Clinical Policy: Benzodiazepine with Concurrent Opioid Analgesic

Reference Number: IN.CP.PPA.13
Effective Date: 10.18
Last Review Date: 11.18
Line of Business: Medicaid

Revision Log

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

Description

To limit the unsafe concurrent use of benzodiazepine and opioids or carisoprodol containing products through medical necessity review.

FDA Approved Indication(s)

All edits are based on FDA labeling as published by the manufacturer

Brand

Multiple Medication classes are included in this edit

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 MHS that concurrent use of benzodiazepines with opioids or carispoprodol when the following criteria are met:

I. Benzodiazepine and Opioids Concurrent Therapy (for benzodiazepine therapy exceeding 7 days in 180 days OR benzodiazepine therapy exceeding quantity limits for initiation of concurrent therapy):

A. Must provide diagnoses for both agents
   i. AND

B. Must provide previous therapy attempted
   i. AND

C. Prescriber must sign attestation confirming regular review of INSPECT, that the prescriber has educated the member of the risks of concurrent utilization, and that the prescriber and member accept the risks associated with concurrent utilization
   i. AND

D. Must meet utilization edits (see Appendix A below)

NOTES:

- Concurrent utilization will include members with a claim for an opiate in the past 30 days

- Current utilizers of benzodiazepines and opiates concurrently (utilizing for 90 of the past 120 days) will be exempt from this PA criteria
- Utilization of benzodiazepines with carisoprodol and combinations will require prior authorization for medical necessity
- Documentation will be reviewed for medical necessity including, but not limited to, appropriate diagnoses and trials of other agents
- Prescriber must submit documentation via fax form with signed attestation

Approval duration: Up to 3 months

II. Criteria for concurrent carisoprodol and benzodiazepine

A. Documentation shows clear need for muscle relaxant

B. Requires trial of at least 2 preferred muscle relaxants including baclofen, chlorzoxazone, cyclobenzaprine, methocarbamol or tizanidine

C. APPENDIX A – Utilization Edits

GPI	Product name	Dosage Form	Route	Strength		Utilization Edit
57100010000305	XANAX	TABS	OR	0.25	MG	4/DAY
57100010000305	ALPRAZOLAM	TABS	OR	0.25	MG	4/DAY
57100010000310	XANAX	TABS	OR	0.5	MG	4/DAY
57100010000310	ALPRAZOLAM	TABS	OR	0.5	MG	4/DAY
57100010000315	XANAX	TABS	OR	1	MG	4/DAY
57100010000315	ALPRAZOLAM	TABS	OR	1	MG	4/DAY
57100010000320	XANAX	TABS	OR	2	MG	4/DAY
57100010000320	ALPRAZOLAM	TABS	OR	2	MG	4/DAY
57100010001310	ALPRAZOLAM INTENSOL	CONC	OR	1	MG/ML	4ML/DAY
57100010007205	ALPRAZOLAM ODT	TBDP	OR	0.25	MG	4/DAY
57100010007210	ALPRAZOLAM ODT	TBDP	OR	0.5	MG	4/DAY
57100010007215	ALPRAZOLAM ODT	TBDP	OR	1	MG	4/DAY
57100010007220	ALPRAZOLAM ODT	TBDP	OR	2	MG	4/DAY
57100010007505	XANAX XR	TB24	OR	0.5	MG	1/DAY
57100010007505	ALPRAZOLAM ER	TB24	OR	0.5	MG	1/DAY
57100010007505	ALPRAZOLAM XR	TB24	OR	0.5	MG	1/DAY
57100010007510	XANAX XR	TB24	OR	1	MG	1/DAY
57100010007510	ALPRAZOLAM ER	TB24	OR	1	MG	1/DAY
57100010007510	ALPRAZOLAM XR	TB24	OR	1	MG	1/DAY
57100010007520	XANAX XR	TB24	OR	2	MG	1/DAY
57100010007520	ALPRAZOLAM ER	TB24	OR	2	MG	1/DAY
57100010007520	ALPRAZOLAM XR	TB24	OR	2	MG	1/DAY
57100010007530	XANAX XR	TB24	OR	3	MG	1/DAY
57100010007530	ALPRAZOLAM ER	TB24	OR	3	MG	1/DAY
57100010007530	ALPRAZOLAM XR	TB24	OR	3	MG	1/DAY

