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PHARMACY POLICY – 5.01.529

Management of Opioid Therapy

Effective Date:	Mar. 1, 2025	RELATED MEDICAL POLICIES:
Last Revised:	Feb. 24, 2025	None
Replaces:	5.01.579, 5.01.583	

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | CODING | RELATED INFORMATION
EVIDENCE REVIEW | REFERENCES | HISTORY

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Introduction

Opioids are chemicals that bind to receptors in the brain or body. An opioid can be natural or synthetic. Opioid medications can be used to manage certain types of pain. Opioids are prescribed by and in consultation with a licensed healthcare professional. Examples of opioids are oxycodone, hydrocodone, fentanyl, and morphine.

This policy describes when you have to take certain drugs before an opioid can be prescribed. This policy also describes coverage criteria for quantities of some of the commonly prescribed opioid medications when prescribed above the allowable limit. Quantity limits in this policy are based on the maximum dose approved by the US Food and Drug Administration. These dose limits are the upper range that clinical trials show to provide a balance between safety and effectiveness. Higher quantities may be approved based on adequate evidence from published peer reviewed clinical studies, comprehensive medical records history, and the criteria below. It is very easy to become dependent on opioids, and there is growing public concern about illegal drug use. For this reason, it is important to prescribe only as many opioid pills as a individual is expected to need. Properly disposing of unused pills is also important for safety. To learn more about this, ask your pharmacist or visit the FDA's drug disposal page at **https://www.fda.gov/forconsumers/consumerupdates/ucm101653.htm**.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Note: A copy of medical records history is required when submitting prior authorization requests for the drugs affected by this policy.

Note: This policy applies to all formulary types across all lines of business (see **Definition of Terms** below). As used in this policy, "Formulary" refers to the applicable formulary list specified in a member's contract.

Note: Dispensing quantity limits are not intended to apply in circumstances where logistics may dictate otherwise. These circumstances include but are not limited to member vacation or business travel, disruption of normal prescription supply chains due to adverse weather events or other disasters, and members living in remote areas where travel to the nearest pharmacy may sometimes be problematic.

Click on the links below to be directed to that section of the policy:

Short-Acting Opioid Step Therapy

A quantity sufficient for a 7-day supply will be covered for individuals ≥ 18 years of age without prior authorization. Additional quantities of **BOTH brand and commercially available generic products** for greater than a 7-day supply will require coverage review for opioid naïve individuals. Opioid naïve is defined as not having history of any opioid within the past 130 days.

A quantity sufficient for a 3-day supply will be covered for individuals < 18 years of age without prior authorization. Additional quantities of **BOTH brand and commercially available generic products** for greater than a 3-day supply will require coverage review for opioid naïve individuals. Opioid naïve is defined as not having history of any opioid within the past 130 days.

Short-Acting Opioid Step Therapy

For a list of applicable drugs, see the **table** in the Related Information section below.

Short-Acting Opioid, Greater Than 7-Day Supply: Medical Necessity

This policy does not apply to individuals with cancer, sickle cell disease, or those in a hospice program, end-of-life care, or palliative care.

Requests for more than 7 days of a short-acting opioid for individuals ≥ 18 years of age may be considered medically necessary in individuals who meet ALL of the following criteria:

- At least one trial of a non-opioid medication (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs], acetaminophen) has provided an inadequate response, or non-opioid medications are inappropriate according to the prescribing clinician

AND

- The individual's history of controlled substance prescriptions has been checked within the last 3 months using the state prescription drug monitoring program (PDMP), unless unavailable in the state

Note: Exceptions may be medically necessary for certain clinical situations on a case-by-case basis including but not limited to traumatic injury or surgeries with extended recovery time.

Note: Documentation is required in the form of medical records for all reviews. All approvals are provided one time only and, on a case-by-case basis.

Short-Acting Opioid, Greater Than 3-Day Supply: Medical Necessity

This policy does not apply to individuals with cancer, sickle cell disease, or those in a hospice program, end-of-life care, or palliative care.

Requests for more than 3 days of a short-acting opioid for individuals < 18 years of age may be considered medically necessary in individuals who meet ALL of the following criteria:

- At least one trial of a non-opioid medication (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs], acetaminophen) has provided an inadequate response, or non-opioid medications are inappropriate according to the prescribing clinician

AND

- The individual's history of controlled substance prescriptions has been checked within the last 3 months using the state prescription drug monitoring program (PDMP), unless unavailable in the state

Short-Acting Opioid Step Therapy

Note: Exceptions may be medically necessary for certain clinical situations on a case-by-case basis including but not limited to traumatic injury or surgeries with extended recovery time.

Note: Documentation is required in the form of medical records for all reviews. All approvals are provided one time only and, on a case-by-case basis.

