STEP THERAPY WITH QUANTITY LIMIT AND POST LIMIT PRIOR AUTHORIZATION CRITERIA

DRUG CLASS EXTENDED-RELEASE OPIOID ANALGESICS

**BRAND NAME*
(generic)**

ARYMO ER
(morphine sulfate extended-release tablets)

AVINZA
(morphine extended-release capsules)

BELBUCA
(buprenorphine buccal film)

BUTRANS
(buprenorphine transdermal system)

CONZIP
(tramadol hydrochloride extended-release)

DOLOPHINE 5 MG, 10 MG
(methadone hydrochloride tablets)

DURAGESIC
(fentanyl transdermal system)

EMBEDA
(morphine sulfate and naltrexone hydrochloride extended-release caps)

EXALGO
(hydromorphone hydrochloride extended-release tablets)

HYSINGLA ER
(hydrocodone bitartrate extended-release tablets)

KADIAN
(morphine extended-release capsules)

METHADONE 5 MG, 10 MG
(methadone hydrochloride tablets)

METHADONE 200 MG/20 ML INJ

(methadone hydrochloride injection)

METHADONE INTENSOL 10 MG/ML
(methadone oral concentrate)

METHADONE 5 MG/5 ML & 10 MG/5 ML ORAL SOLN
(methadone hydrochloride oral solution)

MORPHABOND ER
(morphine extended-release tablets)

MS CONTIN
(morphine extended-release tablets)

NUCYNTA ER
(tapentadol extended-release tablets)

OPANA ER
(oxymorphone hydrochloride extended-release tablets)

OXYCONTIN
(oxycodone hydrochloride extended-release tablets)

(oxymorphone hydrochloride extended-release tablets)

TARGINIQ ER
(oxycodone HCl/naloxone HCl extended-release tablets)

(tramadol hydrochloride extended-release)

TROXYCA ER
(oxycodone hydrochloride/naltrexone extended-release capsules)

ULTRAM ER
(tramadol hydrochloride extended-release tablets)

VANTRELA ER
(hydrocodone bitartrate extended-release tablets)

XTAMPZA ER
(oxycodone extended-release capsules)

ZOHYDRO ER
(hydrocodone bitartrate extended-release capsules)

** Drugs that are listed in the target drug box include both brand and generic and all dosage forms and strengths unless otherwise stated. OTC products are not included unless otherwise stated.*

FDA-APPROVED INDICATIONS

Arymo ER, Avinza, Kadian, MorphaBond ER, MS Contin, and Embeda

Arymo ER, Avinza, Kadian, MorphaBond ER, MS Contin, and Embeda 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.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Arymo ER, Avinza, Kadian, MorphaBond ER, MS Contin, and Embeda for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Arymo ER, Avinza, Kadian, MorphaBond ER, MS Contin, and Embeda are not indicated as an as-needed (prn) analgesic.

Belbuca and Butrans

Belbuca and Butrans 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.

Limitations of Use

- Because of the risks of addiction, abuse and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-acting opioid formulations, reserve Belbuca and Butrans for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Belbuca and Butrans are not indicated as an as-needed (prn) analgesic.

ConZip, Ultram ER, and Tramadol Hydrochloride Extended-Release

ConZip, Ultram ER, and Tramadol Hydrochloride Extended-Release 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.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release/long-acting opioid formulations, reserve ConZip, Ultram ER, and Tramadol Hydrochloride Extended-Release for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- ConZip, Ultram ER, and Tramadol Hydrochloride Extended-Release is not indicated as an as-needed (prn) analgesic.

Dolophine Tablets

Dolophine tablets 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.
  Limitations of Use
  - Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-acting opioids, reserve Dolophine tablets for use in patients for whom alternative analgesic treatment options (e.g., non-opioid analgesics or immediate-release opioid analgesics) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
  - Dolophine tablets are not indicated as an as-needed (prn) analgesic.
- Detoxification treatment of opioid addiction (heroin or other morphine-like drugs).

- Maintenance treatment of opioid addiction (heroin or other morphine-like drugs), in conjunction with appropriate social and medical services.
  Limitations of Use
  - Methadone products used for the treatment of opioid addiction in detoxification or maintenance programs are subject to the conditions for distribution and use required under 42 CFR 8.12.

Duragesic

Duragesic is indicated for the management of pain in opioid-tolerant patients, severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.
Patients considered opioid-tolerant are those who are taking, for one week or longer, at least 60 mg morphine per day, 25 mcg transdermal fentanyl per hour, 30 mg oral oxycodone per day, 8 mg oral hydromorphone per day, 25 mg oral oxymorphone per day, 60 mg hydrocodone per day, or an equianalgesic dose of another opioid.
Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release/long-acting opioid formulations, reserve Duragesic for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Duragesic is not indicated as an as-needed (prn) analgesic.

Exalgo

Exalgo is indicated for the management of pain in opioid-tolerant patients severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.
Patients considered opioid tolerant are those who are receiving, for one week or longer, at least 60 mg oral morphine per day, 25 mcg transdermal fentanyl per hour, 30 mg oral oxycodone per day, 8 mg oral hydromorphone per day, 25 mg oral oxymorphone per day, 60 mg oral hydrocodone per day, or an equianalgesic dose of another opioid.
Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Exalgo for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Exalgo is not indicated as an as-needed (prn) analgesic.

Hysingla ER

Hysingla ER is 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.
Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Hysingla ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Hysingla ER is not indicated as an as-needed (prn) analgesic.

Methadone Injection

Methadone Injection is indicated:

- For the management of pain severe enough to require an opioid analgesic and for which alternative treatment options are inadequate.
  Limitations of Use
  - Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses reserve Methadone Hydrochloride Injection for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products):
    - Have not been tolerated, or are not expected to be tolerated,
    - Have not provided adequate analgesia, or are not expected to provide adequate analgesia.
- For use in temporary treatment of opioid dependence in patients unable to take oral medication.
  Limitations of Use
  - Injectable methadone products are not approved for the outpatient treatment of opioid dependence. In this patient population, parenteral methadone is to be used only for patients unable to take oral medication, such as hospitalized patients.

Conditions For Distribution And Use Of Methadone Products For The Treatment Of Opioid Addiction

Code of Federal Regulations, Title 42, Sec 8
Methadone products when used for the treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed only by opioid treatment programs (and agencies, practitioners or institutions by formal agreement with the program sponsor) certified by the Substance Abuse and Mental Health Services Administration and approved by the designated state authority. Certified treatment programs shall dispense and use methadone in oral form only and according to the treatment requirements stipulated in the Federal Opioid Treatment Standards (42 CFR 8.12). See below for important regulatory exceptions to the general requirement for certification to provide opioid agonist treatment.
Failure to abide by the requirements in these regulations may result in criminal prosecution, seizure of the drug supply, revocation of the program approval, and injunction precluding operation of the program.
Regulatory Exceptions To The General Requirement For Certification To Provide Opioid Agonist Treatment:
During inpatient care, when the patient was admitted for any condition other than concurrent opioid addiction [pursuant to 21CFR 1306.07(c)], to facilitate the treatment of the primary admitting diagnosis.
During an emergency period of no longer than 3 days while definitive care for the addiction is being sought in an appropriately licensed facility [pursuant to 21CFR 1306.07(b)].

Methadone Intensol

Methadone Hydrochloride Intensol (oral concentrate) is 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.
  Limitations of Use
  - Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-acting opioids, reserve methadone for use in patients for whom alternative analgesic treatment options (e.g., non-opioid analgesics or immediate-release opioid analgesics) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
  - Methadone is not indicated as an as-needed (prn) analgesic.
- Detoxification treatment of opioid addiction (heroin or other morphine-like drugs).
- Maintenance treatment of opioid addiction (heroin or other morphine-like drugs), in conjunction with appropriate social and medical services.

Conditions For Distribution And Use Of Methadone Products For The Treatment Of Opioid Addiction

Code of Federal Regulations, Title 42, Sec 8
Methadone products when used for the treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed only by opioid treatment programs (and agencies, practitioners or institutions by formal agreement with the program sponsor) certified by the Substance Abuse and Mental Health Services Administration and approved by the designated state authority. Certified treatment programs shall dispense and use methadone in oral form only and according to the treatment requirements stipulated in the Federal Opioid Treatment Standards (42 CFR 8.12). See below for important regulatory exceptions to the general requirement for certification to provide opioid agonist treatment.
Failure to abide by the requirements in these regulations may result in criminal prosecution, seizure of the drug supply, revocation of the program approval, and injunction precluding operation of the program.
Regulatory Exceptions To The General Requirement For Certification To Provide Opioid Agonist Treatment:
During inpatient care, when the patient was admitted for any condition other than concurrent opioid addiction [pursuant to 21CFR 1306.07(c)], to facilitate the treatment of the primary admitting diagnosis.
During an emergency period of no longer than 3 days while definitive care for the addiction is being sought in an appropriately licensed facility [pursuant to 21CFR 1306.07(b)].

