MEDICATION COVERAGE POLICY

PHARMACY AND THERAPEUTICS ADVISORY COMMITTEE

Health Plan of San Joaquin

POLICY	Opioids	**LAST REVIEW**	02/09/2021
THERAPEUTIC CLASS	Pain	**REVIEW HISTORY** (MONTH/YEAR)	5/19, 5/18, 5/17, 5/16, 5/15, 2/12, 2/11, 2/07
LOB AFFECTED	Medi-Cal		

This policy has been developed through review of medical literature, consideration of medical necessity, generally accepted medical practice standards, and approved by the HPSJ Pharmacy and Therapeutic Advisory Committee.

BACKGROUND

The standard of proper pain management has changed over the last 20 years. Hydrocodone is one of the most commonly prescribed drugs in the country, and the large increase in utilization of opioids has resulted in increased rates of overdose and diversion. The balance between chronic pain management and opioid abuse has always been difficult to discern. Adequate pain management entails more than opiate prescribing. Current pain management guidelines recognize different factors (i.e. pain origin, type, severity, frequency, etc) guide the type of analgesic agent used. Opioid therapy is effective primarily for management of severe, acute somatic pain. In contrast, opioid therapy is less effective for patients with visceral or neuropathic pain. The purpose of this coverage policy is to review the coverage criteria of HPSJ's formulary opioid analgesics *(Table 1)* based on evidence of safety and effectiveness.

Table 1: Available Opioid Analgesics *(Current as of 2/2021)*

Short-Acting Opioids					
Note	**Brand Name**	**Generic Name**	**Strengths & Dosage Forms**	**Formulary Limits**	**Cost/Rx**
For short-acting opioid analgesics, HPSJ encourages the use non-opioid adjunctive agents prior to or along with opioid therapy.	**Acetaminophen-Codeine**	Acetaminophen/ Codeine	120-12 mg/5 ml	Tablets/Capsules: Limited to a combined total 120 units per 30 days Oral solution (if available): Limited 946 per 30 days Tramadol, Codeine sulfate, and Acetaminophen/ Codeine only: Must be greater than or equal to 12 years of age **All opioids are limited to a combined total daily dose of < 90 morphine milligram equivalents (MME) per day.** **The first fill of an opioid is limited to a maximum 7 days' supply.** Butorphanol spray, Vicodin tablets are non-formulary.	$3.92
	Tylenol #2		300-15 mg tablet		$3.31
	Tylenol #3		300-30 mg tablet		$3.45
	Tylenol #4		300-60 mg tablet		$14.68
	Fioricet with Codeine	Butalbital-acetaminophen-caffeine-codeine	50-325-40-30 mg capsule		$27.63
	Butorphanol	Butorphanol tartrate	10 mg/ml spray		$43.53
	Codeine	Codeine sulfate	15 mg tablet		-
			30 mg tablet		-
			60 mg tablet		-
	Ascomp with Codeine, Fiorinal with Codeine	Codeine-butalbital-aspirin-caffeine	30-50-325-40 mg capsule		$42.26
	Hycet	Hydrocodone/ Acetaminophen	7.5-325 mg/15 ml		$27.22
	Vicodin		5-300 mg tablet		$149.95
			7.5-300 mg tablet		$61.57
			10-300mg tablet		-
	Norco		5-325 mg tablet		$3.75
			7.5-325 mg tablet		$9.11
			Norco 7.5-325 mg tablet		$420.91
			10 mg-325 mg tablet		$10.16
			Norco 10-325 mg tablet		-
	Vicoprofen	Hydrocodone/ Ibuprofen	7.5-200 mg tablet		$17.18
	Dilaudid	Hydromorphone	2 mg tablet		$3.97
			4 mg tablet		$8.96
			8 mg tablet		$48.22
	Levorphanol	Levorphanol	2 mg tablet		$192.71
	Demerol	Meperidine	50 mg/5 ml oral solution		-
			50 mg tablet		$9.56
			100 mg tablet		$31.47
	Morphine IR	Morphine Sulfate IR	10 mg/5 ml solution		$11.80
			20 mg/5 ml solution		$39.79
			100 mg/5 ml solution		$53.68
			5 mg suppository		-