Long-Acting Opioid Step Therapy

This step therapy is applicable to **BOTH brand and commercially available generic products**. **This policy does not apply to individuals with cancer, sickle cell disease, or those in a hospice program, end-of-life care, or palliative care.**

This step therapy does not apply to methadone, Dolophine, and Methadose when prescribed to treat opioid addiction (Opioid Use Disorder).

For a list of applicable drugs, see the **table** in the Related Information section below.

Long-Acting Opioid Therapy: Medical Necessity

A long-acting opioid may be considered medically necessary in individuals with pain severe enough to require daily, around-the-clock, long-term opioid treatment where individuals meet ALL of the following criteria:

- The individual has chronic pain and is not opioid naïve (opioid naïve is defined as not having history of any opioid within the past 130 days)

AND

- Individual has a concurrent prescription or previous use of a short-acting opioid

AND

- Non-opioid therapies (e.g., non-opioid medications [e.g., nonsteroidal anti-inflammatory drugs {NSAIDs}, tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitors {SNRIs}, anticonvulsants], exercise therapy, weight loss, cognitive behavioral therapy) have been optimized and are being used in conjunction with opioid therapy, or they have failed according to the prescribing clinician

AND

- Treatment plan (including goals for pain and function) is in place and reassessments (including pain levels and function) are scheduled at regular intervals according to the prescribing clinician

AND

Long-Acting Opioid Step Therapy

- The individual's history of controlled substance prescriptions has been checked within the last 3 months using the state prescription drug monitoring program (PDMP), unless unavailable in the state

Note: Documentation is required in the form of medical records for all reviews. Approvals are provided for one year in duration.

Long-Acting Opioid Quantity Limits

Coverage Guidelines for Quantity Limits that Exceed National Guidelines

This policy does not apply to individuals with cancer, sickle cell disease or those in a hospice program, end-of-life care, or palliative care.

ALL of the following criteria must be met for short-term approval to be granted:

- Individual is being seen by a board-certified pain specialist as defined by the American Board of Medical Specialties (ABMS)

AND

- Individual has had trials of 2 or more non-pharmacologic therapies, such as physical therapy, acupuncture, massage therapy, etc.

AND

- Individual has had trials of 3 or more non-opioid therapies, such as acetaminophen, NSAIDs, gaba-analogues, tricyclic antidepressants, SNRI's, etc.

AND

- Individual and the doctor have a pain management contract in place

AND

- Chart notes must include documentation that the (state-specific) Prescription Drug Monitoring Program was checked in the last 3 months

AND

- Individual participates in urine drug screening as per frequency documented in the provider's chronic opioid therapy plan per medical records OR urine drug screening has been documented within the last 6 months

Note: Requests may be approved on a case-by-case basis for a maximum of 3 months to allow the provider time to reduce the dose to the allowed quantities (as described in the **Long-Acting Opioid Quantity Limit** table below).

Note: Documentation is required in the form of medical records for all reviews

Dispensing Quantity Limits

Quantity limits apply to **BOTH** brand and commercially available generic products.

The following drugs have quantity limits that are of **ALL** strengths combined in 30 days:

- Hydromorphone ER, Kadian, morphine sulfate ER, Morphabond ER, MS Contin, Nucynta ER, and oxymorphone ER

The following dispensing quantity limits are based on the maximum dose recommendations in the product's FDA-approved labeling. This information is available for each product at the manufacturer's web site or **www.fda.gov**. Opioid drugs with dispensing quantity limits are listed in the following table:

Drug	Dosage / Strength	Quantity Limit Allowed Without Review
Bunavail (buprenorphine/naloxone)	2.1/0.3 mg, 4.2/0.7 mg buccal film	Limit: 90 films per fill
Bunavail (buprenorphine/naloxone)	6.3/1 mg buccal film	Limit: 60 films per fill
Hydromorphone HCl ER	8 mg, 12 mg, 16 mg, 32 mg ER tablet	Limit: 60 tablets per 30 days
Kadian (morphine sulfate ER)	10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 80 mg, 100 mg, 200 mg ER capsule	Limit: 90 capsules per 30 days
Morphabond ER (morphine sulfate ER)	15 mg, 30 mg, 60 mg, 100 mg ER tablet	Limit: 60 tablets per 30 days
MS Contin (morphine sulfate ER)	15 mg, 30 mg, 60 mg, 100 mg, 200 mg ER tablet	Limit: 120 tablets per 30 days
Nucynta (tapentadol HCl)	50 mg, 75 mg, 100 mg tablet	Limit: 181 tablets per fill
Nucynta ER (tapentadol HCl)	50 mg, 100 mg, 150 mg, 200 mg, 250 mg ER tablet	Limit: 60 tablets per 30 days
Oxymorphone HCl ER	5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, 30 mg, 40 mg tablet	Limit: 90 tablets per 30 days
OxyContin (oxycodone HCl ER)	10mg, 15 mg, 20 mg, 30 mg, 40 mg ER tablet	Limit: 90 tablets per 30 days
OxyContin (oxycodone HCl ER)	60 mg, 80 mg ER tablet	Limit: 120 tablets per 30 days
Suboxone (buprenorphine/naloxone)	12/3 mg film	Limit: 60 films per fill

