes	-	-
North Dakota	Yes	No	Yes	-	Yes	-	-
Ohio	Yes	Yes[c]	Yes	-	Yes	-	Yes
Oklahoma	Yes	No	Yes	-	Yes	-	Yes
Oregon	Yes	Yes	Yes	-	Yes	-	No
Pennsylvania	Yes	Yes	Yes	Yes	Yes	-	-
Puerto Rico	Yes	Yes	Yes	-	No	-	No
Rhode Island	Yes	Yes	No	-	No	-	No
South Carolina	Yes	Yes	No	-	Yes	-	Yes
South Dakota	Yes	-	Yes	-	Yes	-	-
Tennessee	Yes	Yes[c]	Yes	Yes	Yes	-	Yes
Texas	Yes	Yes[c]	Yes[c]	-	Yes	-	-

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psycho-social treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
U.S. Virgin Islands	-	-	-	-	-	-	-
Utah	Yes	No	Yes[c]	Yes[c]	Yes	No[c]	-
Vermont	Yes	No	Yes	-	Yes	-	-
Virginia	Yes	Yes	Yes	Yes	Yes	-	No
Washington	Yes[c]	No	Yes	-	Yes	-	-
West Virginia	Yes	No	Yes	-	Yes	-	Yes
Wisconsin	Yes	No	Yes	-	No	-	-
Wyoming	Yes	No	Yes	-	Yes	-	Yes[c]
Totals for All States							
Yes	52	29	40	16	45	0	9
No	0	21	12	0	7	3	10
Unknown	1	3	1	37	1	50	34

Abbreviations: DSM, Diagnostic and Statistical Manual of Mental Disorders; FFS, fee-for-service; MCO, managed care organization; PDL, Preferred Drug List.

[a] Dashes indicate unknown or not applicable for each item.

[b] Materials reviewed were those available in the third quarter of 2018.

[c] See state information below.

Alabama: The drug is not preferred. Prior authorization is required, and quantity limits apply.

Alaska: The drug is not preferred, and prior authorization, quantity limits, and "medically necessary documentation" are required.

Arizona: The drug is preferred for pregnant women, and prior authorization is not required if the prescriber indicates appropriate pregnancy coding.

Arkansas: The formulary identifies the preferred status as "N/A." The PDL indicates that sublingual is preferred. The prior authorization criteria and linked memorandum indicate it is preferred with prior authorization criteria. Prior authorization is required, as are documented counseling and quantity limits.

California: The drug is preferred without limits on the Health and Wellness PDL.

Colorado: The drug is not identified as preferred, and prior authorization and quantity limits are required for FFS Medicaid.

Connecticut: Buprenorphine sublingual is preferred. The FFY 2017 CMS Drug Utilization Review State Comparison/Summary Report indicates that, for FFS enrollees, there were some quantity or time limits for buprenorphine in FFY 2017.

Delaware: Sublingual buprenorphine tablet is preferred with quantity limits.

District of Columbia: The drug is not preferred and requires prior authorization on the FFS PDL. The selected MCO also requires prior authorization. The FFY 2017 CMS Drug Utilization Review State Comparison/Summary Report indicates that, for FFS enrollees, there were some quantity or time limits for buprenorphine in FFY 2017.

Florida: Generic sublingual is preferred with prior authorization indicating clinical conditions are met, including counseling. The prior authorization form asks about failure of other therapies in the prior 12 months, but presumably this is not a requirement if being administered to a pregnant woman. The FFY 2017 CMS Drug Utilization Review State Comparison/Summary Report indicates that, for FFS enrollees, there were some quantity or time limits for buprenorphine in FFY 2017.

Hawaii: It is listed on the FFS formulary. The selected MCO identifies it as preferred without prior authorization or quantity limits.

Idaho: The drug is nonpreferred; prior authorization is required with multiple requirements, limit of 24 mg/day. Step therapy is required for all nonpreferred agents, likely not for pregnant women.

Illinois: The buprenorphine hydrochloride is preferred on the FFS PDL, without prior authorization. The FFY 2017 CMS Drug Utilization Review State Comparison/Summary Report indicates that, for FFS enrollees, there were some quantity or time limits for buprenorphine in FFY 2017.

Indiana: For FFS, generic sublingual is preferred with prior authorization, clinical criteria, counseling, and quantity limits. It is identified as preferred on a selected MCO formulary.

Iowa: The drug is not preferred; prior authorization, clinical criteria, counseling, and quantity and dose limits apply; drug is available only for pregnant women.

Kansas: The drug is not on the PDL; it appears that prior authorization, counseling, and quantity limits (24 mg/day) are required. These requirements are unclear because the buprenorphine requirements incorporate by reference buprenorphine-naloxone requirements that have been removed, whereas supplemental requirements only applicable to buprenorphine apply. Authorizations last 3 months.

Kentucky: The drug is not included on the FFS PDL. For multiple MCOs, preferred with prior authorization and, in some cases, quantity limits and psychosocial treatment are required.

Louisiana: The drug is not preferred for FFS, and prior authorization is required. At least one MCO lists it on its PDL but imposes quantity limits.

Maine: The drug is not preferred; prior authorization is required; counseling, clinical criteria (i.e., pregnant or proven allergy), and quantity limits apply. There is a 24-month lifetime limit which, Maine has represented to CMS, offers unlimited 12-month extensions beyond the 24-month lifetime limitation to persons who meet the state's medical necessity criteria for continued methadone treatment (they must be considered successful based on a clinical review of the ASAM six dimensions placement criteria). Those persons who do not meet the criteria for continued treatment beyond the 24 months (they are not successful in the program) are referred to other medically necessary services. Step therapy applies to nonpreferred medications; presumably this would apply to the allergy criteria but not the pregnancy criteria.

Maryland: The drug is preferred, and there are clinical criteria (pregnant, breastfeeding, or intolerance of naloxone) after first fill; there also are quantity limits (three tablets/day).

Massachusetts: Prior authorization is required, particularly in certain circumstances when the patient is stable and has had a recent opioid claim.

Michigan: The state explicitly states there is no lifetime limit on treatment with any buprenorphine drugs for opioid use disorder treatment.

Minnesota: The drug is preferred for induction. Prior authorization is required.

Mississippi: Buprenorphine is not preferred and requires prior authorization on the FFS PDL. At least one MCO gives preferred status to buprenorphine sublingual tablets but not to other forms. Quantity limits apply for both FFS and the MCO.

Missouri: Buprenorphine monotherapy is not preferred, may be prescribed only for pregnant women, and may be subject to clinical approval. Quantity limits apply.

Montana: The sublingual drug is not preferred for induction or pregnancy only. Counseling and quantity limits apply.

Nebraska: The drug is not preferred, prior authorization is required, and there are quantity limits and clinical criteria (consent form includes requirement of documented counseling). Nonpreferred required failure on preferred drugs (unlikely to apply in the case of pregnancy).

New Hampshire: For FFS, the drug is preferred, but prior authorization is required for the entire class of drugs. The selected MCO lists it as treatment, imposes quantity limits and dose requirements, and requires prior authorization, clinical criteria, and counseling.

New Jersey: Drug status is preferred on the selected MCO formulary.

New Mexico: Three MCOs identify it as preferred; one requires prior authorization.

New York: The drug is preferred on the FFS PDL with quantity limits. The selected MCO does not prefer it and requires prior authorization and quantity limits.

North Dakota: The drug is not preferred, prior authorization is required, and quantity and other restrictions apply.

Ohio: The drug is not preferred and requires prior authorization and quantity limits. Step therapy is required in that, if the patient is not pregnant or breastfeeding, an intolerance of naloxone must be shown. The selected MCO does identify it as preferred.

