DURATION LIMIT WITH QUANTITY LIMIT AND POST LIMIT PRIOR AUTHORIZATION CRITERIA

DRUG CLASS **IMMEDIATE-RELEASE OPIOID ANALGESICS (BRAND AND GENERIC)***

(generic name, dosage form)

(codeine sulfate tablets)

(hydromorphone hydrochloride oral solution, suppositories, tablets)

(levorphanol tartrate tablets)

(meperidine hydrochloride oral solution, tablets)

(morphine sulfate oral soln, oral soln concentrate, suppositories, tablets)

(oxycodone hydrochloride capsules, oral soln, oral soln concentrate, tabs)

(oxymorphone hydrochloride tablets)

(pentazocine/naloxone tablets)

(tapentadol oral solution, tablets)

(tramadol hydrochloride oral solution, tablets)

Status: CVS Caremark Criteria
Type: Duration Limit; Initial Limit; Post Limit PA ***Ref # 2221-M***

** 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

Codeine Sulfate

Codeine sulfate tablets are indicated for the management of mild to moderate pain, where treatment with an opioid is appropriate and for which alternative treatments are inadequate.

Limitations of Use

Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve codeine sulfate tablets 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.

Hydromorphone Hydrochloride
Hydromorphone hydrochloride oral solution, suppositories, and tablets are indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.
Limitations of Use
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve hydromorphone hydrochloride oral solution, suppositories, and tablets 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.

Levorphanol Tartrate
Levorphanol tartrate tablets are indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.
Limitations of Use
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve levorphanol tartrate tablets 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.

Meperidine Hydrochloride
Meperidine hydrochloride is indicated for the management of acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.
Limitations of Use
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve meperidine hydrochloride oral solution and tablets 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.

Meperidine hydrochloride oral solution and tablets should not be used for treatment of chronic pain. Prolonged meperidine use may increase the risk of toxicity (e.g., seizures) from the accumulation of the meperidine metabolite, normeperidine.

Morphine Sulfate
Oral Solution
Morphine sulfate oral solution is indicated for the management of acute and chronic pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.
Morphine sulfate oral solution 100 mg per 5 mL (20 mg/mL) is indicated for the relief of acute and chronic pain in opioid-tolerant patients.
Suppositories
Morphine sulfate suppositories are indicated for the management of acute and chronic pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.
Tablets
Morphine sulfate tablets are indicated for the management of:
- Adults and pediatric patients weighing at least 50 kg with acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate
- Adults with chronic pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate

Limitations of Use
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve morphine sulfate products 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.

Nucynta (tapentadol)
Nucynta (tapentadol) is indicated for the management of acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate in adults.
Limitations of Use
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve Nucynta (tapentadol) 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.

Oxaydo (oxycodone hydrochloride)
Oxaydo (oxycodone hydrochloride) is indicated for the management of acute and chronic pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.
Limitations of Use
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve Oxaydo (oxycodone hydrochloride) 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.

Oxycodone Hydrochloride
Capsules and Tablets
Oxycodone hydrochloride capsules and tablets are indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.
Oral Concentrate and Oral Solution
Oxycodone hydrochloride oral concentrate and oral solution are indicated in adults for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.
Oxycodone hydrochloride oral solution 100 mg per 5 mL (20 mg/mL) is indicated for the relief of pain in opioid-tolerant patients.
Limitations of Use
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve oxycodone hydrochloride capsules, oral concentrate, oral solution, and tablets 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.

Oxymorphone Hydrochloride
Oxymorphone hydrochloride tablets are indicated for the management of acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.
Limitations of Use
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve oxymorphone hydrochloride tablets 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.

Pentazocine/Naloxone
Pentazocine and naloxone tablets are indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

Limitations of Use
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve pentazocine and naloxone tablets for use in patients for whom alternative treatment options (e.g., non-opioid analgesics):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

RoxyBond (oxycodone hydrochloride)
RoxyBond (oxycodone hydrochloride) is indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.
Limitations of Use
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve RoxyBond (oxycodone hydrochloride) 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.

Tramadol
Tramadol is indicated in adults for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.
Limitations of Use
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve tramadol for use in patients for whom alternative treatment options (e.g., non-opioid analgesics):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

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 patient can safely take the requested dose based on their history of opioid use. [Note: The lowest effective dosage should be prescribed for opioid naïve patients.]
  AND
- The patient has been evaluated and the patient will be monitored regularly for the development of opioid use disorder
  AND
  - The requested drug is being prescribed for moderate to severe CHRONIC pain where use of an opioid analgesic is appropriate. [Note: Chronic pain is generally defined as pain that typically lasts greater than 3 months.]
    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

  OR
  - The patient requires extended treatment beyond 7 days for moderate to severe ACUTE pain where use of an opioid analgesic is appropriate

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. Codeine sulfate is indicated for the management of mild to moderate pain, where treatment with an opioid is appropriate and for which alternative treatments are inadequate. Hydromorphone, levorphanol, oxycodone capsules and tablets, pentazocine/naloxone, and tramadol are indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. Oxycodone hydrochloride oral concentrate and oral solution are indicated in adults for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. Oxycodone hydrochloride oral solution 100 mg per 5 mL (20 mg/mL) is indicated for the relief of pain in opioid-tolerant patients. Morphine sulfate oral solution and tablets and Oxaydo are indicated for the management of acute and chronic pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. Morphine sulfate suppositories are indicated for the management of acute and chronic pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. Morphine sulfate tablets are indicated for the management of adults and pediatric patients weighing at least 50 kg with acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate, and for adults with chronic pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. Oxymorphone, meperidine, and tapentadol are indicated for the relief of acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve immediate-release opioids for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products) 1) have not been tolerated or are not expected to be tolerated, or 2) have not provided adequate analgesia or are not expected to provide adequate analgesia.[1-23]

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 an 8-day supply of an immediate-release (IR) or 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 IR Quantity Limits Chart below).

If the patient does not have at least an 8-day supply of an IR or ER opioid agent indicated for the management of pain within prescription claim history in the past 90 days (i.e., this is the patient's first fill of an opioid) and the incoming prescription drug is being filled for more than a 7-day supply, then the claim will reject with a message indicating that the patient can receive a 7-day supply (until 7-days of therapy in a 90-day period have been filled) or submit a prior

authorization (PA) for additional quantities. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit. If the incoming prescription drug is being filled for less than a 7-day supply, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below).