Drug	Dosage / Strength	Quantity Limit Allowed Without Review
Suboxone (buprenorphine/naloxone)	2/0.5 mg, 4/1 mg, 8/2 mg film 2/0.5 mg, 8/2 mg SL tablet	Limit: 90 films per fill
Zubsolv (buprenorphine/naloxone)	0.7/0.18 mg, 1.4/0.36 mg, 2.9/0.71 mg, 5.7/1.4 mg SL tablet	Limit: 90 tablets per fill
Zubsolv (buprenorphine/naloxone)	8.6/2.1 mg SL tablet	Limit: 60 tablets per fill
Zubsolv (buprenorphine/naloxone)	11.4/2.9 mg SL tablet	Limit: 30 tablets per fill
Buprenorphine/naloxone (generic Suboxone)	12/3 mg film	Limit: 60 films per fill
Buprenorphine/naloxone (generic Suboxone)	2/0.5 mg, 4/1 mg, 8/2 mg film 2/0.5 mg, 8/2 mg SL tablet	Limit: 90 films per fill
Hydromorphone ER (generic Exalgo)	8 mg, 12 mg, 16 mg, 32 mg tablet	Limit: 60 tablets per 30 days
Morphine sulfate ER (generic Kadian)	10 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg, 100 mg, 200 mg ER capsule	Limit: 90 capsules per 30 days
Morphine sulfate ER (generic MS Contin)	15 mg, 30 mg, 60 mg, 100 mg, 200 mg ER tablet	Limit: 120 tablets per 30 days
Morphine sulfate ER, 24 HR (generic Avinza)	30 mg, 45 mg, 60 mg, 75 mg, 90 mg, 120 mg capsule	Limit: 60 capsules per 30 days
Oxycodone HCl ER (generic OxyContin)	10 mg, 15 mg, 20 mg, 30 mg, 40 mg ER tablet	Limit: 90 tablets per 30 days
Oxycodone HCl ER (generic OxyContin)	60 mg, 80 mg ER tablet	Limit: 120 tablets per 30 days
Oxymorphone ER (generic Opana ER)	5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, 30 mg, 40 mg ER tablet	Limit: 90 tablets per 30 days
Hydrocodone ER (generic Hysingla ER)	20 mg, 30 mg, 40 mg, 60 mg, 80 mg, 100 mg, and 120 mg	Limit: 60 tablets per 30 days
Hydorocodone ER (generic Zohydro ER)	10 mg, 15 mg, 20 mg, 30 mg, 40 mg, and 50 mg	Limit: 60 capsules per 30 days
Hysingla ER (hydorocodone bitartrate ER)	20 mg, 30 mg, 40 mg, 60 mg, 80 mg, 100 mg, and 120 mg	Limit: 60 tablets per 30 days
Zohydro ER (hydrocodone bitartrate ER)	10 mg, 15 mg, 20 mg, 30 mg, 40 mg, and 50 mg	Limit: 60 capsules per 30 days

Transmucosal Fentanyl Citrate Products
Transmucosal fentanyl citrate products (e.g., Actiq, Fentora, Lazanda, Subsys) may be considered medically necessary for the treatment of breakthrough cancer pain in adult individuals with compromised oral intake or absorption.

Drug	Investigational
As listed	**The medications listed in this policy are subject to the product's US Food and Drug Administration (FDA) dosage and administration prescribing information.**

Length of Approval	
Approval	**Criteria**
Initial authorization	**Non-formulary exception reviews for all drugs listed in this policy may be approved up to 12 months.**
Re-authorization criteria	**Non-formulary exception reviews for all drugs listed in this policy may be approved up to 12 months.**

Coding

N/A

Related Information

Short-Acting Opioid Therapy Drugs
Acetaminophen with codeine: Oral suspension, tablet • Tylenol with codeine **Acetaminophen/caffeine/dihydrocodeine: Capsule, tablet** • Trezix **Aspirin/caffeine/dihydrocodeine: Capsule** **Belladonna and Opium: Suppository** **Benzhydrocodone/acetaminophen**

