Health Alliance™

Pharmacy Drug Policy & Procedure

Policy Name:	Opioids: Long Acting and Short Acting	Policy #:	1942P

Purpose of the Policy

The purpose of this policy is to ensure the appropriate prescribing of pain medication as well as to identify members who may benefit from referral to Care Coordination. The policy also clarifies the step-edit procedures that require the use of the most cost-effective drugs on formulary prior to coverage of other alternative agents. Opioid pain relievers should be prescribed for the shortest period of time and at the lowest effective dose for pain management unrelated to cancer diagnosis, sickle cell anemia, and hospice. This policy is intended to address the concerns related to pain medication over prescribing and prevent members from developing dependence on pain medications. The Morphine Equivalence Dose (MED) can be calculated using this calculator. The policy closely follows the CDC guidelines for chronic pain management and is not intended to replace individualized, patient centered care.

Statement of the Policy

Coverage of the pain medications require the following considerations and step therapy.

Criteria

1. All Opioid Claims

1.1 The use of opioids for the following conditions will be approved for 12 months of coverage without an upper limit on MED and will not require any additional documentation, such as step therapy:

- Chronic pain associated with a cancer diagnosis, OR
- Chronic pain associated with a diagnosis of sickle cell disease, OR
- Patients receiving Hospice Services

1.2 The use of opioid medications for conditions not listed in step 1 will be subject to a safety edit requirement. The safety edit will screen for a paid claim for an opioid medication in the previous 120 days.

- If a claim for an opioid is found, it is determined that the member is NOT opioid-naive.
- If a claim for an opioid is not found, it is determined that the member is opioid-naive, and therefore the member will be limited to a 7-day supply of initial opioid therapy.
  - Opioid prescriber may submit chart notes that indicate that the patient is not opioid-naive or that there is medical necessity for an opioid-naive patient to receive opioid therapy for greater than 7 days.

1.3 The Pharmacy Benefits Manager (PBM) will look back in pharmacy drug history for an overlapping claim of an opioid when a benzodiazepine claim is submitted, or for a benzodiazepine claim when an opioid claim is submitted and cause the claim to reject at the pharmacy. Coverage for the use of an opioid AND benzodiazepine will require the following:

- Provider may submit a statement that the benefit of using an opioid with a benzodiazepine

outweighs the risks AND documentation that the patient has been educated on the availability and proper use of immediate opioid antagonist therapy (naloxone, Narcan).
- Members are exempt from this restriction if treatment is for a diagnosis of cancer or sickle cell disease, or patients receiving hospice services.

2. Coverage Criteria for Any Opioid Therapies with a Total Daily Morphine Equivalence Dose (MED) of 100mg or More

2.1 Members requesting the use of opioid therapy with an MED of 100mg or more that have a chronic pain diagnosis unrelated to cancer, sickle cell disease, or hospice care will require prior authorization with the following requirements being met:
- Documentation that the provider has seen the patient in the last 3 months and has done a full evaluation of the member's pain as well as identified any potential underlying causes
- Documentation that non-pharmacological and non-opioid treatments have been optimized
- Documentation that the provider feels that treating the member's pain at a MED over 100mg is necessary and that the patient has been escalated to that dose
- Documentation that the provider and member have discussed goals of treatment, risk versus benefits of treating the member's pain with opioid medications and strategies for opioid discontinuation if the benefits no longer outweigh the risks
- Documentation that the provider has a pain contract with the member limiting pain medication through only themselves or 1–2 additional providers as listed
- Documentation that the provider has taken a urine toxicology screen at least annually if the provider feels that toxicology screening is warranted
- Documentation that the provider has reviewed the member's state prescription monitoring program at least once in the last 3 months
- Documentation that provider has discussed strategies to mitigate risk of opioid-related harms, including education on the availability and proper use of immediate opioid antagonist therapy (such as naloxone)
- Approval for 6 months at current or calculated MED level at the time of request

2.2 Members requesting the use of opioid therapy with an MED of 100mg or more for the short-term treatment of post-operative or traumatic injury pain will require prior authorization with the following requirements being met:
- Documentation that appropriate non-pharmacological and non-opioid therapies have been optimized and the risks and benefits of using opioid therapy have been discussed
- If opioid therapy is needed >7days, documentation that the post-operative treatment plan includes a tapering of pain medications
- Approval for 1 month at calculated MED level
- Reapproval: 3 months at the calculated MED level with documentation that opioid therapy is to be tapered and discontinued in that time
    - If documentation indicates long term therapy requested, criteria from section 2.1 applies

3. Long-Acting Opioids for New Starts to Therapy

3.1 The use of long-acting opioids to treat a chronic pain diagnosis unrelated to cancer, sickle cell disease, or hospice care will require claims history for a long acting opioid in the previous 180 days.