			10 mg suppository		-
			20 mg suppository		-
			30 mg suppository		-
			15 mg tablet		$14.04
			30 mg tablet		$46.86
	BELLADONNA-OPIUM	Opium/ belladonna alkaloids	16.2-60 mg suppository		-
	Oxycodone IR	Oxycodone IR	5 mg/5 ml solution		$34.27
			100 mg/5 ml solution		$282.01
			5 mg capsule		$17.91
			5 mg tablet		$6.37
			10 mg tablet		$14.19
			15 mg tablet		$27.03
			20 mg tablet		$28.75
			30 mg tablet		$56.58
	Endocet, Roxicet Percocet,	Oxycodone/ Acetaminophen	5-325 mg tablet		$4.71
			Endocet 5-325 mg tablet		$4.28
			7.5-325 mg tablet		$28.19
			Endocet 7.5-325 mg tablet		$16.93
			10-325 mg tablet		$23.09
			Endocet 10-325 mg tablet		$20.68
	Ultram	Tramadol	50 mg tablet		$1.59
	Nucynta	Tapentadol	50 mg tablet	NF	$303.98
			75 mg tablet		-
			100 mg tablet		$664.72
Long-Acting Opioids					
Tier	**Brand Name**	**Generic Name**	**Strengths & Dosage Forms**	**Formulary Limits**	**Cost/Rx**
1st line	**Dolophine, Methadose**	Methadone	5 mg/5 ml solution	Methadone Limit 40 mg per day: ○ **10 mg tablets:** 120 per 30 days ○ **5 mg tablets:** 240 per 30 days ○ **5 mg/5ml soln:** 1200 ml per 30 days ○ **10 mg/5 ml soln:** 600 ml per 30 days ○ **10 mg/ml oral concentrate:** 120 ml per 30 days MS Contin tablets: Limit 90 per 30 days Fentanyl patch: ****PA required**** Limit 10 per 30 days Oxycodone ER tablets: ****PA required**** Limit 60 per 30 days **All opioids are limited to a total daily dose of < 90 morphine milligram equivalents (MME) per day.** **The first fill of an opioid is limited to a maximum 7 days' supply.**	$11.35
			10 mg/5 ml solution		$18.50
			10 mg/ml oral concentrate		$1.45
			Methadone Intensol 10 mg/ml oral concentrate		$20.77
			5 mg tablet		$12.12
			10 mg tablet		$18.32
1st line	**MS Contin**	Morphine Sulfate ER	15 mg ER tablet		$18.91
			30 mg ER tablet		$33.40
			60 mg ER tablet		$107.34
			100 mg ER tablet		$260.32
			200 mg ER tablet		$256.78
2nd line	**Duragesic Patch**	Fentanyl	12 mcg/hr patch		$136.54
			25 mcg/hr patch		$40.83
			50 mcg/hr patch		$65.97
			75 mcg/hr patch		$98.73
			100 mcg/hr patch		$140.60
3rd line	**OxyContin**	Oxycodone ER	10 mg ER tablet		$116.61
			Oxycontin 10 mg ER tablet		$277.65
			15 mg ER tablet		-
			Oxycontin 15 mg ER tablet		$376.40
			20 mg ER tablet		$231.53
			Oxycontin 20 mg ER tablet		$416.04
			30 mg ER tablet		-
			Oxycontin 30 mg ER tablet		$579.11
			40 mg ER tablet		$336.75
			Oxycontin 40 mg ER tablet		$679.20
			60 mg ER tablet		-
			Oxycontin 60 mg ER tablet		$932.06
			80 mg ER tablet		$1,413.19
			Oxycontin 80 mg ER tablet		$3,134.70

Non-Formulary	**Kadian**	Morphine Sulfate ER	10 mg ER capsule	NF	$130.15
			Kadian 10 mg ER capsule		-
			20 mg ER capsule		$143.52
			Kadian 20 mg ER capsule		-
			30 mg ER capsule		$61.15
			Kadian 30 mg ER capsule		-
			Kadian 40 mg ER capsule		-
			50 mg ER capsule		-
			Kadian 50 mg ER capsule		-
			60 mg ER capsule		-
			Kadian 60 mg ER capsule		-
			80 mg ER capsule		-
			Kadian 80 mg ER capsule		-
			100 mg ER capsule		-
			Kadian 100 mg ER capsule		-
			Kadian 200 mg ER capsule		-
	Arymo ER	Morphine Sulfate, Abuse-Deterrent	15 mg ER tablet	NF	-
			30 mg ER tablet		-
			60 mg ER tablet		-
	Subsys	Fentanyl	100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg SL spray	NF	$605.76
	Actiq	Fentanyl citrate	200 mcg	NF	-
			400 mcg		-
			1200 mcg		-
			1600 mcg		$5,505.87
	Hysingla ER	Hydrocodone bitartrate	Hysingla 30 mg ER tablet	NF	-
	Opana ER	Oxymorphone HCl	5 mg ER tablet	NF	-
			7.5 mg ER tablet		-
			10 mg ER tablet		-
			15 mg ER tablet		-
			20 mg ER tablet		-
			30 mg ER tablet		-
			40 mg ER tablet		-
	Nucynta ER	Tapentadol HCl	50 mg ER tablet	NF	-
			100 mg ER tablet		-
			150 mg ER tablet		-
			200 mg ER tablet		-
			250 mg ER tablet		-
	Ultram ER	Tramadol HCl	100 mg ER tablet	NF	-
			200 mg ER tablet		-
			300 mg ER tablet		-
	ConZip	Tramadol HCl	100 mg ER capsule	NF	-
			150 mg ER capsule		-
			200 mg ER capsule		-
			300 mg ER capsule		-
	Opana ER	Oxymorphone HCl	5 mg ER tablet	NF	-
			7.5 mg ER tablet		-
			10 mg ER tablet		-
			15 mg ER tablet		-
			20 mg ER tablet		-
			30 mg ER tablet		-
			40 mg ER tablet		-