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.[27] 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.[25] The NCCN Palliative Care pain management recommendation is to treat according to NCCN guidelines for adult cancer pain.[24] 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, acute pain duration limits 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.[29] 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, acute pain duration limits and post limit quantities will not apply.

According to the CDC Guideline for Prescribing Opioids for Chronic Pain, long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should not prescribe a greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.[27] Coverage is provided for up to 7 days initially to provide an amount sufficient for the treatment of acute pain.

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, then clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.[27]

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.[27]

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, carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 MME/day, and avoid increasing the dosage to ≥90 MME/day or carefully justify a decision to titrate the dosage to ≥90 MME/day.[27] The immediate-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).[26] The immediate-release opioid drug post limit quantities are set to encompass the usual dosage and frequency range recommendations in labeling, or up to 1.5 times the initial quantity limit, without exceeding 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.

Although meperidine is commonly used for acute pain relief, use of this drug as first-line opiate therapy is discouraged because of central excitatory toxicity of the metabolite (normeperidine). Because of extensive first-pass metabolism in the liver of normeperidine, the risk of excitatory toxicity is increased with oral administration of meperidine. Therefore, oral therapy is discouraged. Use of meperidine for chronic pain is discouraged because of its short duration of effect and risk of accumulation. Meperidine should be limited to short-term (i.e., a few days) because of the risk of accumulation of the toxic normeperidine metabolite with repeated or large doses.[22] The initial quantity limit for meperidine will be set at a quantity that corresponds to a 72 hour supply (allows for weekend coverage, if necessary). The post limit quantity will be set at a quantity that corresponds to a 96 hour supply, allowing one additional day of therapy beyond the initial quantity limit.

The limit for codeine is set reflective of its questionable role in chronic or moderate to severe pain management as compared to other opioid medications. When prescribing codeine, healthcare providers should choose the lowest effective dose for the shortest period of time. The initial quantity limit for codeine will be set at a quantity that corresponds to a one-week supply. The post limit quantity will be set at a quantity that corresponds to a two-week supply.

Pentazocine is not commonly used in clinical practice due to the occurrence of dysphoric reactions and its relatively short duration of action.[28] According to the NCCN Guidelines for Adult Cancer Pain, mixed agonist-antagonist drugs (including pentazocine) have limited usefulness and are not recommended for the treatment of cancer pain.[25] The one month and three month limits for pentazocine/naloxone are set as the same based on these significant safety concerns.

Studies of opioid therapy for chronic pain that did not have a non-opioid control group have found that although many patients discontinue opioid therapy for chronic non-cancer 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.[27] Therefore, patients who meet the prior authorization criteria for chronic pain will be approved for 6 months.

REFERENCES

1. Codeine Sulfate tablets [package insert]. Philadelphia, PA: Lannett Company, Inc.; November 2019.
2. Dilaudid oral solution, tablets [package insert]. Coventry, RI: Rhodes Pharmaceuticals L.P.; March 2021.
3. Hydromorphone HCl oral solution, tablets [package insert] Coventry, RI: Rhodes Pharmaceuticals L.P.; March 2021.
4. Hydromorphone HCl suppositories [package insert]. Minneapolis, MN: Perrigo; November 2020.
5. Levorphanol Tartrate [package insert]. Solana Beach, CA: Sentynl Therapeutics, Inc.; January 2021.
6. Meperidine Hydrochloride oral solution, tablets [package insert]. Eatontown, NJ: West-Ward Pharmaceuticals Corp.; March 2021.
7. Morphine Sulfate 10 mg/5 mL, 20 mg/5 mL, 100 mg/5 mL (20 mg/mL) oral solution [package insert]. Coventry, RI: Rhodes Pharmaceuticals L.P.; March 2021.
8. Morphine Sulfate suppositories [package insert]. Minneapolis, MN: Perrigo; March 2019.
9. Morphine Sulfate tablets [package insert]. Berkeley Heights, NJ: Hikma Pharmaceuticals USA Inc..; June 2021.
10. Nucynta oral solution [package insert]. Stoughton, MA: Collegium Pharmaceutical, Inc.; March 2021.
11. Nucynta tablets [package insert]. Stoughton, MA: Collegium Pharmaceutical, Inc.; March 2021.
12. Oxaydo [package insert]. Wayne, PA: Zyla Life Sciences US Inc.; March 2021.

13. Oxycodone Hydrochloride tablets [package insert]. Brookhaven, NY: Amneal Pharmaceuticals of NY LLC; April 2021.
14. Oxycodone Hydrochloride capsules [package insert]. Philadelphia, PA: Lannett Company, Inc.; November 2019.
15. Oxycodone Hydrochloride 5 mg/5 mL, 100 mg/5 mL (20 mg/mL) oral solution [package insert]. Allentown, PA: Genus Lifesciences Inc.; July 2021.
16. Oxymorphone [package insert]. Newtown, PA: KVK-Tech, Inc.; February 2021.
17. Pentazocine and Naloxone [package insert]. Parsippany, NJ: Actavis Pharma, Inc; July 2020.
18. Qdolo [package insert]. Athens, GA: Athena Bioscience, LLC; September 2021.
19. RoxyBond [package insert]. Basking Ridge, NJ: Daiichi Sankyo, Inc.; March 2021.
20. Tramadol [package insert]. Tampa, FL: Trupharma, LLC; April 2019
21. Ultram [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc.; September 2021.
22. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Hudson, OH: Wolters Kluwer Clinical Drug Information, Inc. http://online.lexi.com/. Accessed December 2021.
23. Micromedex (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. http://www.micromedexsolutions.com/. Accessed December 2021.
24. Palliative Care. NCCN Guidelines version 2.2021. Available at: http://www.nccn.org/professionals/physician_gls/pdf/palliative.pdf. Accessed December 2021.
25. Adult Cancer Pain. NCCN Guidelines version 2.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/pain.pdf. Accessed December 2021.
26. 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.
27. 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 December 2021.
28. Clinical Pharmacology [database online]. Tampa, FL: Elsevier/Gold Standard; http://clinicalpharmacology.com/ [available with subscription]. Accessed December 2021.
29. 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 December 2021.

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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.

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 an 8-day supply of an immediate-release (IR) or 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 IR Quantity Limits Chart below).