Short-Acting Opioid Therapy Drugs

- Apadaz
- Benzhydrocodone/acetaminophen

Buprenorphine: Injection

- Buprenex

Butalbital/acetaminophen/caffeine/codeine: Capsule

- Fioricet with Codeine

Butorphanol: Injection, nasal spray

Carisoprodol/aspirin/codeine: Tablet

Codeine sulfate: Tablet

Codeine/butalbital/aspirin/caffeine: Capsule

- Fiorinal with Codeine

Hydrocodone/acetaminophen: Oral elixir, oral solution, oral tablet

- Lorcet, Lorcet HD, Lorcet Plus
- Lortab, Lortab Elixir
- Norco
- Vicodin, Vicodin HP

Hydrocodone/ibuprofen: Tablet

- Ibudone

Hydromorphone: Injection, oral solution, rectal suppository, tablet

- Dilaudid

Ibuprofen/oxycodone: Tablet

Levorphanol: Tablet

Meperidine: Injection, oral solution, oral syrup, tablet

- Demerol

Morphine: Injection, oral solution, rectal suppository, tablet

- Duramorph
- Infumorph
- Mitigo

Nalbuphine: Injection

Oxycodone: Capsule, injection, oral concentrate, oral solution, tablet

- Oxaydo
- Roxicodone
- Roxybond

Oxycodone/acetaminophen: Tablet, solution

- Endocet
- Nalocet
- Percocet
- Primlev
- Prolate

Short-Acting Opioid Therapy Drugs

Oxycodone/aspirin: Tablet

Oxymorphone: Tablet

- Opana

Pentazocine lactate: Injection

- Talwin

Pentazocine/naloxone: Tablet

Tapentadol: Tablet

- Nucynta

Tramadol: Oral suspension, tablet

- Qdolo
- Ultram

Tramadol/acetaminophen: Tablet

- Ultracet

Tramadol/celecoxib: Tablet

- Seglentis

Long-Acting Opioid Therapy Drugs

Buprenorphine: Buccal film, injection, intradermal implant, transdermal patch

- Belbuca
- Buprenex
- Buprenorphine patch
- Butrans

Fentanyl: Transdermal patch

- Duragesic

Hydrocodone ER: Capsule, tablet

- Hysingla ER
- Zohydro ER

Methadone: Injection, oral solution, tablet, tablet for suspension

- Diskets Dispersible
- Dolophine HCl
- Methadone HCl Intensol
- Methadose

Morphine sulfate ER: Capsule, tablet

- Kadian ER
- Morphabond ER
- MS Contin

Oxycodone HCl ER: Tablet

- OxyContin ER

Long-Acting Opioid Therapy Drugs
Oxycodone ER: Capsule • Xtampza ER **Oxymorphone ER: Tablet** **Tapentadol ER: Tablet** • Nucynta ER **Tramadol ER: Capsule, tablet** • Conzip

Benefit Application

This policy is managed through the pharmacy benefit. It applies to all pharmacy benefit contracts that include pharmacy prior authorization edits.

Definition of Terms

Formulary: A formulary is a list of drugs approved by the Pharmacy and Therapeutics Committee (P&T) for routine use. A well-designed formulary should provide adequate drug selection to meet the treatment needs of most individuals; however, there will always be exceptional cases where a non-formulary drug may be the best therapeutic choice.

Formulary drug: A formulary drug (also known as a preferred drug) is a drug that is on the formulary list. Drugs that are not on the list are referred to as non-formulary drugs.

Label: Product label refers to the FDA approved prescribing information that is available for every legend drug approved for use in the US The label includes indications, contraindications, recommended dosing, warnings, precautions, side effects, drug interactions, and information on safety in pregnancy and other special populations. The drug's pharmacology, pharmacokinetics, and available dosage forms are also provided. The current format also includes a summary of the pivotal clinical trials that were submitted to FDA in support of the New Drug Application.

This prescribing information is included as a package insert with the product and is available on the manufacturer's web site.

Quantity limits: A quantity limit is the maximum amount of a medication that may be dispensed during a given calendar period or at one prescription fill without an exception request. Dispensing of a larger quantity may be approved, based on individual case review. A

specified larger quantity may be approved when individual-specific circumstances require it, or when published clinical evidence supports a higher dose protocol.

Evidence Review

Background

Opioid analgesics are commonly used for the management of pain. An estimated 20% of individuals presenting to physician offices with pain symptoms or pain-related diagnoses (including acute and chronic pain) unrelated to cancer receive an opioid prescription.

Short-acting opioids are indicated for the management of pain severe enough to require an opioid analgesic. The objective of this quantity limit is to restrict the initial days' supply of short-acting opioids to seven days, thus decreasing the quantity dispensed to align with current guidelines and prevent stockpiling and/or misuse.

The currently available long-acting (due to either an extended-release formulation or a long half-life [i.e., methadone]) opioids are buprenorphine, hydrocodone, hydromorphone, methadone, morphine sulfate, oxycodone, oxymorphone, tapentadol, and tramadol. All of the long-acting opioids are indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. Extended-release opioid dosage forms offer a long duration of effect, reduce severity of end-of-dose pain, and allow many individuals to sleep through the night. Long-acting products should be prescribed with an immediate-release dosage form, to be used as needed for breakthrough pain.

