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: 11/2021**
Policy Number: PHW.PDL.145.01	**Effective Date: 01/01/2020** **Revision Date: 10/2021**
Policy Name: Opioid Dependence Treatments	

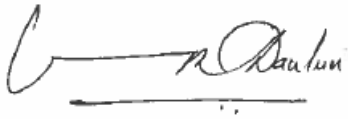
Type of Submission – Check all that apply:

- ☐ **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:

Q1 2022: policy revised according to DHS revisions effective 01/03/2022

Name of Authorized Individual (Please type or print): **Venkateswara R. Davuluri, MD**	**Signature of Authorized Individual:** 

Clinical Policy: Opioid Dependence Treatments

Reference Number: PHW.PDL.145.01
Effective Date: 01/01/2020
Last Review Date: 10/2021

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 Opioid Dependence Treatments are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Opioid Dependence Treatments

A. Prescriptions That Require Prior Authorization

Prescriptions for Opioid Dependence Treatments that meet any of the following conditions must be prior authorized:

1. An oral buprenorphine Opioid Dependence Treatment without naloxone.

2. A non-preferred Opioid Dependence Treatment. See the Preferred Drug List (PDL) for the list of preferred Opioid Dependence Treatments at: https://papdl.com/preferred-drug-list.

3. An Opioid Dependence Treatment with a prescribed quantity that exceeds the quantity limit.

   REMINDER: A prescription for a benzodiazepine, opioid analgesic, controlled substance sedative hypnotic, or carisoprodol requires prior authorization when a member has a concurrent prescription for a buprenorphine Opioid Dependence Treatment. Refer to the specific individual handbook chapters (e.g., Analgesics, Opioid Long-Acting, Analgesics, Opioid Short-Acting, Anticonvulsants, Anxiolytics, Skeletal Muscle Relaxants, Sedative Hypnotics) for corresponding prior authorization guidelines.

   REMINDER: A prescription for an opioid analgesic requires prior authorization when a member has a concurrent prescription for Vivitrol.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Opioid Dependence Treatment, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. Is prescribed the Opioid Dependence Treatment for treatment of a

diagnosis that is indicated in the U.S. Food and Drug Administration-approved package labeling OR a medically accepted indication; **AND**

2. For Lucemyra (lofexidine), is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. For an oral buprenorphine Opioid Dependence Treatment that does not contain naloxone, **one** of the following:

   a. Is prescribed the agent for induction therapy,
   b. Is pregnant,
   c. Is breastfeeding,
   d. Has a history of contraindication or intolerance to naloxone;

   AND

4. For a non-preferred Opioid Dependence Treatment, **one** of the following:

   a. For an oral buprenorphine Opioid Dependence Treatment, has a history of therapeutic failure, contraindication, or intolerance of the preferred oral buprenorphine Opioid Dependence Treatments,
   b. For an alpha-2 adrenergic agonist Opioid Dependence Treatment, has a history of therapeutic failure, contraindication, or intolerance of the preferred alpha-2 adrenergic agonist Opioid Dependence Treatments,
   c. For a non-oral buprenorphine Opioid Dependence Treatment, has a history of therapeutic failure, contraindication, or intolerance of the preferred non-oral buprenorphine Opioid Dependence Treatments;

   AND

5. Has documentation that the prescriber or the prescriber's delegate conducted a search of the Pennsylvania Prescription Drug Monitoring Program for the member's controlled substance prescription history; **AND**

6. If a prescription for an Opioid Dependence Treatment is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override; **AND**

7. If a prescription for an oral buprenorphine Opioid Dependence Treatment is for a daily dose that exceeds 24 mg/day, **all** of the following:

   a. Whether the member is prescribed a daily dose consistent with medically accepted prescribing practices and standards of care,

b. Whether the member has documentation of an evaluation to determine the recommended level of care,

c. Whether the member has documentation of participation in a substance abuse or behavioral health counseling or treatment program or an addictions recovery program,

d. Whether the member has a recent urine drug screen for drugs with the potential for abuse,

e. For a member already established on buprenorphine, whether the member has a recent urine drug screen that is positive for buprenorphine and norbuprenorphine.

NOTE: If the member does not meet the clinical review guidelines and quantity limit guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, 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 Opioid Dependence Treatment. 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 member.

D. **Approval Duration:**

Requests for prior authorization of Lucemyra (lofexidine) will be approved for a dose and duration of therapy consistent with the FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

All other agents: 12 months

E. References

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Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Per direction from DHS, removing criteria for an oral buprenorphine Opioid Dependence Treatment when used in combination with a benzodiazepine or CNS depressant	01/13/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021: policy revised according to DHS revisions effective 01/05/2021	11/2020
Q1 2022: policy revised according to DHS revisions effective 01/03/2022	10/2021