If the patient does not have at least an 8-day supply of an IR or ER opioid agent indicated for the management of pain within prescription claim history in the past 90 days (i.e., this is the patient's first fill of an opioid) and the incoming prescription drug is being filled for more than a 7-day supply, then the claim will reject with a message indicating that the patient can receive a 7-day supply (until 7-days of therapy in a 90-day period have been filled). A prior authorization (PA) may be submitted for additional quantities. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit. If the incoming prescription drug is being filled for less than a 7-day supply, then the initial quantity limit criteria will apply until 7 days of therapy in a 90-day period have been filled. (see Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below). If the patient is exceeding 7 days of opioid therapy for the first time in a 90-day period, then the claim will reject with a message indicating that the patient must submit a prior authorization (PA) for additional quantities. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

LIMIT CRITERIA*
Neither acute pain duration limits nor quantity limits apply if the patient has a drug in claims history in the past year that indicates the patient is being treated for cancer or sickle cell disease. In addition, neither acute pain duration limits nor quantity limits will apply if a prescription claim is submitted with an ICD 10 diagnosis code indicating cancer, sickle cell disease, or palliative care, if the patient has an ICD 10 diagnosis code indicating cancer or palliative care in their member health profile in the past 365 days, if the patient has a history of an ICD 10 diagnosis code indicating sickle cell disease in their member health profile, or if a prescription claim is submitted using a hospice patient residence code.

ACUTE PAIN DURATION LIMIT:
The acute pain duration limit portion of this program applies to patients identified with potential first fills of immediate-release opioid prescriptions for the treatment of non-cancer, non-sickle cell, non-hospice, and non-palliative care related pain. Patients are limited to a maximum of a 7-day supply per fill up to 7 days of therapy in a 90-day period. When the patient exceeds 7 days of opioid therapy for the first time in a 90-day period, prior authorization is required.

If the patient does not have at least an 8-day supply of an IR or ER opioid agent indicated for the management of pain within prescription claim history in the past 90 days (i.e., this is the patient's first fill of an opioid) and the incoming prescription drug is being filled for more than a 7-day supply, then the claim will reject with a message indicating that the patient can receive a 7-day supply (until 7-days of therapy in a 90-day period have been filled). A prior authorization (PA) may be submitted for additional quantities. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit. If the incoming prescription drug is being filled for less than a 7-day supply, then the initial quantity limit criteria will apply until 7 days of therapy in a 90-day period have been filled. (see Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below). If the patient is exceeding 7 days of opioid therapy for the first time in a 90-day period, then the claim will reject with a message indicating that the patient must submit a prior authorization

(PA) for additional quantities. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

INITIAL QUANTITY LIMIT:
Morphine milligram equivalent (MME) quantity limits for IR opioids provide coverage for an initial amount of a monthly quantity that corresponds to 90 MME or less per day. Coverage is provided for up to the initial quantity limit per Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below. Prior authorization review is required to determine coverage for additional quantities above the initial limit.

**Acute Pain Duration Limit logic will apply first, followed by initial quantity limit logic.*

CRITERIA FOR APPROVAL

1	Is the requested drug being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through hospice or palliative care? [If yes, then no further questions.]	Yes	No
2	Can the patient safely take the requested dose based on their history of opioid use? [Note: The lowest effective dosage should be prescribed for opioid naive patients.] [If no, then no further questions.]	Yes	No
3	Has the patient been evaluated and will the patient be monitored regularly for the development of opioid use disorder? [If no, then no further questions.]	Yes	No
4	Is the requested drug being prescribed for moderate to severe CHRONIC pain where use of an opioid analgesic is appropriate? [Note: Chronic pain is generally defined as pain that typically lasts greater than 3 months.] [If no, then skip to question 7.]	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? [If no, then no further questions.]	Yes	No
6	Which drug is being requested (applies to brand or generic)? [Note: Please check the drug being requested (applies to brand or generic).] [] codeine tablets (if checked, go to 9) [] hydromorphone oral solution, suppositories, or tablets (if checked, go to 10) [] levorphanol tablets (if checked, go to 11) [] meperidine oral solution or tablets (if checked, go to 12) [] morphine sulfate oral concentrate or oral solution (if checked, go to 13) [] morphine sulfate suppositories (if checked, go to question 14) [] morphine sulfate tablets (if checked, go to question 15) [] oxycodone, Oxaydo, or RoxyBond capsules or tablets (if checked, go to question 16) [] oxycodone oral concentrate or oral solution (if checked, go to 17) [] oxymorphone tablets (if checked, go to question 18) [] pentazocine/naloxone tablets (if checked, go to 19) [] tapentadol oral solution or tablets (Nucynta) (if checked, go to 20) [] tramadol oral solution or tablets (if checked, go to 21)		

7	Does the patient require extended treatment beyond 7 days for moderate to severe ACUTE pain where use of an opioid analgesic is appropriate? [If no, then no further questions.]	Yes	No
8	Which drug is being requested (applies to brand or generic)? [Note: Please check the drug being requested (applies to brand or generic).] [] codeine tablets (if checked, go to 22) [] hydromorphone oral solution, suppositories, or tablets (if checked, go to 23) [] levorphanol tablets (if checked, go to 24) [] meperidine oral solution or tablets (if checked, go to 25) [] morphine sulfate oral concentrate or oral solution (if checked, go to 26) [] morphine sulfate suppositories (if checked, go to question 27) [] morphine sulfate tablets (if checked, go to question 28) [] oxycodone, Oxaydo, or RoxyBond capsules or tablets (if checked, go to question 29) [] oxycodone oral concentrate or oral solution (if checked, go to 30) [] oxymorphone tablets (if checked, go to question 31) [] pentazocine/naloxone tablets (if checked, go to 32) [] tapentadol oral solution or tablets (Nucynta) (if checked, go to 33) [] tramadol oral solution or tablets (if checked, go to 34)		
9	Does the patient require use of MORE than the plan allowance of 6 tablets per day OR MORE than 84 tablets in a one month period (quantity sufficient for a 14-day supply) of codeine? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 6 tablets per day and 84 tablets per month of codeine.]	Yes	No
10	Does the patient require use of MORE than the plan allowance of any of the following: A) 50 mL per day of hydromorphone oral solution, B) 6 hydromorphone suppositories per day, C) 9 tablets per day of hydromorphone 2 mg, D) 7.5 tablets per day of hydromorphone 4 mg, E) 3 tablets per day of hydromorphone 8 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 50 mL per day of hydromorphone oral solution, B) 6 hydromorphone suppositories per day, C) 9 tablets per day of hydromorphone 2 mg, D) 7.5 tablets per day of hydromorphone 4 mg, E) 3 tablets per day of hydromorphone 8 mg.]	Yes	No
11	Does the patient require use of MORE than the plan allowance of 6 levorphanol tablets per day? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 6 levorphanol tablets per day.]	Yes	No
12	Does the patient require use of MORE than the plan allowance of any of the following: A) 30 mL per day OR 120 mL in a one month period (quantity sufficient for a 4-day supply) of meperidine oral solution, B) 6 tablets per day OR 24 tablets in a one month period (quantity sufficient for a 4-day supply) of meperidine tablets?	Yes	No

[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for A) 30 mL per day and 120 mL in a one month period (quantity sufficient for a 4-day supply) of meperidine oral solution, B) 6 tablets per day and 24 tablets in a one month period (quantity sufficient for a 4-day supply) of meperidine tablets.]