Partial Agonists, Opioid Antagonists			
Note	**Drug Name**	**Medi-Cal Limits**	**TAR required for Medi-Cal FFS?**
HPSJ encourages patients on chronic opioid therapy to obtain a naloxone	Buprenorphine HCl Film (Belbuca)	Carved out to Fee-For-Service (FFS). Bill straight Medi-Cal.	Yes
	Buprenorphine SQ Implant (Probuphine)		Yes
	Buprenorphine HCl Patch. Injection (Buprenex), SL Tablet		No
	Buprenorphine Extended-Release Injection (Sublocade)		Yes
	Buprenorphine/ Naloxone		No
	Naloxone 0.4 mg/0.4 ml auto injector (Evzio)		Not a Medi-Cal benefit

prescription as a safety precaution measure.	Naloxone HCl Injection Solution, Injection Cartridge, Injection Prefilled Syringe		No
	Naloxone 4mg/0.1ml Nasal Spray (Narcan)		No
	Naltrexone (oral)		No
	Naltrexone Microsphere Injectable Suspension (Vivitrol)		Yes

PA = Prior Authorization; IR = Immediate-Release; ER = Extended-Release; NF = Non-formulary

EVALUATION CRITERIA FOR APPROVAL AND/OR EXCEPTION CONSIDERATION

All Opioids – Requests for over 90 MME/day

Based on CDC Guidelines for Prescribing Opioids for Chronic Pain recommendation to avoid prescribing more than a 7-day supply for the first fill and ≥ 90 morphine milligram equivalents (MME) per day,[3] HPSJ has a days' supply limit for the first fill of an opioid and a combined dose limit for all opioids: < 90 MME/day. Individual drugs or groups of drugs may also have their own quantity limits described below.

Short Acting Opioids – Requests for over 120 tablets/month

The adopted HPSJ position on short-acting opioids is that they should be used for acute pain for short periods of time (e.g., post procedure, fractures) or as breakthrough pain control for patients with chronic pain. For patients with chronic pain who require greater than 120 tablets per month, a long-acting opioid should be initiated (or increased) instead of exceeding 120 tablets per 30 days.

Examples of conditions for which using more than 90 MME/day or 120 short-acting tablets may be considered include:

- Documentation of an acute injury (e.g., post surgery, fractures) not expected to exceed 3 months of therapy
- Treatment of terminal-illness or request is for palliative care.

All quantity limit exception requests are considered on a case-by-case basis. Supporting documentation of condition and treatment plan is strongly encouraged. For patients with chronic pain uncontrolled by the current regimen, long acting opioids should be initiated and/or optimized.

Short-Acting Opioids
Acetaminophen/Codeine, Codeine Sulfate, Hydrocodone/Acetaminophen (Norco), Hydromorphone (Dilaudid), Oxycodone IR, Oxycodone/Acetaminophen (Percocet, Endocet), Oxymorphone (Opana ER), Tramadol (Ultram), Tramadol/Acetaminophen (Ultracet)

- ❒ **Coverage Criteria:** None
- ❒ **Limits:**
  - First opioid prescription is limited to a 7-day supply
  - 120 tablets/capsules per month (combined total)
  - All opioids are limited to a combined dose limit of < 90 MME/day
  - Tramadol, Codeine sulfate, and Acetaminophen/Codeine: Must be greater than or equal to 12 years of age
- ❒ **Required Information for Approval:** For acute pain, documentation of an acute injury (e.g., post surgery, fractures) not expected to exceed 3 months of therapy. For treatment of terminal-illness or request is for palliative care, documentation of the patient's condition, prognosis, and treatment plan. For chronic pain not managed by non-opioid medications and alternative pain management interventions, documentation of alternative(s) tried, opioid risk assessments (e.g., ORT), urine drug test results; copy of a signed patient contract; and a detailed description of the patient's current regimen and treatment plan.
- ❒ **Other Notes:** If use is for chronic pain, may want to consider long-acting opiates and referral to a pain specialist.
- ❒ **Non-Formulary:** Tapentadol (Nucynta), Butorphanol spray, Vicodin tablets (5-300mg, 7.5-300mg, 10-300mg tablets)

Long Acting Opioids:

With the exception of Fentanyl Patch and Oxycodone ER Tablets, HPSJ's formulary opioid analgesics do not require prior authorization for coverage when filled within the designated quantity limit. The *Prior Authorization Approval Criteria* for Fentanyl Patch and Oxycodone Extended-Release Tablets are described below:

Long-Acting Opioids
Hydrocodone bitartrate (Hysingla ER), Morphine Sulfate ER tablets (MS Contin), Morphine Sulfate ER capsules (Kadian), Morphine sulfate abuse-deterrent ER tablet (Arymo ER), Methadone, Fentanyl Patch (Duragesic Patch),

Fentanyl citrate (Actiq), Fentanyl SL spray (Subsys), Oxycodone ER (Oxycontin), Oxymorphone ER (Opana ER), Tramadol ER (Ultram ER, ConZip), Tapentadol ER (Nucynta ER)

Morphine Sulfate ER tablets (MS Contin)

- ❒ **Coverage Criteria:** None
- ❒ **Limits:**
  - 90 tablets per 30 days
  - All opioids are limited to a combined dose limit of < 90 MME/day
- ❒ **Required Information for Approval:** N/A
- ❒ **Other Notes:** None
- ❒ **Non-Formulary:** Morphine sulfate ER capsules (Kadian), Morphine sulfate abuse-deterrent ER tablet (Arymo ER), Oxymorphone ER (Opana ER)