Methadone Oral Solution

Methadone Hydrochloride Oral Solution is 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.
  Limitations of Use
  - Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-acting opioids, reserve Methadone Hydrochloride Oral Solution for use in patients for whom alternative analgesic treatment options (e.g., non-opioid analgesics or immediate-release opioid analgesics) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
  - Methadone Hydrochloride Oral Solution is not indicated as an as-needed (prn) analgesic.
- Detoxification treatment of opioid addiction (heroin or other morphine-like drugs).

- Maintenance treatment of opioid addiction (heroin or other morphine-like drugs), in conjunction with appropriate social and medical services.
  Limitations of Use
  - Methadone products used for the treatment of opioid addiction in detoxification or maintenance programs are subject to the conditions for distribution and use required under 42 CFR 8.2.

Methadone Tablets

Methadone Hydrochloride tablets 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.
  Limitations of Use
  - Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-acting opioids, reserve Methadone Hydrochloride Tablets for use in patients for whom alternative analgesic treatment options (e.g., non-opioid analgesics or immediate-release opioid analgesics) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
  - Methadone Hydrochloride Tablets are not indicated as an as-needed (prn) analgesic.
- Detoxification treatment of opioid addiction (heroin or other morphine-like drugs).
- Maintenance treatment of opioid addiction (heroin or other morphine-like drugs), in conjunction with appropriate social and medical services.
  Limitations of Use
  - Methadone products used for the treatment of opioid addiction in detoxification or maintenance programs are subject to the conditions for distribution and use required under 42 CFR 8.2.

Nucynta ER

Nucynta ER is 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.
- Neuropathic pain associated with diabetic peripheral neuropathy (DPN) in adults severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Nucynta ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Nucynta ER is not indicated as an as-needed (prn) analgesic.

Opana ER

Opana ER is 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.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Opana ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Opana ER is not indicated as an as-needed (prn) analgesic.

OxyContin

OxyContin is 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 in:

- Adults; and
- Opioid-tolerant pediatric patients 11 years of age and older who are already receiving and tolerate a minimum daily opioid dose of at least 20 mg oxycodone orally or its equivalent.

Limitations of Usage

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Oxycontin for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.

- OxyContin is not indicated as an as-needed (prn) analgesic.

Targiniq ER

Targiniq ER is 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.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Targiniq ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Targiniq ER is not indicated as an as-needed (prn) analgesic.
- The maximum total daily dose of Targiniq ER should not exceed 80 mg/40 mg (40 mg/20 mg q12h) because higher doses may be associated with symptoms of opioid withdrawal or decreased analgesia.

Troxyca ER

Troxyca ER is 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.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Troxyca ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Troxyca ER is not indicated as an as-needed (prn) analgesic.

Vantrela ER

Vantrela ER is an opioid agonist 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.

Limitation of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Vantrela ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Vantrela ER is not indicated as an as-needed (prn) analgesic.

Xtampza ER

Xtampza ER is 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.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Xtampza ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Xtampza ER is not indicated as an as-needed (prn) analgesic.

Zohydro ER

Zohydro ER is 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.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Zohydro ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Zohydro ER is not indicated as an as-needed (prn) analgesic.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through hospice or palliative care

OR

- The requested drug is being prescribed for CHRONIC pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid [Note: Chronic pain is generally defined as pain that typically lasts greater than 3 months.]

AND

- The patient can safely take the requested dose based on their history of opioid use

AND

- The patient has been evaluated and the patient will be monitored regularly for the development of opioid use disorder

AND

- The patient's pain will be reassessed in the first month after the initial prescription or any dose increase AND every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety

AND

- This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days **OR**
- The patient has taken an immediate-release opioid for at least one week

AND

- If the request is for a methadone product, then it is NOT being prescribed for detoxification treatment or as part of a maintenance treatment plan for opioid/substance abuse or addiction

[Note: These drugs should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.]

Quantity Limits may apply.

RATIONALE

The intent of the criteria is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines. Extended-release 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. Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve extended-release opioids for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. Extended-release opioids are not indicated as as-needed (prn) analgesics. These drugs should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.[1-30]

If the patient has filled a prescription for at least a 1-day supply of a drug indicating the patient is being treated for cancer or sickle cell disease (SCD) within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.

If a claim is submitted with an ICD 10 diagnosis code indicating cancer, sickle cell disease, or palliative care under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.

If the patient has an ICD 10 diagnosis code indicating cancer or palliative care in their member health profile in the past 365 days, then the requested drug will be paid under that prescription benefit.

If the patient has any history of an ICD 10 diagnosis code indicating sickle cell disease in their member health profile, then the requested drug will be paid under that prescription benefit.

If a claim is submitted using a hospice patient residence code under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.

For patients with no prescription claims of a cancer drug or a sickle cell disease drug in the past 365 days, no ICD 10 diagnosis code indicating cancer, sickle cell disease, or palliative care submitted with their prescription claim, no ICD 10 diagnosis code indicating cancer or palliative care in their member health profile in the past 365 days, no history of an ICD 10 diagnosis code indicating sickle cell disease in their member health profile, or no hospice patient residence code submitted with their prescription claim:
If the patient has filled a prescription for at least a 7-day supply of an immediate-release (IR) opioid agent indicated for the management of pain within prescription claim history in the past 90 days under a prescription benefit administered by CVS Caremark, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics ER Quantity Limits Chart below).

If the patient has filled a prescription for at least a 30-day supply of an extended-release (ER) opioid agent indicated for the management of pain within prescription claim history in the past 90 days under a prescription benefit administered by CVS Caremark, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics ER Quantity Limits Chart below).

If the patient does not have at least a 7-day supply of an IR opioid agent indicated for the management of pain OR at least a 30-day supply of an ER opioid agent indicated for the management of pain within prescription claim history in the past 90 days (i.e., the patient has not used an IR opioid prior to the ER opioid OR the patient is not already stable on an ER opioid), then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

The Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, sickle cell disease, palliative care, and end-of-life care. [31] The National Comprehensive Cancer Network (NCCN) guidelines for Adult Cancer Pain recommend for continuous pain, it is appropriate to give pain medication on a regular schedule with supplemental doses for breakthrough pain. Add an extended-release or long-acting formulation to provide background analgesia for control of chronic persistent pain controlled on stable doses of short-acting opioids. Allow rescue doses of short-acting opioids up to every 1 hour as needed.[33] The NCCN Palliative Care pain management recommendation is to treat according to NCCN guidelines for adult cancer pain.[32] For patients with no prescription claims of a cancer drug in the past 365 days, no ICD 10 diagnosis code indicating cancer or palliative care submitted with their prescription claim, no ICD 10 diagnosis code indicating cancer or palliative care in their member health profile in the past 365 days, or no hospice patient residence code submitted with their prescription claim who are identified through the prior authorization criteria as having cancer, a terminal condition, or pain being managed through hospice or palliative care, step therapy criteria and post limit quantities will not apply.

According to the National Heart, Lung, and Blood Institute's (NHLBI) guidelines for Sickle Cell Disease (SCD), pain is the most common symptom of SCD. Pain can be acute, chronic, or an acute episode superimposed on chronic pain. Recurrent acute pain crises (also known as vaso-occlusive crises) are the most common manifestation of SCD. Chronic pain is also one of the most common chronic complications of SCD. Pain management must be guided by patient report of severity. No biomarkers or imaging studies can validate pain or assess its severity. Medications used to treat SCD-related pain should be tailored to the individual. For pain that is not relieved by nonsteroidal anti-inflammatory drugs (NSAIDs) or other measures, either short-acting or long-acting opioids may be used to manage pain in SCD.[35] For patients with no prescription claims of a sickle cell disease drug in the past 365 days, no ICD 10 diagnosis code indicating sickle cell disease submitted with their prescription claim, or no history of an ICD 10 diagnosis code indicating sickle cell disease in their member health profile who are identified through the prior authorization criteria as having sickle cell disease, step therapy criteria and post limit quantities will not apply.