Oklahoma: The drug is nonpreferred, prior authorization is required, and dose and quantity limits apply. Other than for treatment during pregnancy, allergy or adverse reaction to naloxone is required for approval.

Oregon: The FFS PDL does not list buprenorphine, which indicates that prior authorization is required. The FFS PDL does indicate that quantity limits apply to buprenorphine-containing drugs. The Oregon Health Plan formulary lists buprenorphine without prior authorization but with quantity limits.

Pennsylvania: Sublingual is preferred with prior authorization, clinical criteria, counseling, and quantity limits. It is to be used only for induction, during pregnancy, or during breastfeeding.

Puerto Rico: Generic sublingual film is preferred with prior authorization required.

Rhode Island: Generic sublingual tablet is preferred without prior authorization.

South Carolina: The FFS PDL and formulary do not require prior authorization, nor does the selected MCO. The selected MCO does have quantity limits and imposes step therapy in that, absent pregnancy, there must be a documented intolerance of naloxone.

South Dakota: The state seemingly does not have a PDL. Quantity limits apply. Prior authorization is required on the basis of an algorithm that applies to Subutex and Suboxone.

Tennessee: The drug is preferred if the patient is pregnant, prior authorization is required, and there are counseling and quantity limits. Unless pregnant, inability to take buprenorphine-naloxone must be demonstrated.

Texas: Sublingual buprenorphine is preferred for women who are pregnant and is available without PDL prior authorization, although clinical authorization is required. The FFY 2017 CMS Drug Utilization Review State Comparison/Summary Report indicates that, for FFS enrollees, there were some quantity or time limits for buprenorphine in FFY 2017.

Utah: The drug is nonpreferred with quantity limits, but prior authorization is required only for continuation after 180 days. Continuation also requires documentation of psychosocial support, and continuation after 180 days plus 3 years requires additional justification. Step therapy is required in that it is only available, if not pregnant, with documented naloxone allergy.

Vermont: The drug is not preferred; prior authorization, clinical criteria related to pregnancy, and quantity limits apply.

Virginia: Buprenorphine sublingual is preferred with prior authorization, counseling, quantity limits and other restrictions (including pregnancy).

Washington: Buprenorphine monotherapy is covered only for pregnant women who meet DSM-IV criteria for opioid dependence or DSM-V criteria for moderate or severe opioid disorder; prior authorization and quantity limits apply. After delivery, the woman must be transitioned to a buprenorphine/naloxone combination medication.

West Virginia: Prior approval is required, and there are limited reasons for authorization. Quantity limits apply. Absent pregnancy, step therapy is required, in that there must be clinically verified, life-threatening allergy to naloxone.

Wisconsin: The drug is not preferred, and prior authorization is required.

Wyoming: The drug is not preferred, generic is mandatory, and prior authorization and quantity limits apply. Step therapy is required in that the patient must have a demonstrated allergy to naloxone. The drug also will be approved for use during pregnancy.

Table A-8. Medicaid Coverage of Implantable Buprenorphine, by State, 2016–2017[a, b]

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psychosocial treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
Alabama	Yes	No	Yes	-	-	-	-
Alaska	Yes	No	Yes	-	-	-	Yes
Arizona	No	-	-	-	-	-	-
Arkansas	Yes	No	-	-	-	-	-
California	Yes	Yes	No	-	No	-	No
Colorado	No	-	-	-	-	-	-
Connecticut	No	-	-	-	-	-	-
Delaware	No	-	-	-	-	-	-
District of Columbia	Yes	No	Yes	-	-	-	-
Florida	No	-	-	-	-	-	-
Georgia	No	-	-	-	-	-	-
Hawaii	No	-	-	-	-	-	-
Idaho	Yes	No	Yes	-	-	-	Yes
Illinois	Yes	Yes	No	-	-	-	-
Indiana	Yes	-	-	-	-	-	-
Iowa	No	-	-	-	-	-	-
Kansas	Yes	No	Yes	Yes	Yes	-	Yes
Kentucky	Yes	No	Yes	-	Yes	-	-
Louisiana	Yes	No	Yes	-	-	-	-
Maine	Yes	No	Yes	-	-	-	Yes
Maryland	Yes	-	-	-	-	-	-
Massachusetts	Yes	No	Yes	-	-	-	Yes
Michigan	Yes	-	Yes	-	-	-	-
Minnesota	Yes	No	Yes	-	Yes	-	-
Mississippi	Yes	No	Yes	-	-	-	-
Missouri	Yes	No	Yes	No	Yes	-	Yes
Montana	Yes	-	-	-	-	-	-
Nebraska	No	-	-	-	-	-	-
Nevada	No	-	-	-	-	-	-
New Hampshire	Yes	No	Yes	Yes	Yes	-	Yes
New Jersey	Yes	No	Yes	-	No	-	No
New Mexico	Yes	No	Yes	-	No	-	No
New York	Yes	No	Yes	Yes	Yes	Yes	-
North Carolina	Yes	-	Yes	Yes	Yes	-	Yes
North Dakota	Yes	No	Yes	-	Yes	-	-
Ohio	Yes	No	Yes	-	-	-	-
Oklahoma	Yes	No	Yes	-[c]	Yes	-	Yes
Oregon	Yes	-	-	-	-	-	-
Pennsylvania	Yes	No	Yes	Yes	Yes	-	-
Puerto Rico	-	-	-	-	-	-	-
Rhode Island	Yes	No	Yes	-	-	-	-
South Carolina	Yes	No	Yes	-	Yes	-	-
South Dakota	No	-	-	-	-	-	-
Tennessee	No	-	-	-	-	-	-
Texas	Yes	-	-	-	-	-	-

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psycho-social treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
U.S. Virgin Islands	-	-	-	-	-	-	-
Utah	Yes	-	-	-	-	-	-
Vermont	Yes	No	Yes	-	Yes	-	-
Virginia	Yes	No	No	-	No	-	-
Washington	Yes	No	Yes	-	-	-	-
West Virginia	Yes	-	-	-	Yes	-	-
Wisconsin	No	-	-	-	-	-	-
Wyoming	No	-	-	-	-	-	-
Totals for All States							
Yes	37	2	26	5	13	1	9
No	14	26	3	1	4	0	3
Unknown	2	25	24	47	36	52	41

Abbreviations: FFS, fee-for-service; MCO, managed care organization; PDL, Preferred Drug List.

[a] Dashes indicate unknown or not applicable for each item.

[b] Materials reviewed were those available in the third quarter of 2018.

[c] See state information below.

Alaska: At least one failed attempt at treatment with another medication is required to obtain authorization.

Arizona: No evidence of coverage was found.

Arkansas: Probuphine is listed on the PDL as a medical benefit, rather than preferred or nonpreferred.

California: The Health and Wellness PDL identifies it as covered without limits specified.

Colorado: No evidence of coverage was found.

Connecticut: No evidence of coverage was found.

Delaware: No evidence of coverage was found.

District of Columbia: The FFS PDL identifies it as nonpreferred, requiring prior authorization.

Florida: No evidence of coverage was found.

Georgia: No evidence of coverage was found.

Hawaii: No evidence of coverage was found.

Illinois: The drug is preferred without prior authorization.

Indiana: The drug is identified as covered by the code J0570 in provider fee schedules.

Iowa: No evidence of coverage was found.

Kansas: The drug is not on the PDL; prior authorization, counseling, step therapy, and quantity limits are required.

Kentucky: The drug is not on the PDL for any plan examined, although one plan does require prior authorization and imposes quantity limits.

Louisiana: The FFS PDL identifies Probuphine as requiring prior authorization.

Maine: Probuphine is not preferred and requires prior authorization and failure of preferred treatment. Given the structure of the PDL, it is unclear what quantity limits, psychosocial counseling requirements, and lifetime limits may apply specifically to Probuphine.

