Abuse-Deterrent Formulations Summit
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Aligning Market Objectives and Policy for National Public Health

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CLAAD Disclosures

CLAAD's funders include members of the pharmaceutical, addiction treatment, and laboratory industries, and are disclosed on its website, www.claad.org.

Preview

- Background and context
- Market uncertainty
- Trump administration's potential impact
- Federal legislation
- State legislation
- Discussion

Purpose

- New federal and state legislative sessions began in January
- Federal abuse-deterrence legislation, if any, would likely be part of PDUFA VI (current authorization ends Sept. 2017)
- Market uncertainty could impact innovation and progress
- Legislative proposals should align with market objectives to improve public health

Comprehensive National Strategy

- Prescriber education (covering all controlled medications)
- Public awareness and patient counseling, including safe storage and responsible disposal
- Prescription monitoring programs
- Prosecution of criminals, rehabilitation of negligent prescribers
- Overdose rescues, interventions, and referrals to treatment
- Access to effective treatments for substance use disorder
- Development, use, and coverage of non-pharmacologic treatments; non-controlled, lower scheduled, and medications with abuse-deterrent properties (ADPs)

Policy Goals: Reduce Unnecessary Exposure to and Risks of Controlled Medications (1/2)

- Development and use (when appropriate) of alternatives to commonly abused medications
  - Non-pharmacologic treatments, *e.g.*, virtual reality
  - Non-controlled medications, *e.g.*, biologics
  - Lower risk (lower scheduled) controlled medications
  - Medications with ADPs and novel delivery systems
    - Extended release, immediate release
    - Brand, generic
    - Not just opioids for pain; not just opioids

Policy Goals: Reduce Unnecessary Exposure to and Risks of Controlled Medications (2/2)

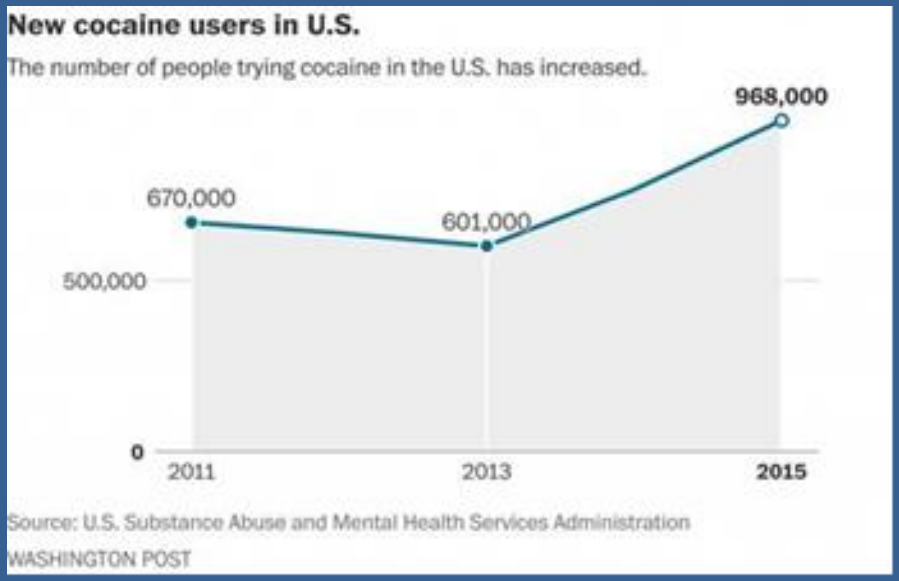
- Broad market transition
- Regulatory clarity and flexibility
- Recognition of benefits (providers, patients, and public)
- Advance notice of transition deadline to ensure product availability, competition, and lower costs
- Public and private insurance coverage

Shift in Opioid Overdose Epidemic: Supply Reduction

- DEA 2016 Drug Threat Assessment
  - Decline in abuse of prescription opioids
  - Increase in abuse of illicit fentanyl and heroin
  - Heroin overdose deaths more than tripled between 2010 and 2014, with the most recent data reporting 10,574 people in the United States died in 2014 from heroin overdoses
- CDC
  - Heroin related overdose tripled from 2010 to 2015
  - One in four drug overdoses in 2015 related to heroin

Cocaine Abuse

- Heroin and illicitly manufactured fentanyl driving a recent increase in cocaine-related overdose deaths
- The number of overdose deaths in the United States involving cocaine in 2015 was the highest since 2006 and the second-highest since 1999



Abuse of Non-Opioid Controlled Rx Medications

- Prescription Stimulants
  - 5.3 million people abused prescription stimulants in 2014
  - Between the ages of 18 to 25: One in six have abused prescription stimulants
  - College students: One in five has abused prescription stimulants
  - The most common medications of abuse are IR medications
- Benzodiazepines
  - Involved in ~ 30% of prescription drug overdose deaths in 2013
  - 4.3 fold increase in benzodiazepine-related deaths from 2002 to 2015
- Sleep medications
  - “Ambien-defense” to murder
  - Most common date-rape drug