The CDC Guideline for Prescribing Opioids for Chronic Pain states that for patients not already receiving opioids, clinicians should not initiate opioid treatment with extended-release opioids and should not prescribe extended-release

opioids for intermittent use. Extended-release opioids should be reserved for severe, continuous pain and should be considered only for patients who have received immediate-release opioids daily for at least one week.[31]

Patients with chronic pain may need to be dosed on an around-the-clock basis rather than on an as needed basis. The American Pain Society (APS) Chronic Pain guideline states that short-acting opioids are probably safer for initial therapy since they have a shorter half-life and may be associated with a lower risk of inadvertent overdose. Proposed benefits of transitioning to long-acting opioids with around-the-clock dosing include more consistent control of pain, improved adherence, and lower risk of addiction or abuse. In patients on around-the-clock chronic opioid therapy with breakthrough pain, clinicians may consider as-needed opioids.[34]

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.[31]

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should consider history of overdose, history of substance use disorder, higher opioid dosages [≥50 morphine milligram equivalents per day (MME/day)], or concurrent benzodiazepine use. [31]

The CDC Guideline for Prescribing Opioids for Chronic Pain recommends that 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 MME/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.[31] The extended-release opioid drug initial quantity limits are set to encompass the usual/starting dosage and frequency range recommendations in labeling without exceeding a monthly quantity that corresponds to 90 MME/day. If the patient is requesting more than the initial quantity limit, then the system will reject with a message indicating that a prior authorization is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

The American Pain Society Opioid Treatment Guidelines state that a reasonable definition for high dose opioid therapy is >200 mg daily of oral morphine (or equivalent).[34] The extended-release opioid drug post limit quantities for approval are set to encompass the usual dosage and frequency range recommendations in labeling, or up to one additional dose per day above the initial quantity limit without exceeding a monthly quantity that corresponds to 200 MME/day (unless minimum FDA-labeled strength/dose/frequency exceeds a monthly quantity that corresponds to 200 MME/day) to promote optimization of pain management, safe and effective use, and to reduce misuse, abuse, and overdose.

Methadone products, when used for the treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed only by opioid treatment programs (and agencies, practitioners or institutions by formal agreement with the program sponsor) certified by the Substance Abuse and Mental Health Services Administration and approved by the designated state authority. Certified treatment programs shall dispense and use methadone in oral form only and according to the treatment requirements stipulated in the Federal Opioid Treatment Standards (42 CFR 8.12).[6,12-15, 29-30] The limit is set to reflect the use of methadone for the relief of pain. The limit is not intended for patients in detoxification and methadone maintenance programs. A separate initial quantity limit criteria exists for methadone concentrate and dispersible tablets since they are indicated for opioid dependence only.

Studies of opioid therapy for chronic pain that did not have a nonopioid control group have found that although many patients discontinue opioid therapy for chronic noncancer pain due to adverse effects or insufficient pain relief, there is weak evidence that patients who are able to continue opioid therapy for at least six months can experience clinically significant pain relief and insufficient evidence that function or quality of life improves. These findings suggest that it is very difficult for clinicians to predict whether benefits of opioids for chronic pain will outweigh risks of ongoing treatment for individual patients.[31] Therefore, patients who meet the prior authorization criteria for chronic pain will be approved for 6 months.

REFERENCES

1. Arymo ER [package insert]. Wayne, PA: Zyla Life Sciences US Inc.; October 2019.
2. Avinza [package insert]. New York, NY: Pfizer, Inc.; April 2014.
3. Belbuca [package insert]. Raleigh, NC: BioDelivery Sciences International, Inc.; October 2019.
4. Butrans [package insert]. Stamford, CT: Purdue Pharma L.P.; October 2019.
5. ConZip [package insert]. Bridgewater, NJ: Vertical Pharmaceuticals, Inc.; October 2019.
6. Dolophine Tablets [package insert]. Eatontown, NJ: West-Ward Pharmaceuticals Corp.; October 2019.
7. Duragesic [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc; October 2019.
8. Embeda [package insert]. New York, NY: Pfizer, Inc.; October 2019.
9. Exalgo [package insert]. Webster Groves, MO: Mallinckrodt Pharmaceuticals; October 2019.
10. Hysingla ER [package insert]. Stamford, CT: Purdue Pharma L.P.; October 2019.
11. Kadian [package insert]. Madison, NJ: Allergan USA, Inc.; October 2019.
12. Methadone Injection [package insert]. Rockford, IL: Mylan Institutional LLC; October 2019.
13. Methadone Intensol Concentrate [package insert]. Eatontown, NJ: West-Ward Pharmaceuticals Corp; September 2016.
14. Methadone Oral Solution [package insert]. Eatontown, NJ: West-Ward Pharmaceuticals Corp; November 2019.
15. Methadone Tablets [package insert]. Mahwah, NJ: Glenmark Pharmaceuticals, Inc.; December 2019.
16. MorphaBond ER [package insert]. Basking Ridge, NJ: Daiichi Sankyo, Inc.; October 2019.
17. MS Contin [package insert]. Stamford, CT: Rhodes Pharmaceuticals L.P.; October 2019.
18. Nucynta ER [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc; October 2019.
19. Opana ER [package insert]. Malvern, PA: Endo Pharmaceuticals Inc.; October 2019.
20. OxyContin [package insert]. Stamford, CT: Purdue Pharma L.P.; October 2019.
21. Targiniq ER [package insert]. Stamford, CT: Purdue Pharma L.P.; September 2018.
22. Tramadol extended-release capsules [package insert]. Los Angeles, CA: SA3, LLC; September 2018.
23. Tramadol extended-release tablets [package insert]. Morgantown, WV: Mylan Pharmaceuticals Inc.; August 2019.
24. Troxyca ER [package insert]. New York, NY: Pfizer, Inc.; December 2016.
25. Ultram ER [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc.; August 2017.
26. Vantrela ER [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc.; January 2017.
27. Xtampza ER [package insert]. Cincinnati, OH: Patheon Pharmaceuticals; October 2019.
28. Zohydro ER [package insert]. Morristown, NJ: Persion Pharmaceuticals, LLC; October 2019.
29. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Hudson, OH: Wolters Kluwer Clinical Drug Information, Inc. http://online.lexi.com/. Accessed January 2020.
30. Micromedex (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. http://www.micromedexsolutions.com/. Accessed January 2020.
31. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65:1–49. Available at: http://dx.doi.org/10.15585/mmwr.rr6501e1. Accessed January 2020.
32. Palliative Care. NCCN Guidelines version 2.2019. Available at: http://www.nccn.org/professionals/physician_gls/pdf/palliative.pdf. Accessed January 2020.
33. Adult Cancer Pain. NCCN Guidelines version 3.2019. Available at: https://www.nccn.org/professionals/physician_gls/pdf/pain.pdf. Accessed January 2020.
34. Chou R, Fanciullo G, Fine P, et al. Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain The Journal of Pain 2009;10:113-130.
35. National Heart, Lung, and Blood Institute. Evidence-Based Management of Sickle Cell Disease: Expert Panel Report, 2014. Available at: https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%20020816_0.pdf. Accessed January 2020.

Written by:	UM Development (CF/JH)
Date Written:	04/2016
Revised:	06/2016, 08/2016 (added Troxyca ER), 10/2016, 01/2017 (added Arymo ER, Vantrela ER), 03/2017 (removed prescriber specialty question/added prescriber note, added Methadone Intensol), 05/2017 (updated Belbuca MME), 07/2017 (updated Rationale), 08/2017 (combined step therapy and limit/PL criteria, no clinical changes), 08/2017 (decreased methadone quantities), 01/2018, 06/2018 (updated MorphaBond ER QLs); (CF/DS) 01/2019 (added SCD), 05/2019 (added ICD10 code and hospice screenouts), 07/2019 (added member health profile screenout), 01/2020 (member health profile lifetime for SCD); (DS) 07/2020 (decreased DOA for chronic pain to 6 months)

Reviewed: Medical Affairs: (DNC) 05/2016, 06/2016, 08/2016, 10/2016, 01/2017, 03/2017, 05/2017, 07/2017, 08/2017, 01/2018, 06/2018; (TKP) 03/2019; (DNC) 05/2019, 07/2019; (CHART) 01/30/2020, 07/23/20
External Review: 06/2016, 10/2016, 12/2016, 04/2017, 06/2017, 10/2017, 04/2018, 08/2018, 04/2019, 06/2019 (FYI), 08/2019 (FYI), 04/2020, 10/2020

SCREENOUT LOGIC

If the patient has filled a prescription for at least a 1-day supply of a drug indicating the patient is being treated for cancer or sickle cell disease within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.

If a claim is submitted with an ICD 10 diagnosis code indicating cancer, sickle cell disease, or palliative care under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.

If the patient has an ICD 10 diagnosis code indicating cancer or palliative care in their member health profile in the past 365 days, then the requested drug will be paid under that prescription benefit.

If the patient has any history of an ICD 10 diagnosis code indicating sickle cell disease in their member health profile, then the requested drug will be paid under that prescription benefit.

If a claim is submitted using a hospice patient residence code under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.

INITIAL STEP THERAPY

For patients with no prescription claims of a cancer drug or a sickle cell disease drug in the past 365 days, no ICD 10 diagnosis code indicating cancer, sickle cell disease, or palliative care submitted with their prescription claim, no ICD 10 diagnosis code indicating cancer or palliative care in their member health profile in the past 365 days, no history of an ICD 10 diagnosis code indicating sickle cell disease in their member health profile, or no hospice patient residence code submitted with their prescription claim:

If the patient has filled a prescription for at least a 7-day supply of an immediate-release (IR) opioid agent indicated for the management of pain within prescription claim history in the past 90 days under a prescription benefit administered by CVS Caremark, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics ER Quantity Limits Chart below).