13	Does the patient require use of MORE than the plan allowance of 45 mL per day of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution OR MORE than the plan allowance of 9 mL per day of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 45 mL/day of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution OR 9 mL/day of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution.]	Yes	No
14	Does the patient require use of MORE than the plan allowance of 9 suppositories per day of morphine sulfate 5 mg, 10 mg, 20 mg OR MORE than the plan allowance of 6 suppositories per day of morphine sulfate 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 9 suppositories per day of morphine sulfate 5 mg, 10 mg, 20 mg OR 6 suppositories per day of morphine sulfate 30 mg.]	Yes	No
15	Does the patient require use of MORE than the plan allowance of 9 tablets per day of morphine sulfate 15 mg OR MORE than the plan allowance of 6 tablets per day of morphine sulfate 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 9 tablets per day of morphine sulfate 15 mg OR 6 tablets per day of morphine sulfate 30 mg.]	Yes	No
16	Does the patient require use of MORE than the plan allowance of any of the following: A) 9 capsules or tablets per day of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 6 tablets per day of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg C) 4 tablets per day of oxycodone 30 mg or RoxyBond 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 9 capsules or tablets per day of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 6 tablets per day of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg C) 4 tablets per day of oxycodone 30 mg or RoxyBond 30 mg.]	Yes	No
17	Does the patient require use of MORE than the plan allowance of 90 mL per day of oxycodone 5 mg/5 mL oral solution OR MORE than the plan allowance of 6 mL per day of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 90 mL/day of oxycodone 5 mg/5 mL oral solution OR 6 mL/day of oxycodone 100 mg/5 mL (20 mg/mL) oral	Yes	No

concentrate.]

18	Does the patient require use of MORE than the plan allowance of 12 tablets per day of oxymorphone 5 mg OR MORE than the plan allowance of 6 tablets per day of oxymorphone 10 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 12 tablets per day of oxymorphone 5 mg OR 6 tablets per day of oxymorphone 10 mg.]	Yes	No
19	Does the patient require use of MORE than the plan allowance of 10 pentazocine/naloxone tablets per day? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 10 pentazocine/naloxone tablets per day.]	Yes	No
20	Does the patient require use of MORE than the plan allowance of any of the following: A) 23.33 mL per day of Nucynta (tapentadol) oral solution, B) 8 tablets per day of Nucynta (tapentadol) 50 mg tablets, C) 6 tablets per day of Nucynta (tapentadol) 75 mg tablets, D) 4 tablets per day of Nucynta (tapentadol) 100 mg tablets? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 23.33 mL per day of Nucynta (tapentadol) oral solution, B) 8 tablets per day of Nucynta (tapentadol) 50 mg tablets, C) 6 tablets per day of Nucynta (tapentadol) 75 mg tablets, D) 4 tablets per day of Nucynta (tapentadol) 100 mg tablets.]	Yes	No
21	Does the patient require use of MORE than the plan allowance of any of the following: A) 80 mL per day of tramadol 5 mg/mL oral solution, B) 8 tablets per day of tramadol 50 mg, C) 4 tablets per day of tramadol 100 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 80 mL per day of tramadol 5 mg/mL oral solution, B) 8 tablets per day of tramadol 50 mg, C) 4 tablets per day of tramadol 100 mg.]	Yes	No
22	Does the patient require use of MORE than the plan allowance of 6 tablets per day OR MORE than 84 tablets in a one month period (quantity sufficient for a 14-day supply) of codeine? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 6 tablets per day and 84 tablets per month of codeine.]	Yes	No
23	Does the patient require use of MORE than the plan allowance of any of the following: A) 50 mL per day of hydromorphone oral solution, B) 6 hydromorphone suppositories per day, C) 9 tablets per day of hydromorphone 2 mg, D) 7.5 tablets per day of hydromorphone 4 mg, E) 3 tablets per day of hydromorphone 8 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 50	Yes	No

	mL per day of hydromorphone oral solution, B) 6 hydromorphone suppositories per day, C) 9 tablets per day of hydromorphone 2 mg, D) 7.5 tablets per day of hydromorphone 4 mg, E) 3 tablets per day of hydromorphone 8 mg.]		
24	Does the patient require use of MORE than the plan allowance of 6 levorphanol tablets per day? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 6 levorphanol tablets per day.]	Yes	No
25	Does the patient require use of MORE than the plan allowance of any of the following: A) 30 mL per day OR 120 mL in a one month period (quantity sufficient for a 4-day supply) of meperidine oral solution, B) 6 tablets per day OR 24 tablets in a one month period (quantity sufficient for a 4-day supply) of meperidine tablets? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for A) 30 mL per day and 120 mL in a one month period (quantity sufficient for a 4-day supply) of meperidine oral solution, B) 6 tablets per day and 24 tablets in a one month period (quantity sufficient for a 4-day supply) of meperidine tablets.]	Yes	No
26	Does the patient require use of MORE than the plan allowance of 45 mL per day of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution OR MORE than the plan allowance of 9 mL per day of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 45 mL/day of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution OR 9 mL/day of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution.]	Yes	No
27	Does the patient require use of MORE than the plan allowance of 9 suppositories per day of morphine sulfate 5 mg, 10 mg, 20 mg OR MORE than the plan allowance of 6 suppositories per day of morphine sulfate 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 9 suppositories per day of morphine sulfate 5 mg, 10 mg, 20 mg OR 6 suppositories per day of morphine sulfate 30 mg.]	Yes	No
28	Does the patient require use of MORE than the plan allowance of 9 tablets per day of morphine sulfate 15 mg OR MORE than the plan allowance of 6 tablets per day of morphine sulfate 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 9 tablets per day of morphine sulfate 15 mg OR 6 tablets per day of morphine sulfate 30 mg.]	Yes	No
29	Does the patient require use of MORE than the plan allowance of any of the following: A) 9 capsules or tablets per day of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 6 tablets per day of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg C)	Yes	No