GPI	Product name	Dosage Form	Route	Strength		Utilization Edit
96426448542900	ALPRAZOLAM	POWD				
57100020100105	CHLORDIAZEPOXIDE HCL	CAPS	OR	5	MG	4/DAY
57100020100110	CHLORDIAZEPOXIDE HCL	CAPS	OR	10	MG	4/DAY
57100020100115	CHLORDIAZEPOXIDE HCL	CAPS	OR	25	MG	4/DAY
57100030100305	CLORAZEPATE DIPOTASSIUM	TABS	OR	3.75	MG	4/DAY
57100030100310	TRANXENE T	TABS	OR	7.5	MG	4/DAY
57100030100310	CLORAZEPATE DIPOTASSIUM	TABS	OR	7.5	MG	4/DAY
57100030100320	CLORAZEPATE DIPOTASSIUM	TABS	OR	15	MG	4/DAY
5710004000D520	DIAZEPAM	DEVI	IM	10	MG/2ML	
57100040000305	VALIUM	TABS	OR	2	MG	4/DAY
57100040000305	DIAZEPAM	TABS	OR	2	MG	4/DAY
57100040000310	VALIUM	TABS	OR	5	MG	4/DAY
57100040000310	DIAZEPAM	TABS	OR	5	MG	4/DAY
57100040000315	VALIUM	TABS	OR	10	MG	4/DAY
57100040000315	DIAZEPAM	TABS	OR	10	MG	4/DAY
57100040001310	DIAZEPAM INTENSOL	CONC	OR	5	MG/ML	8ML/DAY
57100040002001	DIAZEPAM	SOLN	OR	1	MG/ML	
57100040002001	DIAZEPAM	SOLN	OR	5	MG/5ML	
57100040002010	DIAZEPAM	SOLN	IJ	5	MG/ML	
96485803002900	DIAZEPAM	POWD				
57100060000305	ATIVAN	TABS	OR	0.5	MG	4/DAY-MAX QTY 120
57100060000305	LORAZEPAM	TABS	OR	0.5	MG	4/DAY-MAX QTY 120
57100060000310	ATIVAN	TABS	OR	1	MG	4/DAY-MAX QTY 120
57100060000310	LORAZEPAM	TABS	OR	1	MG	4/DAY-MAX QTY 120
57100060000315	ATIVAN	TABS	OR	2	MG	4/DAY-MAX QTY 120
57100060000315	LORAZEPAM	TABS	OR	2	MG	4/DAY-MAX QTY 120
57100060001320	LORAZEPAM INTENSOL	CONC	OR	2	MG/ML	
57100060001320	LORAZEPAM	CONC	OR	2	MG/ML	
57100060002005	ATIVAN	SOLN	IJ	2	MG/ML	
57100060002005	LORAZEPAM	SOLN	IJ	2		
57100060002005	LORAZEPAM	SOLN	IJ	20	MG/10ML	
57100060002010	ATIVAN	SOLN	IJ	4	MG/ML	
57100060002010	LORAZEPAM	SOLN	IJ	4	MG/ML	
96647076002900	LORAZEPAM	POWD				
57100070000105	OXAZEPAM	CAPS	OR	10	MG	4/DAY-MAX QTY 120

GPI	Product name	Dosage Form	Route	Strength		Utilization Edit
57100070000110	OXAZEPAM	CAPS	OR	15	MG	4/DAY-MAX QTY 120
57100070000115	OXAZEPAM	CAPS	OR	30	MG	4/DAY-MAX QTY 120
57200050000305	MEPROBAMATE	TABS	OR	200	MG	4/DAY
57200050000310	MEPROBAMATE	TABS	OR	400	MG	4/DAY
72100010000305	KLONOPIN	TABS	OR	0.5	MG	3/DAY
72100010000305	CLONAZEPAM	TABS	OR	0.5	MG	3/DAY
72100010000310	KLONOPIN	TABS	OR	1	MG	3/DAY
72100010000310	CLONAZEPAM	TABS	OR	1	MG	3/DAY
72100010000315	KLONOPIN	TABS	OR	2	MG	3/DAY
72100010000315	CLONAZEPAM	TABS	OR	2	MG	3/DAY
72100010007210	CLONAZEPAM ODT	TBDP	OR	0.125	MG	3/DAY
72100010007215	CLONAZEPAM ODT	TBDP	OR	0.25	MG	3/DAY
72100010007220	CLONAZEPAM ODT	TBDP	OR	0.5	MG	3/DAY
72100010007230	CLONAZEPAM ODT	TBDP	OR	1	MG	3/DAY
72100010007240	CLONAZEPAM ODT	TBDP	OR	2	MG	3/DAY
58120050100305	NEFAZODONE HCL	TABS	OR	50	MG	2/DAY
58120050100310	NEFAZODONE HCL	TABS	OR	100	MG	2/DAY
58120050100320	NEFAZODONE HCL	TABS	OR	150	MG	2/DAY
58120050100330	NEFAZODONE HCL	TABS	OR	200	MG	2/DAY
58120050100340	NEFAZODONE HCL	TABS	OR	250	MG	2/DAY
62992002200310	CHLORDIAZEPOXIDE/AMITRIPTYLINE	TABS	OR	5-12.5	MG	
62992002200320	CHLORDIAZEPOXIDE/AMITRIPTYLINE	TABS	OR	10-25	MG	
60100010102110	AMYTAL SODIUM	SOLR	IJ	500	MG	
60100025100310	BUTISOL SODIUM	TABS	OR	30	MG	3/DAY
60100055102010	NEMBUTAL SODIUM	SOLN	IJ	50	MG/ML	
60100055102010	PENTOBARBITAL SODIUM	SOLN	IJ	50	MG/ML	
60100055102900	PENTOBARBITAL SODIUM	POWD	XX	0		
60100070100110	SECONAL SODIUM	CAPS	OR	100	MG	
60200020003800	CHLORAL HYDRATE	CRYS	XX	0		
60201005000310	ESTAZOLAM	TABS	OR	1	MG	1/DAY
60201005000320	ESTAZOLAM	TABS	OR	2	MG	1/DAY
60201010100105	FLURAZEPAM HCL	CAPS	OR	15	MG	1/DAY
60201010100110	FLURAZEPAM HCL	CAPS	OR	30	MG	1/DAY
60201025101220	MIDAZOLAM HCL	SYRP	OR	2	MG/ML	
60201025102002	MIDAZOLAM HCL	SOLN	IJ	2	MG/2ML	
60201025102003	MIDAZOLAM HCL	SOLN	IJ	5	MG/5ML	
60201025102004	MIDAZOLAM HCL	SOLN	IJ	10	MG/10ML	