If the patient has filled a prescription for at least a 30-day supply of an extended-release (ER) opioid agent indicated for the management of pain within prescription claim history in the past 90 days under a prescription benefit administered by CVS Caremark, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics ER Quantity Limits Chart below).

If the patient does not have at least a 7-day supply of an IR opioid agent indicated for the management of pain OR at least a 30-day supply of an ER opioid agent indicated for the management of pain within prescription claim history in the past 90 days (i.e., the patient has not used an IR opioid prior to the ER opioid OR the patient is not already stable on an ER opioid), then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

CRITERIA FOR APPROVAL

1	Is the requested drug being prescribed for pain associated with cancer, sickle cell disease, a	Yes	No

terminal condition, or pain being managed through hospice or palliative care?
[If yes, then no further questions.]

2	Is the requested drug being prescribed for CHRONIC pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid? [Note: Chronic pain is generally defined as pain that typically lasts greater than 3 months.]	Yes	No
3	Can the patient safely take the requested dose based on their history of opioid use?	Yes	No
4	Has the patient been evaluated and will the patient be monitored regularly for the development of opioid use disorder?	Yes	No
5	Will the patient's pain be reassessed in the first month after the initial prescription or any dose increase AND every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety?	Yes	No
6	Is this request for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days? [If yes, then skip to question 8.]	Yes	No
7	Has the patient taken an immediate-release opioid for at least one week?	Yes	No

8 Which drug is being requested? Please check the drug being requested.
[Note: These drugs should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.]

[] Arymo ER (morphine extended-release tablets) (if checked, go to 20)
[] Avinza (morphine extended-release capsules) (if checked, go to 12)
[] Belbuca (buprenorphine buccal film) (if checked, go to 13)
[] Butrans (buprenorphine transdermal system) (if checked, go to 14)
[] ConZip (tramadol hydrochloride extended-release) (if checked, go to 15)
[] Dolophine 5 mg, 10 mg (methadone hydrochloride tablets) (if checked, go to 10)
[] Duragesic (fentanyl transdermal system) (if checked, go to question 16)
[] Embeda (morphine sulfate/naltrexone HCl extended-release) (if checked, go to question 17)
[] Exalgo (hydromorphone hydrochloride extended-release tabs) (if checked, go to question 18)
[] Hysingla ER (hydrocodone bitartrate extended-release tablets) (if checked, go to 9)
[] Kadian (morphine extended-release capsules) (if checked, go to question 19)
[] Methadone 5 mg, 10 mg (methadone hydrochloride tablets) (if checked, go to 10)
[] Methadone 10 mg/mL Intensol soln (if checked, go to 10)
[] Methadone 5 mg/5 mL,10 mg/5 mL oral soln, 200 mg/20 mL injection (if checked, go to 10)
[] MorphaBond ER (morphine extended-release tablets) (if checked, go to 20)
[] MS Contin (morphine extended-release tablets) (if checked, go to 20)
[] Nucynta ER (tapentadol extended-release tablets) (if checked, go to 21)
[] Opana ER (oxymorphone hydrochloride extended-release tablets) (if checked, go to 22)
[] OxyContin (oxycodone hydrochloride extended-release tablets) (if checked, go to 23)
[] Targiniq ER (oxycodone HCl/naloxone HCl extended-release tablets) (if checked, go to 24)
[] Tramadol hydrochloride extended-release (if checked, go to 15)
[] Troxyca ER (oxycodone/naltrexone extended-release capsules) (if checked, go to 26)
[] Ultram ER (tramadol hydrochloride extended-release tablets) (if checked, go to 15)
[] Vantrela ER (hydrocodone bitartrate extended-release tablets) (if checked, go to 9)
[] Xtampza ER (oxycodone extended-release capsules) (if checked, go to 25)
[] Zohydro ER (hydrocodone bitartrate extended-release capsules) (if checked, go to 9)

9	Does the patient require use of MORE than the plan allowance PER MONTH of any of the	Yes	No

following: A) 90 units of Zohydro ER 10 mg, 15 mg, 20 mg, 30 mg, 40 mg OR Vantrela ER 15 mg, 30 mg, 45 mg, B) 60 units of Hysingla ER 20 mg, 30 mg, 40 mg, 60 mg, 80 mg, 100 mg OR Zohydro ER 50 mg OR Vantrela ER 60 mg, 90 mg, C) 30 units of Hysingla ER 120 mg?
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 90 units/month of Zohydro ER 10 mg, 15 mg, 20 mg, 30 mg, 40 mg OR Vantrela ER 15 mg, 30 mg, 45 mg, B) 60 units/month of Hysingla ER 20 mg, 30 mg, 40 mg, 60 mg, 80 mg, 100 mg OR Zohydro ER 50 mg OR Vantrela ER 60 mg, 90 mg, C) 30 units/month of Hysingla ER 120 mg.]

10 Is the requested methadone product being prescribed for detoxification treatment or as part of a maintenance treatment plan for opioid/substance abuse or addiction? Yes No

11 Does the patient require use of MORE than the plan allowance PER MONTH of any of the following: A) 120 tablets of Dolophine 5 mg or Methadone 5 mg, B) 90 tablets of Dolophine 10 mg or Methadone 10 mg, C) 600 mL of Methadone 5 mg/5 mL oral solution, D) 450 mL of Methadone 10 mg/5 mL oral solution, E) 90 mL of Methadone 10 mg/mL Intensol solution, F) 40 mL (2 multidose vials) of Methadone 200 mg/20 mL injection? Yes No
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 120 tablets/month of Dolophine 5 mg or Methadone 5 mg, B) 90 tablets/month of Dolophine 10 mg or Methadone 10 mg, C) 600 mL/month of Methadone 5 mg/5 mL oral solution, D) 450 mL/month of Methadone 10 mg/5 mL oral solution, E) 90 mL/month of Methadone 10 mg/mL Intensol solution, F) 40 mL/month (2 multidose vials) of Methadone 200 mg/20 mL injection.]

12 Does the patient require use of MORE than the plan allowance PER MONTH of 60 capsules of Avinza 30 mg, 45 mg, 60 mg, 75 mg, 90 mg OR MORE than the plan allowance PER MONTH of 30 capsules of Avinza 120 mg? Yes No
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for 60 capsules/month of Avinza 30 mg, 45 mg, 60 mg, 75 mg, 90 mg OR 30 capsules/month of Avinza 120 mg.]

13 Does the patient require use of MORE than the plan allowance PER MONTH of 90 films of Belbuca 75 mcg, 150 mcg, 300 mcg, 450 mcg OR MORE than the plan allowance PER MONTH of 60 films of Belbuca 600 mcg, 750 mcg, 900 mcg? Yes No
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for 90 films/month of Belbuca 75 mcg, 150 mcg, 300 mcg, 450 mcg OR 60 films/month of Belbuca 600 mcg, 750 mcg, 900 mcg.]

14 Does the patient require use of MORE than the plan allowance PER MONTH of 8 patches of Butrans 5 mcg/hr, 7.5 mcg/hr, 10 mcg/hr OR MORE than the plan allowance PER MONTH of 4 patches of Butrans 15 mcg/hr, 20 mcg/hr? Yes No
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for 8 patches/month of Butrans 5 mcg/hr, 7.5 mcg/hr, 10 mcg/hr OR 4 patches/month of Butrans 15 mcg/hr, 20 mcg/hr.]

15 Does the patient require use of MORE than the plan allowance PER MONTH of 60 units of ConZip 100 mg, tramadol ER 100 mg, 150 mg, or Ultram ER 100 mg, OR MORE than the plan Yes No

allowance PER MONTH of 30 units of ConZip 200 mg, 300 mg, or tramadol ER 200 mg, 300 mg, or Ultram ER 200 mg, 300 mg?
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for 60 units/month of ConZip 100 mg, tramadol ER 100 mg, 150 mg, or Ultram ER 100 mg, OR 30 units/month of ConZip 200 mg, 300 mg, or tramadol ER 200 mg, 300 mg, or Ultram ER 200 mg, 300 mg.]

16 Does the patient require use of MORE than the plan allowance PER MONTH of 20 patches of Duragesic 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hr OR MORE than the plan allowance PER MONTH of 10 patches of Duragesic 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr, 87.5 mcg/hr, 100 mcg/hr? Yes No
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for 20 patches/month of Duragesic 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hr OR 10 patches/month of Duragesic 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr, 87.5 mcg/hr, 100 mcg/hr.]