Description

Analgesics are used to treat a wide variety of pain syndromes. Traditionally, these have been classified in three groups: acute pain, chronic cancer pain and chronic pain in non-cancer individuals. Each requires a different approach. In acute pain the goal is to keep the individual comfortable while avoiding respiratory depression and minimizing the potential of opioid dependence. Oncology individuals are managed to achieve the best functional balance of analgesia versus sedation. No maximum dose limits exist in this setting, while chronic non-cancer pain should be managed with regimens that combine drugs from different

pharmacologic classes to minimize opioid use (e.g., antidepressants, NSAIDs or acetaminophen, muscle relaxants, and anticonvulsants).

Opioid Abuse

Abuse of prescription opioid products is a growing concern. The 2006 National Survey on Drug Use and Health (NSDUH) found 4.7 million people used a prescription opioid for non-medical purposes in the month prior to the survey. More than 2 million per year are considered new illicit users of prescription opioids, a 5-fold increase from the 1980s. For people older than age 12 in 2007, more began illicitly using opioids than marijuana, cocaine, or any other illegal drug. In addition to abuse of opioids, prescriptions of opioids for pain are also increasing. From 1992 to 2002 prescriptions for opioids increased 154% while the US population increased 13%. Along with this increase in legitimate and illicit use of opioids has come an increase in ER visits and deaths due to opioids use.

- The public health surveillance system, Drug Abuse Warning System (DAWN), last published data on drug related emergency visits from 2008 and found the largest number of ER visits occurred with oxycodone combinations (105,214) followed by hydrocodone combinations (89,051), and then methadone (63,629). These numbers have increased dramatically from 2004 with a 152% increase for oxycodone, 123% with hydrocodone, and 73% with methadone (all $p<0.05$). The rationale for the ER visit (drug abuse, side effects, etc.) was not included.

- An analysis of serious events from the FDA's adverse event reporting system found oxycodone (with 5,548 reports) was suspected in the largest number of deaths and serious nonfatal outcomes. The cause of the adverse event (drug abuse, side effects etc.) was not included.

- An analysis of deaths among Medicaid enrollees from overdose in Washington state from 2004–2007 found methadone was involved in the most deaths (64%), followed by oxycodone (22.9%), and hydrocodone (13.9%).

- Adverse events related to methadone have increased 1800% from 1997 to 2004, with a 390% increase in fatalities during the same period. Most methadone deaths appear to be the result of accidental exposures, although more data are needed.

While it is clear that use of and adverse events caused by opioids are increasing, the data do not differentiate between events due to increased legitimate prescribing for pain and those due to

illicit use. Additionally, as the number of total exposures to each drug is unknown, it is difficult to determine the risk associated with each drug due to lack of a meaningful denominator.

In 2010, the Washington State Legislature passed a statute requiring professional boards to draft regulations managing high-dose opioid use, clearly recognized as a serious threat to public health.

Extended-Release Oxycodone

The purpose of the OxyContin quantity limit is fourfold:

- Reduce unnecessarily large quantities from being dispensed, thereby decreasing the likelihood of unnecessary tablets remaining in medicine cabinets where relatives and other visitors to the home could pilfer them.
- Remind prescribers to select a larger tablet size when increasing the dose, rather than ordering two tablets to be taken at one time.
- Serve as a warning signal is cases where a individual may be using part of the prescription non-medically, or may be diverting pills for use by others for whom they were not prescribed.

OxyContin is normally dosed every 12 hours and is designed to be administered as 2 tablets per day. In individuals with more-rapid-than-normal clearance of oxycodone, or other unusual clinical circumstances, it is likely that 3 per day would be required. By setting the limit at 3, the Plan allows for flexibility on the part of practitioners and their individuals. OxyContin is available in tablet sizes of 10, 15, 20, 30, 40, 60, and 80 mg. When the 80mg tablet size is reached, the individual should be receiving 160mg/day. For cancer individuals needing to go beyond this dose, the 4 tablet limit allows a further escalation to 320mg/day before approval of a quantity override would be needed. Exception for medical necessity will be routinely given when the individual is being treated for cancer pain and has reached the maximum dosage achievable with 4 tablets per day.

Transmucosal Fentanyl

Transmucosal fentanyl agents are potent analgesics approved for the treatment of breakthrough pain in opioid-treated and tolerant cancer individuals. There is no fully published randomized controlled evidence for use of these products for non-cancer pain at this time.