Massachusetts: Prior authorization requires showing an allergic reaction, contraindication, or inadequate response to alternatives.

Michigan: The drug is covered as a medical benefit.

Mississippi: The FFS PDL identifies it as covered and not preferred. At least one MCO does not cover it.

Montana: The drug is covered as a medical benefit.

Nebraska: The formulary explicitly does not cover the drug.

Nevada: No evidence of coverage was found.

New Hampshire: The drug is not listed on the FFS PDL, but it is authorized as treatment by the selected MCO, with prior authorization, quantity limits, counseling, step therapy, and an expectation but not a mandate that treatment not be longer than 12 months.

New Mexico: One MCO lists it as covered and nonpreferred with prior authorization required.

New Jersey: A selected MCO PDL look-up identifies it as nonpreferred with prior authorization.

New York: The drug is not on the FFS PDL, but it is identified as nonpreferred with limits by the selected MCO. These include prior authorization, quantity limits, counseling, and step therapy. Use beyond 1 year is considered investigational and not medically necessary.

North Dakota: The formulary identifies it as covered with prior authorization and quantity limits.

Ohio: The drug is not preferred and requires prior authorization.

Oklahoma: Probuphine is not preferred; prior authorization is required, and there are quantity limits and step therapy requirements.

Oregon: The drug is listed on the Oregon Health Plan FFS fee schedule.

Pennsylvania: The FFS PDL identifies the drug as nonpreferred.

Puerto Rico: There is no evidence of coverage.

Rhode Island: The FFS PDL identifies it as nonpreferred with prior authorization required.

South Carolina: The FFS and selected MCO formularies identify it as nonpreferred. Prior authorization and quantity limits are imposed by the FFS formulary.

South Dakota: There is no evidence of coverage.

Tennessee: There is no evidence of coverage.

Texas: The drug is listed on the provider fee schedule.

Utah: The drug is listed on the provider fee schedule.

Virginia: The drug lookup lists it as covered with no limitations identified.

Washington: The PDL identifies it as nonpreferred with prior authorization required.

West Virginia: The drug code list identifies it as reimbursed with quantity limits.

Wisconsin: There is no evidence of coverage.

Wyoming: There is no evidence of coverage.

Table A-9. Medicaid Coverage of Extended-Release Injectable Buprenorphine, by State, 2016–2017[a,b]

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psycho-social treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
Alabama	Yes	No	No	-	Yes	-	-
Alaska	No	-	-	-	-	-	-
Arizona	No	-	-	-	-	-	-
Arkansas	Yes	No	-	-	-	-	-
California	Yes	Yes	No	-	No	-	No
Colorado	Yes	No	Yes	Yes	Yes	-	-
Connecticut	No	-	-	-	-	-	-
Delaware	Yes	Yes	No	-	-	-	-
District of Columbia	Yes	No	Yes	-	-	-	-
Florida	No	-	-	-	-	-	-
Georgia	No	-	-	-	-	-	-
Hawaii	No	-	-	-	-	-	-
Idaho	Yes	No	Yes	-	-	-	Yes
Illinois	Yes	Yes	No	-	-	-	-
Indiana	Yes	No	Yes	Yes	Yes	-	-
Iowa	No	-	-	-	-	-	-
Kansas	No	-	-	-	-	-	-
Kentucky	Yes	No	Yes	-	Yes	-	-
Louisiana	No	-	-	-	-	-	-
Maine	Yes	No	Yes	-	-	-	Yes
Maryland	Yes	No	Yes	Yes	Yes	-	No
Massachusetts	Yes	No	Yes	-	-	-	-
Michigan	Yes	No	Yes	Yes	Yes	No	-
Minnesota	Yes	No	Yes	-	Yes	-	-
Mississippi	Yes	No	Yes	-	-	-	No
Missouri	Yes	No	Yes	-	-	-	-
Montana	No	-	-	-	-	-	-
Nebraska	No	-	-	-	-	-	-
Nevada	No	-	-	-	-	-	-
New Hampshire	Yes	No	Yes	Yes	Yes	-	Yes
New Jersey	Yes	-	No	-	Yes	-	No
New Mexico	Yes	-	No	-	Yes	-	No
New York	Yes	Yes	Yes	Yes	Yes	-	-
North Carolina	Yes	Yes	No	-	Yes	-	-
North Dakota	Yes	No	Yes	-	Yes	-	-
Ohio	Yes	Yes[c]	Yes	-	Yes	-	-
Oklahoma	No	-	-	-	-	-	-
Oregon	No	-	-	-	-	-	-
Pennsylvania	Yes	No	Yes	Yes	Yes	-	-
Puerto Rico	-	-	-	-	-	-	-
Rhode Island	Yes	No	Yes	-	-	-	-
South Carolina	Yes	Yes	Yes[c]	No	No	-	-
South Dakota	No	-	-	-	-	-	-
Tennessee	No	-	-	-	-	-	-

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psycho-social treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
Texas	No	-	-	-	-	-	-
U.S. Virgin Islands	-	-	-	-	-	-	-
Utah	Yes	No	Yes	Yes	-	-	-
Vermont	Yes	No	Yes	-	No	-	-
Virginia	Yes	No	Yes	Yes	Yes	-	-
Washington	Yes	No	Yes	-	-	-	-
West Virginia	Yes	No	Yes	-	Yes	-	-
Wisconsin	Yes	No	Yes	Yes	-	-	-
Wyoming	No	-	-	-	-	-	-
Totals for All States							
Yes	33	7	25	10	17	0	3
No	18	24	7	1	3	1	5
Unknown	2	22	21	42	33	52	45

Abbreviations: FFS, fee-for-service; HCPCS, Healthcare Common Procedure Coding System; MAT, medication-assisted treatment; MCO, managed care organization; PDL, Preferred Drug List.

[a] Dashes indicate unknown or not applicable for each item.

[b] Materials reviewed were those available in the third quarter of 2018.

[c] See state information below.

Alaska: No evidence of coverage was found.

Arizona: No evidence of coverage was found.

Arkansas: Sublocade is listed on the PDL as a medical benefit, rather than preferred or nonpreferred.

California: The Health and Wellness PDL identifies it as covered without limits specified.

Colorado: This drug is approved to be administered only in a long-term care facility or the person's home by a home health care professional, if the person is in psychosocial treatment and with quantity limits. Other limits also apply.

Connecticut: No evidence of coverage was found.

Delaware: The drug is listed as preferred on the PDL.

District of Columbia: The FFS PDL identifies it as nonpreferred, requiring prior authorization.

Florida: No evidence of coverage was found.

Georgia: No evidence of coverage was found.

Hawaii: No evidence of coverage was found.

Illinois: The drug is preferred without prior authorization.

Indiana: The drug is nonpreferred but reimbursed with limits.

Iowa: No evidence of coverage was found.

Kansas: We did not find the drug listed on the PDLs checked nor the HCPCS code on the professional fee schedule.

Kentucky: This drug is identified as nonpreferred on one managed care formulary, with prior authorization and quantity limits required.

Louisiana: We did not find the drug listed on the PDLs checked nor the HCPCS code on the professional fee schedule.

Maine: Sublocade is not preferred and requires prior authorization and failure of preferred treatment. Given the structure of the PDL, it is unclear what quantity limits, psychosocial counseling requirements, and lifetime limits may apply specifically to the drug.

Michigan: The state explicitly states there is no lifetime limit on MAT treatment with buprenorphine drugs.

Montana: There is no evidence of coverage in Montana.

Nebraska: The formulary explicitly does not cover the drug.

Nevada: No evidence of coverage was found.

New Hampshire: The drug is not on the FFS PDL or one MCO PDL. It is listed with limits on a second MCO formulary.

New Jersey: A selected MCO PDL look-up identifies it as a medical benefit with quantity limits but no prior authorization.