	4 tablets per day of oxycodone 30 mg or RoxyBond 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 9 capsules or tablets per day of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 6 tablets per day of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg C) 4 tablets per day of oxycodone 30 mg or RoxyBond 30 mg.]		
30	Does the patient require use of MORE than the plan allowance of 90 mL per day of oxycodone 5 mg/5 mL oral solution OR MORE than the plan allowance of 6 mL per day of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 90 mL/day of oxycodone 5 mg/5 mL oral solution OR 6 mL/day of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate.]	Yes	No
31	Does the patient require use of MORE than the plan allowance of 12 tablets per day of oxymorphone 5 mg OR MORE than the plan allowance of 6 tablets per day of oxymorphone 10 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 12 tablets per day of oxymorphone 5 mg OR 6 tablets per day of oxymorphone 10 mg.]	Yes	No
32	Does the patient require use of MORE than the plan allowance of 10 pentazocine/naloxone tablets per day? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 10 pentazocine/naloxone tablets per day.]	Yes	No
33	Does the patient require use of MORE than the plan allowance of any of the following: A) 23.33 mL per day of Nucynta (tapentadol) oral solution, B) 8 tablets per day of Nucynta (tapentadol) 50 mg tablets, C) 6 tablets per day of Nucynta (tapentadol) 75 mg tablets, D) 4 tablets per day of Nucynta (tapentadol) 100 mg tablets? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 23.33 mL per day of Nucynta (tapentadol) oral solution, B) 8 tablets per day of Nucynta (tapentadol) 50 mg tablets, C) 6 tablets per day of Nucynta (tapentadol) 75 mg tablets, D) 4 tablets per day of Nucynta (tapentadol) 100 mg tablets.]	Yes	No
34	Does the patient require use of MORE than the plan allowance of any of the following: A) 80 mL per day of tramadol 5 mg/mL oral solution, B) 8 tablets per day of tramadol 50 mg, C) 4 tablets per day of tramadol 100 mg? [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 80 mL per day of tramadol 5 mg/mL oral solution, B) 8 tablets per day of tramadol 50 mg, C) 4 tablets per day of tramadol 100 mg.]	Yes	No

Mapping Instructions			
	Yes	**No**	**DENIAL REASONS – DO NOT USE FOR MEDICARE PART D**
1.	Approve, 12 months, No set post limit quantity [Enter approval for quantity of 999999.]	Go to 2	
2.	Go to 3	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.]
3.	Go to 4	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.]
4.	Go to 5	Go to 7	
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 by your doctor 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.	1=9; 2=10; 3=11; 4=12; 5=13; 6=14; 7=15; 8=16; 9=17; 10=18; 11=19; 12=20; 13=21	N/A	
7.	Go to 8	Deny	You do not meet the requirements of your plan. Your plan covers this drug when you have any of these conditions: - Pain due to cancer, sickle cell disease, or a terminal condition - Pain being managed through hospice or palliative care - Moderate to severe chronic pain that requires treatment with an opioid - Moderate to severe acute pain that requires treatment with an opioid for more than seven days Your request has been denied based on the information we have. [Short Description: No approvable diagnosis.]
8.	1=22; 2=23; 3=24; 4=25; 5=26; 6=27; 7=28; 8=29; 9=30; 10=31;	N/A	

	11=32; 12=33; 13=34		
9.	Deny	Approve, 6 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to 6 tablets/day AND 84 tablets/month of the requested drug and strength. Your request has been partially approved. 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 – codeine, chronic pain]
10.	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 IR 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: - 50 mL/day of hydromorphone oral solution - 6 suppositories/day hydromorphone suppositories - 9 tablets/day of hydromorphone 2 mg tablets - 7.5 tablets/day of hydromorphone 4 mg tablets - 3 tablets/day of hydromorphone 8 mg tablets Your request has been partially approved. 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 - hydromorphone, chronic pain]
11.	Deny	Approve, 6 months See Opioid Analgesics IR 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 6 tablets/day of the requested drug and strength. Your request has been partially approved. 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 - levorphanol, chronic pain]
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 IR Quantity Limits Chart (Column C for 1 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 30 mL/day AND 120 mL/month of meperidine oral solution - 6 tablets/day AND 24 tablets/month of meperidine tablets Your request has been partially approved. 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 - meperidine, chronic pain]
13.	Deny RPh Note: For the denial verbiage,	Approve, 6 months	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to:

	only include the requested drug. Remove all the other drugs from the verbiage.	See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	- 45 mL/day of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution - 9 mL/day of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution Your request has been partially approved. 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 – morphine solution, chronic pain]
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 IR 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: - 9 suppositories/day of morphine sulfate suppository 5 mg, 10 mg, or 20 mg - 6 suppositories/day of morphine sulfate suppository 30 mg Your request has been partially approved. 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 – morphine suppository, chronic pain]
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 IR 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: - 9 tablets/day of morphine sulfate 15 mg tablets - 6 tablets/day of morphine sulfate 30 mg tablets Your request has been partially approved. 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 – morphine tablet, chronic pain]
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 IR 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: - 9 capsules or tablets/day of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg - 6 tablets/day of oxycodone 15 mg, 20 mg or RoxyBond 15 mg - 4 tablets/day of oxycodone 30 mg or RoxyBond 30 mg Your request has been partially approved. 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 – oxycodone, Oxaydo, RoxyBond, chronic pain]
17.	Deny RPh Note: For the denial verbiage, only include the	Approve, 6 months See Opioid	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 90 mL/day of oxycodone 5 mg/5 mL oral solution

	requested drug. Remove all the other drugs from the verbiage.	Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	- 6 mL/day of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate Your request has been partially approved. 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 – oxycodone solution, chronic pain]
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 IR 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: - 12 tablets/day of oxymorphone 5 mg - 6 tablets/day of oxymorphone 10 mg Your request has been partially approved. 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 - oxymorphone, chronic pain]
19.	Deny	Approve, 6 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to 10 tablets/day of the requested drug and strength. Your request has been partially approved. 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 – pentazocine/naloxone, chronic pain]
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 IR 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: - 23.33 mL/day of Nucynta (tapentadol) oral solution - 8 tablets/day of Nucynta (tapentadol) 50 mg tablets - 6 tablets/day of Nucynta (tapentadol) 75 mg tablets - 4 tablets/day of Nucynta (tapentadol) 100 mg tablets Your request has been partially approved. 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 - Nucynta, chronic pain]
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 IR Quantity Limits Chart (Column C for 1 month supply or Column	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 80 mL/day of tramadol 5 mg/mL oral solution - 8 tablets/day of tramadol 50 mg - 4 tablets/day of tramadol 100 mg Your request has been partially approved. 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