17 Does the patient require use of MORE than the plan allowance PER MONTH of 90 capsules of Embeda 20 mg/0.8 mg, 30 mg/1.2 mg OR MORE than the plan allowance PER MONTH of 60 capsules of Embeda 50 mg/2 mg, 60 mg/2.4 mg, 80 mg/3.2 mg, 100 mg/4 mg? Yes No
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for 90 capsules/month of Embeda 20 mg/0.8 mg, 30 mg/1.2 mg OR 60 capsules/month of Embeda 50 mg/2 mg, 60 mg/2.4 mg, 80 mg/3.2 mg, 100 mg/4 mg.]

18 Does the patient require use of MORE than the plan allowance PER MONTH of 60 tablets of Exalgo 8 mg, 12 mg, 16 mg OR MORE than the plan allowance PER MONTH of 30 tablets of Exalgo 32 mg? Yes No
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for 60 tablets/month of Exalgo 8 mg, 12 mg, 16 mg OR 30 tablets/month of Exalgo 32 mg.]

19 Does the patient require use of MORE than the plan allowance PER MONTH of any of the following: A) 90 capsules of Kadian 10 mg, 20 mg, 30 mg, 40 mg, B) 60 capsules of Kadian 50 mg, 60 mg, 80 mg, 100 mg, C) 30 capsules of Kadian 200 mg? Yes No
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 90 capsules/month of Kadian 10 mg, 20 mg, 30 mg, 40 mg, B) 60 capsules/month of Kadian 50 mg, 60 mg, 80 mg, 100 mg, C) 30 capsules/month of Kadian 200 mg.]

20 Does the patient require use of MORE than the plan allowance PER MONTH of any of the following: A) 120 tablets of Arymo ER 15 mg, 30 mg or MorphaBond ER 15 mg, 30 mg or MS Contin 15 mg, 30 mg, B) 90 tablets of Arymo ER 60 mg or MorphaBond ER 60 mg or MS Contin 60 mg, C) 60 tablets of MorphaBond ER 100 mg or MS Contin 100 mg, 200 mg? Yes No
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 120 tablets/month of Arymo ER 15 mg, 30 mg or MorphaBond ER 15 mg, 30 mg or MS Contin 15 mg, 30 mg, B) 90 tablets/month of Arymo ER 60 mg or MorphaBond ER 60 mg or MS Contin 60 mg, C) 60 tablets/month of MorphaBond ER 100 mg or MS Contin 100 mg, 200 mg.]

21	Does the patient require use of MORE than the plan allowance PER MONTH of 90 tablets of Nucynta ER 50 mg, 100 mg, 150 mg OR MORE than the plan allowance PER MONTH of 60 tablets of Nucynta ER 200 mg, 250 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 90 tablets/month of Nucynta ER 50 mg, 100 mg, 150 mg OR 60 tablets/month of Nucynta ER 200 mg, 250 mg.]	Yes	No
22	Does the patient require use of MORE than the plan allowance PER MONTH of 90 tablets of Opana ER 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, OR MORE than the plan allowance PER MONTH of 60 tablets of Opana ER 30 mg, 40 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 90 tablets/month of Opana ER 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, OR 60 tablets/month of Opana ER 30 mg, 40 mg.]	Yes	No
23	Does the patient require use of MORE than the plan allowance PER MONTH of 90 tablets of OxyContin 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, OR MORE than the plan allowance PER MONTH of 60 tablets of OxyContin 60 mg, 80 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 90 tablets/month of OxyContin 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, OR 60 tablets/month of OxyContin 60 mg, 80 mg.]	Yes	No
24	Does the patient require use of MORE than the plan allowance PER MONTH of 90 tablets of Targiniq ER 10 mg/5 mg, 20 mg/10 mg OR MORE than the plan allowance PER MONTH of 60 tablets of Targiniq ER 40 mg/20 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 90 tablets/month of Targiniq ER 10 mg/5 mg, 20 mg/10 mg OR 60 tablets/month of Targiniq ER 40 mg/20 mg.]	Yes	No
25	Does the patient require use of MORE than the plan allowance PER MONTH of 90 capsules of Xtampza ER? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 90 capsules/month of Xtampza ER.]	Yes	No
26	Does the patient require use of MORE than the plan allowance PER MONTH of 90 capsules of Troxyca ER 10 mg/1.2 mg, 20 mg/2.4 mg, 30 mg/3.6 mg, 40 mg/4.8 mg OR MORE than the plan allowance PER MONTH of 60 capsules of Troxyca ER 60 mg/7.2 mg, 80 mg/9.6 mg? [RPh Note: If yes, then deny and enter a partial approval for 90 capsules/month of Troxyca ER 10 mg/1.2 mg, 20 mg/2.4 mg, 30 mg/3.6 mg, 40 mg/4.8 mg OR 60 capsules/month of Troxyca ER 60 mg/7.2 mg, 80 mg/9.6 mg.]	Yes	No

Mapping Instructions			
	YES	**NO**	**DENIAL REASONS – DO NOT USE FOR MEDICARE PART D**
1.	Approve, 12 months, No set post	Go to 2	

	limit quantity [Enter approval for quantity of 999999.]		
2.	Go to 3	Deny	You do not meet the requirements of your plan. Your plan covers this drug when you meet one of the following conditions: - You have been taking an opioid and you are using the drug for chronic pain that is severe enough that you need daily, around-the-clock, long-term treatment - You have pain due to cancer, sickle cell disease, or a terminal condition - Your pain is being managed through hospice or palliative care Your request has been denied based on the information we have. [Short Description: No approvable diagnosis.]
3.	Go to 4	Deny	You do not meet the requirements of your plan. Your plan covers this drug when you can safely take the drug based on your history of opioid use. Your request has been denied based on the information we have. [Short Description: Patient cannot safely take requested dose.]
4.	Go to 5	Deny	You do not meet the requirements of your plan. Your plan covers this drug when you will be monitored regularly. Your request has been denied based on the information we have. [Short Description: Patient not monitored regularly for opioid use disorder.]
5.	Go to 6	Deny	You do not meet the requirements of your plan. Your plan covers this drug when you meet all of these conditions: - Your pain will be checked the first month after your initial prescription or after a dose increase and every 3 months after that - The benefits outweigh the risks of taking the medication Your request has been denied based on the information we have. [Short Description: Patient's pain is not being reassessed.]
6.	Go to 8	Go to 7	
7.	Go to 8	Deny	You do not meet the requirements of your plan. Your plan covers this drug when you have one of these conditions: - You have already been taking an extended-release opioid drug for at least 30 days - You have taken an immediate-release opioid for at least one week Your request has been denied based on the information we have. [Short Description: No 30-day ER or 7-day IR opioid in history.]
8.	1=20; 2=12; 3=13; 4=14; 5=15; 6=10; 7=16; 8=17; 9=18; 10=9; 11=19; 12=10; 13=10; 14=10; 15=20; 16=20; 17=21; 18=22; 19=23; 20=24; 21=15; 22=26;	N/A	

	23=15; 24=9; 25=25; 26=9		
9.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 6 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 90 units/month of Zohydro ER 10 mg, 15 mg, 20 mg, 30 mg, 40 mg OR Vantrela ER 15 mg, 30 mg, 45 mg - 60 units/month of Hysingla ER 20 mg, 30 mg, 40 mg, 60 mg, 80 mg, 100 mg OR Zohydro ER 50 mg OR Vantrela ER 60 mg, 90 mg - 30 units/month of Hysingla ER 120 mg You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
10.	Deny	Go to 11	You do not meet the requirements of your plan. Your plan covers this drug when you meet all of these conditions: - You are not using the drug for detoxification treatment - You are not using the drug as part of a treatment plan for opioid/substance abuse or addiction Your request has been denied based on the information we have. [Short Description: Should not be used for opioid/substance abuse or addiction.]
11.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 6 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 120 tablets/month of Dolophine 5 mg or Methadone 5 mg - 90 tablets/month of Dolophine 10 mg or Methadone 10 mg - 600 mL/month of Methadone 5 mg/5 mL oral solution - 450 mL/month of Methadone 10 mg/5 mL oral solution - 90 mL/month of Methadone 10 mg/mL Intensol solution - 40 mL (2 multidose vials) of Methadone 200 mg/20 mL injection You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
12.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 6 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 60 capsules/month of Avinza 30 mg, 45 mg, 60 mg, 75 mg, 90 mg - 30 capsules/month of Avinza 120 mg You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
13.	Deny RPh Note: For the denial verbiage, only include the requested drug.	Approve, 6 months See Opioid Analgesics ER Quantity Limits	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 90 films/month of Belbuca 75 mcg, 150 mcg, 300 mcg, or 450 mcg - 60 films/month of Belbuca 600 mcg, 750 mcg, or 900 mcg You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the