New Mexico: Only one MCO identifies it as covered, and that is as a medical benefit without prior authorization.

New York: Preferred on FFS PDL. The selected MCO considers it nonpreferred and imposes limits.

North Dakota: The formulary identifies it as covered with prior authorization and quantity limits.

Ohio: The drug is preferred within the FFS plan with prior authorization and quantity limits. The selected MCO does not list it on the PDL.

Oklahoma: There is no evidence of coverage.

Oregon: There is no evidence of coverage.

Pennsylvania: This drug is covered as nonpreferred with prior authorization, counseling, and quantity limits.

Puerto Rico: There is no evidence of coverage.

Rhode Island: The FFS PDL identifies the drug as not preferred and requires prior authorization.

South Carolina: The FFS PDL identifies the drug as preferred without prior authorization. The FFS formulary indicates prior authorization is required. The drug is treated as a nonpreferred medical benefit on the selected MCO formulary.

South Dakota: There is no evidence of coverage.

Tennessee: There is no evidence of coverage.

Texas: The physician fee schedule look-up checked indicates it is not payable.

Utah: The drug is nonpreferred on the FFS PDL and requires clinical prior authorization with documented psychosocial services.

Virginia: The drug is listed on the PDL as not preferred and requires prior authorization, quantity limits, and participation in counseling.

Washington: The PDL identifies the drug as not preferred and requires prior authorization.

West Virginia: The PDL identifies the drug as not preferred and requires prior authorization and quantity limits.

Wisconsin: The drug is nonpreferred and requires prior authorization and participation in counseling.

Wyoming: There is no evidence of coverage.

Table A-10. Medicaid Coverage of Buprenorphine-Naloxone, by State, 2016–2017[a,b]

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psychosocial treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
Alabama	Yes	Yes	Yes	-	Yes	-	-
Alaska	Yes	Yes	Yes	-	Yes	-	-
Arizona	Yes	Yes	No	-	No	-	-
Arkansas	Yes	Yes	Yes	Yes	Yes	-	-
California	Yes	Yes	No	-	No	-	No
Colorado	Yes	Yes	Yes	-	Yes	-	-
Connecticut	Yes	Yes	No	-	Yes	-	-
Delaware	Yes	Yes	No	-	Yes	-	No
District of Columbia	Yes	Yes	No	-	Yes	-	-
Florida	Yes	Yes	Yes	Yes	Yes	-	Yes
Georgia	Yes	Yes	No	-	Yes	-	-
Hawaii	Yes	Yes	No	-	No	-	-
Idaho	Yes	Yes	Yes	-	Yes	-	No
Illinois	Yes	Yes	No	-	Yes	-	-
Indiana	Yes	Yes	Yes	Yes	Yes	-	-
Iowa	Yes	Yes	Yes	Yes	Yes	-	-
Kansas	Yes	No	No	-	Yes	-	-
Kentucky	Yes	Yes	Yes	Yes	Yes	-	-
Louisiana	Yes	Yes	No	-	Yes	-	-
Maine	Yes	Yes	Yes	Yes	Yes	No[c]	-
Maryland	Yes	Yes	No	-	Yes	-	-
Massachusetts	Yes	Yes	Yes	-	Yes	-	Yes
Michigan	Yes	Yes	Yes	Yes	Yes	No	No
Minnesota	Yes	Yes	Yes	-	Yes	-	-
Mississippi	Yes	Yes	No	-	Yes	-	No
Missouri	Yes	Yes	Yes	-	Yes	-	No
Montana	Yes	Yes	Yes	Yes	Yes	-	-
Nebraska	Yes	Yes	No	Yes	Yes	-	No
Nevada	Yes	Yes	Yes	Yes	Yes	-	-
New Hampshire	Yes	Yes	No	Yes	Yes	-	-
New Jersey	Yes	Yes	Yes	-	Yes	-	No
New Mexico	Yes	Yes	Yes	-	Yes	-	No
New York	Yes	Yes	Yes	-	Yes	-	-
North Carolina	Yes	Yes	No	-	Yes	-	-
North Dakota	Yes	Yes	Yes	-	Yes	-	-
Ohio	Yes	Yes	Yes	Yes	Yes	-	-
Oklahoma	Yes	Yes	Yes[c]	-	Yes	-	-
Oregon	Yes	Yes	No	-	Yes	-	No
Pennsylvania	Yes	Yes	Yes	Yes	Yes	-	-
Puerto Rico	Yes	Yes	Yes	-	No	-	No
Rhode Island	Yes	Yes	No	-	No	-	No
South Carolina	Yes	Yes	No	-	Yes	-	No
South Dakota	Yes	Yes	Yes	-	Yes	-	-
Tennessee	Yes	Yes	Yes	Yes	Yes	-	-
Texas	Yes	Yes	Yes[c]	-	Yes	-	-

State	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psycho-social treatment required?	Are there quantity limits or maximum daily doses?	Are there lifetime limits?	Is step therapy used?
U.S. Virgin Islands	-	-	-	-	-	-	-
Utah	Yes	Yes	No[c]	Yes[c]	Yes	No[c]	-
Vermont	Yes	Yes	No	-	Yes	-	-
Virginia	Yes	Yes	Yes	Yes	Yes	-	No
Washington	Yes	Yes	No[c]	-	Yes	No[c]	-
West Virginia	Yes	Yes	Yes	-	Yes	-	-
Wisconsin	Yes	Yes	Yes	-	No	-	-
Wyoming	Yes	Yes	Yes	-	Yes	-	No
Totals for All States							
Yes	52	51	31	16	46	0	2
No	0	1	21	0	6	4	15
Unknown	1	1	1	37	1	49	36

Abbreviations: DSM, Diagnostic and Statistical Manual of Mental Disorders; FFS, fee-for-service; MAT, medication-assisted treatment; MCO, managed care organization; PDL, Preferred Drug List; SL, sublingual.

[a] Dashes indicate unknown or not applicable for each item.

[b] Materials reviewed were those available in the third quarter of 2018.

[c] See state information below.

Alabama: Suboxone is preferred. Prior authorization is required, and quantity limits apply.

Alaska: Suboxone film and buprenorphine-naloxone SL are preferred; others are not. Prior authorization, quantity limits, and "medically necessary documentation" are required.

Arizona: Only Suboxone film is preferred.

Arkansas: Suboxone film is preferred with prior authorization, quantity limits, and counseling required. Other versions are not preferred.

California: The Health and Wellness PDL identifies it as covered without limits being identified.

Colorado: Suboxone is preferred, prior authorization is required, there are quantity limits.

Connecticut: Suboxone film is preferred. The FFY 2017 CMS Drug Utilization Review State Comparison/Summary Report indicates that, for FFS enrollees, there were some quantity or time limits for buprenorphine-naloxone formulations in FFY 2017.

Delaware: Suboxone and Zubsolv are preferred, but there are quantity limits.

District of Columbia: Suboxone film is preferred and other formulations are nonpreferred. Prior authorization is required for nonpreferred drugs. The selected MCO does not require prior authorization unless the dose is above the established quantity limit. The FFY 2017 CMS Drug Utilization Review State Comparison/Summary Report indicates that, for FFS enrollees, there were some quantity or time limits for buprenorphine-naloxone formulations in FFY 2017.

Florida: Suboxone film is preferred with prior authorization required indicating clinical criteria are met, including participation in counseling and, apparently, failure of some previous treatment in the past 12 months. The FFY 2017 CMS Drug Utilization Review State Comparison/Summary Report indicates that, for FFS enrollees, there were some quantity or time limits for buprenorphine-naloxone formulations in FFY 2017.

Georgia: Suboxone is preferred; others are not. Prior authorization is required for nonpreferred versions. Quantity limits apply.

