RESOLUTION –FOR THE FALL 2025 MEDCHI HOUSE OF DELEGATES
Title: **Reduction of Insurance Barriers to the Use of Buprenorphine for Pain**
Sponsor: The MedChi Opioid, Pain and Addiction Committee.

Whereas, non-pharmacologic and non-opioid pharmacologic treatments are considered to be the first-line options for management of chronic non-cancer pain, and some experts have recommended that long-term opioids not be initiated (NICE 2021) (VA/DOD 2022) or should be rarely initiated (ASAM Pain & Addiction Essentials") for chronic non-cancer pain because of their limited effectiveness and the fact that they continue to be significant factors in overdose (OD) deaths and the development of opioid use disorder (OUD), and

Whereas, if initiating a trial of an opioid is felt to be warranted for chronic non-cancer pain, reducing barriers to the use of the partial opioid buprenorphine, if a full opioid would otherwise be used, is likely to reduce the incidence of OUD and OD. The 2022 VA/DoD Practice Guidelines on the Use of Opioids in the Management of Chronic Pain recommend that "For patients receiving daily opioids for the treatment of chronic pain, we suggest the use of buprenorphine instead of full agonist opioids due to lower risk of overdose and misuse" (VA/DoD 2022) and

Whereas, pharmaceutical industry promotion of widespread use of full opioids has contributed to the current epidemics of OUD and of OD (Ballantyne 2017) (Dowell 2016) and continues to contribute to these epidemics. County-by-county opioid sales in the U.S. have been closely associated with subsequent county-by-county heroin and fentanyl-related death rates according to CDC and DEA data.; (Washington Post 2023) and

Whereas, while the number of opioid prescriptions per capita has declined in the U.S., the volume of opioid prescribing per capita, in terms of morphine milligram equivalents (MME), remains approximately double what it was at the start of the opioid epidemic. (IQVIA Institute, 2021). More opioids per capita are prescribed in the U.S. than in any other nation. (CRS 2021) The new onset of long-term opioid use is now a common complication of both minor and major routine surgery. (Brummett 2017) (Larach 2023).

Whereas, approximately one in ten patients on long-term prescription opioids for pain have OUD and approximately one in five have opioid misuse; (Vowles 2015) and

Whereas, there is insufficient evidence of effectiveness of long-term opioids for chronic non-cancer pain; (CDC 2022) and

Whereas, in its 2022 review of all 70 randomized controlled trials of opioid effectiveness for pain or function after at least one month of therapy, the Agency for Health Care Research and Quality (AHRQ) has concluded that, ***for opioids compared to non-opioid pharmacotherapy:*** there is evidence of lack of effectiveness for pain or function at any duration of therapy greater than one month, and ***for opioids compared to placebo:***
(1) There is evidence of slight effectiveness (average reduction of 0.8 points on a 0 – 10-point scale) for pain or function at 1 – 6 months,
(2) There is no-evidence of effectiveness at 6-12 months, and
(3) There is evidence of lack of effectiveness at 12 months; (AHRQ 2022) and

Whereas, available evidence shows that buprenorphine has an effect on pain that is comparable to full opioids. That is, with a low effect size of about -0.8 points on a 0 – 10-point scale when used for up to approximately 3 months, with waning effectiveness over time, and no effectiveness compared with non-

opioid analgesics; (Wong 2023) and

Whereas, unlike full opioids, buprenorphine is relatively safe, is not known to result in OUD, and reduces OD by 50 -80% when used to treat OUD. (Like all opioids, buprenorphine leads to physical opioid dependence with sustained therapy). Buprenorphine's safety is consistent with the fact that, unlike full opioids, it has a ceiling effect for respiratory depression and euphoria, but not for analgesia; (Wong 2023) (Pergolizzi 2019) (Auriacombe 2004) and

Whereas, insurance formulary practices in Maryland typically impose significantly greater restrictions (such as prior authorization, exclusion from preferred drug lists, and higher costs) on the use of partial opioid agonists (i.e., buprenorphine) FDA-approved for pain than they do for full opioid agonists, that likely leads to the use of full opioids preferentially and

Whereas, this resolution is also supported by the Maryland-DC Society of Addiction Medicine, therefore be it

Resolved: MedChi will introduce legislation in the 2026 and/or 2027 session of the Maryland General Assembly to reduce costs and other insurance barriers to the use of buprenorphine for pain so they are comparable to those for full opioids for pain.

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