Low back pain is one of the leading causes of disability and chronic pain among adults and one of the most common reasons for which patients are treated with opioids. However, there is growing evidence that opioid analgesics are not superior to nonopioid treatment strategies for low back pain. Recent data from the first randomized clinical trial with long-term outcomes demonstrated that opioid treatment did not confer benefit with respect to pain-related function and that adverse medication-related events were more common among patients receiving opioid therapy. In contrast, pain intensity was improved among patients randomized to nonopioid treatment. Although opioids provide effective analgesia for acute pain, their initiation for the management of chronic pain remains problematic. For chronic pain, long-term opioid therapy is associated with poorer patient-reported pain, function, and quality-of-life outcomes and may be less effective among individuals with mood disorders, centralized pain syndromes, neuropathic pain, and psychiatric disorders. Opioid therapy is also associated with numerous dose-related adverse effects, such as respiratory depression and overdose, as well as dependence, tolerance, worsened pain, depression, constipation, and confusion. Approximately 20% of individuals receiving long-term opioid therapy develop an opioid use disorder. Therefore, given the prevalence of chronic low back pain in the United States, identifying effective nonopioid alternatives for chronic low back pain is a top health care priority.

In a cross-sectional study, Lin et al examine the attributes of 50 federal and commercial health plans to characterize coverage of opioid and nonopioid pharmacologic treatments for low back pain. Although numerous factors have driven the escalation of opioid-related morbidity and mortality in the United States, little is known regarding the potential role of private and public insurance payers to provide coverage for nonopioid analgesics prior to initiation of opioids, and this cross-sectional analysis fills an important gap in knowledge. The authors identify that many plans have adopted the Centers for Disease Control and Prevention guidelines for prescribing opioids for chronic pain, largely through quantity and dose limits. However, the authors also found that opioids and nonopioid medications were frequently classified on low formulary tiers with nonopioid alternatives, with little difference in cost sharing between these medication classes. Moreover, nonopioid treatments frequently had similar restrictions, and relatively few plans advocated for step therapy, which could direct prescribers toward nonopioid treatment options earlier and avoid new initiation of opioid therapy in favor of more effective alternatives.

Prior research highlights the important influence of payer policies and cost sharing on patient and clinician behaviors and outcomes. For example, patients are less likely to fill medications with increases in cost sharing and may select lower-value treatments or avoid treatment altogether as treatment-related prices increase. It is unclear the extent to which patients may choose opioids over other alternatives to manage chronic pain or even at the expense of treatment for other medical conditions based on cost. However, Lin et al identify the potential opportunity to tailor the coverage of opioid alternatives and encourage their use over prescription opioids as first-line therapy for chronic low back pain. In addition, the use of prior authorization strategies in Medicaid plans has been shown to potentially curb opioid-related morbidity and discourage the new initiation of long-acting opioid therapy. However, most plans included in the study by Lin et al relied on quantity limits rather than preauthorization. Transitioning to greater engagement of clinicians in the decision
for treatment and incentivizing the use of opioid alternatives when appropriate could lower the potential untoward effects of prescribing limits not tailored to the nuances of clinical care.

In the United States, 84% of individuals have health care coverage through federal or employer-based programs, which play a critical role in implementing standards to promote high-quality, evidence-based care. In the context of the opioid epidemic, large payers represent an important opportunity to encourage pharmacologic and nonpharmacologic opioid alternatives for chronic pain conditions in which the data to support the initiation of opioids as first-line treatment remain unclear. For chronic low back pain, comprehensive care should ideally include exercise, physical therapy, behavioral therapy, and, in some cases, complementary and alternative medicine. Therefore, creating policies that empower patients and clinicians to adopt opioid alternatives represents a critical pathway to changing the culture of pain management and slowing opioid-related morbidity and mortality in the United States.

REFERENCES