	Remove all the other drugs from the verbiage.	Chart (Column C for 1 month supply or Column D for a 3 month supply)	requested drug and strength has been denied. [Short Description: Over max quantity.]
14.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 6 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 8 patches/month of Butrans 5 mcg/hr, 7.5 mcg/hr, or 10 mcg/hr - 4 patches/month of Butrans 15 mcg/hr or 20 mcg/hr You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
15.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 6 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 60 units/month of ConZip 100 mg, tramadol ER 100 mg, 150 mg, or Ultram ER 100 mg - 30 units/month of ConZip 200 mg, 300 mg, or tramadol ER 200 mg, 300 mg, or Ultram ER 200 mg, 300 mg You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
16.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 6 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 20 patches/month of Duragesic 12 mcg/hr, 25 mcg/hr, or 37.5 mcg/hr - 10 patches/month of Duragesic 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr, 87.5 mcg/hr, or 100 mcg/hr You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
17.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 6 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 90 capsules/month of Embeda 20/0.8 mg or 30/1.2 mg - 60 capsules/month of Embeda 50/2 mg, 60/2.4 mg, 80/3.2 mg, or 100/4 mg You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]

18.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 6 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 60 tablets/month of Exalgo 8 mg, 12 mg, or 16 mg - 30 tablets/month of Exalgo 32 mg You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
19.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 6 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 90 capsules/month of Kadian 10 mg, 20 mg, 30 mg, or 40 mg - 60 capsules/month of Kadian 50 mg, 60 mg, 80 mg, or 100 mg - 30 capsules/month of Kadian 200 mg You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
20.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 6 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 120 tablets/month of Arymo ER 15 mg, 30 mg or MorphaBond ER 15 mg, 30 mg or MS Contin 15 mg, 30 mg - 90 tablets/month of Arymo ER 60 mg or MorphaBond ER 60 mg or MS Contin 60 mg - 60 tablets/month of MorphaBond ER 100 mg or MS Contin 100 mg, 200 mg You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
21.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 6 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 90 tablets/month of Nucynta ER 50 mg, 100 mg, 150 mg - 60 tablets/month of Nucynta ER 200 mg, 250 mg You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
22.	Deny RPh Note: For the denial verbiage, only include the	Approve, 6 months See Opioid Analgesics ER	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 90 tablets/month of Opana ER 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg - 60 tablets/month of Opana ER, 30 mg, 40 mg You have been approved for the maximum quantity that your plan covers

	requested drug. Remove all the other drugs from the verbiage.	Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
23.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 6 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 90 tablets/month of OxyContin 10 mg, 15 mg, 20 mg, 30 mg, 40 mg - 60 tablets/month of OxyContin 60 mg, 80 mg You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
24.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 6 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 90 tablets/month of Targiniq ER 10 mg/5 mg, 20 mg/10 mg - 60 tablets/month of Targiniq ER 40 mg/20 mg You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
25.	Deny	Approve, 6 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to 90 capsules/month of the requested drug and strength. You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
26.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 6 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 90 capsules/month of Troxyca ER 10 mg/1.2 mg, 20 mg/2.4 mg, 30 mg/3.6 mg, 40 mg/4.8 mg - 60 capsules/month of Troxyca ER 60 mg/7.2 mg, 80 mg/9.6 mg You have been approved for the maximum quantity that your plan covers for a duration of 6 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]

Opioid Analgesics ER Quantity Limits Chart

Coverage is provided without prior authorization for a 30-day or 90-day supply of an extended-release opioid for a quantity that corresponds to ≤ 90 MME/day (when Step Therapy criteria met). Coverage for quantities that correspond to ≤ 200 MME/day (unless FDA-labeled strength/dose/frequency exceeds 200 MME/day) for a 30-day or 90-day supply is provided through prior authorization when coverage conditions are met.

These quantity limits should accumulate across all drugs of the same unit limit (i.e., drugs with 30 units accumulate together, drugs with 60 units accumulate together, etc).

		COLUMN A	COLUMN B	COLUMN C	COLUMN D
Drug/Strength	**Labeled Dosing**	**Initial 1 Month Limit* ≤ 90 MME/day (per 25 days)**	**Initial 3 Month Limit* ≤ 90 MME/day (per 75 days)**	**Post 1 Month Limit* ≤ 200 MME/day** (per 25 days)**	**Post 3 Month Limit* ≤ 200 MME/day** (per 75 days)**
Arymo ER 15 mg	q8-12h	90 tabs (45 MME/day)	270 tabs (45 MME/day)	120 tabs (60 MME/day)	360 tabs (60 MME/day)
Arymo ER 30 mg	q8-12h	90 tabs (90 MME/day)	270 tabs (90 MME/day)	120 tabs (120 MME/day)	360 tabs (120 MME/day)
Arymo ER 60 mg	q8-12h	0***	0***	90 tabs (180 MME/day)	270 tabs (180 MME/day)
Avinza 30 mg	q24h, MAX 1600 mg/day	30 caps (30 MME/day)	90 caps (30 MME/day)	60 caps (60 MME/day)	180 caps (60 MME/day)
Avinza 45 mg	q24h, MAX 1600 mg/day	30 caps (45 MME/day)	90 caps (45 MME/day)	60 caps (90 MME/day)	180 caps (90 MME/day)
Avinza 60 mg	q24h, MAX 1600 mg/day	30 caps (60 MME/day)	90 caps (60 MME/day)	60 caps (120 MME/day)	180 caps (120 MME/day)
Avinza 75 mg	q24h, MAX 1600 mg/day	30 caps (75 MME/day)	90 caps (75 MME/day)	60 caps (150 MME/day)	180 caps (150 MME/day)
Avinza 90 mg	q24h, MAX 1600 mg/day	30 caps (90 MME/day)	90 caps (90 MME/day)	60 caps (180 MME/day)	180 caps (180 MME/day)
Avinza 120 mg	q24h, MAX 1600 mg/day	0***	0***	30 caps (120 MME/day)	90 caps (120 MME/day)
Belbuca 75 mcg	q12h, MAX 900 mcg/12 hrs	60 films (4.5 MME/day)	180 films (4.5 MME/day)	90 films (6.75 MME/day)	270 films (6.75 MME/day)
Belbuca 150 mcg	q12h, MAX 900 mcg/12 hrs	60 films (9 MME/day)	180 films (9 MME/day)	90 films (13.5 MME/day)	270 films (13.5 MME/day)
Belbuca 300 mcg	q12h, MAX 900 mcg/12 hrs	60 films (18 MME/day)	180 films (18 MME/day)	90 films (27 MME/day)	270 films (27 MME/day)
Belbuca 450 mcg	q12h, MAX 900 mcg/12 hrs	60 films (27 MME/day)	180 films (27 MME/day)	90 films (40.5 MME/day)	270 films (40.5 MME/day)
Belbuca 600 mcg	q12h, MAX 900	0***	0***	60 films	180 films