Methadone

- ❒ **Coverage Criteria:** None
- ❒ **Limits:**
  - **Maximum of 40 mg per day:**
    - **Methadone 10 mg tablets:** Limit 120 tablets per 30 days
    - **Methadone 5 mg tablets:** Limit 240 tablets per 30 days
    - **Methadone 5 mg/5ml oral solution:** Limit 1200 ml per 30 days
    - **Methadone 10 mg/5 ml oral solution:** Limit 600 ml per 30 days
    - **Methadone 10 mg/ml oral concentrate:** Limit 120 ml per 30 days
  - All opioids are limited to a combined dose limit of < 90 MME/day
- ❒ **Required Information for Approval:** N/A
- ❒ **Other Notes:** None
- ❒ **Non-Formulary:** Tramadol ER (Ultram ER, ConZip), Tapentadol ER (Nucynta ER)

Fentanyl Patch

- ❒ **Coverage Criteria:** Fentanyl patch is step therapy to treatment failure of adequate dose of or intolerance to MS Contin OR documentation (as evidenced by clinic notes) that patient is unable to take medications by mouth.
- ❒ **Limits:**
  - 10 patches per month
  - All opioids are limited to a combined dose limit of < 90 MME/day
- ❒ **Required Information for Approval:** Drug refill history showing patient has tried MS Contin in the past or clinic notes stating patient cannot swallow tablets/capsules
- ❒ **Other Notes:** Patient must be opioid tolerant (>60mg/day morphine or morphine dose-equivalent opioid for 1 week or longer).
- ❒ **Non-Formulary:** Fentanyl citrate (Actiq), Fentanyl SL spray (Subsys), Fentanyl Patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr

Oxycodone ER (Oxycontin)

- ❒ **Coverage Criteria:** Oxycontin is reserved for treatment failure of adequate dose of or intolerance to MS Contin AND Fentanyl Patch.
- ❒ **Limits:**
  - 60 tablets per 30 days
  - All opioids are limited to a combined dose limit of < 90 MME/day
- ❒ **Required Information for Approval:** Drug refill history showing patient has tried MS Contin AND Fentanyl patch in the past.
- ❒ **Other Notes:** None
- ❒ **Non-Formulary:** Hydrocodone bitartrate (Hysingla ER)

Clinical Justification

HPSJ's opioid management policy is based on recommendations by the *American Pain Society (APS), American Academy of Pain Medicine (AAPM), American Academy of Neurology (AAN)*, *Veterans Affairs*, *California Medical Board, and Centers for Disease Control & Prevention (CDC).* In general, opioid therapy is effective primarily for management of severe-acute somatic pain. Although opioid therapy is sometimes prescribed for chronic use, safety and efficacy evidence supporting its use for chronic pain is very limited. The current standard of practice for prescribing opioid therapy for treatment of chronic pain is to optimize one long-acting opioid therapy first then add one short-acting opioid agent (if necessary) for

break-through pain. Break-through dose should only be 5-15% of total daily opioid dose. Therefore, HPSJ limits members to 1 long-acting opioid and 1 short-acting opioid agent at any given time. In addition, the formulary short-acting opioid restriction to combined total of 120 tablets/capsules per month is to encourage patients that require more than the monthly limit to consider adding long-acting agent as part of their pain management plan.

For patients with neuropathic, visceral, or central pain, opioid therapy is not the standard of care and will typically lead to poor response to pain relief. The *American Academy of Neurology (AAN), American Association of Neuromuscular and Electrodiagnositic Medicine (AANEM), American Academy of Physical Medicine and Rehabilitation (AAPMR), and the American Society of Anesthesiologists (ASA)* recommend the following:

- Gabapentin, pregabalin, sodium valproate, tricyclic antidepressants (amitriptyline, nortriptyline, and desipramine) and SNRIs (venlafaxine and duloxetine) should be considered for treatment of painful diabetic neuropathy.
- Venlafaxine may be used in conjunction with gabapentin for improved response.
- Topical agents that may possibly be effective for neuropathy include: lidocaine patch and capsaicin cream.
- NSAIDs should be used for chronic back pain.
- Agents NOT recommended for long-term use for the treatment of neuropathic pain/ or chronic back pain: opioid agents, benzodiazepines, skeletal muscle relaxants.
- Opioids should not be used for treatment of chronic/recurrent headaches, abdominal pain, or menstrual cramps.

Opioid use in pregnant patients are associated with numerous risks: premature births, spontaneous abortions, birth defects, neonatal abstinence syndrome (NAS), etc. Initiating opioid therapy in this population should only be done if all other options have been exhausted and the benefits outweigh the risks. For pregnant women already receiving opioids, clinicians should assess for medical appropriateness and consider tapering opioids because of possible risk to the pregnant patient and to the fetus. For pregnant women with opioid use disorder, medication-assisted therapy with buprenorphine or methadone has been associated with improved maternal outcomes.
Table 2 below outlines evidence-based recommendations for the management of common types of non-somatic pain. For HPSJ's current formulary alternatives to opioid analgesics, please refer to *Table 3***.**

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016[3]

Key Points:

- Chronic pain is defined as pain lasting more than 3 months.