Hawaii: The FFS formulary does not include it, but the selected MCO identifies it as preferred without prior authorization or quantity limits.

Idaho: Suboxone film is preferred, and other formulations are nonpreferred. Prior authorization and quantity limits are required for all versions. Step therapy is required for all nonpreferred agents, and other requirements exist.

Illinois: The generic Suboxone, Bunavail, and Zubsolv are all preferred on the FFS PDL. The FFY 2017 CMS Drug Utilization Review State Comparison/Summary Report indicates that, for FFS enrollees, there were some quantity or time limits for buprenorphine-naloxone formulations in FFY 2017.

Indiana: For FFS, Suboxone and the generic are preferred; the remainder are not. All require prior authorization and have clinical criteria, counseling, and quantity limits.

Iowa: Suboxone is preferred; all others are not preferred. All require prior authorization, clinical criteria, counseling, and quantity and dose limits. Step therapy is required for nonpreferred drugs.

Kansas: The FFY 2017 CMS Drug Utilization Review State Comparison/Summary Report indicates that, for FFS enrollees, there were some quantity or time limits for buprenorphine-naloxone formulations in FFY 2017.

Kentucky: The drug is not included on the FFS PDL. Multiple MCOs may have a drug preference (which depends on the MCO). All require prior authorization and, in some cases, quantity limits that vary by formulation. One requires failure first with generic to obtain brand.

Louisiana: For FFS, buprenorphine-naloxone and Suboxone film are preferred; others are not preferred and require prior authorization. At least one MCO imposes prior authorization and quantity limits.

Maine: Suboxone film is preferred; the remainder are not. For all versions, prior authorization is required, and there are counseling, clinical criteria, and quantity limits. Preferred must be tried before nonpreferred. For Bunavail and Zubsolv, authorization may be granted after 24 months if certain criteria are met. There is a 24-month lifetime limit in both the PDL and in the Maine statutes which Maine has represented to CMS offers unlimited 12-month extensions beyond the 24-month lifetime limitation to persons who meet the state's medical necessity criteria for continued methadone treatment (they must be considered successful based on a clinical review of the ASAM six dimensions placement criteria). Those persons who do not meet the criteria for continued treatment beyond the 24 months (they are not successful in the program) are referred to other medically necessary services.

Maryland: Suboxone film, Bunavail, and Zubsolv are preferred; Suboxone that is not film is not preferred and requires prior authorization. All have quantity limits that vary by dose and formulation.

Massachusetts: Suboxone film is preferred but with prior authorization, and the type of authorization documentation varies by dose, route, and whether the person also is prescribed an opioid.

Michigan: The state explicitly states that there is no lifetime limit on MAT treatment with buprenorphine products.

Minnesota: Suboxone film is preferred; other formulations are not. All require prior authorization. There is a quantity limit of 24 mg/day for all but Zubsolv, which has different limits based on dose. Zubsolv requires step therapy.

Mississippi: Suboxone film is preferred in the FFS program. Among nonpreferred drugs, Bunavail is preferred over others including generic, although Bunavail is not indicated for induction and has certain step therapy requirements. All require prior authorization, and quantity limits and other restrictions apply. At least one MCO prefers SL tablets and does not require prior authorization for that formulation.

Missouri: Suboxone film is preferred, but it is likely that prior authorization continues to be required. Quantity limits apply and vary depending on route, dose, and stage of treatment. Step therapy is required only for nonpreferred formulations.

Montana: Suboxone film is preferred with prior authorization required; all others are not preferred. There are counseling and quantity limits, and annual updates are required.

Nebraska: Suboxone film is preferred, the remainder are not preferred. Prior authorization is required for all versions except the preferred; quantity limits vary by formulation. There are clinical criteria; the consent form includes a requirement of documented counseling. Nonpreferred requires failure on preferred drugs.

Nevada: Bunavail, Suboxone, and Zubsolv are preferred, with prior authorization, quantity limits, and counseling required.

New Hampshire: For FFS, Suboxone is preferred and the remaining drugs are not preferred; prior authorization is required for all. One selected MCO prefers Suboxone film and does not require prior authorization for lower doses of the preferred drug, but it does impose prior authorization and failure with the preferred drug for nonpreferred approval. It also imposes quantity limits and dose requirements, clinical criteria, and counseling.

New Jersey: On a selected MCO PDL, the status was preferred with quantity limits and prior authorization.

New Mexico: The drug is preferred by at least two MCOs, although one requires prior authorization.

New York: For FFS and the selected MCO, Suboxone film is preferred; the remaining drugs are not preferred and require prior authorization. Quantity limits apply.

North Carolina: Suboxone film is preferred and the remaining drugs are not. Trial and failure of two preferred agents are required before authorization for nonpreferred is allowed. Prior authorization is not required for Suboxone film.

North Dakota: Zubsolv is preferred with prior authorization and quantity limits. Other formulations are not preferred.

Ohio: For FFS, Suboxone film and Zubsolv tablets are preferred with prior authorization, counseling, and quantity limits. The selected MCO identifies generic SL tablets and the generic film as preferred with prior authorization required.

Oklahoma: Suboxone film is preferred and the remaining drugs are nonpreferred. Prior authorization is required, although it is less than clear for Suboxone; dose and quantity limits apply depending on the formulation. Step therapy is required only for nonpreferred formulations.

Oregon: The FFS formulary lists suboxone film, Zubsolv, and the generic SL tablet as covered with quantity limits. The Oregon Health Plan formulary lists the generic without prior authorization but with quantity limits. Prior authorization would be required for the brands not listed on the FFS PDL or Oregon Health Plan formulary.

Pennsylvania: Suboxone film is preferred; all others are nonpreferred. All drugs require prior authorization, clinical criteria, counseling, and quantity limits.

Puerto Rico: Suboxone film is preferred with prior authorization required.

Rhode Island: Suboxone film is preferred without prior authorization on the FFS PDL. A selected MCO prefers the SL generic tablet.

South Carolina: The FFS PDL and formulary prefer Suboxone and the generic SL tablet without limits. The selected MCO identifies Suboxone film and generic buprenorphine/naloxone as preferred but includes quantity limits.

South Dakota: The state seemingly does not have a PDL. Quantity limits and prior authorization apply. The FFY 2017 CMS Drug Utilization Review State Comparison/Summary Report indicates that, for FFS enrollees, there was at least one preferred buprenorphine-naloxone formulation in FFY 2017.

Tennessee: Only Bunavail is preferred; the remaining drugs are not preferred. All require prior authorization, counseling, and quantity limits. Step therapy is required for nonpreferred formulations only.

Texas: Only Suboxone film is preferred. All require clinical authorization, and all but Suboxone require PDL prior authorization. The FFY 2017 CMS Drug Utilization Review State Comparison/Summary Report indicates that, for FFS enrollees, there were some quantity or time limits for buprenorphine-naloxone formulations in FFY 2017.

Utah: Suboxone is preferred; Bunavail, generic, and Zubsolv are not preferred. The drug has quantity limits, but prior authorization is required only for continuation after 180 days. Continuation also requires documentation of psychosocial support, and continuation after 180 days plus 3 years requires additional justification.

Vermont: Suboxone film is preferred; the remaining drugs are not preferred. Prior authorization (only for nonpreferred), clinical criteria, and quantity limits apply.

Virginia: Suboxone film is preferred with prior authorization. There are requirements for counseling and quantity limits, and there are other restrictions.

Washington: Buprenorphine/naloxone is preferred without limits up to a dose of 24 mg/day for individuals aged 16 years and older who meet DSM-IV criteria for opioid dependence or DSM-V criteria for moderate or severe opioid disorder. Otherwise, prior authorization is required. Additionally, prescribers are required to follow several prescribing guidelines “voluntarily”; failure to do so as a prescriber community may result in reinstitution of prior authorization requirements. Included in the voluntary guidelines are participation in more comprehensive treatment, induction limits, and other restrictions. Washington state MAT guidelines expressly state that there is no lifetime limit for buprenorphine.

