Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: N/A**
Policy Number: PHW.PDL.109	**Effective Date: 01/01/2020** **Revision Date: 07/2020**
Policy Name: Analgesics, Opioid Short-Acting	

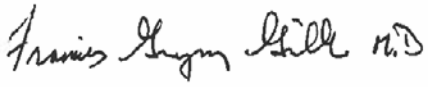
Type of Submission – Check all that apply:

- ☐ **New Policy**
- ☐ **Revised Policy***
- ✓ **Annual Review - No Revisions**
- ✓ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

Q3 2020 annual review: no changes.

Name of Authorized Individual (Please type or print): **Francis G. Grillo, MD**	**Signature of Authorized Individual:** 

Clinical Policy: Analgesics, Opioid Short-Acting

Reference Number: PHW.PDL.109
Effective Date: 01/01/2020
Last Review Date: 07/2020

Revision Log

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 PA Health and Wellness® that Short-acting Opioid Analgesics are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Analgesics, Opioid Short-Acting

A. Prescriptions That Require Prior Authorization

Prescriptions for Analgesics, Opioid Short-Acting that meet any of the following conditions must be prior authorized:

1. A non-preferred Analgesic, Opioid Short-Acting regardless of the quantity prescribed.

2. An Analgesic, Opioid Short-Acting with a prescribed quantity that exceeds the quantity limit.

3. An Analgesic, Opioid Short-Acting when there is a record of a recent paid claim for another drug within the same therapeutic class of drugs (therapeutic duplication).

4. An Analgesic, Opioid Short-Acting when a beneficiary has a concurrent prescription for a buprenorphine agent with a U.S. Food and Drug Administration (FDA)-approved indication for opioid dependence **OR** naltrexone for extended-release injectable suspension (Vivitrol).

5. An Analgesic, Opioid Short-Acting that contains codeine or tramadol when prescribed for a child under 18 years of age.

6. An Analgesic, Opioid Short-Acting that contains codeine or tramadol when prescribed for a child 18-20 years of age and at least **one** of the following:

    a. More than a 3-day supply is prescribed
    b. The child has a history of a paid claim for an Analgesic, Opioid Short-Acting within the past 365 days.

[1] Opioid tolerant is defined as taking at least morphine 60 mg/day, transdermal fentanyl 25 mcg/h, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equianalgesic dose of another opioid for one (1) week or longer.

7. An Analgesic, Opioid Short-Acting that does not contain codeine or tramadol when prescribed for a child under 21 years of age and at least **one** of the following:

    a. More than a 3-day supply is prescribed
    b. The child has a history of a paid claim for an Analgesic, Opioid Short-Acting within the past 365 days.

8. An Analgesic, Opioid Short-Acting when prescribed for an adult 21 years of age or older and at least **one** of the following:

    a. More than a 5-day supply is prescribed
    b. The beneficiary has a history of a paid claim for an Analgesic, Opioid Short-Acting within the past 180 days.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Analgesic, Opioid Short-Acting, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a transmucosal fentanyl product, **all** of the following:

    a. Has a diagnosis of cancer,
    b. Is opioid-tolerant,[1]
    c. Is prescribed the requested transmucosal fentanyl product by a specialist certified in pain medicine, oncology, or hospice and palliative medicine by the American Board of Medical Specialties,
    d. Has a history of a contraindication to the preferred Analgesics, Opioid Short-Acting;

    AND

2. For nasal butorphanol, **both** of the following:

    a. Is not opioid-tolerant[1]

    b. **One** of the following:

        i. **All** of the following:

            a) Has a diagnosis of pain,
            b) Is being prescribed nasal butorphanol by a specialist certified in neurology, pain medicine, oncology, or hospice and palliative

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medicine by the American Board of Medical Specialties,

c) Has a history of therapeutic failure, contraindication, or intolerance to at least 3 unrelated (i.e., different opioid ingredient) preferred Analgesics, Opioid Short- Acting (single-entity or combination products),

ii. **All** of the following:

a) Has a diagnosis of migraine,

b) Is prescribed nasal butorphanol by a neurologist or headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties,

c) Has a history of therapeutic failure, contraindication, or intolerance of **all** of the following abortive therapies:

(i) Acetaminophen,
(ii) Non-steroidal anti-inflammatory drugs (NSAIDs),
(iii) Triptans,
(iv) Dihydroergotamine,

d) Has a history of therapeutic failure, contraindication, or intolerance to the **all** of following preventive therapies:

(i) Anticonvulsants,
(ii) Beta blockers,
(iii) Botulinum toxin (for a diagnosis of chronic migraine only),
(iv) Calcitonin gene-related peptide (CGRP) inhibitors/antagonists,
(v) Calcium channel blockers,
(vi) Serotonin-norepinephrine reuptake inhibitors (SNRIs),
(vii) Tricyclic antidepressants;

AND

3. For a combination agent containing a barbiturate, also meets the guidelines in PHW.PDL.692 Analgesics, Non-Opioid Barbiturate Combinations; **AND**

4. For a non-preferred Analgesic, Opioid Short-Acting, has a history of therapeutic failure, contraindication, or intolerance of the preferred Analgesics, Opioid Short-Acting; **AND**

5. For a beneficiary with a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder **OR** naltrexone for extended-release injectable suspension (Vivitrol), **both** of the following:

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a. Is prescribed both prescriptions by the same prescriber or, if prescribed by different prescribers, all prescribers are aware of the other prescription(s)
b. Has an acute need for therapy with an Analgesic, Opioid Short-Acting and the other therapy will be suspended during the treatment for acute pain;

AND

6. For therapeutic duplication, **one** of the following:
   a. Is being titrated to or tapered from a drug in the same class
   b. Has a clinical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

AND

7. **One** of the following:

   a. **One** of the following:

      i. For a beneficiary under 18 years of age, **both** of the following:

         a) Has a diagnosis of active cancer, sickle cell with crisis, or neonatal abstinence syndrome or is receiving palliative care or hospice services
         b) The Analgesic, Opioid Short-Acting does not contain codeine or tramadol

      ii. For a beneficiary 18 years of age or older, has a diagnosis of active cancer or sickle cell with crisis or is receiving palliative care or hospice services

   b. **All** of the following:

      i. Has documentation of pain that is **all** of the following:

         a) Caused by a medical condition,

         b) Not neuropathic or migraine in type,

         c) **One** of the following:

            (i) For a beneficiary under 21 years of age, severe as documented by a pain assessment tool measurement (e.g., a numeric or visual analog scale)
            (ii) For a beneficiary 21 years of age or older, moderate-to-severe as documented by a pain assessment tool measurement (e.g., a numeric

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or visual analog scale),

ii. Has documentation of the anticipated duration of therapy,

iii. Has documentation of therapeutic failure, contraindication, or intolerance to both of the following pain management modalities:

a) Non-pharmacologic techniques (e.g., behavioral, cognitive, physical, and/or supportive therapies)
b) Non-opioid analgesics (e.g., acetaminophen, NSAIDs),

iv. Has documentation that the Analgesic, Opioid Short-Acting will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy,

v. Was assessed for potential risk of misuse, abuse, or addiction based on family and social history obtained by the prescribing provider,

vi. **One** of the following:

a) For a beneficiary under 21 years of age, has documentation that the beneficiary or parent/guardian has been educated on the potential adverse effects of opioid analgesics, including the risk for misuse, abuse, and addiction
b) For a beneficiary 21 years of age or older, has documentation of education on the potential adverse effects of opioid analgesics, including the risk for misuse, abuse, and addiction,

vii. Is prescribed a medication and dose that is appropriate based on the beneficiary's age, weight, and concurrent medical conditions and is consistent with FDA- approved package labeling, nationally recognized compendia, or peer- reviewed medical literature,

viii. Was assessed for recent use (within the past 60 days) of an opioid,

ix. Was evaluated for risk factors for opioid-related harm; if the beneficiary is identified as high-risk for opioid related harm, the prescriber considered prescribing naloxone,

x. Is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined to be medically necessary,

xi. Has results of a recent urine drug screen (UDS) testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone,

