Clinical Policy: Opioid Analgesics

Reference Number: NH.PMN.97
Effective Date: 06.24
Last Review Date: 04.26
Line of Business: Medicaid

Revision Log

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

Description

Opioid analgesics exert their analgesic effect through opiate receptors distributed in tissues throughout the body. All opioid analgesic therapies (both preferred and non-preferred agents) that do not abide with the short-term therapy criteria (I.A) will require prior authorization.

FDA Approved Indication(s)

Opioid analgesics are indicated for the management and treatment of moderate to severe pain.

Policy/Criteria

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

It is the policy of NH Healthy Families that opioid analgesics are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Short-Term Therapy (Prior authorization will NOT be required for opioid use meeting all the following criteria. Requests for > 28-day supply of opioid or for extended-release opioids will be evaluated using the Long-Term Therapy criteria unless the request is for cancer, sickle cell disease or palliative care as presented in Section I.B)**:**

1. Rationale is provided to justify need for greater than 7-day supply.
2. Request is for an immediate-release opioid.
3. Member is taking no more than 2 different opioid analgesics concurrently.
4. Total opioid dose does NOT exceed 100 morphine milligram equivalents (MME) per day.
5. If total opioid dose exceeds 100 morphine milligram equivalents (MME) per day member must meet all the following:
   a. If concurrent use of benzodiazepine: Prescriber attests to awareness of the risks associated with concomitant use of benzodiazepines and narcotic opioids and have made attempts to reduce/discontinue use.
   b. Prescriber has checked the Prescription Drug Monitoring Program (PDMP) for this patient.
   c. Prescriber documents how often the patient will be re-evaluated for pain control and dose review.
   d. Prescriber attests Member has been compliant with appointments.
   e. Prescriber provides rationale for prescribing >100 morphine milligram equivalents per day.

f. Prescriber attests to having prescribed or dispensed naloxone if the member requires >100 morphine milligram equivalent for 90 or more days.
g. Prescriber attests to have completed a pain assessment form, treatment plan, and treatment agreement, consistent with NH Board Administrative Rule 502 Opioid Prescribing (e.g., utilizing written, informed consent, consent to perform periodic and random urine drug screens, etc.), to be maintained and updated at the practice office.

Approval duration: 3 months

B. Cancer, Sickle Cell Disease, Long-Term Care Facility or Hospice/Palliative Care (must meet all)**:**

1. Prescribed for pain associated with one of the following (a, b, c, or d):
   a. Cancer.
   b. Sickle cell disease.
   c. Long-term care facility
   d. Hospice/palliative care.
2. One of the following (a or b):
   a. Request is for a preferred drug.
   b. Member has failed two or more preferred drugs, unless clinically significant adverse effects are experienced, or all are contraindicated.
3. If request is for Oxycontin®, both of the following (a and b):
   a. Age ≥ 11 years.
   b. Member has failed two other preferred long-acting opioids*, unless clinically significant adverse effects are experienced, or all are contraindicated.

   **Long-acting opioid therapy may require prior authorization.*
4. If request is for concurrent use of > 2 opioids, prescriber must submit a documented clinical rationale supporting the addition of an extended-release opioid and that upward titration of existing opioid analgesics is inappropriate or contraindicated.
5. Patient has been compliant with appointments.
6. Prescriber provides rationale for prescribing >100 morphine milligram equivalents.
7. Prescriber attests to having prescribed or dispensed naloxone if the member requires >100 morphine milligram equivalent for 90 or more days.
8. Prescriber attests to having completed a pain assessment form to be maintained and updated at the practice office.
9. Request does not exceed health plan quantity limit.

Approval duration: 12 months

C. Members Transitioning from Short-Term Therapy to Long-Term Therapy (defined as a claims history of > 28-day supply of opioid within a 90-day period or request for an extended-release opioid) (must meet all)**:**

1. Previously received short-term opioid therapy via NH Healthy Families benefit.
2. Prescribed for the treatment of pain unrelated to active cancer, sickle cell disease or palliative care.
3. Member meets one of the following (a or b):
   a. Failure of at least 2 non-opioid ancillary treatments (e.g., non-steroidal anti-inflammatory drugs [NSAIDs], acetaminophen, anticonvulsants, antidepressants),

unless clinically significant adverse effect are experienced, or all are contraindicated.
   b. Member has received a total of 90 cumulative days of opioid therapy in the last 120 days.
4. One of the following (a or b):
   a. Request is for a preferred drug.
   b. Member has failed two or more preferred drugs, unless clinically significant adverse effects are experienced, or all are contraindicated.
5. If request is for an extended-release agent, documented failure of an immediate release opioid.
6. If request is for Oxycontin, both of the following (a and b):
   a. Age ≥ 11 year.
   b. Member has failed two other preferred long-acting opioids*, unless clinically significant adverse effects are experienced, or all are contraindicated.