BOX 1. CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care
Determining When to Initiate or Continue Opioids for Chronic Pain 1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate. 2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety. 3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.
Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation 4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids. 5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to =50 morphine milligram equivalents (MME)/day, and **should avoid increasing dosage to =90 MME/day** or carefully justify a decision to titrate dosage to =90 MME/day. 6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; **more than seven days will rarely be needed.** 7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy

with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
Assessing Risk and Addressing Harms of Opioid Use 8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (=50 MME/day), or concurrent benzodiazepine use, are present. 9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months. 10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs. 11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible. 12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

* All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guideline for evidence ratings.

The FDA has made several safety announcements regarding safety risks with opioids:[4-9]

- 3/22/16: Opioid Label Changes[4]
    - Opioids can interact with antidepressants, migraine medications, and nausea medications, resulting in serotonin syndrome
    - Opioids may lead to adrenal insufficiency
    - Long-term opioid use may be associated with decreased sex hormones
- 3/22/16: Immediate-Release Opioid Black Box Warning[5]
    - Immediate-release (short-acting) opioids are associated with risk of opioid addiction, abuse, and misuse—which can lead to overdose and death
- 5/26/16: Methadone and Buprenorphine Black Box Warning[6]
    - Methadone and buprenorphine products when used by pregnant women for medication-assisted treatment (MAT) of opioid use disorder can be associated with risk of neonatal opioid withdrawal syndrome (NOWS), but these risks must be balanced against the risk of untreated opioid addiction during pregnancy. Of note: buprenorphine for pain already had a boxed warning for risk of NOWS.
- 8/31/16: Opioids, Prescription Opioid Cough Products, Benzodiazepine Black Box Warning[7]
    - Concomitant use of opioids with benzodiazepines or other CNS depressants, including alcohol, may result in sedation, respiratory depression, coma, and death. Treatment should be reserved for use in patients in whom alternative treatment options are inadequate using the minimum required dosage and duration.
- 4/20/17: Prescription Codeine and Tramadol Contraindications[1]
    - The FDA safety announcement on April 20, 2017 reported the results of their review of adverse event reports from January 1969 to May 2015—which identified 64 cases of serious breathing problems (including 24 deaths) with codeine-containing medicines in children under 18 and 9 cases of serious breathing problems (including 3 deaths) with the use of tramadol in children under 18 years from. The majority of serious side effects with these medications occurred in children younger than 12 years, and some cases occurred after a single dose of the medicine. Based on these results, the FDA added a contraindication to all prescription codeine- and tramadol-containing products to avoid use in all children under 12. The labeling change also added the following warnings:[1]
        - Tramadol is contraindicated in children under 18 to treat pain after surgery to remove tonsils and/or adenoids
        - Codeine or tramadol should not be used in adolescents between 12-18 who are obese or have condition such as obstructive sleep apnea or severe lung disease, which may increase risk of serious breathing problems

        - Codeine or tramadol should not be used in breastfeeding mothers due to the increased risk of adverse reactions (increased sleepiness, difficulty breastfeeding, breathing problems, death) in breastfed infants
    - Based on the new FDA labeling update of codeine- or tramadol-containing products, HPSJ has added the following age restriction to these agents: "Must be greater than or equal to 12 years of age".
- 9/18/18: FDA approved the Opioid Analgesic REMS[8]
    - The REMS program applies to all opioid analgesics intended for outpatient use and requires that training be made available to all health care providers who are involved in the management of patients with pain.
- 4/9/19: Harm reported from sudden discontinuation of opioid pain medications[9]
    - The FDA safety announcement on April 9, 2019 was based on reports of serious harm in patients who are physically dependent on opioids and suddenly having these medicines discontinued or the dose rapidly decreased. Rapid discontinuation can result in serious withdrawal symptoms, uncontrolled pain, psychological distress, suicide, and attempts to find other sources of opioid analgesics or illicit substances.
    - The FDA is requiring labeling changes to provide guidance on how to safely decrease the dose in the outpatient setting. The FDA recommends that when the health care professional and provider have agreed to taper the opioid, consider: the dose of the drug, duration of treatment, type of pain being treated, and physical and psychological attributes of the patient. A patient-specific plan should be created to gradually taper the dose of the opioid and ensure ongoing monitoring and support.
    - In general, for patients who are physically dependent on opioids, taper by an increment of no more than 10 to 25% every 2 to 4 weeks. It may be necessary to provide the patient with lower dosage strengths to accomplish a successful taper. If the patient is experiencing increased pain or serious withdrawal symptoms, it may be necessary to pause the taper for a period of time, raise the opioid analgesic to the previous dose, and then once stable, proceed with a more gradual taper.
    - When managing patients taking opioid analgesics, particularly those who have been treated for a long duration and/or with high doses for chronic pain, ensure that a multimodal approach to pain management, including mental health support (if needed), is in place prior to initiating an opioid analgesic taper. A multimodal approach to pain management may optimize the treatment of chronic pain, as well as assist with the successful tapering of the opioid analgesic. Patients who have been taking opioids for shorter time periods may tolerate a more rapid taper.
    - When opioid analgesics are being discontinued due to a suspected substance use disorder, evaluate and treat the patient, or refer him/her for evaluation and treatment of the substance use disorder. Treatment should include evidence-based approaches such as medication assisted treatment of opioid use disorder. Complex patients with comorbid pain and substance use disorders may benefit from referral to a specialist.

