Clinical Policy: Opioid Analgesics

Reference Number: NH.PPA.12
Effective Date: 06.16
Last Review Date: 02.19 Revision Log
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 [Brand name(s)] [is/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. Attestation of completion of a pain assessment form at practice location
5. State PDMP is accessed and reviewed;
6. The prescriber must have a plan of evaluating the patient within three months (within six months for patients with cancer;
7. Submission of a pain management contract between the prescriber and the patient;
8. Patient is compliant with appointments;

9. 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 Date
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	04.16	04.16
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.	07.16	07.16
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 prior authorization form	07.18	07.18
Removed conversion table 1 and 2 as well as outdated literature articles as form offers conversion charts. Updated template and references.	02.19	02.19

nh healthy families

envolve Pharmacy Solutions

NH HEALTHY FAMILIES

PRIOR AUTHORIZATION REQUEST FORM

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

Submit request via: Fax – 1-866-399-0929 or MAIL to Envolve Pharmacy Solutions c/o Prior Authorization Department at 5 River Park Place East, Suite 210, Fresno, California 93720

The patient's medical record must substantiate the information provided on this form and compare for consistency.

Patient name: _____ **DOB :** _____

Medicaid ID number: _____ **Diagnosis:** _____

Prescriber name: _____ **NPI/DEA:**_____

Office phone number: _____ **Office fax number:** _____

Pharmacy requested: _____

***Prior authorization is required for all patients receiving more than 100mg morphine or its equivalent every 24 hours.**

Preferred Long-Acting Opioids (GENERICS ONLY)				
Known Brand Name	**Generic Name**	**Doses/ Dosage Form**	**Morphine dose equivalent**	**Restrictions**
MS Contin	Morphine Sulfate ER	Tab: 15, 30, 60, 100, 200	1.0	Limit 3 tabs per day
Duragesic	Fentanyl TD Patch 72HR	Patches: 12.5, 25, 50, 75, 100 mcg/ hr	2.4	Limit 10 patches per 30 days
OxyContin	Oxycodone ER 12HR Deter	Tabs: 10, 15, 20, 20, 40, 60, 80 mg	1.5	***PA required* criteria avail upon request** Limit 2 per day

Preferred Short-Acting Opioids (GENERICS ONLY)				
Known Brand Name	**Generic Name**	**Doses/ Dosage Form**	**Morphine dose equivalent**	**Restrictions**
Tylenol-Codeine	Acetaminophen/ Codeine	Tabs: 300 - 15 mg, 300 - 60 Mg Oral Soln: 120 - 12 mg/ 5 mL	0.15	Limit 6 tabs per day Oral Soln: Limit 30 mL per day
Norco, Lortab, Hycet	Hydrocodone/ Acetaminophen	Tabs: 7.5-325 mg, 10-325 mg Oral Soln: 7.5-325 mg/ 15 mL	1.0	Limit 6 tabs per day Oral Soln: Limit 180 mL per day
Dilaudid	Hydromorphone	Tabs: 2, 4, 8 mg Suppository: 3mg	4.0	Limit 8 tabs per day; 12 supp per day
Codeine Sulfate	Codeine sulfate	Tabs:15,30,60mg	0.15	Limit 2 tabs per day
Ultracet	Tramadol-Acetaminophen	Tab: 37.5-325 mg	0.1	Limit 4 tabs per day
Demerol	Meperidine	Tabs: 50, 100 mg Oral Soln: 50 mg/ 5 mL	0.1	Limit 6 tabs per day
Morphine Sulfate IR	Morphine Sulfate IR	Tabs: 15, 30 mg Oral Soln: 10 mg/ 5mL, 20 mg/ 5 mL Supp: 5, 10, 20, 30 mg	1.0	Limit 6 tabs per day Limit 24 supp per day Limit 240 mL per day
Roxicodone	Oxycodone IR	Cap: 5 mg Tabs: 5, 10, 20 mg Oral Soln: 20 mg/ mL	1.5	Limit 6 caps/tabs per day Limit 6 mL per day
Percodan	Oxycodone-Aspirin	Tab: 4.8-325 mg	1.5	Limit 6 tabs per day
Fiorinal-Codeine	Butalbital-Aspirin-Caff w/ Codeine	Cap: 50-325-40-30 mg	0.15	Limit 4 caps per day
Fioricet-Codeine	Butalbital-Acetaminophen-Caff w/ Codeine	Cap: 50-325-40-30 mg	0.15	Limit 4 caps per day

Requested Drug _____
Dosage _____

Dosage Form Directions

Please fill out the form completely-write N/A if not applicable. Each response is required for approval.		
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. Isthepatientcurrentlyaresidentofalong-termcareorhospicefacility? If yes, what is the name & address of the facility?(**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 for approval.)	☐Yes	☐No
6. How often will the patient be reevaluated for pain control and dose		
7. Is the pain management contract 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 individually or cumulatively? (required)		
10. 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)

_____

Date:

_____

This signature certifies that the information provided here is accurate

and substantiated by the patient's medical records. Revised 7/20/18

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.