		D for a 3 month supply)	strength has been denied. [Short Description: Over max quantity - tramadol, chronic pain]
22.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to 6 tablets/day AND 84 tablets/month of the requested drug and strength. Your request has been partially approved. You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity – codeine, acute pain]
23.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 50 mL/day of hydromorphone oral solution - 6 suppositories/day hydromorphone suppositories - 9 tablets/day of hydromorphone 2 mg tablets - 7.5 tablets/day of hydromorphone 4 mg tablets - 3 tablets/day of hydromorphone 8 mg tablets Your request has been partially approved. You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity - hydromorphone, acute pain]
24.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to 6 tablets/day of the requested drug and strength. Your request has been partially approved. You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity - levorphanol, acute pain]
25.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 30 mL/day AND 120 mL/month of meperidine oral solution - 6 tablets/day AND 24 tablets/month of meperidine tablets Your request has been partially approved. You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity - meperidine, acute pain]
26.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 45 mL/day of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution - 9 mL/day of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution Your request has been partially approved. You have been approved for

	the verbiage.		the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity – morphine solution, acute pain]
27.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 9 suppositories/day of morphine sulfate suppository 5 mg, 10 mg, or 20 mg - 6 suppositories/day of morphine sulfate suppository 30 mg Your request has been partially approved. You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity – morphine suppository, acute pain]
28.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 9 tablets/day of morphine sulfate 15 mg tablets - 6 tablets/day of morphine sulfate 30 mg tablets Your request has been partially approved. You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity – morphine tablet, acute pain]
29.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 9 capsules or tablets/day of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg - 6 tablets/day of oxycodone 15 mg, 20 mg or RoxyBond 15 mg - 4 tablets/day of oxycodone 30 mg or RoxyBond 30 mg Your request has been partially approved. You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity – oxycodone, Oxaydo, RoxyBond, acute pain]
30.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 90 mL/day of oxycodone 5 mg/5 mL oral solution - 6 mL/day of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate Your request has been partially approved. You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied.

			[Short Description: Over max quantity – oxycodone solution, acute pain]
31.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 12 tablets/day of oxymorphone 5 mg - 6 tablets/day of oxymorphone 10 mg Your request has been partially approved. You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity - oxymorphone, acute pain]
32.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to 10 tablets/day of the requested drug and strength. Your request has been partially approved. You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity – pentazocine/naloxone, acute pain]
33.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 23.33 mL/day of Nucynta (tapentadol) oral solution - 8 tablets/day of Nucynta (tapentadol) 50 mg tablets - 6 tablets/day of Nucynta (tapentadol) 75 mg tablets - 4 tablets/day of Nucynta (tapentadol) 100 mg tablets Your request has been partially approved. You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity - Nucynta, acute pain]
34.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 80 mL/day of tramadol 5 mg/mL oral solution - 8 tablets/day of tramadol 50 mg - 4 tablets/day of tramadol 100 mg Your request has been partially approved. You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity - tramadol, acute pain]

Opioid Analgesics IR Quantity Limits Chart
Coverage is provided without prior authorization (for patients not identified as potential first fills) for a 30-day or 90-day supply of an immediate-release opioid for a quantity that corresponds to ≤ 90 MME/day. Coverage for

quantities that correspond to ≤ 200 MME/day for a 30-day or 90-day supply is provided through prior authorization when criteria for approval 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)**
Codeine sulfate tab 15 mg	q4h, Max Daily Dose 360 mg	42 tabs/month‡ 6 tabs/day (13.5 MME/day)	Does Not Apply‡	84 tabs/month‡ 6 tabs/day (13.5 MME/day)	Use Column C
Codeine sulfate tab 30 mg	q4h, Max Daily Dose 360 mg	42 tabs/month‡ 6 tabs/day (27 MME/day)	Does Not Apply‡	84 tabs/month‡ 6 tabs/day (27 MME/day)	Use Column C
Codeine sulfate tab 60 mg	q4h, Max Daily Dose 360 mg	42 tabs/month‡ 6 tabs/day (54 MME/day)	Does Not Apply‡	84 tabs/month‡ 6 tabs/day (54 MME/day)	Use Column C
Hydromorphone oral soln 5 mg/5 mL (1 mg/mL)	q3-6h	600 mL/month 20 mL/day (80 MME/day)	1800 mL/3 months 20 mL/day (80 MME/day)	1500 mL/month 50 mL/day (200 MME/day)	4500 mL/3 months 50 mL/day (200 MME/day)
Hydromorphone supp 3 mg	q6-8h	120 supps/month 4 supps/day (48 MME/day)	360 supps/3 months 4 supps/day (48 MME/day)	180 supps/month 6 supps/day (72 MME/day)	540 supps/3 months 6 supps/day (72 MME/day)
Hydromorphone tab 2 mg	q4-6h	180 tabs/month 6 tabs/day (48 MME/day)	540 tabs/3 months 6 tabs/day (48 MME/day)	270 tabs/month 9 tabs/day (72 MME/day)	810 tabs/3 months 9 tabs/day (72 MME/day)
Hydromorphone tab 4 mg	q4-6h	150 tabs/month 5 tabs/day (80 MME/day)	450 tabs/3 months 5 tabs/day (80 MME/day)	225 tabs/month 7.5 tabs/day (120 MME/day)	675 tabs/3 months 7.5 tabs/day (120 MME/day)
Hydromorphone tab 8 mg	q4-6h	60 tabs/month 2 tabs/day (64 MME/day)	180 tabs/3 months 2 tabs/day (64 MME/day)	90 tabs/month 3 tabs/day (96 MME/day)	270 tabs/3 months 3 tabs/day (96 MME/day)
Levorphanol tab 1 mg	q6-8h	120 tabs/month 4 tabs/day (44 MME/day)	360 tabs/3 months 4 tabs/day (44 MME/day)	180 tabs/month 6 tabs/day (66 MME/day)	540 tabs/3 months 6 tabs/day (66 MME/day)
Levorphanol tab 2 mg	q6-8h	120 tabs/month 4 tabs/day (88 MME/day)	360 tabs/3 months 4 tabs/day (88 MME/day)	180 tabs/month 6 tabs/day (132 MME/day)	540 tabs/3 months 6 tabs/day (132 MME/day)
Levorphanol tab 3 mg	q6-8h	60 tabs/month 2 tabs/day (66 MME/day)	180 tabs/3 months 2 tabs/day (66 MME/day)	180 tabs/month 6 tabs/day (198 MME/day)	540 tabs/3 months 6 tabs/day (198 MME/day)
Meperidine oral soln 50 mg/5 mL	q3-4h	90 mL/month**** 30 mL/day (30 MME/day)	Does Not Apply****	120 mL/month**** 30 mL/day (30 MME/day)	Use Column C
Meperidine tab 50 mg	q3-4h	18 tabs/month**** 6 tabs/day (30 MME/day)	Does Not Apply****	24 tabs/month**** 6 tabs/day (30 MME/day)	Use Column C
Meperidine tab 100 mg	q3-4h	18 tabs/month**** 6 tabs/day (60 MME/day)	Does Not Apply****	24 tabs/month**** 6 tabs/day (60 MME/day)	Use Column C