West Virginia: Suboxone film is preferred but still has clinical and quantity limits. All others are nonpreferred.

Wisconsin: Suboxone film and Zubsolv are preferred; remaining drugs are not preferred. Prior authorization is required.

Wyoming: Suboxone film is preferred; clinical criteria, prior authorization, and quantity limits apply. Step therapy is required only for nonpreferred forms.

Table A-11. Medicaid Coverage of Methadone as MAT, by State, 2016–2017[a,b]

State	Is this drug covered by Medicaid?	Is prior authorization required?[c]	Are there quantity limits or maximum daily doses?	Are there lifetime limits?
Alabama	Yes	-	-	-
Alaska	Yes[c]	-	-	-
Arizona	Yes	-	-	-
Arkansas	No	-	-	-
California	Yes	-	-	-
Colorado	Yes	-	-	-
Connecticut	Yes	Yes	-	-
Delaware	Yes	-	-	-
District of Columbia	Yes	-	-	-
Florida	Yes	-	-	-
Georgia	Yes	-	-	-
Hawaii	Yes	-	-	-
Idaho	No	-	-	-
Illinois	Yes	-	-	-
Indiana	Yes	-	-	-
Iowa	Yes	-	-	-
Kansas	Yes[c]	-	-	-
Kentucky	No	-	-	-
Louisiana	No	-	-	-
Maine	Yes	Yes	Yes	Yes[c]
Maryland	Yes	-	-	-
Massachusetts	Yes	-	-	-
Michigan	Yes	-	-	-
Minnesota	Yes	-	-	-
Mississippi	Yes[c]	-	-	-
Missouri	Yes[c]	-	-	-
Montana	Yes[c]	-	-	-
Nebraska	No	-	-	-
Nevada	Yes	-	-	-
New Hampshire	Yes	-	-	-
New Jersey	Yes	No	-	-
New Mexico	Yes	-	-	-
New York	Yes	-	-	-
North Carolina	Yes	Yes	-	-
North Dakota	No	-	-	-
Ohio	Yes	-	-	-
Oklahoma	Yes[c]	-	-	-
Oregon	Yes	-	-	-
Pennsylvania	Yes	-	-	-
Puerto Rico	-	-	-	-
Rhode Island	Yes	No	-	-
South Carolina	No	-	-	-
South Dakota	Yes[c]	-	-	-
Tennessee	No	-	-	-
Texas	Yes	-	-	-
U.S. Virgin Islands	-	-	-	-

State	Is this drug covered by Medicaid?	Is prior authorization required?[c]	Are there quantity limits or maximum daily doses?	Are there lifetime limits?
Utah	Yes	-	-	-
Vermont	Yes	-	-	-
Virginia	Yes	-	-	-
Washington	Yes	-	-	-
West Virginia	Yes	No	-	-
Wisconsin	Yes	-	-	-
Wyoming	No	-	-	-
Totals for All States				
Yes	42	3	1	1
No	9	3	0	0
Unknown	2	47	52	52

Abbreviation: MAT, medication-assisted treatment.

[a] Because of the unique regulatory structure around methadone as MAT for substance use disorders (in contrast to use for treatment of pain), some requirements such as counseling, step therapy for those younger than 18 years old, and daily dosing requirements are uniformly part of the federal regulations governing dispensing of methadone in an opioid treatment program. For these reasons, only certain unique state-specific limits are addressed in this table. In general, preferred status is not a relevant inquiry for methadone treatment of opioid use disorder.

[b] Materials reviewed were those available in the second and third quarters of 2018.

[c] Additional requirements for prior authorization may exist as imposed by specific state Medicaid managed care organizations.

Alabama: The FY2017 Kaiser Family Foundation Medicaid Budget Survey summary indicates that Alabama reports not reimbursing methadone for purposes of MAT. A 2017 Alabama Medicaid document indicates that code H0020 is covered. We are counting it as covered.

Alaska: We find no evidence that methadone is covered for purposes of MAT in any Medicaid documents. The Kaiser Family Foundation State Health Facts based on the FY2017 Medicaid Budget Survey summary indicate that Alaska reports reimbursing methadone for purposes of MAT. We are counting it as covered.

Connecticut: Prior authorization is required for code H0020.

Kansas: We find no evidence that methadone is covered for purposes of MAT in any Medicaid documents. The Kaiser Family Foundation State Health Facts based on the FY2017 Medicaid Budget Survey summary indicate that Kansas reports reimbursing methadone for purposes of MAT. We are counting it as covered.

Maine: Treatment with methadone is limited to 24 months absent prior authorization.

Mississippi: We find no evidence that methadone is covered for purposes of MAT in any Medicaid documents. The Kaiser Family Foundation State Health Facts based on the FY2017 Medicaid Budget Survey summary indicate that Mississippi reports reimbursing methadone for purposes of MAT. We are counting it as covered.

Missouri: The Kaiser Family Foundation State Health Facts based on the FY2017 Medicaid Budget Survey summary indicate that Missouri reports reimbursing methadone for purposes of MAT and the state has advised CMS that it has multiple sites furnishing methadone, with Medicaid as a payer.

Montana: We find no evidence that methadone is covered for purposes of MAT in any Medicaid documents. The Kaiser Family Foundation State Health Facts based on the FY2017 Medicaid Budget Survey summary indicate that Montana reports reimbursing methadone for purposes of MAT. We are counting it as covered.

North Carolina: Initial authorization shall not exceed 60 days. Reauthorization shall not exceed 180 days. All utilization review activity shall be documented in the Provider's Service Plan.

Oklahoma: We find no evidence that methadone is covered for purposes of MAT in any Medicaid documents. The Kaiser Family Foundation State Health Facts based on the FY2017 Medicaid Budget Survey summary indicate that Oklahoma reports reimbursing methadone for purposes of MAT. We are counting it as covered.

Rhode Island: Prior authorization is explicitly not required.

South Dakota: We find no evidence that methadone is covered for purposes of MAT in any Medicaid documents. The Kaiser Family Foundation State Health Facts based on the FY2017 Medicaid Budget Survey summary indicate that South Dakota reports reimbursing methadone for purposes of MAT. We are counting it as covered.
Virginia: Section 1115 waiver indicates that service authorization is required.
West Virginia: Prior authorization is explicitly not required.

Table A-12. Medicaid Coverage of Naloxone, by State, 2016–2017[a,b]