3.2 If claims history does not contain claims for a long-acting opioid in the previous 180 days, member is considered a new start to therapy and coverage requires prior authorization with the following requirements being met:
- Documentation that the provider has seen the patient in the last 3 months and has done a full evaluation of the member's pain as well as identified any potential underlying causes
- Documentation that non-pharmacological and non-opioid treatments have been optimized

- Documentation that the provider feels that treating the member's pain at a MED over 100mg is necessary and that the patient has been escalated to that dose
- Documentation that the provider and member have discussed goals of treatment, risk versus benefits of treating the member's pain with opioid medications and strategies for opioid discontinuation if the benefits no longer outweigh the risks
- Documentation that the provider has a pain contract with the member limiting pain medication through only themselves or 1–2 additional providers as listed
- Documentation that the provider has taken a urine toxicology screen at least annually if the provider feels that toxicology screening is warranted
- Documentation that the provider has reviewed the member's state prescription monitoring program at least once in the last 3 months
- Documentation that provider has discussed strategies to mitigate risk of opioid-related harms, including education on the availability and proper use of immediate opioid antagonist therapy (such as naloxone)
- Approval for 6 months at current or calculated MED level at the time of request

3.3 The use of long-acting opioids to treat post-operative and traumatic injury pain will require prior authorization with the following requirements to be met:

- Documentation that appropriate non-pharmacological and non-opioid therapies have been optimized and the risks and benefits of using opioid therapy have been discussed
- If opioid therapy is needed >7days, documentation that the post-operative treatment plan includes a tapering of pain medications
- Approval for 1 month at calculated MED level
- Reapproval: 3 months at the calculated MED level with documentation that opioid therapy is to be tapered and discontinued in that time
  - If documentation indicates long term therapy requested, criteria from section 3.2 applies
  - Note: Long-acting opioid medications are not recommended for the use of treating post-operative pain. Non-opioid analgesics and immediate-release opioids are recommended therapies for short- term use.

4. Tramadol Extended-Release (generic Ultram ER; CIV in Illinois) Step Therapy

4.1 The use of tramadol ER to treat a chronic pain diagnosis unrelated to cancer, sickle cell disease, or hospice care will require that step therapy has been met. An electronic step edit will be in place that will require a 30- day supply of tramadol immediate-release formulation within the previous 120 days prior to coverage of tramadol ER.

4.2 If claims history does not satisfy electronic-step edit, coverage of tramadol ER requires the following requirements being met:

- Documentation that the provider has seen the patient in the last three months and has done a full evaluation of the member's pain as well as identified any potential underlying causes
- Documentation that non-pharmacological and non-opioid treatments have been optimized
- Documentation that the provider feels that treating the member's pain at the requested dose is necessary
- Documentation that the provider and member have discussed goals of treatment, risk versus benefits of treating the member's pain with opioid medications and strategies for opioid discontinuation if the benefits no longer outweigh the risks
- Documented failure of a 30-day trial of tramadol immediate-release formulation

4.3 Approval for 6 months at current or calculated MED level at the time of request

5. Nucynta Immediate-Release Step Therapy

5.1 The use of Nucynta IR to treat a chronic pain diagnosis unrelated to cancer, sickle cell disease, or hospice care will require that step therapy has been met. An electronic step edit will be in place that will

require a 30-day supply of tramadol IR or any formulary short-acting opioid within the previous 120 days prior to coverage of Nucynta IR.

5.2 If claims history does not satisfy electronic-step edit, coverage of Nucynta IR requires the following requirements being met:

- Documentation that the provider has seen the patient in the last three months and has done a full evaluation of the member's pain as well as identified any potential underlying causes
- Documentation that non-pharmacological and non-opioid treatments have been optimized
- Documentation that the provider feels that treating the member's pain at the requested dose is necessary
- Documentation that the provider and member have discussed goals of treatment, risk versus benefits of treating the member's pain with opioid medications and strategies for opioid discontinuation if the benefits no longer outweigh the risks
- Documented failure of a 30-day trial of tramadol IR or any formulary short-acting opioid medication.

5.3 Approval for 6 months at current or calculated MED level at the time of request

CPT Codes	

HCPCS Codes	

References

1. Kroenke K, Alford D, Argoff C, et al. Challenges with Implementing the Centers for Disease Control and Prevention Opioid Guideline: A Consensus Panel Report. Pain Medicine, Volume 20, Issue 4, April 2019, Pages 724–735, https://doi.org/10.1093/pm/pny307
2. Argoff C, Alford D, Fudin J, et al. Rational Urine Drug Monitoring in Patients Receiving Opioids for Chronic Pain: Consensus Recommendations. Pain Medicine, Volume 19, Issue 1, January 2018, Pages 97–117, https://doi.org/10.1093/pm/pnx285.
3. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95.

Created Date: 10/03/12
Effective Date: 10/03/12
Posted to Website: 01/01/22
Revision Date: 08/07/24

DISCLAIMER

This Medical Policy has been developed as a guide for determining medical necessity. The process of medical necessity review also entails review of the most recent literature and physician review. Medical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care. Health Alliance encourages input from providers when developing and implementing medical policies. Benefit determinations are based on applicable contract language in the member's Policy/ Subscription Certificate/ Summary Plan Description. This Medical Policy does not guarantee coverage. There may be a delay between the revision of this policy and the posting on the web. Please contact the Health Alliance Customer Service Department at 1-800-851-3379 for verification of coverage.