There are 8 FDA-approved abuse-deterrent opioid products. According to the FDA, abuse-deterrent is not the same as abuse-proof. The fact that a product has FDA-approved labeling describing abuse-deterrent properties does not mean the product is impossible to abuse or that these properties necessarily prevent overdose and death – currently marketed technologies do not effectively deter one of the most common forms of opioid abuse – swallowing a number of intact tablets or capsules. Because opioid medications must in the end be able to deliver the opioid to the patient, there may always be some potential for abuse of these products. All of the manufacturers that have approved opioids with AD properties reflected in their labeling are being required to conduct postmarketing studies to determine the impact that AD technologies are having in practice. The FDA looks forward to a future in which most or all opioid medications are available in formulations that are less susceptible to abuse than the formulations that lack abuse-deterrent properties. The FDA also supports the efficient development of non-opioid alternatives for treating pain.[2]

The CDC recommends extra caution for MME dose calculations with agents such as methadone, as the conversion factor increases at higher doses. This is because of its long and unpredictable half-life, and higher doses are associated with additional safety risks such as QTc prolongation and potential cardiac arrhythmia.[7] According to the American Pain Society 2014 Methadone Safety Guidelines, clinicians who start methadone should not use more than 30 to 40 mg daily.[10] Based on the dose-dependent safety risks associated with methadone, HPSJ has a quantity limit on formulary methadone products limiting fills to a maximum of 40 mg per day.

HPSJ MANAGEMENT OF OPIOIDS FOR CHRONIC PAIN POLICY & PROCEDURES

Background

The standard of proper pain management has changed over the last 20 years. Hydrocodone is one of the most commonly prescribed drugs in the country, and the large increase in utilization of opioids has resulted in increased rates of overdose and diversion. The purpose of this Opioid Analgesics Coverage Policy is to review the coverage criteria of HPSJ's formulary opioid-analgesics based on evidence of safety and effectiveness and to promote the standard of care and appropriate opioid prescribing practices.

Policy Transition Plan

Members who receive an initial prescription for opioids (i.e., first prescription in 90 days) will be limited to a maximum of 7 days' supply for the first fill. Larger quantities will require prior authorization.

Members previously on chronic opioid therapy prior to the transition to morphine milligram equivalent (MME) limit of 90 mg/day will receive communications 90 days prior to the transition. All providers will also receive notice of the transition with recommendations to adjust their patients' therapy or submit prior authorizations.

Members with terminal illness will have their opioid medications renewed on the basis of continuity of care and will not be subjected to this pain management policy.

Definitions

- Chronic opioid therapy (COT) is defined as ≥90 days continuous opioid therapy.
- High-dose opioid therapy (HD-COT) is defined as ≥90 mg/day morphine equivalent dose (MED).
    - HPSJ recognizes the definition of high-dose opioid therapy varies between different organizations. However, HPSJ has chosen to adapt the common cutoff of 90 mg MED/day as "HD-COT." This definition is also in alignment with CDC Prescribing Guidelines.
- Chronic pain is defined as any painful condition leading to continual opioid use of ≥90 days such as a diagnosis of "chronic pain syndrome," "chronic lower back/neck pain," or "malignant pain in non-terminal patients."
- Terminal illness is defined as "an individual's medical prognosis as certified by a physician which results in a life expectancy of 6 months or less."[13,14]
- Palliative care is defined as "patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice."[14]

Quantity Limits

- Short-acting opioids will be limited to a combined total of #120 units/month.
    - E.g. A member cannot fill more than a combined total of #120 tablets from hydrocodone/APAP, tramadol, and/or other short-acting opioids.
- Members will be limited to 1 type of long-acting opioid.
- HPSJ's current long-opioid opioid quantity limits are still in effect:
    - **MS Contin** Morphine sulfate extended-release is limited to 90 tablets per month.
        - Avinza & Kadian are reserved for TPA line-of-business only; PA required and limited to 30 capsules per month.
    - **OxyContin:** Oxycodone extended-release is limited to 60 tablets per month (PA required)
    - **Duragesic:** Fentanyl patches are limited to 10 patches per month (PA required)

Coverage Criteria – Long Term Opioid Therapy

- If a member requires dose escalation despite currently being on at least 1 dose-optimized, **non—opioid adjuvant agent (i.e. gabapentin, venlafaxine, etc) for at least 8 weeks** and 1 long-acting opiate, HPSJ may authorize a dose escalation of the long-acting opiate to allow up to 50% increase in total daily opioid dose provided the **following** are submitted:
    - **Opioid Risk Tool (ORT)**—required for initial quantity override request only
        - a 5-questionaire that helps providers identify patients at high risk of opioid misuse
    - **Urine Drug Test (UDT)**—required for initial quantity override request only for members taking less than 120 mg/day MED; for members receiving ≥120 mg/day MED, recent UDT (within last 90 days of request) is required annually
    - **Pain Treatment Plan & Agreement**—required for initial quantity override request only