State	Formulation	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psycho-social treatment required?	Are there quantity limits or maximum daily doses?	Are there life-time limits?	Is step therapy used?
Alabama	Naloxone	Yes	No	No	-	Yes	-	-
	Narcan	Yes	No	No	-	Yes	-	-
	Evzio	No	-	-	-	-	-	-
Alaska	Naloxone	Yes	-	-	-	-	-	-
	Narcan	Yes	-	-	-	-	-	-
	Evzio	Yes	No	Yes	-	Yes	-	-
Arizona	Naloxone	Yes	Yes	No	-	No	-	-
	Narcan	Yes	Yes	No	-	No	-	-
	Evzio	No	-	-	-	-	-	-
Arkansas	Naloxone	Yes	No	No	-	-	-	-
	Narcan	Yes	No	No	-	Yes	-	-
	Evzio	Yes	No	Yes	-	-	-	-
California	Naloxone	Yes	Yes	No	-	No	-	No
	Narcan	Yes	Yes	No	-	No	-	No
	Evzio	No	-	-	-	-	-	-
Colorado	Naloxone	Yes	Yes	No	-	-	-	-
	Narcan	Yes	Yes	No	-	-	-	-
	Evzio	No	-	-	-	-	-	-
Connecticut	Naloxone	Yes	Yes	No	-	-	-	-
	Narcan	Yes	Yes	No	-	-	-	-
	Evzio	No	-	-	-	-	-	-
Delaware	Naloxone	Yes	Yes	No	-	-	-	-
	Narcan	Yes	Yes	No	-	-	-	-
	Evzio	Yes	No	Yes	-	-	-	-
District of Columbia	Naloxone	Yes	Yes	No	-	-	-	-
	Narcan	Yes	Yes	No	-	-	-	-
	Evzio	Yes	No	Yes	-	-	-	-
Florida	Naloxone	Yes	Yes	No	-	-	-	-
	Narcan	Yes	Yes	No	-	-	-	-
	Evzio	No	-	-	-	-	-	-
Georgia	Naloxone	Yes	Yes	No	-	No	-	-
	Narcan	Yes	Yes	Yes	-	No	-	-
	Evzio	Yes	No	Yes	-	Yes	-	-
Hawaii	Naloxone	Yes	Yes	No	-	-	-	-
	Narcan	Yes	No	-	-	Yes	-	-
	Evzio	No	-	-	-	-	-	-
Idaho	Naloxone	Yes	Yes	Yes	-	-	-	-
	Narcan	Yes	Yes	Yes	-	-	-	-
	Evzio	No	-	-	-	-	-	-
Illinois	Naloxone	Yes	Yes	No	-	-	-	-
	Narcan	Yes	Yes	No	-	-	-	-
	Evzio	No	-	-	-	-	-	-

State	Formulation	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psycho-social treatment required?	Are there quantity limits or maximum daily doses?	Are there life-time limits?	Is step therapy used?
Indiana	Naloxone	Yes	Yes	No	-	-	-	-
	Narcan	Yes	Yes	No	-	-	-	-
	Evzio	Yes	No	Yes	-	-	-	-
Iowa	Naloxone	Yes	Yes	No	-	-	-	-
	Narcan	Yes	Yes	No	-	-	-	-
	Evzio	No	-	-	-	-	-	-
Kansas	Naloxone	Yes	No	No	-	-	-	-
	Narcan	Yes	No	No	-	-	-	-
	Evzio	No	No	-	-	-	-	-
Kentucky	Naloxone	Yes	Yes	Yes	-	Yes	-	-
	Narcan	Yes	Yes	Yes	-	Yes	-	-
	Evzio	Yes	No	Yes	-	Yes	-	-
Louisiana	Naloxone	Yes	Yes	No	-	Yes	-	-
	Narcan	Yes	Yes	No	-	Yes	-	-
	Evzio	Yes	No	Yes	-	-	-	-
Maine	Naloxone	Yes	No	Yes	-	-	-	-
	Narcan	Yes	Yes	No	-	Yes	-	-
	Evzio	Yes	No	Yes	-	-	-	-
Maryland	Naloxone	Yes	Yes	No	-	No	-	-
	Narcan	Yes	Yes	No	-	No	-	-
	Evzio	Yes	No	Yes	-	No	-	-
Massachusetts	Naloxone	Yes	Yes	No	-	-	-	-
	Narcan	Yes	Yes	No	-	-	-	-
	Evzio	No	-	-	-	-	-	-
Michigan	Naloxone	Yes	Yes	No	-	Yes	-	No
	Narcan	Yes	Yes	No	-	Yes	-	No
	Evzio	No	-	-	-	-	-	-
Minnesota	Naloxone	Yes	Yes	No	-	Yes	-	-
	Narcan	Yes	Yes	No	-	Yes	-	-
	Evzio	No	-	-	-	-	-	-
Mississippi	Naloxone	Yes	Yes	No	-	Yes	-	-
	Narcan	Yes	Yes	No	-	Yes	-	-
	Evzio	Yes	No	No	-	-	-	-
Missouri	Naloxone	Yes	Yes	No	-	-	-	-
	Narcan	Yes	Yes	No	-	-	-	-
	Evzio	No	-	-	-	-	-	-
Montana	Naloxone	Yes	Yes	No	-	No	-	-
	Narcan	Yes	Yes	No	-	No	-	-
	Evzio	No	-	-	-	-	-	-
Nebraska	Naloxone	Yes	Yes	No	-	-	-	-
	Narcan	Yes	Yes	No	-	-	-	-
	Evzio	No	-	-	-	-	-	-
Nevada	Naloxone	Yes	Yes	No	-	Yes	-	-
	Narcan	Yes	Yes	No	-	Yes	-	-
	Evzio	Yes	Yes	No	-	Yes	-	-

State	Formulation	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psycho-social treatment required?	Are there quantity limits or maximum daily doses?	Are there life-time limits?	Is step therapy used?
New Hampshire	Naloxone	Yes	Yes	No	-	No	-	-
	Narcan	Yes	Yes	No	-	No	-	-
	Evzio	Yes	No	Yes	Yes	No	-	-
New Jersey	Naloxone	Yes	Yes	No	-	Yes	-	-
	Narcan	Yes	Yes	No	-	-	-	-
	Evzio	Yes	Yes	No	-	-	-	-
New Mexico	Naloxone	Yes	Yes	No	-	No	-	No
	Narcan	Yes	Yes	Yes	-	Yes	-	-
	Evzio	Yes	No	Yes	-	Yes	-	No
New York	Naloxone	Yes	Yes	No	-	Yes	-	-
	Narcan	Yes	Yes	No	-	Yes	-	-
	Evzio	Yes	No	Yes	-	Yes	-	Yes
North Carolina	Naloxone	Yes	Yes	No	-	-	-	-
	Narcan	Yes	Yes	No	-	-	-	-
	Evzio	No	-	-	-	-	-	-
North Dakota	Naloxone	Yes	Yes	No	-	No	-	-
	Narcan	Yes	Yes	No[c]	Yes	Yes	-	-
	Evzio	Yes	No	Yes	Yes	Yes	-	-
Ohio	Naloxone	Yes	Yes	No	-	No	-	-
	Narcan	Yes	Yes	No	-	No	-	-
	Evzio	No	-	-	-	-	-	-
Oklahoma	Naloxone	Yes	-	-	-	-	-	-
	Narcan	Yes	-	-	-	-	-	-
	Evzio	No	-	-	-	-	-	-
Oregon	Naloxone	Yes	Yes	No	-	Yes	-	-
	Narcan	Yes	Yes	Yes	-	Yes	-	-
	Evzio	No	-	-	-	-	-	-
Pennsylvania	Naloxone	Yes	Yes	No	-	No	-	-
	Narcan	Yes	Yes	No	-	No	-	-
	Evzio	Yes	No	Yes	-	No	-	-
Puerto Rico	Naloxone	-	-	-	-	-	-	-
	Narcan	-	-	-	-	-	-	-
	Evzio	-	-	-	-	-	-	-
Rhode Island	Naloxone	Yes	Yes	No	-	Yes	-	-
	Narcan	Yes	Yes	No	-	Yes	-	-
	Evzio	No	-	-	-	-	-	-
South Carolina	Naloxone	Yes	Yes	No	-	Yes	-	-
	Narcan	Yes	Yes	No	-	Yes	-	-
	Evzio	Yes	No	Yes	-	Yes	-	Yes
South Dakota	Naloxone	Yes	-	No	-	-	-	-
	Narcan	Yes	-	No	-	-	-	-
	Evzio	Yes	No	Yes	-	-	-	-
Tennessee	Naloxone	Yes	No	-	-	-	-	-
	Narcan	Yes	Yes	Yes	-	Yes	-	-
	Evzio	No	-	-	-	-	-	-