Market Uncertainty – Federal

- U.S. Food and Drug Administration
  - Rejected labeling claims for the newly-approved morphine sulfate extended-release tablets re: nasal and oral abuse
  - Convening an advisory-committee to review risk-benefit of oxymorphone
  - Complete Response Letter to hydromorphone NME prodrug
- Centers for Medicare and Medicaid Services:
  - Advance notice and open call letter proposed changes to 2018 Medicare Advantage and Part D plans
    - Utilize 90 MME cutoff to determine overutilization
    - Requires plan sponsors to adopt hard formulary-level edits based on 200 MME

Market Uncertainty – Payment

- Medicare, Medicaid, and private insurance plans
  - Require PA or "fail-first" before covering opioid analgesics with ADPs (*e.g.* majority of states still list methadone on their preferred drug lists)
  - Deny coverage of practitioner-administered opioids for treatment for OUD
- Veterans Administration
  - Robert McDonald: "Vets are 10 times more likely to abuse opioids than the civilian population;" yet last year, VA advocated against the coverage of opioids with ADPs
  - Does not cover practitioner-administered opioids for treatment of OUD

Market Uncertainty – Legislative (1/2)

- States enacting parts of the CDC Opioid Guideline as law
  - New York: 7-day supply for acute pain
  - Rhode Island: Max 30 MME/day and 20 total doses for acute pain
  - Massachusetts: 7-day supply for all initial opioid analgesic prescriptions
    - Can prescribe more if document condition in the patient record and indicate that a non-opioid alternative was not appropriate
  - Maine: Max of (1) 7-day supply for acute pain; (2) 30-day supply for chronic pain; or (3) 100 MME/day
- Product-specific legislation
  - NJ: Passed resolution urging FDA to reconsider approval of reformulated ER hydrocodone without AD-labeling pending comprehensive testing, despite evidence that the product "is either not desirable or unavailable for abuse"

Market Uncertainty – Legislative

- Bills with unintended consequences
  - Buprenorphine-mono bills meant to reduce diversion, misuse, or abuse of oral buprenorphine for the treatment of OUD
    - Could stifle treatment with practitioner-administered opioids for treatment of OUD and interfere with treatment for pain
  - Georgia bill meant to reduce prescription drug abuse
    - Initially required ADHD medications to receive a new prescription every five days
- Other relevant bills
  - Bills that look to criminalize a person who has experienced an opioid overdose and is revived with naloxone

Current Administration

- Pres. Donald Trump
  - "The FDA has been far too slow to approve abuse-deterring drugs"
  - "As president, I'd work to lift the cap on the number of patients that doctors can treat, provided they follow safe prescribing practices and proper treatment supervision"
  - Vowed to "slash restraints" on drug development and emphasized need to "speed up approval of life-saving medications"
  - "We're going to expand access to abuse-deterring drugs…They're out and they're very hard to get"
- HHS Sec. Tom Price
  - "We believe that patients and doctors should be in control of health care"
  - "We need . . . to make certain that we are on the cutting edge of innovation"
  - The new FDA commissioner "understands and respects" that taking "10 to 14 years (to bring a drug to market) is simply too long"

New Laws

- Comprehensive Addiction and Recovery Act
  - HHS task force to recommend best practices for pain management
  - Must be established by July 2018; make recommendations one year from date of establishment

- 21st Century Cures Act
  - Directs the FDA to consider a broader range of real-world evidence when approving new indications for a drug

Federal Legislation

- 2016: Curb Opioid Misuse By Advancing Technology (COMBAT) Act, H.R. 5127
  - Incentives to develop new products with abuse-deterrent technologies
    - Approval based on new clinical abuse potential studies
    - FDA labeling of abuse-deterrent properties
  - Additional 12 months of data exclusivity for "other" drugs
  - Additional 60 days of data exclusivity for patent-challenge generics
  - Creates new class of opioids with ADPs that can breach exclusivity
  - Does not require second-in-time opioids with ADPs to have a new, different, or better abuse-deterrent technology