	mcg/12 hrs			(36 MME/day)	(36 MME/day)
Belbuca 750 mcg	q12h, MAX 900 mcg/12 hrs	0***	0***	60 films (45 MME/day)	180 films (45 MME/day)
Belbuca 900 mcg	q12h, MAX 900 mcg/12 hrs	0***	0***	60 films (54 MME/day)	180 films (54 MME/day)
Butrans 5 mcg/hr	q7d, MAX 20 mcg/hr	4 patches (9 MME/day)	12 patches (9 MME/day)	8 patches (18 MME/day)	24 patches (18 MME/day)
Butrans 7.5 mcg/hr	q7d, MAX 20 mcg/hr	4 patches (13.5 MME/day)	12 patches (13.5 MME/day)	8 patches (27 MME/day)	24 patches (27 MME/day)
Butrans 10 mcg/hr	q7d, MAX 20 mcg/hr	4 patches (18 MME/day)	12 patches (18 MME/day)	8 patches (36 MME/day)	24 patches (36 MME/day)
Butrans 15 mcg/hr	q7d, MAX 20 mcg/hr	0***	0***	4 patches (27 MME/day)	12 patches (27 MME/day)
Butrans 20 mcg/hr	q7d, MAX 20 mcg/hr	0***	0***	4 patches (36 MME/day)	12 patches (36 MME/day)
ConZip 100 mg	qd, MAX 300 mg/day	30 caps (10 MME/day)	90 caps (10 MME/day)	60 caps (20 MME/day)	180 caps (20 MME/day)
ConZip 200 mg	qd, MAX 300 mg/day	0***	0***	30 caps (20 MME/day)	90 caps (20 MME/day)
ConZip 300 mg	qd, MAX 300 mg/day	0***	0***	30 caps (30 MME/day)	90 caps (30 MME/day)
Dolophine 5 mg	q8-12h	90 tabs (60 MME/day)	270 tabs (60 MME/day)	120 tabs (80 MME/day)	360 tabs (80 MME/day)
Dolophine 10 mg	q8-12h	60 tabs (80 MME/day)	180 tabs (80 MME/day)	90 tabs (120 MME/day)	270 tabs (120 MME/day)
Duragesic 12 mcg/hr	q72h	10 patches (28.8 MME/day)	30 patches (28.8 MME/day)	20 patches (57.6 MME/day)	60 patches (57.6 MME/day)
Duragesic 25 mcg/hr	q72h	10 patches (60 MME/day)	30 patches (60 MME/day)	20 patches (120 MME/day)	60 patches (120 MME/day)
Duragesic 37.5 mcg/hr	q72h	10 patches (90 MME/day)	30 patches (90 MME/day)	20 patches (180 MME/day)	60 patches (180 MME/day)
Duragesic 50 mcg/hr	q72h	0***	0***	10 patches (120 MME/day)	30 patches (120 MME/day)
Duragesic 62.5 mcg/hr	q72h	0***	0***	10 patches (150 MME/day)	30 patches (150 MME/day)
Duragesic 75 mcg/hr	q72h	0***	0***	10 patches (180 MME/day)	30 patches (180 MME/day)
Duragesic 87.5 mcg/hr	q72h	0***	0***	10 patches (210 MME/day)	30 patches (210 MME/day)
Duragesic 100 mcg/hr	q72h	0***	0***	10 patches (240 MME/day)	30 patches (240 MME/day)
Embeda 20 mg/0.8 mg	q12-24h	60 caps (40 MME/day)	180 caps (40 MME/day)	90 caps (60 MME/day)	270 caps (60 MME/day)
Embeda 30 mg/1.2 mg	q12-24h	60 caps (60 MME/day)	180 caps (60 MME/day)	90 caps (90 MME/day)	270 caps (90 MME/day)
Embeda 50 mg/2 mg	q12-24h	30 caps (50 MME/day)	90 caps (50 MME/day)	60 caps (100 MME/day)	180 caps (100 MME/day)
Embeda 60 mg/2.4 mg	q12-24h	30 caps (60 MME/day)	90 caps (60 MME/day)	60 caps (120 MME/day)	180 caps (120 MME/day)
Embeda 80 mg/3.2 mg	q12-24h	30 caps (80 MME/day)	90 caps (80 MME/day)	60 caps (160 MME/day)	180 caps (160 MME/day)
Embeda 100 mg/4 mg	q12-24h	0***	0***	60 caps (200 MME/day)	180 caps (200 MME/day)
Exalgo 8 mg	qd	30 tabs (32 MME/day)	90 tabs (32 MME/day)	60 tabs (64 MME/day)	180 tabs (64 MME/day)
Exalgo 12 mg	qd	30 tabs (48 MME/day)	90 tabs (48 MME/day)	60 tabs (96 MME/day)	180 tabs (96 MME/day)
Exalgo 16 mg	qd	30 tabs (64 MME/day)	90 tabs (64 MME/day)	60 tabs (128 MME/day)	180 tabs (128 MME/day)

Exalgo 32 mg	qd	0***	0***	30 tabs (128 MME/day)	90 tabs (128 MME/day)
Hysingla ER 20 mg	q24h	30 tabs (20 MME/day)	90 tabs (20 MME/day)	60 tabs (40 MME/day)	180 tabs (40 MME/day)
Hysingla ER 30 mg	q24h	30 tabs (30 MME/day)	90 tabs (30 MME/day)	60 tabs (60 MME/day)	180 tabs (60 MME/day)
Hysingla ER 40 mg	q24h	30 tabs (40 MME/day)	90 tabs (40 MME/day)	60 tabs (80 MME/day)	180 tabs (80 MME/day)
Hysingla ER 60 mg	q24h	30 tabs (60 MME/day)	90 tabs (60 MME/day)	60 tabs (120 MME/day)	180 tabs (120 MME/day)
Hysingla ER 80 mg	q24h	30 tabs (80 MME/day)	90 tabs (80 MME/day)	60 tabs (160 MME/day)	180 tabs (160 MME/day)
Hysingla ER 100 mg	q24h	0***	0***	60 tabs (200 MME/day)	180 tabs (200 MME/day)
Hysingla ER 120 mg	q24h	0***	0***	30 tabs (120 MME/day)	90 tabs (120 MME/day)
Kadian 10 mg	q12-24h	60 caps (20 MME/day)	180 caps (20 MME/day)	90 caps (30 MME/day)	270 caps (30 MME/day)
Kadian 20 mg	q12-24h	60 caps (40 MME/day)	180 caps (40 MME/day)	90 caps (60 MME/day)	270 caps (60 MME/day)
Kadian 30 mg	q12-24h	60 caps (60 MME/day)	180 caps (60 MME/day)	90 caps (90 MME/day)	270 caps (90 MME/day)
Kadian 40 mg	q12-24h	60 caps (80 MME/day)	180 caps (80 MME/day)	90 caps (120 MME/day)	270 caps (120 MME/day)
Kadian 50 mg	q12-24h	30 caps (50 MME/day)	90 caps (50 MME/day)	60 caps (100 MME/day)	180 caps (100 MME/day)
Kadian 60 mg	q12-24h	30 caps (60 MME/day)	90 caps (60 MME/day)	60 caps (120 MME/day)	180 caps (120 MME/day)
Kadian 80 mg	q12-24h	30 caps (80 MME/day)	90 caps (80 MME/day)	60 caps (160 MME/day)	180 caps (160 MME/day)
Kadian 100 mg	q12-24h	0***	0***	60 caps (200 MME/day)	180 caps (200 MME/day)
Kadian 200 mg	q12-24h	0***	0***	30 caps (200 MME/day)	90 caps (200 MME/day)
Methadone 5 mg****	q8-12h	90 tabs (60 MME/day)	270 tabs (60 MME/day)	120 tabs (80 MME/day)	360 tabs (80 MME/day)
Methadone 10 mg****	q8-12h	60 tabs (80 MME/day)	180 tabs (80 MME/day)	90 tabs (240 MME/day)	270 tabs (240 MME/day)
Methadone 200 mg/20 mL injection****	q8-12h	20 mL (1 multidose vial) (26.7 MME/day)	60 mL (3 multidose vials) (26.7 MME/day)	40 mL (2 multidose vials) (53.3 MME/day)	120 mL (6 multidose vials) (53.3 MME/day)
Methadone 10 mg/mL Intensol soln****	q8-12h	60 mL (80 MME/day)	180 mL (80 MME/day)	90 mL (240 MME/day)	270 mL (240 MME/day)
Methadone 5 mg/5 mL Oral soln****	q8-12h	450 mL (60 MME/day)	1350 mL (60 MME/day)	600 mL (80 MME/day)	1800 mL (80 MME/day)
Methadone 10 mg/5 mL Oral soln****	q8-12h	300 mL (80 MME/day)	900 mL (80 MME/day)	450 mL (240 MME/day)	1350 mL (240 MME/day)
MorphaBond ER 15 mg	q8-12h	90 tabs (45 MME/day)	270 tabs (45 MME/day)	120 tabs (60 MME/day)	360 tabs (60 MME/day)
MorphaBond ER 30 mg	q8-12h	90 tabs (90 MME/day)	270 tabs (90 MME/day)	120 tabs (120 MME/day)	360 tabs (120 MME/day)
MorphaBond ER 60 mg	q8-12h	0***	0***	90 tabs (180 MME/day)	270 tabs (180 MME/day)
MorphaBond ER 100 mg	q8-12h	0***	0***	60 tabs (200 MME/day)	180 tabs (200 MME/day)
MS Contin 15 mg	q8-12h	90 tabs (45 MME/day)	270 tabs (45 MME/day)	120 tabs (60 MME/day)	360 tabs (60 MME/day)
MS Contin 30 mg	q8-12h	90 tabs	270 tabs	120 tabs	360 tabs