State	Formulation	Is this drug covered by Medicaid?	Does this drug have preferred status?	Is prior authorization required?	Is psycho-social treatment required?	Are there quantity limits or maximum daily doses?	Are there life-time limits?	Is step therapy used?
Texas	Naloxone	Yes	Yes	No	-	-	-	-
	Narcan	Yes	Yes	No	-	-	-	-
	Evzio	No	-	-	-	-	-	-
U.S. Virgin Islands	-	-	-	-	-	-	-	-
Utah	Naloxone	Yes	-	-	-	-	-	-
	Narcan	Yes	-	-	-	-	-	-
	Evzio	No	-	-	-	-	-	-
Vermont	Naloxone	Yes	Yes	No	-	No	-	-
	Narcan	Yes	Yes	No	-	Yes	-	-
	Evzio	No	-	-	-	-	-	-
Virginia	Naloxone	Yes	Yes	No	-	-	-	-
	Narcan	Yes	Yes	No	-	-	-	-
	Evzio	Yes	No	Yes	-	-	-	-
Washington	Naloxone	Yes	Yes	No	-	No	-	-
	Narcan	Yes	Yes	No	-	No	-	-
	Evzio	No	-	-	-	-	-	-
West Virginia	Naloxone	Yes	Yes	No	-	Yes[c]	-	-
	Narcan	Yes	Yes	No	-	No[c]	-	-
	Evzio	Yes	No	Yes	-	Yes	-	-
Wisconsin	Naloxone	Yes	Yes	No	-	No	-	-
	Narcan	Yes	Yes	No	-	No	-	-
	Evzio	No	-	-	-	-	-	-
Wyoming	Naloxone	Yes	No	-[c]	-	Yes	-	-
	Narcan	Yes	No	-[c]	-	Yes	-	-
	Evzio	Yes	No	Yes	-	Yes	-	-
Totals for All States								
Yes	-	51	43	21	2	25	0	2
No	-	0	6	28	0	8	0	3
Unknown	-	2	4	4	51	20	53	48

Abbreviations: FFS, fee-for-service; MCO, managed care organization.

[a] Dashes indicate unknown or not applicable for each item.

[b] Materials reviewed were those available in the third quarter of 2018.

[c] See state information below.

Alabama: Evzio is explicitly not covered.

Alaska: The state does not list any on the PDL, and only Evzio is identified as requiring prior authorization, quantity limits, and step therapy. The state does reimburse for naloxone and Narcan.

Arizona: There is no evidence of coverage of Evzio.

Arkansas: Narcan has a quantity limit; it is unclear whether Evzio does. Evzio requires manual review for prior authorization.

Colorado: Generic naloxone and Narcan are covered without prior authorization. Evzio is not covered.

Connecticut: There is no evidence that Evzio is covered. Naloxone generic and Narcan are preferred.

Florida: There is no evidence that Evzio is covered. Naloxone generic and Narcan are preferred.

Georgia: Naloxone and Narcan are preferred on the FFS PDL. Narcan and Evzio require prior authorization, and Evzio has quantity limits.

Hawaii: The FFS formulary lists only naloxone as covered; the CMS data show a minimal quantity reimbursed. The selected MCO does not include naloxone but does include Narcan with quantity limits, and the CMS data show reimbursement for Narcan. There is no evidence of coverage of Evzio.

Idaho: There is no evidence that Evzio is covered by the state Medicaid program.

Illinois: There is no evidence that Evzio is covered by the state Medicaid program.

Iowa: There is no evidence that Evzio is covered by the state Medicaid program.

Kansas: The CMS Medicaid Drug Utilization data for 2018 indicate the program has reimbursed for both naloxone and Narcan. There is no evidence of reimbursement of Evzio.

Kentucky: Requirements vary greatly by MCO. None prefer Evzio, and where it is listed, it has prior authorization and quantity limits. Some MCOs prefer naloxone and Narcan; some require prior authorization, and others do not. Similarly, some impose quantity limits and others do not.

Louisiana: Naloxone and Narcan are preferred. At least one MCO has quantity limits.

Maine: Narcan has a quantity limit of two units per 28 days.

Massachusetts: The state apparently does not reimburse for Evzio, and the CMS 2018 Medicaid Drug Utilization data indicate no reimbursement in this year.

Michigan: The state apparently does not reimburse for Evzio, and the CMS 2018 Medicaid Drug Utilization data indicate no reimbursement in this year.

Minnesota: The state stopped reimbursing for Evzio in 2017.

Mississippi: FFS Medicaid covers all three, with naloxone and Narcan having preferred status and no prior authorization. Evzio is not preferred by FFS, and at least one MCO does not cover it. The MCO imposes quantity limits on the other two formulations.

Missouri: The state apparently does not reimburse for Evzio, and the CMS 2018 Medicaid Drug Utilization data indicate no reimbursement in this year.

Nebraska: Evzio is expressly not covered on the formulary.

Nevada: All three are preferred on the FFS PDL. At least one new MCO identifies only naloxone and Narcan as preferred and imposes quantity limits.

New Jersey: MCO treatment varies, but a selected MCO treats all as preferred at different tiers, requiring quantity limits only for generic naloxone.

New Mexico: MCOs treat the three formulations differently. Two do not reimburse for Evzio, and the MCO that does requires prior authorization and quantity limits. One requires prior authorization and quantity limits for Narcan.

New York: Evzio is not on the FFS PDL. It is identified as nonpreferred with quantity and step therapy limits on the selected MCO formulary. The other two formulations are preferred with quantity limits for the MCO.

North Carolina: The state apparently does not reimburse for Evzio, and the CMS 2018 Medicaid Drug Utilization data indicate no reimbursement in this year.

North Dakota: All three formulations are covered. Naloxone does not require prior authorization, and Narcan only requires it after the first dispensing. Evzio requires prior authorization. Naloxone is covered without quantity limits; both other formulations have quantity limits and a requirement of psychosocial treatment. Although not step therapy, the prescriber of Evzio must justify why the other formulations are not being prescribed.

Ohio: Naloxone and Narcan are on the list of drugs for which no prior authorization is required. There also are no quantity limits. Evzio is not covered by the FFS plan, nor was there reimbursement in the 2018 CMS data. The selected MCO only lists the generic on the PDL.

Oklahoma: Evzio is explicitly not covered.

Oregon: The Oregon Health Plan formulary imposes quantity limits on naloxone and Narcan. Evzio was not reimbursed in 2018.

Pennsylvania: Evzio is reimbursed but is not preferred and requires prior authorization.

Puerto Rico: There is no evidence of coverage.

Rhode Island: The state does not cover Evzio. A selected MCO requires quantity limits for naloxone and Narcan.

South Carolina: FFS covers naloxone and Narcan as preferred. It expressly does not cover Evzio. The selected MCO covers all three formulations with quantity limits, treating Evzio as nonpreferred and requiring step therapy and prior authorization.

South Dakota: All are covered. Evzio requires prior authorization.

Tennessee: Narcan is preferred, requires prior authorization, and has a quantity limit. Naloxone is reimbursed. Evzio is not.

Texas: There is no evidence of coverage of Evzio.

Utah: Evzio is not covered. The FFS PDL and other documents do not include any formulation, leaving requirements uncertain. The selected MCO covers naloxone and Narcan without limit.

Vermont: Narcan has a quantity limit, and Evzio is not covered.

Washington: There is no evidence of coverage of Evzio.

West Virginia: All three are covered, with naloxone and Narcan preferred with no prior approval. The drug limits document indicates that quantity limits apply for generic naloxone and Evzio. The drug code document indicates that quantity limits apply for injection naloxone (with Narcan listed as the brand alternative).

Wisconsin: Evzio is not covered.

Wyoming: Any Evzio requires prior authorization. The other two formulations require prior authorization after the first fill.

VIII. Appendix B. Authors and Acknowledgements

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