        - [1] Establish achievable, function goals (rather than pain)
        - [2] Outline patient/provider roles and responsibilities
        - [3] Pain management plan
        - [4] Duration of opioid trial
        - [5] Establish cut-off point at which further increases in opioid dose is futile
- **Patients above 120 mg/day MED will be limited to 3 increases in opioid dose over a period of 12 months without clearly documented progression in disease**. The following should be considered:
    - Changes in patient health/disease
    - Patient adherence to treatment plan
    - Opioid-Induced Hyperalgesia (OIH)

Opioid Intolerance & Converting to Long-Acting Formulations

- If the member is unable to tolerate the prescribed opioid or if member is developing opioid tolerance towards a specific drug, the following should be considered:
    - **Convert to long-acting opioid**
        - Patients requiring more than 120 tablets/capsules of short-acting opioid monthly will require conversion to long-acting opioid for improved baseline pain control.
        - HPSJ preferred long-acting opioid:
            - 1st line—morphine sulfate ER or methadone
            - 2nd line—fentanyl patch (step therapy to morphine sulfate ER or methadone)
            - 3rd line—oxycodone ER (step therapy to morphine sulfate AND fentanyl)
    - **Opioid rotation**
        - Covert total daily dose of current opioid to new opioid using Equianalgesic Conversion Table

Long-Acting vs. Short-Acting Opioids

- Once a chronic patient has achieved a stable opioid dose, longer-acting opioids preferred since they provide a more stable drug concentration to allow for smoother pain control and less risk of side effects, and convenient dosing so that the patient would have a lower risk of being psychologically tied to the thought of taking his/her medication throughout the day.

Scheduled Vs. As-Needed Dosing

- Scheduled dosing is preferred over as-needed dosing for more effective chronic pain control.

Opioid Adherence Monitoring Tools

- **COMM**—a 17-questionaire that helps providers identify patients exhibiting aberrant behaviors
- **CURES/PDMP Report**—California-facilitated report that generates all controlled medication claims paid by both the insurance and out-of-pocket by the patient**;** may be useful in identifying patients attempting to "doctor shopping" or "pharmacy hopping"
- **Urine Drug Screening (UDT)**—recommend screening for cocaine, amphetamine, marijuana, benzodiazepines, opiates

Opioid Tapering & Discontinuation

- **Authorizations for tapering regimen** will be approved for **up to 90 days.** Extension beyond 90 days will be reviewed on a case-by-case basis.

Special Situations

- For **patients with acute on chronic pain** (i.e. patient on COT went to ER due to car accident), HPSJ will approve requests for opioid dose escalation for short-acting opioids a month at-a-time. Long-acting opioids should not be used for acute pain.
- For patients in which the **treatment intent is palliative** or the **treatment request is for terminally-ill patients** (as defined from above), HPSJ will cover formulary pain medications for the requested quantity. Formulary drug criteria (step therapy) will still be in effect unless clinically justified (member is unable to swallow tablets/capsules) by requesting physician. For non-formulary pain medication requests, see HPSJ's Non-Formulary Policy & Procedure.

Table 2: Summary Table for Treatment of Non-Somatic Pain[7]

Pain Type	Recommended Pharmacologic Agents/Class
Acute Somatic Pain, Cancer-Related Pain	Mild-Topical/Systemic NSAIDs, APAP Moderate—Opioid Combinations (i.e. Hydrocodone/APAP) Severe—Opioids
Musculoskeletal Pain	APAP, NSAIDs, SNRIs, TCAs, musculoskeletal relaxants
Neuropathy Neuralgia	SNRIs, antiepileptics, lidocaine patch
Fibromyalgia	SNRIs, TCAs, antiepileptics, musculoskeletal relaxants, APAP, NSAIDs
Abdominal Pain	Antispasmodic agents
Headaches/Migraines	Symptomatic management: NSAIDs, APAP, "-Triptans," Ergot Derivatives Migraine prophylaxis: Antiepileptics, Non-selective beta-blockers

Non-Steroidal Anti-Inflammatory Agents (NSAIDs); Acetaminophen (APAP); Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs); Tricyclic Antidepressants (TCAs)

Table 3: Usual Effective Dose for Commonly Prescribed Adjuvant Analgesics[15-20]