Availability of longer-term safety/tolerability data with Fentora is limited. Because life-threatening respiratory depression could occur at any dose in opioid non-tolerant individuals, Fentora and Actiq are contraindicated in the management of acute or postoperative pain, and for use in opioid non-tolerant individuals. A unique adverse event issue identified with use of Fentora is application site reactions, including ulceration. Risk is difficult to define, due to the limited number of individuals and duration of exposure to this formulation in clinical trials. This side effect has the potential to alter the formulation's absorption characteristics and may increase risk for serious side effects in some individuals. To ensure safety, a cautious approach to use of either transmucosal fentanyl product is warranted.

Management of chronic severe pain in cancer individuals requires the effective use of long-acting opioids, supplemented with limited doses of a short-acting opioid (rescue medication). Excessive doses of rescue medication usually indicate suboptimal pain control. This problem can be alleviated by increasing the fraction of the total daily opioid dose given as long-acting opioid.

2019 Updates

A literature search was conducted from October 1, 2018, to November 1, 2019, and no new evidence was found that would change this policy. Review of FDA labeling updates for long-acting opioids in this policy found no new evidence that would change the quantity limits listed on this policy.

2021 Updates

A literature search was conducted from July 1, 2020, to June 30, 2021, and no new evidence was found that would change this policy.

2022 Updates

Updated the short-acting opioid step-therapy requirement to limit to a 3-day supply for individuals < 18 years of age. Conducted an extensive review of product availability and removed from the short-acting opioid table and the long-acting opioid table many products that are no longer available. Also added a couple new products, Qdolo (tramadol oral solution) and Seglentis (tramadol and celecoxib), to the short-acting opioid table.

2023 Updates

Removed OxyContin ER and Zohydro ER criteria and added OxyContin ER and Zohydro ER into the long-acting opioid step therapy criteria. Added generic Hysingla ER, Hysingla ER, generic Zohydro ER, and Zohydro ER to the long-acting opioid quantity limits criteria.

2024 Updates

A literature search was conducted from April 1, 2023 to March 31, 2024, and no new evidence was found that would change this policy.

2025 Updates

Removed Abstral (fentanyl) from the policy as it has been withdrawn from the market. Clarified that non-formulary exception review authorizations for all drugs listed in this policy may be approved up to 12 months. Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information.

References

1. Silverstein FE, Faich G, Goldstein JL et al. Gastrointestinal toxicity with celecoxib vs nonsteroidal anti-inflammatory drugs for osteoarthritis and rheumatoid arthritis: The CLASS study: A randomized controlled trial. Celecoxib Long-term Arthritis Safety Study. JAMA 2000; 284:1247-55.
2. Bombardier C, Laine L, Reicin A et al. Comparison of upper gastrointestinal toxicity of rofecoxib and naproxen in patients with rheumatoid arthritis. (VIGOR) NEJM 2000; 343:1520-28.
3. Lai KC, Chu KM, Hui WM, et al. Celecoxib compared with lansoprazole and naproxen to prevent gastrointestinal ulcer complications. Am J Med. 2005 Nov;118(11):1271-8.
4. Chan FK, Hung LC, Suen BY, et al. Celecoxib versus diclofenac and omeprazole in reducing the risk of recurrent ulcer bleeding in patients with arthritis. NEJM. 2002 Dec 26;347(26):2104-10.
5. Celecoxib plus aspirin versus naproxen and lansoprazole plus aspirin: a randomized, double-blind, endoscopic trial. Clin Gastroenterol Hepatol. 2007 Oct;5(10):1167-74.
6. Coluzzi PH, Schwartzberg L, Conroy JD et al. Breakthrough cancer pain: a randomized trail comparing oral transmucosal fentanyl citrate (OFTC) and morphine sulfate immediate release (MSIR). Pain. 2001;91:123-130.

7. Payne R, Coluzzi P, Hart L et al. Long-term safety of oral transmucosal fentanyl citrate for breakthrough cancer pain. J Pain Symptom Manage. 2001;22:575-583.

8. Farrar JT, Cleary J, Rauck R et al. Oral transmucosal fentanyl citrate: randomized, double-blind, placebo-controlled trial for treatment of breakthrough pain in cancer patients. J Natl Cancer Inst. 1998;90:611-616.

9. SAMHSA. Results from the 2006 National Survey on Drug Use and Health: national findings. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2007b.

10. US Department of Health and Human Services, substance abuse and mental health services administration. Results from the 2007 national survey on drug use and health: national findings. NSDUH Series H-34, DSHS Publication No. SMA 08-4343. Rockville, MD: Office of Applied Studies, 2008.

11. Webster, L. Update on Abuse-resistant and abuse-deterrent approaches to opioid formulations. Pain Med 2009;10 Suppl 2:S124-S133.

