Clinical Policy: Opioid Analgesics

Reference Number: IN.CP.PPA.12
Effective Date: 10.16
Last Review Date: 10.20
Line of Business: Medicaid

Revision Log

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

Description

The intent of the criteria is to ensure that members follow selection elements established by Centene medical policy for opioid analgesic use.

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 health plans affiliated with Centene Corporation® that opioid analgesics are **medically necessary** for members meeting the following criteria:

Denial Criteria for Opioid Analgesics

- Initial utilizers of opioid therapy (less than 90 days of therapy in the past 120 days; excluding diagnoses of cancer, sickle cell, or other terminal diagnoses associated with significant pain)
    A. Greater than 60mg morphine equivalents per day
    B. First claim does not exceed 7 days supply with subsequent claim(s) not to exceed a 7 days supply (maximum of 14 days supply total) in 45 days
    C. Long-acting opioid agent
- Current utilizers of opioid therapy (at least 90 days of therapy in the past 120 days; excluding diagnoses of cancer, sickle cell, or other terminal diagnoses associated with significant pain)
    A. More than one long-acting opioid agent and one short-acting opioid agent utilized concurrently

- Concurrent use with carisoprodol and combinations require prior authorization for medical necessity
- New opioid claims exceeding 7 days in the past 180 days with concurrent claims for benzodiazepines (claim within past 30 days) will require PA for the following (current utilizers of both agents, utilizing for 90 of the past 120 days, will be exempt from the following criteria at this time):
- Concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), within the past 45 days
    A. See *IN.CP.PMN.47* for PA criteria for concurrent use

I. Criteria for Long term therapy (> 7 day supply) with immediate release or long acting agent (must meet criteria A-D **OR** criterion E or F)

A. Diagnosis of moderate to severe chronic pain;
B. Failure of at least TWO non-opioid ancillary treatments (such as non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, anticonvulsants, antidepressants, etc.) at maximum tolerated doses, unless contraindicated;
C. If request is for an extended release agent, member must have trialed and failed monotherapy with an immediate release agent;
D. Member will be maintained on no more than two opioid analgesics concurrently;
If member requires therapy with two opioid analgesics, regimen must consist of one immediate-release and one extended-release analgesic unless contraindicated

OR

E. Opioid therapy will be used for sickle cell crisis pain/cancer pain/ palliative care;

OR

F. Member had a surgical procedure which requires longer than 14 days of opioid treatment. Prescriber should have a clear plan for dose tapering and discontinuation.

Approval duration:

Chronic Pain: 3 months
Sickle cell crisis/cancer pain/palliative care: 12 months
Post-Surgical: Based on Approved Prescriber Plan

Request for non-preferred medications is subject to policy "CP.PMN.16 - Request for Medically Necessary Drug not on the PDL"

II. Criteria for Request for > 2 opioid analgesics concurrently (applies to opiate naïve and opiate experienced members) (must meet all)

A. *Opioid therapy must be prescribed by a pain or oncology specialist* for sickle cell crisis pain/cancer pain/palliative care;

B. Prescriber will be requested to discontinue opioid analgesic to meet the two (2) or less opioid limit by any of the following methods:

a. Addition of an extended release opioid analgesic, if not present,

b. Upward titration of existing opioids within plan allowed quantity limits,

C. *Prescriber must provide documented clinical rationale for the use of > 2 opioid analgesics concurrently instead of adding an extended release opioid or titrating/discontinuing current opioid analgesics.*

Approval duration: 6 months

Request for non-preferred medications is subject to policy "CP.PMN.16 - Request for Medically Necessary Drug not on the PDL"

III. Criteria for concurrent carisoprodol and opioid analgesic

A. Opioid meets other opioid analgesic criteria including trial of non-opioid pain management therapy, day supply and morphine equivalence limits
B. Documentation shows clear need for muscle relaxant
C. Requires trial of at least 2 preferred muscle relaxants including baclofen, chlorzoxazone, cyclobenzaprine, methocarbamol or tizanidine

Approval Duration: 3 months

IV. Criteria for Concurrent Opioid and Benzodiazepine

A. Must provide diagnoses for both agents
B. Must provide previous therapy attempted for each indication
C. Prescriber must submit faxed form with signed 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 (see pharmacy services website for Benzodiazepine and Opioid Concurrent Therapy Prior Authorization Form)

Approval Duration: 3 months

Continued Approval for long term therapy (must meet all as applicable)**:**

I. Long term therapy (must meet A **OR** B)

A. For treatment of chronic pain:

a. Member has previously met all initial approval criteria for long-term opioid use,
b. Prescriber provides rationale for continued treatment,
c. Member will not be maintained on > 2 opioid analgesic concurrently;

OR

B. Opioid therapy will be used for sickle cell crisis pain/ cancer pain/palliative care

Approval Duration
Chronic Pain: 3 months
Sickle cell/cancer/palliative care: 12 months

II. Request for > 2 opioid analgesic concurrently

A. Member is currently receiving > two (2) opioid analgesic via Centene benefit;
B. Opioid therapy will be used for sickle cell pain/ cancer pain/palliative care
C. Prescriber provides rationale for continued treatment.

Approval duration: 6 months

Background

Opioid analgesics provide relief of acute or chronic pain symptoms. The most profound analgesic effects of opioids are mediated at the mu receptors. Within the central nervous system (CNS), mu receptors are found in large numbers in the midbrain and the in the dorsal horn of the spinal cord where they induce intense analgesia, and a number of other effects such as bradycardia, sedation, euphoria, physical dependence, and respiratory depression. Some common opioid analgesics include buprenorphine, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, methadone, meperidine, morphine, oxycodone, oxymorphone, pentazocine, tramadol, and tapentadol.

References (or Bibliography):

1. Rosenquist EW. Overview of the treatment of chronic pain. Aronson MD, Park L. (Ed), UpToDate. Waltham MA. Accessed November 2015.
2. Initial and Continued Approval follow-up periods based on the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain – 2016. http://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added that criteria is for opioid naïve members	7/2017	7/2017
Annual Review – No changes	7/2018	7/2018
Added concurrent carisoprodol and benzodiazepine criteria Reformatted criteria to include all opioid denial criteria	10/2018	10/2018
Annual Review – No changes	10/2019	10/2019
Annual Review: No changes	10/14/2020	10/14/2020

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.