Recommendations: Federal Legislation

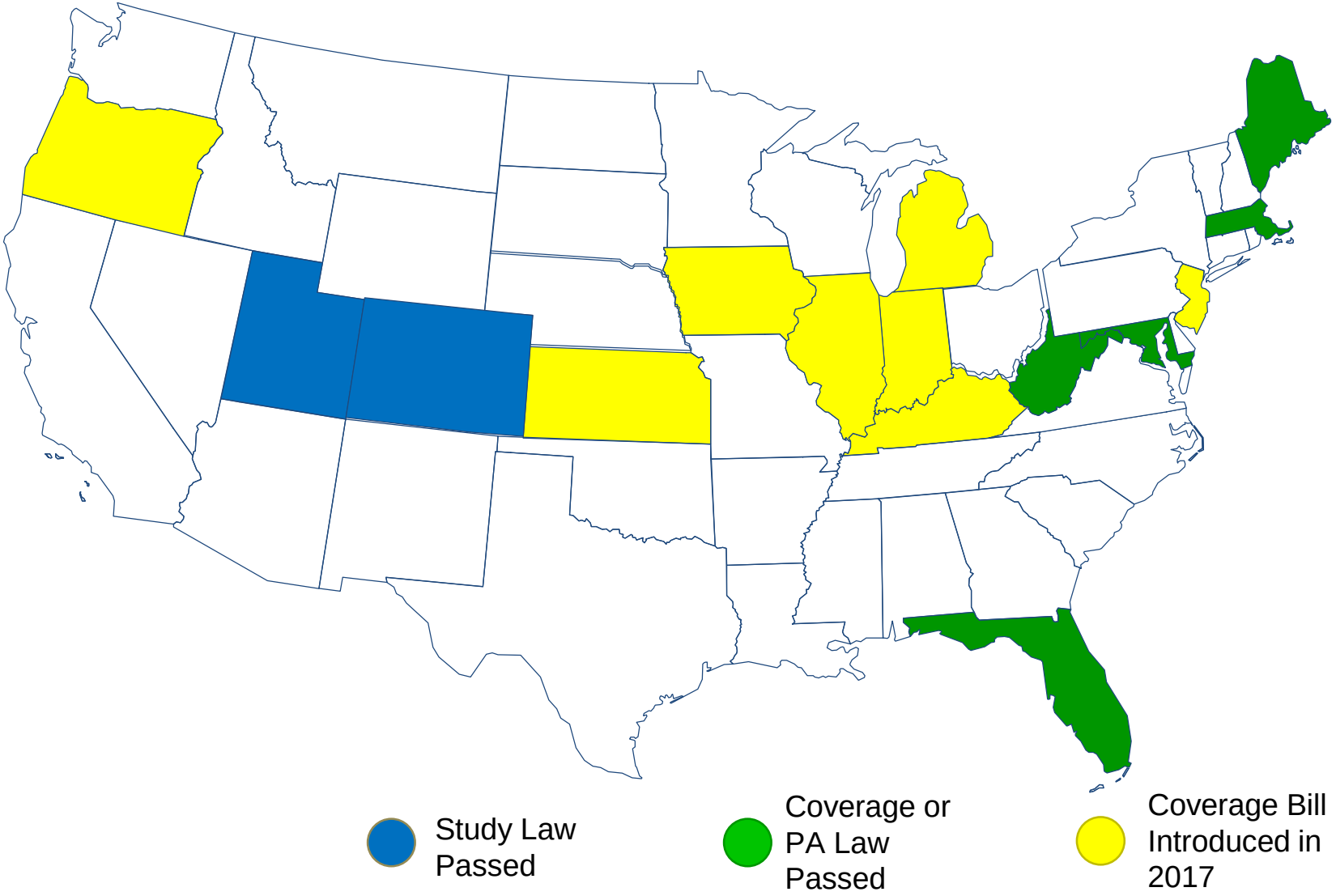
- Incentivize development of controlled prescription medications with ADPs
  - Grant a bonus period of exclusivity (TBD)
- Eventually transition highest-risk, non-abuse-deterrent controlled medications off the market
  - *E.g.*, once three medications with the same active ingredient have received FDA abuse-deterrent labeling, require non-abuse-deterrent medications with that same active ingredient to be reformulated with approved with approved with labeling within five years
- Require coverage by federal health programs
- Address delivery systems separately

State Legislation: Coverage (West Virginia)

- Applies to:
  - Opioid analgesics (agonists)
  - With FDA abuse-deterrent labeling
- Insurers to provide coverage for at least one opioid with AD labeling for each active ingredient
- Cost-sharing for brand opioids with AD labeling is no higher than lowest tier for brand drugs
- Cost-sharing for generic opioids with AD labeling no higher than lowest level for generics
- Insurers may not require step therapy
- Preauthorization permitted if the same requirements are applied to non-abuse-deterrent opioids with the same type of drug release, immediate or extended

State Abuse-Deterrence Legislation

January 2017



2017 State Filings

Nine states have introduced coverage bills so far:

- Iowa
- Illinois
- Indiana
- Kansas
- Kentucky
- Michigan
- New Jersey (vetoed in 2016)
- Oregon

Model Legislation for Diversion-Resistant Opioids for OUD

- Applies to:
  - Practitioner-administered opioids for treatment of OUD
- Insurers shall provide coverage for all FDA-approved diversion-resistant opioids on a basis no less favorable than coverage for self-administered opioids
- Out-of-pocket costs for diversion-resistant opioids shall not exceed the lowest tier applied to self-administered opioids
- Insurers may not require a patient to first use self-administered opioids before covering diversion-resistant opioids

Recommendations: State Legislation

- Advance coverage of brand and generic opioid analgesics with FDA abuse-deterrent labeling
- Advance coverage of diversion-resistant medications for the treatment of OUD
- Integrate efforts and revise bills (or amend laws) as other products with abuse-deterrent properties come to market, *e.g.*, crush-resistant stimulants or benzodiazepines that do not interact with other substances

Conclusion

- Thanks to CBI and conference sponsors
- Twitter: @claad_coalition
- Thank you
- Questions and discussion