12. Drug Abuse Warning Network, 2011: National Estimates of Drug-Related Emergency Department Visits [online]. Available online: **https://www.samhsa.gov/data/sites/default/files/DAWN2k11ED/DAWN2k11ED/DAWN2k11ED.pdf** Accessed February 10, 2025.

13. Moore TJ, Cohen MR and Furberg CD. Serious adverse drug events reported to the Food and Drug Administration, 1998-2005. Arch Intern Med 2007;167 (16):1752-1759.

14. Coolen P, Best S, Lima A, et al. Overdose deaths involving prescription opioids among Medicaid enrollees – Washington, 2004-2007. MMWR 2009;58(42):1171-1175.

15. US Department of Health and Human Services, Substance Abuse and Mental Health Services. Summary report of the meeting: methadone mortality – a reassessment.

16. Walsh SL, Nuzzo PA, Lofwall MR and Holtman JR. The relative abuse liability of oral oxycodone, hydrocodone, and hydromorphone assessed in prescription opioid abusers. Drug Alcohol Depend 2008;98(3):191-202.

17. Twycross R, Prommer E, Mihalyo M, Wilcock A. Fentanyl (transmucosal). J Pain Symptom Management 2012;44(1):131-149.

18. Nalamachu S, Rauck R, Dilaha L, Parikh N. Lack of correlation between the dose of fentanyl sublingual spray for breakthrough cancer pain and the dose of around-the-clock opioid for persistent pain. J Pain 2013;14:S74.

19. Zeppetella G, Davies AN. Opioids for the management of breakthrough pain in cancer patients. Cochrane Database Syst Rev 2013; Oct 21;10:CD004311. doi: 10.1002/14651858.CD004311.pub3.

20. Friedrichsdorf SJ, Postier A. Management of breakthrough pain in children with cancer. J Pain Research 2014;7:117-123.

21. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016; 65:1–49. **https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm** Accessed February 10, 2025.

22. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *MMWR Recommendations and Reports*. 2016;65(1):1-49.

23. Nucynta ER extended-release oral tablets [prescribing information]. Titusville, NJ: Janssen Pharmaceuticals, Inc.; Revised December 2023.

24. Kadian capsules [prescribing information]. Parsippany, NJ: Actavis Pharma, Inc.; Revised March 2021.

25. MS Contin tablets [prescribing information]. Stamford, CT: Purdue Frederick; Revised December 2023.

26. OxyContin tablets [prescribing information]. Stamford, CT: Purdue Pharma LP; Revised December 2023.

27. Zohydro ER extended-release capsules [prescribing information]. San Diego, CA: Zogenix, Inc; Revised March 2021.

28. Hysingla ER extended-release tablets [prescribing information]. Stamford, CT: Purdue Pharma L.P.; Revised December 2023.

29. Xtampza ER extended-release capsules [prescribing information]. Cincinnati, OH: Patheon Pharmaceuticals; Revised December 2023.

30. Conzip extended-release capsules [prescribing information]. Sayreville, NJ: Vertical Pharmaceuticals, LLC; Revised December 2023.
31. Dolophine [prescribing information]. Eatontown, NJ: West-Ward Pharmaceuticals Corp.; Revised June 2021.
32. Belbuca buccal film [prescribing information]. Raleigh, NC: BioDelivery Sciences International, Inc.; Revised December 2023.
33. Motheral BR, Henderson R, Cox ER. Plan sponsor savings and member experience with point-of-service prescription step therapy. Am J Manag Care 2004;10:457-464.
34. Morley CP, Badolato DJ, Hickner J, et al. The impact of prior authorization requirements on primary care physician's offices: report of two parallel network studies. J Am Board Fam Med. 2013;26(1):93-95.
35. Funkenstein A, Malowney M, Boyd JW. Insurance Prior Authorization Approval Does Not Substantially Lengthen the Emergency Department Length of Stay for Patients With Psychiatric Conditions Ann Emerg Med 2013;61(5):596-597.
36. Hoadley JF, Merrell K, Hargrave E, et al. In Medicare Part D plans, low or zero copay and other features to encourage the use of generics could save billions. Health Aff (Millwood) 2012;31(10):2266-2275.
37. Lu CY, Law MR, Soumerai SB, et al. Impact of prior authorization on the use and costs of lipid-lowering medications among Michigan and Indiana dual enrollees in Medicaid and Medicare: results of a longitudinal, population-based study. Clin Ther. 2011;33(1):135-44.
38. Law MR, Lu CY, Soumerai SB, et al. Impact of prior authorization on the use and costs of lipid-lowering medications among Michigan and Indiana dual enrollees in Medicaid and Medicare: results of a longitudinal, population-based study. Clin Ther. 2011;33(1):135-44.
39. 21 CFR 201.5: Labeling Requirements for Prescription Drugs. Adequate Directions for Use. Available at **http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCFR/CFRSearch.cfm?CFRPart=201** Accessed February 10, 2025.
40. Apadaz [prescribing information]. Coralville, IA. KemPharm, Inc.; Revised December 2023.