Drug Class	Drug	Usual Effective Dose
TCAs	Amitriptyline (Elavil)	50-100 mg/day
	Imipramine (Tofranil)	50-100 mg/day
	Nortriptyline (Pamelor)	75 mg/day
	Desipramine (Norpramin)	50-100 mg/day
SNRIs	Venlafaxine (Effexor)	150-225 mg/day
	Duloxetine (Cymbalta)	60-120 mg/day
Antiepileptics	Gabapentin (Neurontin)	1,800-3,600 mg/day
	Pregabalin (Lyrica)	300-600 mg/day
	Carbamazepine (Tegretol)	400-1,200 mg/day
	Topiramate (Topamax)	400 mg/day
Musculoskeletal relaxants	Cyclobenzaprine (Flexeril)	10 mg three times daily
	Carisoprodol (Soma)	350 mg three times daily
	Baclofen (Lioresal)	5-10 mg three times daily
	Methocarbamol (Robaxin)	1500 mg four times a day
	Tizanidine (Zanaflex)	2-4 mg three times daily
	Dantrolene (Dantrium)	100 mg three to four times daily
Other	Lidocaine Patch (Lidoderm)	1 patch daily (leave on for 12 hours then remove after 12 hours)
	Capsaicin Cream	0.075% topically four times daily
	Acetaminophen	325-600 mg every 4-6 hours
NSAIDs	Naproxen	250-500 mg every 12 hours
	Ibuprofen (Motrin)	200-400 mg every 4-6 hours 800 mg every 6-8 hours
	Diclofenac	50 mg every 8 hours
	Etodolac	200-400 mg every 6-8 hours
	Indomethacin	25-50 every 8-12 hours
	Sulindac	150-200 every 12 hours
	Meloxicam (Mobic)	7.5-15 mg once daily
	Nabumetone	250 mg every 6 hours
	Celecoxib (Celebrex)	200 mg daily or 100 mg every 12 hours

Table 4: Formulary Non-Opioid Analgesics

	Drug	Restrs	Criteria
NSAIDs	Ibuprofen		No restrictions.
	Naproxen		
	Nabumetone		
	Diclofenac		
	Indomethacin		
	Sulindac		
	Meloxicam		

	Etodolac		
	Celecoxib (Celebrex)	ST	Reserved for treatment failure/intolerance to 3 first-line NSAIDs (including meloxicam or etodolac), unless over 65 or at high risk for GI events.
	Diclofenac topical gel/soln. (Voltaren , Pennsaid)	ST	
Neuropathic Agents	Gabapentin		No restrictions.
	Amitriptyline, Nortriptyline		
	Venlafaxine IR / XR		
	Duloxetine (Cymbalta)	PA	Reserved for failure to dose-optimized venlafaxine for 2 months; limit 60mg/d.
	Milnacipran (Savella)	PA	Reserved for treatment failure of two different dose-optimized formulary antidepressants for 2 months each.
	Pregabalin (Lyrica)	PA	Reserved for treatment failure of a TCA (eg amitriptyline, nortriptyline, etc) AND gabapentin at dose larger than 1800mg/day for at 2 months.
Anti-spasmodic Agents	Dicyclomine		No restrictions.
	Hyocyamine Sulfate IR/ER		
Migraines	Rizatriptan (Maxalt)	QL	Limit 9 tablets per month. For frequent migraines, consider migraine prophylaxis.
	Sumatriptan tablets	QL	
	Sumatriptan nasal spray	PA, QL	Reserved for patients unable to take oral formulations (including ODT); limit 6 units per month. For frequent migraines, consider migraine prophylaxis.
	Butalbital/APAP/ caffeine ± codeine	QL	Restricted to 30 tabs/caps per 30 days.

PA = Prior Authorization; QL = Quantity Limit; ST = Step Therapy

Table 5: Opioid Equianalgesic Conversion Table[21]

Drug	Morphine Dose Equivalent Factor
Butorphanol	7
Codeine	0.15
Dihydrocodeine	0.25
Fentanyl buccal/SL tablet or lozenge/troche	0.13
Fentanyl film or oral spray	0.18
Fentanyl nasal spray	0.16
Fentanyl transdermal patch	7.2
Hydrocodone	1
Hydromorphone	4
Levorphanol	11
Meperidine	0.1
Methadone	3
Morphine	1
Opium	1
Oxycodone	1.5
Oxymorphone	3
Tapentadol	0.4
Tramadol	0.1

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⌗ REVIEW & EDIT HISTORY

Document Changes	Reference	Date	P&T Chairman
Creation of Opioid Policy	Narcotic Analgesics 2-20-07.doc	2/2007	A. Shek, PharmD, BCPS
OxyContin Update	Oxycontin final 2-11-11.docx	2/2011	A. Shek, PharmD, BCPS
APAP Limitation added	Acetaminophen Limit 2-21-2012.docx	2/2012	A. Shek, PharmD, BCPS
Opioid Management Procedure	HPSJ Handbook to Opioid Prescribing 1-2015.docx	1/2015	J. Szkotak, PharmD, BCACP
Evaluation Criteria for Approval	HPSJ Handbook to Opioid Prescribing 1-2015.docx	4/2015	J. Szkotak, PharmD, BCACP
Update to Policy	HPSJ Coverage Policy – Pain – Opioid 2016-05.docx	5/2016	J. Yeh, PharmD
Update to Policy	HPSJ Coverage Policy – Pain – Opioid 2017-05.docx	5/2017	J. Yeh, PharmD
Update to Policy	HPSJ Coverage Policy – Pain – Opioid 2018-05.docx	5/2018	J. Yeh, PharmD
Update to Policy	HPSJ Coverage Policy – Pain – Opioid 2019-05.docx	5/2019	M. Garrett, PharmD
Review of Policy	Opioid	2/2021	M. Garrett, PharmD

Note: All changes are approved by the HPSJ P&T Committee before incorporation into the utilization policy