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fentanyl, tramadol, and carisoprodol) that is consistent with prescribed controlled substances;

AND

8. Has documentation that the prescriber or the prescriber's delegate conducted a search of the Pennsylvania Prescription Drug Monitoring Program (PDMP) for the beneficiary's controlled substance prescription history; **AND**

9. If a prescription for an Analgesic, Opioid Short-Acting is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override and **all** of the following:

    a. **One** of the following:

        i. For a beneficiary under 21 years of age, has severe pain as documented by a pain assessment tool measurement (e.g., a numeric or visual analog scale)
        ii. For a beneficiary 21 years of age or older, has moderate-to-severe pain as documented by a pain assessment tool measurement (e.g., a numeric or visual analog scale),

    b. The medication is being prescribed by an appropriate specialist or in consultation with an appropriate specialist,

    c. An opioid analgesic at the requested dose is the most appropriate treatment option as documented by at least **one** of the following:

        i. Pain is inadequately controlled at the current quantity limit
        ii. Pain is inadequately controlled by other Analgesics, Opioid Short-Acting or the beneficiary has a history of a contraindication or adverse reaction to alternative Analgesics, Opioid Short-Acting,

    d. The beneficiary would not be more appropriately pain controlled by initiating or adjusting the dose of an Analgesic, Opioid Long-Acting.

    NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR ANALGESICS, OPIOID SHORT-ACTING: The determination of medical necessity of a request for renewal of a prior authorization for an Analgesic, Opioid Short-Acting that was previously approved will take into account whether the beneficiary:

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1. Experienced an improvement in pain control and level of functioning while on the requested agent; **AND**

2. Has documentation that the Analgesic, Opioid Short-Acting will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy; **AND**

3. Is being monitored by the prescriber for adverse events and warning signs for serious problems, such as overdose and opioid use disorder; **AND**

4. Was evaluated for risk factors for opioid-related harm; if the beneficiary is identified as high-risk for opioid related harm, the prescriber considered prescribing naloxone; **AND**

5. Is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined to be medically necessary; **AND**

6. **One** of the following:

    a. If prescribed less than 50 morphine milligram equivalents (MME) per day, has results of a UDS testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, tramadol, and carisoprodol) every 12 months that is consistent with prescribed controlled substances
    b. If prescribed greater than or equal to 50 MME per day, has results of a UDS testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, tramadol, and carisoprodol) every 3 months that is consistent with prescribed controlled substances;

    AND

7. Has documentation that the prescriber or the prescriber's delegate conducted a search of the PDMP for the beneficiary's controlled substance prescription history; **AND**

8. If a prescription for an Analgesic, Opioid Short-Acting is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override and **all** of the following:

    a. **One** of the following:

        i. For a beneficiary under 21 years of age, has severe pain as documented by a pain assessment tool measurement (e.g., a numeric or visual analog scale)
        ii. For a beneficiary 21 years of age or older, has moderate-to-severe pain as

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documented by a pain assessment tool measurement (e.g., a numeric or visual analog scale),

b. The medication is being prescribed by an appropriate specialist or in consultation with an appropriate specialist,

c. An opioid analgesic at the requested dose is the most appropriate treatment option as documented by at least **one** of the following:

i. Pain is inadequately controlled at the current quantity limit
ii. Pain is inadequately controlled by other Analgesics, Opioid Short-Acting or the beneficiary has a history of a contraindication or adverse reaction to alternative Analgesics, Opioid Short-Acting,

d. The beneficiary would not be more appropriately pain controlled by initiating or adjusting the dose of an Analgesic, Opioid Long-Acting.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Analgesic, Opioid Short-Acting. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. Dose and Duration of Therapy

Requests for prior authorization of an Analgesic, Opioid Short-Acting will be approved for up to 3 months.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020

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