History

Date	Comments
02/08/11	Add to Prescription Drug Section - New Policy.
12/13/11	Replace Policy – Policy updated with additional approval parameters and dosing limitation for OxyContin.
11/13/12	Replace policy. A literature search did not indicate the need to update the criteria in this policy.
03/15/13	Update Related Policies. Add 5.01.542.
07/08/13	Minor Update – Clarification was added to the policy that it is managed through the member's pharmacy benefit; this is now listed in the header and within the coding section.
10/14/13	Replace policy. Medically necessary policy statement for OxyContin updated with new FDA labeling and stricter FDA indication wording.

Date	Comments
04/14/14	Annual review. Policy updated with extended-release hydrocodone (Zohydro ER) as medically necessary for the labeled indication of the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.
12/01/14	Update Related Policies. Add 5.01.546.
10/13/15	Annual Review. Policy statements for Cox-II (Celebrex) removed as this medication no longer requires prior authorization. Title updated, removed "Non-Opioid" as this only pertained to Celebrex.
02/09/16	Annual Review. Criteria for Zohydro ER removed from Policy Guidelines: concomitant therapy with CNS depressants or inhibitors of CYP3A4; no history of COPD; and, no current or recent head injury.
05/01/16	Interim update, approved April 12, 2016. Additional criteria for OxyContin and Zohydro ER quantity limit are included.
01/01/17	Interim Update, approved December 13, 2016. Quantity limit criteria for transmucosal fentanyl products (TIRFs) has been removed.
06/01/17	Annual Review, approved May 23, 2017. Policy moved into new format. Created introduction summary and removed the word "preferred" from the coverage criteria for Zohydro ER. Medical records requirement statement is now included in the policy.
10/01/18	Annual Review, approved September 11, 2018. Significant revision of the policy; added contents of policy 5.01.579 and 5.01.583 to this policy. Title changed from "Opioid Analgesics" to "Management of Opioid Therapy".
05/01/19	Interim Review, approved April 2, 2019. Added Apadaz™ (benzhydrocodone and acetaminophen) and benzhydrocodone/acetaminophen to short-acting opioid therapy. Added buprenorphine patch to long-acting opioid therapy.
07/01/19	Interim Review, approved June 4, 2019. Removed Sublocade and Probuphine under long-acting opioid therapy.
01/01/20	Annual Review, approved December 10, 2019. No changes to policy statement.
03/01/20	Interim Review, approved February 20, 2020. For the Long-Acting Opioid Step Therapy criteria added an exception for methadone, Dolophine and Methadose when prescribed to treat opioid addiction. Added generic hydrocodone bitartrate extended-release to policy.
04/01/20	Interim Review, approved March 19, 2020. Added sickle cell disease as a condition for when coverage criteria do not apply.
09/01/20	Annual Review, approved August 20, 2020. No changes to policy statement. Added Prolate (oxycodone and acetaminophen) to the short-acting opioid table.
09/01/21	Annual Review, approved August 3, 2021. No changes to policy statement.
10/01/22	Annual Review, approved September 13, 2022. Updated the short-acting opioid step-therapy requirement to limit to a 3-day supply for individuals < 18 years of age.

Date	Comments
	Removed Onsolis from list of transmucosal fentanyl citrate products as no longer available. Removed Synalgos-DC, Hycet, Verdrocet, Vicodin ES, Xodol, Reprexain, Vicoprofen, Xylon, Simplist Dilaudid, Meperitab, Oxy IR, Percodan, and FusePaq Synapryn from the short-acting opioid table as products are no longer available. Added Qdolo (tramadol oral solution) and Seglentis (tramadol and celecoxib) to the short-acting opioid table. Removed Embeda ER, Fentanyl Transdermal System Novaplus, Ionsys, Exalgo, Arymo ER, Opana ER, and Ultram ER from the long-acting opioid table as products are no longer available. Changed the wording from "patient" to "individual" throughout the policy for standardization.
04/01/23	Annual Review, approved March 14, 2023. Removed OxyContin ER and Zohydro ER criteria and added OxyContin ER and Zohydro ER into the long-acting opioid step therapy criteria. Added generic Hysingla ER, Hysingla ER, generic Zohydro ER, and Zohydro ER to the long-acting opioid quantity limits criteria.
05/01/24	Annual Review, approved April 22, 2024. No changes to policy statement.
03/01/25	Annual Review, approved February 24, 2025. Removed Abstral (fentanyl) from the policy as it has been withdrawn from the market. Clarified that non-formulary exception review authorizations for all drugs listed in this policy may be approved up to 12 months. Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.