   **Long-acting opioid therapy may require prior authorization.*
7. Member will be maintained on no more than 2 opioid analgesics concurrently.
   **If member requires therapy with two opioid analgesics, regimen must consist of one immediate-release and one extended-release analgesic.*
8. Total opioid dose is not 100 MME per day or more, or for members who are stable (history of > 7 days of therapy) on doses ≥ 100 MME per day, one of the following is met (i or ii):
   i. Provider's attestation that a dose taper will be attempted.
   ii. Documentation that a dose taper has been attempted within the past 6 months, with the reasons for taper failure.
   **Provider will be advised that doses higher than the current dose will not be approved in the future.*
9. If total opioid dose exceeds 100 morphine milligram equivalents (MME) per day member must meet all the following:
   a. If concurrent use of benzodiazepine: Prescriber attests to awareness of the risks associated with concomitant use of benzodiazepines and narcotic opioids and have made attempts to reduce/discontinue use.
   b. Prescriber documents how often the patient will be re-evaluated for pain control and dose review.
   c. Prescriber attests Member has been compliant with appointments.
   d. Prescriber provides rationale for prescribing >100 morphine milligram equivalents per day.
   e. Prescriber attests to having prescribed or dispensed naloxone if the member requires >100 morphine milligram equivalent for 90 or more days.
10. Prescriber attests to have completed a pain assessment form, treatment plan, and treatment agreement, consistent with NH Board Administrative Rule 502 Opioid Prescribing (e.g., utilizing written, informed consent, consent to perform periodic and random urine drug screens, etc.), to be maintained and updated at the practice office.
11. Provider agrees to continuously assess the member's pain management regimen for possible discontinuation of opioid therapy.
12. Documentation that the provider has reviewed the Prescription Drug Monitoring Program (PDMP) to identify concurrently prescribed controlled substances.

Approval duration: 3 months

D. Other diagnoses/indications – Not applicable

II. Continued Therapy

A. Cancer, Sickle Cell Disease, Long-Term Care or Hospice/Palliative Care (must meet all)**:**

1. Currently receiving therapy for pain associated with cancer, sickle cell disease, or palliative care.
2. If request is for Oxycontin, both of the following (a and b):
   a. Age ≥ 11 year.
   b. Member has failed two other preferred long-acting opioids*, unless clinically significant adverse effects are experienced, or all are contraindicated.

   **Long-acting opioid therapy may require prior authorization*
3. If member is receiving more than 2 opioid analgesics concurrently, at least one of the following requirements has been met (a or b):
   a. Prescriber previously provided a documented clinical rationale for the use of > 2 opioid analgesics concurrently.
   b. Prescriber provides a documented clinical rationale supporting that addition of an extended-release agent or upward titration of existing opioid analgesics is inappropriate or contraindicated.
4. Patient has been compliant with appointments.
5. Prescriber provides rationale for prescribing >100 morphine milligram equivalents.
6. Prescriber attests to having prescribed or dispensed naloxone if the member requires >100 morphine milligram equivalent for 90 or more days.
7. Prescriber attests to having completed a pain assessment form to be maintained and updated at the practice office.
8. Request does not exceed health plan quantity limit.

Approval duration: 12 months

B. Long-Term Therapy (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving long-term (defined as a history of chronic opioid use in the 3 months preceding the request) opioid therapy via NH Healthy Families benefit.
   b. Documentation supports that member is currently receiving opioids and has received this medication for at least 28 days in last 90 days.
2. One of the following (a or b):
   a. Request is for a preferred drug.
   b. Member has failed two or more preferred drugs, unless clinically significant adverse effects are experienced, or all are contraindicated.
3. If request is for Oxycontin, both of the following (a and b):
   a. Age ≥ 11 year.
   b. Member has failed two other preferred long-acting opioids*, unless clinically significant adverse effects are experienced, or all are contraindicated.

   **Long-acting opioid therapy may require prior authorization*
4. Prescriber provides documentation supporting inability to discontinue opioid therapy.
5. Member will not be maintained on > 2 opioid analgesics concurrently.

**If member requires therapy with two opioid analgesics, regimen must consist of one immediate-release and one extended-release analgesic*

6. If total opioid dose > 100 MME per day, one of the following is met (a, b, c, or d):
   a. Dose reduction has occurred since previous approval, if applicable.
   b. A dose taper has been attempted within the past 6 months and was not successful. **Reason(s) for taper failure must be provided.*
   c. Medical justification why a taper should not be attempted or for any dose increase that has occurred since previous approval, if applicable.
   d. Prescribed by or in consultation with a pain management specialist.
7. If total opioid dose exceeds 100 morphine milligram equivalents (MME) per day member must meet all the following:
   a. If concurrent use of benzodiazepine: Prescriber attests to awareness of the risks associated with concomitant use of benzodiazepines and narcotic opioids and have made attempts to reduce/discontinue use.
   b. Prescriber documents how often the patient will be re-evaluated for pain control and dose review.
   c. Prescriber attests Member has been compliant with appointments.
   d. Prescriber provides rationale for prescribing >100 morphine milligram equivalents per day.
   e. Prescriber attests to having prescribed or dispensed naloxone if the member requires >100 morphine milligram equivalent for 90 or more days.
8. Prescriber attests to have completed a pain assessment form, treatment plan, and treatment agreement, consistent with NH Board Administrative Rule 502 Opioid Prescribing (e.g., utilizing written, informed consent, consent to perform periodic and random urine drug screens, etc.), to be maintained and updated at the practice office.
9. Provider agrees to continuously assess the member's pain management regimen for possible discontinuation of opioid therapy.
10. Documentation that the provider has reviewed the Prescription Drug Monitoring Program (PDMP) to identify concurrently prescribed controlled substances.
11. Documentation that the provider has reviewed the PDMP to identify concurrently prescribed controlled substances.

