Clinical Policy: Opioid Analgesics
Reference Number: NH.PPA.12
Effective Date: 06.16
Last Review Date: 12.23
Line of Business: Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The following are Opioid Analgesics requiring prior authorization: Short-acting and long-acting opioid prescriptions which have morphine equivalent doses greater than 100mg per day.

FDA Approved Indication(s)
Opioid analgesics are indicated for the management and treatment of moderate to severe pain.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that opioids are **medically necessary** when the following criteria are met:

I. Initial/Continued Approval Criteria

A. Moderate to severe pain (must meet all)**:**

1. Trial and failure of two preferred drug list medications unless insufficient response, adverse effects/intolerance, allergic reactions, or contraindications exist;
2. For short-acting and long-acting opioid prescriptions which have morphine equivalent doses of greater than 100mg per day, prescriber must submit a completed *NH Healthy Families Prior Authorization Form for Long-Acting and Short-Acting opioids Exceeding MED 100 Form* (**see Appendix A**) if the prescriber has not already submitted one on behalf of the member receiving the prescription within the previous 3 months (6 months for members residing in hospice care facilities and for members diagnosed with cancer).
3. All prescribers must provide the rationale for prescribing an opioid dose which is greater than 100mg daily morphine equivalent dose (MED) or a dose which will put the member over the 100mg daily MED limit;
4. If member has or will be on 100mg or greater morphine equivalent dose (MED) for 90 or more days prescriber attests to prescribing or dispensing naloxone on an at least annual basis;
5. Attestation of completion of a pain assessment form at practice location
6. State PDMP is accessed and reviewed;
7. The prescriber must have a plan of evaluating the patient within three months (within six months for patients with cancer;
8. Submission of a pain management contract between the prescriber and the patient in accordance with requirements from NH Board Administrative Rule 502 Opioid Prescribing (e.g. utilizing written, informed consent, consent to perform periodic and random urine drug screens, etc.);

9. Patient is compliant with appointments;
10. Attestation that the prescriber is aware of the risks associated with concomitant use of benzodiazepines (i.e. reaching out to other prescribers for tapering plan or tapering if they are the prescriber of benzodiazepines).
Approval duration: 3 months (6 months if member is diagnosed with cancer or resides in hospice care facility or similar)

II. References

1. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. JAMA. 2016 Apr 19; 315(15):1624-45.
2. Initial and Continued Approval follow up periods based on the Centers for Disease Control and Prevention (CDC) Guidelines for prescribing Opioids for Chronic Pain – 2016. http://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf
3. Kampman K, Jarvis M. American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. J Addict Med. 2015 Sep-Oct;9(5):358-67.

Reviews, Revisions, and Approvals	Date	P&T Approval
Revised and added criteria for approval to meet new morphine equivalent dose 120 guidelines and added new prior authorization form to go along with a pain charting tool	4.16	4.16
Changed benzodiazepine criteria to "Attestation that the provider is aware of the risks associated with concomitant use of benzodiazepines and narcotic opioids and has made all reasonable attempts to reduce/discontinue use of benzodiazepines (i.e. reaching out to other prescriber for tapering plan or tapering if they are the prescriber of benzodiazepines)". Changed all morphine equivalent dose 120's to 100's. Adjusted morphine equivalent dose table. Removed requirement for a pain assessment form and changed to requires attestation of completing a pain assessment form at practice site.	7.16	7.16
Annual review, no changes	12.16	12.16
Annual review, no changes	10.17	10.17
Changes "US Script" to "Envolve Pharmacy Solutions" on the PA form	7.18	7.18
Removed conversion table 1 and 2 as well as outdated literature articles as form offers conversion charts. Updated template and references.	2.19	2.19
Added "If member has or will be on 100mg or greater morphine equivalent dose (MED) for 90 or more days prescriber attests to prescribing or dispensing naloxone on an at least annual basis" to criteria and PA form.	6.19	7.19
Annual Review. No changes.	7.20	7.20
Adjusted methadone conversion due to CMS change to titration methodology.	10.20	10.20
Updated formatting of charts and PA Form	04.21	04.21
Added additional details about NH Board Administrative Rule 502 to criteria and PA form	04.21	04.21
Annual Review, No Changes	01.22	01.22
Updated branding to be NH Healthy Families logo's and template instead of Envolve	03.22	04.22
Annual review, no changes	01.23	01.23
Annual review, no changes	12.23	12.23

