Clinical Policy: Opioid Rx Limits

Reference Number: OH.PHAR.PPA.02
Effective Date: 11.01.2016
Last Review Date: 06.22
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Opioid medications are subject to the dispensing limits as outlined below, requiring prior authorization if those limits are exceeded.

Buckeye Health Plan members may obtain up to ***FIVE*** *opioid analgesic prescriptions within a rolling 30 day period without prior authorization, provided that the claims are within Buckeye Health Plan's approved quantity and refill threshold limits.*

FDA Approved Indication(s)

Opioid medications are indicated for the treatment of:

- Mild to severe pain
- Diarrhea (morphine)

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that opioid medications are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Long term therapy (must meet all):

1. Diagnosis of moderate to severe chronic pain (Prescriber must provide documentation specifying the associated diagnosis/rationale for use), sickle cell crisis pain, cancer pain, or hospice care;
2. Member will be maintained on no more than two opioid analgesics concurrently; **If member requires therapy with two opioid analgesics concurrently, regimen must consist of one immediate-release and one extended-release analgesic unless contraindicated**

Approval duration for chronic pain: 3 months
Approval duration for sickle cell crisis, cancer pain, hospice care: 12 months

B. Request for > 2 opioid analgesics concurrently (must meet all)**:**

1. Opioid therapy must be prescribed by a pain, hospice/palliative care, or oncology specialist for sickle cell crisis pain, cancer pain, or hospice care;
2. Prescriber will be requested to discontinue opioid analgesic to meet the two (2) or less opioid limit by the following methods:
    a. Addition of an extended release opioid analgesic, if not present;
    b. Upward titration of existing opioids within plan allowed quantity limits;
3. Prescriber must provide documented clinical rationale for the use of > 2 opioid analgesics concurrently instead of adding an extended release opioid or titrating/discontinuing current opioid analgesics.

Approval duration: 6 months

C. Other diagnoses/indications

1. Request for other diagnoses will be subject to the off-label use policy CP.PMN.53.

II. Continued Therapy

A. Long term therapy (must meet all)**:**

1. Member has previously met all initial approval criteria;
2. Diagnosis of moderate to severe chronic pain, sickle cell crisis pain, cancer pain, or hospice care;
3. Prescriber provides rationale for continued treatment;
4. Member will not be maintained on > 2 opioid analgesic concurrently; **If member requires therapy with two opioid analgesics concurrently, regimen must consist of one immediate-release and one extended-release analgesic unless contraindicated**

Approval duration for chronic pain: 3 months
Approval duration for sickle cell crisis, cancer pain, hospice care: 12 months

B. Request for >2 opioid analgesics concurrently (must meet all):

1. Member is currently receiving > two (2) opioid analgesic via Buckeye Health Plan benefit;
2. Diagnosis of moderate to severe chronic pain, sickle cell crisis pain, cancer pain, or hospice care;
3. Prescriber provides rationale for continued treatment.

Approval duration: 6 months

III. References

1. Rosenquist EW. Overview of the treatment of chronic pain. Aronson MD, Park L. (Ed), UpToDate. Waltham MA. Accessed October 2016.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	10.16	11.16
Annual Review	10.17	10.17
Annual Review – re-formatted sections I. Initial Approval Criteria and II. Continued Therapy. No significant changes made.	06.19	07.19
Annual Review – no changes deemed necessary	06.20	07.20
Annual Review – no changes deemed necessary	06.21	07.21
Annual Review – no changes deemed necessary	06.22	07.22

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.