

Clinical Policy: OH.PHAR.PPA.21
Clinical Policy: Analgesic Agents – NSAIDs

Effective Date: 01.2020
Last Review Date: 11-21
Line of Business: Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

ANALGESIC AGENTS: NSAIDS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
Celecoxib	Diclofenac/Misoprolol
Diclofenac	Diclofenac Patch 1.3%
Diclofenac DR	Diclofenac Sol 1.5%
Diclofenac ER	Diclofenac
Diclofenac Gel 1%	Diclofenac
Etodolac	Diclofenac
Fenoprofen 600mg	Fenoprofen 400mg
Flurbiprofen	Ibuprofen/Famotidine
Ibuprofen	Ketorolac Tromethamine Nasal Spray
Indocin	Ketoprofen
Indomethacin	Licart Patch
Ketorolac	Meloxicam Cap
Ketoprofen ER	Naproxen CR
Meclofenamate	Naproxen DR
Mefenamic Acid	Naproxen EC
Meloxicam	Naproxen ER
Nabumetone	Naproxen/Esomeprazole
Naproxen	Pennsaid
Naproxen Susp ^{AR}	Qmiiiz ODT
Oxaprozin	Relafen DS
Piroxicam	Zipsor
Sulindac	Zorvolex

AR – Naproxen Suspension: a PA is required for patients over 12 years old

FDA Approved Indication(s)

The list below may not be all inclusive. Varies by drug product. If needed, please see package insert; clinical pharmacology or other appropriate clinical reference.

Ankylosing spondylitis

Arthralgia

Bone pain

Bursitis

Dental pain

Dysmenorrhea

Fever

Gouty arthritis

Headache

Mild pain

Moderate pain

Myalgia

Osteoarthritis

Patent ductus arteriosus (PDA)

Rheumatoid arthritis

Severe pain

Tendinitis

Juvenile rheumatoid arthritis (JRA)/juvenile idiopathic arthritis (JIA)

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 Buckeye Health Plan, an affiliate of Centene Corporation® that a Non-preferred NSAID is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Oral NSAIDs All Indications (must meet all):

1. Failure of no less than a 30 day trial of at least **two medications** not requiring prior approval. UNLESS there is a reason the patient cannot be changed to a PDL Medication

Acceptable reasons include:

- Allergy to all medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
- History of unacceptable/toxic side effects to medications not requiring prior Approval

Approval duration: 12 months (please note the following exceptions)

Member treated for H.pylori = 30 days

B. TRANSDERMAL/TOPICAL NSAIDS All Indications (must meet all):

1. Failure of no less than a 30 day trial of at least two medications not requiring prior approval. UNLESS there is a reason the patient cannot be changed to a PDL Medication

Acceptable reasons include:

- Allergy to all medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
- History of unacceptable/toxic side effects to medications not requiring prior approval

Approval duration: 90 days

D. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

II. Diagnoses/Indications for which coverage is NOT authorized:

Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents.

III. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

PA: Prior Authorization

ER: Extended Release *Appendix B: Therapeutic Alternatives*

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Diclofenac sodium (Voltaren®)	50 mg PO TID	150 mg/day
Etodolac (Lodine®)	400 - 500 mg PO BID	1200 mg/day
Ibuprofen (Motrin®)	400 - 800 mg PO Q6-8hr	3200 mg/day
Indomethacin (Indocin®)	25 - 50 mg PO BID -TID	200 mg/day
Indomethacin SR (Indocin® SR)	75 mg PO QD - BID	150 mg/day
Meclofenamate (Meclomen®)	50 - 100 mg PO Q4-6hr	400 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Meloxicam (Mobic®)	7.5 – 15 mg PO QD	15 mg/day
Nabumetone (Relafen®)	1000 mg PO QD or 500 mg PO BID	2000 mg/day
Naproxen (Naprosyn®)	250 – 500 mg PO BID	1500 mg/day
Oxaprozin (Daypro®)	600 - 1200 mg PO BID	1800 mg/day
Piroxicam (Feldene®)	10 - 20 mg PO QD	20 mg/day
Sulindac (Clinoril®)	150 mg - 200 mg PO BID	400 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- See package insert; clinical pharmacology or other appropriate clinical reference.

IV. Dosage and Administration - varies by drug product. See package insert; clinical pharmacology or other appropriate clinical reference for FDA approved dosing and administration

V. Product Availability – See package insert; clinical pharmacology or other appropriate clinical reference for product availability

VI. References. Refer to see package insert.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created	10.19	
Annual review – no changes deemed necessary	11.20	
Annual review – removed section B. GASTROPROTECTIVE NSAIDS – consolidated to all under Oral NSAIDS- updated preferred-non preferred chart	11.21	

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.

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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.

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