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

nh healthy families

NH HEALTHY FAMILIES' PRIOR AUTHORIZATION REQUEST FORM

For Long and Short-Acting Narcotics Exceeding 100mg MED daily

Submit request via fax at 833-645-2738

The patient's medical record must substantiate the information provided on this form and compare for consistency	
*Prior Authorization is required for all patients exceeding 100mg Morphine Equivalent Dosing every 24 hours	
Patient Name -	**Date of Birth -**
Medicaid ID Number -	**Diagnosis -**
Prescriber Name -	**NPI/DEA -**
Office Phone Number -	**Office Fax Number -**
Requested Drug -	**Date of Request -**
Dosage -	
Dosage Form Directions -	
Pharmacy Requested -	

Please Fill Out the Form Completely - Write N/A if Not Applicable. Each Response Required for Approval	Response	
1. What is the Diagnosis and ICD-10 Code for the Patient?		
2. Is the Patient Diagnosed with Cancer Requiring Narcotics to Control Cancer-Related Pain? (If Yes, Skip to Question 8)	☐ Yes	☐ No
3. Is the Patient Currently a Resident of a Long-Term Care or Hospice Facility? If Yes, what is the Name & Address of the Facility? (If Yes, Skip to Question 9)	☐ Yes	☐ No
4. I am Aware of the Risks Associated with Concomitant Use of Benzodiazepines and Narcotic Opioids and Have Made Every Attempt to Reduce/Discontinue Their Use.	☐ Yes	☐ No
5. Has the Prescription Drug Monitoring Profile Been Checked for this Patient? (Required)	☐ Yes	☐ No
6. How Often Will the Patient be Reevaluated for Pain Control and Dose Review?		
7. Is a Pain Management Contract consistent with requirements from NH Board Administrative Rule 502 Opioid Prescribing (e.g. utilizing written, informed consent, consent to perform periodic and random urine drug screens, etc.) attached? (Required)	☐ Yes	☐ No
8. Has Patient Been Compliant with Appointments? (Required)	☐ Yes	☐ No
9. What is the Rationale for Prescribing >100 Morphine Equivalent Dose (MED) Individually or Cumulatively? (Required)	☐ Yes	☐ No
10. I Attest to Having Prescribed or Dispensed Naloxone if the Member Requires >100 MED for 90 or More Days. (Required)	☐ Yes	☐ No
11. I Attest to Have Completed a Pain Assessment Form to be Maintained and Updated on the Practice Site Premises. (Required)	☐ Yes	☐ No

Prescriber Signature (Required) - _____

This signature certifies that the information provided here is accurate and substantiated by the patient's medical records

Long-Acting Opioids (Refer to Preferred Drug List for Preferred Agents and Quantity Limits)			
Brand Name	**Generic Name**	**Dosage Form**	**Morphine Equivalent Dose**
MS Contin	Morphine Sulfate ER	Tab: 15, 30, 60, 100, 200mg	1
Duragesic	Fentanyl Patch	Patches: 12.5, 25, 50, 75, 100mcg/hr	2.4
Oxycontin	Oxycodone ER	Tabs: 10, 15, 20, 30, 40, 60, 80mg	1.5
Dolophine	Methadone	Tab: 5, 10mg	0-20mg=4, 21-40mg=8, 41-60mg=10, 60mg+=12

Short-Acting Opioids (Refer to Preferred Drug List for Preferred Agents and Quantity Limits)			
Brand Name	**Generic Name**	**Dosage Form**	**Morphine Equivalent Dose**
Tylenol/Codeine	Acetaminophen/Codeine	Tab: 300/15, 300/60mg, Soln: 120/12mg/5ml	0.15
Norco, Lortab, Hycet, Vicodin	Hydrocone/Acetaminophen	Tab: 5/500, 7.5/325, 10/325mg, Soln: 7.5/325mg/15ml	1
Dilaudid	Hydromorphone	Tab: 2, 4, 8mg, Suppository: 3mg	4
Ultracet	Tramadol/Acetaminophen	Tab: 37.5/325mg	0.1
Demerol	Meperidine	Tab: 50, 100mg, Soln: 50mg/5ml	0.1
Morphine IR	Morphine Sulfate IR	Tab: 15, 30mg, Soln: 10mg/5ml, 20mg/5ml	1
Roxicodone	Oxycodone IR	Cap: 5mg, Tab: 5, 10, 20mg, Soln: 20mg/ml	1.5
Percodan	Oxycodone/Aspirin	Tab: 4.8/325mg	1.5
Fiorinal/Codeine	Butalbital/Aspirin/Caffeine w/Codeine	Cap: 50/325/40/30mg	0.15
Fioricet/Codeine	Butalbital/Acetaminophen/Caffeine w/Codeine	Cap: 50/325/40/30mg	0.15
Codeine	Codeine Sulfate	Tab: 15, 30, 60mg	0.15