Approval duration: 3 months

C. Other diagnoses/indications – Not applicable

III. Diagnoses/Indications for which coverage is NOT authorized: Not applicable

IV. Appendices/General Information

Appendix A: Abbreviation Key

ADF: abuse-deterrent formulation	NSAID: non-steroidal anti-inflammatory drug
FDA: Food and Drug Administration	PDL: preferred drug list
MME: morphine milligram equivalents	PDMP: prescription drug monitoring program

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): significant respiratory depression; acute or severe bronchial asthma; gastrointestinal obstruction, including paralytic ileus; hypersensitivity to the opioid active ingredient, salts, or any component of the product.
- Boxed warning(s): potential for addiction, abuse, and misuse; life-threatening respiratory depression; accidental ingestion; neonatal opioid withdrawal syndrome; cytochrome P450 3A4 interactions; risks from concomitant use with benzodiazepines or other CNS depressants.

Appendix D: General Information

Opioid Oral MME Conversion Factors	
Type of Opioid (strength units)	**MME Conversion Factor**
Codeine (mg)	0.15
Dihydrocodeine (mg)	0.25
Fentanyl buccal or SL tablets, or lozenge/troche (mcg)	0.13
Fentanyl film or oral spray (mcg)	0.18
Fentanyl nasal spray (mcg)	0.16
Fentanyl patch (mcg)	7.2
Hydrocodone (mg)	1
Hydromorphone (mg)	4
Levorphanol tartrate (mg)	11
Meperidine hydrochloride (mg)	0.1
Methadone (mg)	
> 0, ≤ 20	4
> 20, ≤ 40	8
> 40, ≤ 60	10
> 60	12
Morphine (mg)	1
Opium (mg)	1
Oxycodone (mg)	1.5
Oxymorphone (mg)	3
Pentazocine (mg)	0.37
Tapentadol (mg)	0.4
Tramadol (mg)	0.1

V. Dosage and Administration
Please refer to the package insert of the requested drug for information on appropriate dosage and administration.

VI. Product Availability

Please refer to the package insert of the requested drug for product availability information.

VII. References

1. Dowell D, Ragan KR, Jones CM, Baldwin GT, and Chou R. CDC clinical practice guideline for prescribing opioids for pain – United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1-95.
2. 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.
3. State of Hawaii Dept of Human Services. QI-1926 Support Act Med-QUEST Division Minimum Standards Effective October 1 2019. Available at: https://medquest.hawaii.gov/en/plans-providers/provider-memo.html. Accessed February 3, 2023.
4. State of New Jersey Dept of Law and Public Safety Division of Consumer Affairs. Naloxone prescribing by health care practitioners – DCA Administrative Order No. 2020-08. Available at: https://www.njconsumeraffairs.gov/Documents/Naloxone%20rule%20adoption.pdf. Accessed February 3, 2023.
5. Dowell D, Ragan KR, Jones CM, Baldwin GT, and Chou R. CDC clinical practice guideline for prescribing opioids for pain – United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1-95.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	03.24	04.24
Updated short term therapy section to adjust needing medical rationale for greater than 7-day supply	07.24	07.24
Annual review, no significant changes	04.25	04.25
2Q 2026 annual review: removed disclaimers directing to CP.PMN.127 for fentanyl IR products due to policy retirement; references reviewed and updated.	04.26	04.26

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

PRIOR AUTHORIZATION REQUEST FORM

For Long and Short-Acting Narcotics
Exceeding 100mg Daily Morphine
Equivalent Dosing and Day Supply Limits

Submit request via fax at 833-645-2738

The Member's medical record must substantiate the information provided on this form		
***Prior Authorization is required for all prescriptions exceeding 100mg Morphine Equivalent Dosing every 24 hours and those exceeding day supply limits outlined in policy NH.PMN.97 Opioid Analgesics**		
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 7)	☐ 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 8)	☐ 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. Has Patient Been Compliant with Appointments? (Required)	☐ Yes	☐ No
8. What is the Rationale for Prescribing >100 Morphine Equivalent Dose (MED) Individually or Cumulatively and/or exceeding day supply limitations? (Required)		
9. I Attest to Having Prescribed or Dispensed Naloxone if the Member Requires >100 MED for 90 or More Days. (Required)	☐ Yes	☐ No
10. I Attest to have completed a Pain Assessment Form, treatment plan, and treatment agreement, consistent with NH Board Administrative Rule 502 Opioid Prescribing, 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.