		(90 MME/day)	(90 MME/day)	(120 MME/day)	(120 MME/day)
MS Contin 60 mg	q8-12h	0***	0***	90 tabs (180 MME/day)	270 tabs (180 MME/day)
MS Contin 100 mg	q8-12h	0***	0***	60 tabs (200 MME/day)	180 tabs (200 MME/day)
MS Contin 200 mg	q8-12h	0***	0***	60 tabs (400 MME/day)	180 tabs (400 MME/day)
Nucynta ER 50 mg	q12h, MAX 500 mg/day	60 tabs (40 MME/day)	180 tabs (40 MME/day)	90 tabs (60 MME/day)	270 tabs (60 MME/day)
Nucynta ER 100 mg	q12h, MAX 500 mg/day	60 tabs (80 MME/day)	180 tabs (80 MME/day)	90 tabs (120 MME/day)	270 tabs (120 MME/day)
Nucynta ER 150 mg	q12h, MAX 500 mg/day	0***	0***	90 tabs (180 MME/day)	270 tabs (180 MME/day)
Nucynta ER 200 mg	q12h, MAX 500 mg/day	0***	0***	60 tabs (160 MME/day)	180 tabs (160 MME/day)
Nucynta ER 250 mg	q12h, MAX 500 mg/day	0***	0***	60 tabs (200 MME/day)	180 tabs (200 MME/day)
Opana ER 5 mg	q12h	60 tabs (30 MME/day)	180 tabs (30 MME/day)	90 tabs (45 MME/day)	270 tabs (45 MME/day)
Opana ER 7.5 mg	q12h	60 tabs (45 MME/day)	180 tabs (45 MME/day)	90 tabs (67.5 MME/day)	270 tabs (67.5 MME/day)
Opana ER 10 mg	q12h	60 tabs (60 MME/day)	180 tabs (60 MME/day)	90 tabs (90 MME/day)	270 tabs (90 MME/day)
Opana ER 15 mg	q12h	60 tabs (90 MME/day)	180 tabs (90 MME/day)	90 tabs (135 MME/day)	270 tabs (135 MME/day)
Opana ER 20 mg	q12h	0***	0***	90 tabs (180 MME/day)	270 tabs (180 MME/day)
Opana ER 30 mg	q12h	0***	0***	60 tabs (180 MME/day)	180 tabs (180 MME/day)
Opana ER 40 mg	q12h	0***	0***	60 tabs (240 MME/day)	180 tabs (240 MME/day)
OxyContin 10 mg	q12h	60 tabs (30 MME/day)	180 tabs (30 MME/day)	90 tabs (45 MME/day)	270 tabs (45 MME/day)
OxyContin 15 mg	q12h	60 tabs (45 MME/day)	180 tabs (45 MME/day)	90 tabs (67.5 MME/day)	270 tabs (67.5 MME/day)
OxyContin 20 mg	q12h	60 tabs (60 MME/day)	180 tabs (60 MME/day)	90 tabs (90 MME/day)	270 tabs (90 MME/day)
OxyContin 30 mg	q12h	60 tabs (90 MME/day)	180 tabs (90 MME/day)	90 tabs (135 MME/day)	270 tabs (135 MME/day)
OxyContin 40 mg	q12h	0***	0***	90 tabs (180 MME/day)	270 tabs (180 MME/day)
OxyContin 60 mg	q12h	0***	0***	60 tabs (180 MME/day)	180 tabs (180 MME/day)
OxyContin 80 mg	q12h	0***	0***	60 tabs (240 MME/day)	180 tabs (240 MME/day)
Targiniq ER 10 mg/5 mg	q12h, MAX 80 mg/40 mg (40 mg/20 mg q12h)	60 tabs (30 MME/day)	180 tabs (30 MME/day)	90 tabs (45 MME/day)	270 tabs (45 MME/day)
Targiniq ER 20 mg/10 mg	q12h, MAX 80 mg/40 mg (40 mg/20 mg q12h)	60 tabs (60 MME/day)	180 tabs (60 MME/day)	90 tabs (90 MME/day)	270 tabs (90 MME/day)
Targiniq ER 40 mg/20 mg	q12h, MAX 80 mg/40 mg (40 mg/20 mg q12h)	0***	0***	60 tabs (120 MME/day)	180 tabs (120 MME/day)
Tramadol ER 100 mg	qd, MAX 300 mg/day	30 tabs (10 MME/day)	90 tabs (10 MME/day)	60 tabs (20 MME/day)	180 tabs (20 MME/day)
Tramadol ER 150 mg	qd, MAX 300 mg/day	30 caps (15 MME/day)	90 caps (15 MME/day)	60 caps (30 MME/day)	180 caps (30 MME/day)
Tramadol ER 200 mg	qd, MAX 300 mg/day	0***	0***	30 tabs	90 tabs

				(20 MME/day)	(20 MME/day)
Tramadol ER 300 mg	qd, MAX 300 mg/day	0***	0***	30 tabs (30 MME/day)	90 tabs (30 MME/day)
Troxyca ER 10 mg/1.2 mg	q12h	60 caps (30 MME/day)	180 caps (30 MME/day)	90 caps (45 MME/day)	270 caps (45 MME/day)
Troxyca ER 20 mg/2.4 mg	q12h	60 caps (60 MME/day)	180 caps (60 MME/day)	90 caps (90 MME/day)	270 caps (90 MME/day)
Troxyca ER 30 mg/3.6 mg	q12h	60 caps (90 MME/day)	180 caps (90 MME/day)	90 caps (135 MME/day)	270 caps (135 MME/day)
Troxyca ER 40 mg/4.8 mg	q12h	0***	0***	90 caps (180 MME/day)	270 caps (180 MME/day)
Troxyca ER 60 mg/7.2 mg	q12h	0***	0***	60 caps (180 MME/day)	180 caps (180 MME/day)
Troxyca ER 80 mg/9.6 mg	q12h	0***	0***	60 caps (240 MME/day)	180 caps (240 MME/day)
Ultram ER 100 mg	qd, MAX 300 mg/day	30 tabs (10 MME/day)	90 tabs (10 MME/day)	60 tabs (20 MME/day	180 tabs (20 MME/day
Ultram ER 200 mg	qd, MAX 300 mg/day	0***	0***	30 tabs (20 MME/day)	90 tabs (20 MME/day)
Ultram ER 300 mg	qd, MAX 300 mg/day	0***	0***	30 tabs (30 MME/day)	90 tabs (30 MME/day)
Vantrela ER 15 mg	q12h, MAX 90 mg q12h (180 mg/day)	60 tabs (30 MME/day)	180 tabs (30 MME/day)	90 tabs (45 MME/day)	270 tabs (45 MME/day)
Vantrela ER 30 mg	q12h, MAX 90 mg q12h (180 mg/day)	60 tabs (60 MME/day)	180 tabs (60 MME/day)	90 tabs (90 MME/day)	270 tabs (90 MME/day)
Vantrela ER 45 mg	q12h, MAX 90 mg q12h (180 mg/day)	60 tabs (90 MME/day)	180 tabs (90 MME/day)	90 tabs (135 MME/day)	270 tabs (135 MME/day)
Vantrela ER 60 mg	q12h, MAX 90 mg q12h (180 mg/day)	0***	0***	60 tabs (120 MME/day)	180 tabs (120 MME/day)
Vantrela ER 90 mg	q12h, MAX 90 mg q12h (180 mg/day)	0***	0***	60 tabs (180 MME/day)	180 tabs (180 MME/day)
Xtampza ER 9 mg	q12h, MAX 288 mg/day	60 caps (30 MME/day)	180 caps (30 MME/day)	90 caps (45 MME/day)	270 caps (45 MME/day)
Xtampza ER 13.5 mg	q12h, MAX 288 mg/day	60 caps (45 MME/day)	180 caps (45 MME/day)	90 caps (67.5 MME/day)	270 caps (67.5 MME/day)
Xtampza ER 18 mg	q12h, MAX 288 mg/day	60 caps (60 MME/day)	180 caps (60 MME/day)	90 caps (90 MME/day)	270 caps (90 MME/day)
Xtampza ER 27 mg	q12h, MAX 288 mg/day	60 caps (90 MME/day)	180 caps (90 MME/day)	90 caps (135 MME/day)	270 caps (135 MME/day)
Xtampza ER 36 mg	q12h, MAX 288 mg/day	0***	0***	90 caps (180 MME/day)	270 caps (180 MME/day)
Zohydro ER 10 mg	q12h	60 caps (20 MME/day)	180 caps (20 MME/day)	90 caps (30 MME/day)	270 caps (30 MME/day)
Zohydro ER 15 mg	q12h	60 caps (30 MME/day)	180 caps (30 MME/day)	90 caps (45 MME/day)	270 caps (45 MME/day)
Zohydro ER 20 mg	q12h	60 caps (40 MME/day)	180 caps (40 MME/day)	90 caps (60 MME/day)	270 caps (60 MME/day)
Zohydro ER 30 mg	q12h	60 caps (60 MME/day)	180 caps (60 MME/day)	90 caps (90 MME/day)	270 caps (90 MME/day)
Zohydro ER 40 mg	q12h	60 caps (80 MME/day)	180 caps (80 MME/day)	90 caps (120 MME/day)	270 caps (120 MME/day)
Zohydro ER 50 mg	q12h	0***	0***	60 caps (100 MME/day)	180 caps (100 MME/day)

**The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing. Limits are set up as quantity versus time edits.*
***Unless minimum FDA-labeled strength/dose/frequency exceeds 200 MME/day.*
****The initial limit is zero. All requests for this drug and strength will be considered through post limit prior authorization.*
*****Calculating MME for methadone in clinical practice often involves a sliding-scale approach whereby the conversion factor increases with increasing dose.*