GPI	Product name	Dosage Form	Route	Strength		Utilization Edit
60201025102005	MIDAZOLAM HCL	SOLN	IJ	5	MG/ML	
60201025102010	MIDAZOLAM HCL	SOLN	IJ	10	MG/2ML	
60201025102010	MIDAZOLAM HCL	SOLN	IJ	5	MG/ML	
60201025102025	MIDAZOLAM HCL	SOLN	IJ	25	MG/5ML	
60201025102025	MIDAZOLAM HCL	SOLN	IJ	5	MG/ML	
60201025102050	MIDAZOLAM HCL	SOLN	IJ	50	MG/10ML	
60201025102050	MIDAZOLAM HCL	SOLN	IJ	5	MG/ML	
60201028000310	DORAL	TABS	OR	15	MG	1/DAY
60201028000310	QUAZEPAM	TABS	OR	15	MG	1/DAY
60201030000103	RESTORIL	CAPS	OR	7.5	MG	1/DAY
60201030000103	TEMAZEPAM	CAPS	OR	7.5	MG	1/DAY
60201030000105	RESTORIL	CAPS	OR	15	MG	1/DAY
60201030000105	TEMAZEPAM	CAPS	OR	15	MG	1/DAY
60201030000108	RESTORIL	CAPS	OR	22.5	MG	1/DAY
60201030000108	TEMAZEPAM	CAPS	OR	22.5	MG	1/DAY
60201030000110	RESTORIL	CAPS	OR	30	MG	1/DAY
60201030000110	TEMAZEPAM	CAPS	OR	30	MG	1/DAY
60201040000305	TRIAZOLAM	TABS	OR	0.125	MG	1/DAY
60201040000310	HALCION	TABS	OR	0.25	MG	1/DAY
60201040000310	TRIAZOLAM	TABS	OR	0.25	MG	1/DAY
60204035000320	LUNESTA	TABS	OR	1	MG	1/DAY
60204035000320	ESZOPICLONE	TABS	OR	1	MG	1/DAY
60204035000330	LUNESTA	TABS	OR	2	MG	1/DAY
60204035000330	ESZOPICLONE	TABS	OR	2	MG	1/DAY
60204035000340	LUNESTA	TABS	OR	3	MG	1/DAY
60204035000340	ESZOPICLONE	TABS	OR	3	MG	1/DAY
60204070000120	SONATA	CAPS	OR	5	MG	2/DAY
60204070000120	ZALEPLON	CAPS	OR	5	MG	2/DAY
60204070000130	SONATA	CAPS	OR	10	MG	2/DAY
60204070000130	ZALEPLON	CAPS	OR	10	MG	2/DAY
60204080100310	AMBIEN	TABS	OR	5	MG	1/DAY
60204080100310	ZOLPIDEM TARTRATE	TABS	OR	5	MG	1/DAY
60204080100315	AMBIEN	TABS	OR	10	MG	1/DAY
60204080100315	ZOLPIDEM TARTRATE	TABS	OR	10	MG	1/DAY
60204080100410	AMBIEN CR	TBCR	OR	6.25	MG	1/DAY
60204080100410	ZOLPIDEM TARTRATE ER	TBCR	OR	6.25	MG	1/DAY
60204080100420	AMBIEN CR	TBCR	OR	12.5	MG	1/DAY
60204080100420	ZOLPIDEM TARTRATE ER	TBCR	OR	12.5	MG	1/DAY
60204080100708	INTERMEZZO	SUBL	SL	1.75	MG	1/DAY

GPI	Product name	Dosage Form	Route	Strength		Utilization Edit
60204080100708	ZOLPIDEM TARTRATE	SUBL	SL	1.75	MG	1/DAY
60204080100715	INTERMEZZO	SUBL	SL	3.5	MG	1/DAY
60204080100715	ZOLPIDEM TARTRATE	SUBL	SL	3.5	MG	1/DAY
60204080100720	EDLUAR	SUBL	SL	5	MG	1/DAY
60204080100730	EDLUAR	SUBL	SL	10	MG	1/DAY
60204080102020	ZOLPIMIST	SOLN	OR	5	MG/ACT	2 SPRAYS (0.25ML)/DAY

ATTACHMENTS

- Prescriber Concurrent Benzodiazepine/Opioids Attestation Form

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy Created	10/17/2018	10/17/2018
Added Carisporodol criteria	11/2018	11/2018

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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.