Morphine sulfate (conc) oral soln 20 mg/mL (100 mg/5 mL)	q4h	135 mL/month 4.5 mL/day (90 MME/day)	405 mL/3 months 4.5 mL/day (90 MME/day)	270 mL/month 9 mL/day (180 MME/day)	810 mL/3 months 9 mL/day (180 MME/day)
Morphine sulfate oral soln 10 mg/5 mL	q4h	900 mL/month 30 mL/day (60 MME/day)	2700 mL/3 months 30 mL/day (60 MME/day)	1350 mL/month 45 mL/day (90 MME/day)	4050 mL/3 months 45 mL/day (90 MME/day)
Morphine sulfate oral soln 20 mg/5 mL	q4h	675 mL/month 22.5 mL/day (90 MME/day)	2025 mL/3 months 22.5 mL/day (90 MME/day)	1350 mL/month 45 mL/day (180 MME/day)	4050 mL/3 months 45 mL/day (180 MME/day)
Morphine sulfate supp 5 mg	q4h	180 supps/month 6 supps/day (30 MME/day)	540 supps/3 month 6 supps/day (30 MME/day)	270 supps/month 9 supps/day (45 MME/day)	810 supps/3 months 9 supps/day (45 MME/day)
Morphine sulfate supp 10 mg	q4h	180 supps/month 6 supps/day (60 MME/day)	540 supps/3 month 6 supps/day (60 MME/day)	270 supps/month 9 supps/day (90 MME/day)	810 supps/3 months 9 supps/day (90 MME/day)
Morphine sulfate supp 20 mg	q4h	120 supps/month 4 supps/day (80 MME/day)	360 supps/3 months 4 supps/day (80 MME/day)	270 supps/month 9 supps/day (180 MME/day)	810 supps/3 months 9 supps/day (180 MME/day)
Morphine sulfate supp 30 mg	q4h	90 supps/month 3 supps/day (90 MME/day)	270 supps/3 months 3 supps/day (90 MME/day)	180 supps/month 6 supps/day (180 MME/day)	540 supps/3 months 6 supps/day (180 MME/day)
Morphine sulfate tab 15 mg	q4h	180 tabs/month 6 tabs/day (90 MME/day)	540 tabs/3 months 6 tabs/day (90 MME/day)	270 tabs/month 9 tabs/day (135 MME/day)	810 tabs/3 months 9 tabs/day (135 MME/day)
Morphine sulfate tab 30 mg	q4h	90 tabs/month 3 tabs/day (90 MME/day)	270 tabs/3 months 3 tabs/day (90 MME/day)	180 tabs/month 6 tabs/day (180 MME/day)	540 tabs/3 months 6 tabs/day (180 MME/day)
Oxaydo 5 mg	q4-6h	180 tabs/month 6 tabs/day (45 MME/day)	540 tabs/3 months 6 tabs/day (45 MME/day)	270 tabs/month 9 tabs/day (67.5 MME/day)	810 tabs/3 months 9 tabs/day (67.5 MME/day)
Oxaydo 7.5 mg	q4-6h	180 tabs/month 6 tabs/day (67.5 MME/day)	540 tabs/3 months 6 tabs/day (67.5 MME/day)	270 tabs/month 9 tabs/day (101.25 MME/day)	810 tabs/3 months 9 tabs/day (101.25 MME/day)
Oxycodone cap 5 mg	q4-6h	180 caps/month 6 caps/day (45 MME/day)	540 caps/3 months 6 caps/day (45 MME/day)	270 caps/month 9 caps/day (67.5 MME/day)	810 caps/3 months 9 caps/day (67.5 MME/day)
Oxycodone oral concentrate 100 mg/5 mL (20 mg/mL)	q4-6h	90 mL/month 3 mL/day (90 MME/day)	270 mL/3 months 3 mL/day (90 MME/day)	180 mL/month 6 mL/day (180 MME/day)	540 mL/3 months 6 mL/day (180 MME/day)
Oxycodone soln 5 mg/5 mL	q4-6h	900 mL/month 30 mL/day (45 MME/day)	2700 mL/3 months 30 mL/day (45 MME/day)	2700 mL/ month 90 mL/day (135 MME/day)	8100 mL/3 months 90 mL/day (135 MME/day)
Oxycodone tab 5 mg	q4-6h	180 tabs/month 6 tabs/day (45 MME/day)	540 tabs/3 months 6 tabs/day (45 MME/day)	270 tabs/month 9 tabs/day (67.5 MME/day)	810 tabs/3 months 9 tabs/day (67.5 MME/day)
Oxycodone tab 10 mg	q4-6h	180 tabs/month 6 tabs/day (90 MME/day)	540 tabs/3 months 6 tabs/day (90 MME/day)	270 tabs/month 9 tabs/day (135 MME/day)	810 tabs/3 months 9 tabs/day (135 MME/day)
Oxycodone tab 15 mg	q4-6h	120 tabs/month 4 tabs/day (90 MME/day)	360 tabs/3 months 4 tabs/day (90 MME/day)	180 tabs/month 6 tabs/day (135 MME/day)	540 tabs/3 months 6 tabs/day (135 MME/day)
Oxycodone tab 20 mg	q4-6h	90 tabs/month 3 tabs/day (90 MME/day)	270 tabs/3 months 3 tabs/day (90 MME/day)	180 tabs/month 6 tabs/day (180 MME/day)	540 tabs/3 months 6 tabs/day (180 MME/day)
Oxycodone tab 30 mg	q4-6h	60 tabs/month 2 tabs/day (90 MME/day)	180 tabs/3 months 2 tabs/day (90 MME/day)	120 tabs/month 4 tabs/day (180 MME/day)	360 tabs/3 months 4 tabs/day (180 MME/day)
Oxymorphone tab 5	q4-6h	180 tabs/month	540 tabs/3 months	360 tabs/month	1080 tabs/3 months

mg		6 tabs/day (90 MME/day)	6 tabs/day (90 MME/day)	12 tabs/day (180 MME/day)	12 tabs/day (180 MME/day)
Oxymorphone tab 10 mg	q4-6h	90 tabs/month 3 tabs/day (90 MME/day)	270 tabs/3 months 3 tabs/day (90 MME/day)	180 tabs/month 6 tabs/day (180 MME/day)	540 tabs/3 months 6 tabs/day (180 MME/day)
Pentazocine/naloxone 50/0.5 mg	q3-4h, Total daily dose should not exceed 12 tablets.	120 tabs/month*** 4 tabs/day (74 MME/day)	Does Not Apply ***	300 tabs/month*** 10 tabs/day (185 MME/day)	Use Column C
RoxyBond tab 5 mg	q4-6h	180 tabs/month 6 tabs/day (45 MME/day)	540 tabs/3 months 6 tabs/day (45 MME/day)	270 tabs/month 9 tabs/day (67.5 MME/day)	810 tabs/3 months 9 tabs/day (67.5 MME/day)
RoxyBond tab 15 mg	q4-6h	120 tabs/month 4 tabs/day (90 MME/day)	360 tabs/3 months 4 tabs/day (90 MME/day)	180 tabs/month 6 tabs/day (135 MME/day)	540 tabs/3 months 6 tabs/day (135 MME/day)
RoxyBond tab 30 mg	q4-6h	60 tabs/month 2 tabs/day (90 MME/day)	180 tabs/3 months 2 tabs/day (90 MME/day)	120 tabs/month 4 tabs/day (180 MME/day)	360 tabs/3 months 4 tabs/day (180 MME/day)
Tapentadol oral soln 20 mg/mL†	q4-6h, Max daily dose is 700 mg on the first day and 600 mg on subsequent days.	300 mL/month 10 mL/day (80 MME/day)	900 mL/3 months 10 mL/day (80 MME/day)	700 mL/month 23.33 mL/day (186.7 MME/day)	2100 mL/3 months 23.33 mL/day (186.7 MME/day)
Tapentadol tab 50 mg	q4-6h, Max daily dose is 700 mg on the first day and 600 mg on subsequent days.	120 tabs/month 4 tabs/day (80 MME/day)	360 tabs/3 months 4 tabs/day (80 MME/day)	240 tabs/month 8 tabs/day (160 MME/day)	720 tabs/3 months 8 tabs/day (160 MME/day)
Tapentadol tab 75 mg	q4-6h, Max daily dose is 700 mg on the first day and 600 mg on subsequent days.	90 tabs/month 3 tabs/day (90 MME/day)	270 tabs/3 months 3 tabs/day (90 MME/day)	180 tabs/month 6 tabs/day (180 MME/day)	540 tabs/3 months 6 tabs/day (180 MME/day)
Tapentadol tab 100 mg	q4-6h, Max daily dose is 700 mg on the first day and 600 mg on subsequent days.	60 tabs/month 2 tabs/day (80 MME/day)	180 tabs/3 months 2 tabs/day (80 MME/day)	120 tabs/month 4 tabs/day (160 MME/day)	360 tabs/3 months 4 tabs/day (160 MME/day)
Tramadol oral soln 5 mg/mL	q4-6h, Max Daily Dose 400 mg	1800 mL/month 60 mL/day (30 MME/day)	5400 mL/3 months 60 mL/day (30 MME/day)	2400 mL/month 80 mL/day (40 MME/day)	7200 mL/3 months 80 mL/day (40 MME/day)
Tramadol 50 mg	q4-6h, Max Daily Dose 400 mg	180 tabs/month 6 tabs/day (30 MME/day)	540 tabs/3 months 6 tabs/day (30 MME/day)	240 tabs/month 8 tabs/day (40 MME/day)	720 tabs/3 months 8 tabs/day (40 MME/day)
Tramadol 100 mg	q4-6h, Max Daily Dose 400 mg	90 tabs/month 3 tabs/day (30 MME/day)	270 tabs/3 months 3 tabs/day (30 MME/day)	120 tabs/month 4 tabs/day (40 MME/day)	360 tabs/3 months 4 tabs/day (40 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 both as quantity versus time and daily dose edits.*

***The limit criteria apply to both brand and generic, if available.*

**** This drug is indicated for short-term acute use; therefore, the 30-day limit will be the same as the 90-day limit. The intent is for prescriptions of the requested drug to be filled one month at a time, even if filled at mail order; there should be no 3 month supplies filled.*

*****Due to risk of accumulation, the initial quantity limit will be set at a quantity that corresponds to a 3-day supply. The post limit quantity will be set at a quantity that corresponds to a 4-day supply. This drug is indicated for short-term acute use; therefore, the 30-day limit will be the same as the 90-day limit. The intent is for prescriptions of the requested drug to be filled one month at a time, even if filled at mail order; there should be no 3 month supplies filled.*

†*Available in 100 mL and 200 mL bottles. It is the discretion of the dispensing pharmacy to fill quantities per package size up to these quantity limits. In such cases the filling limit and day supply may be less than what is indicated.*
‡ *The initial quantity limit for codeine will be set at a quantity that corresponds to a one-week supply. The post limit quantity will be set at a quantity that corresponds to a two-week supply. This drug is indicated for short-term acute use; therefore, the 30-day limit will be the same as the 90-day limit. The intent is for prescriptions of the requested drug to be filled one month at a time, even if filled at mail order; there should be no 3 month supplies filled.*