Short-acting Opioid Analgesics

Goals:

- Restrict use of short-acting opioid analgesics for acute conditions funded by the OHP.
- Promote use of preferred short-acting opioid analgesics.
- Allow case-by-case review for members covered under the EPSDT program.

Length of Authorization:

Initial: 7 to 30 days (except 12 months for end-of-life, sickle cell disease, severe burn injury, or cancer-related pain)
Renewal: Up to 6 months

Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

Requires a PA:

- Non-preferred short-acting opioids and opioid combination products.
- All short-acting products prescribed for more than 14 days. Each prescription is limited to 7 days in treatment-naïve patients. Patients may fill up to 2 prescriptions every 90 days without prior authorization.
- All codeine and tramadol products for patients under 19 years of age

Note:

- Patients on palliative care with a terminal diagnosis or with cancer-related pain or with pain associated with sickle cell disease or severe burn injury are exempt from this PA.

Table 1. Daily Dose Threshold (90 morphine milligram equivalents per day (MME/day) of Oral Opioid Products.

Opioid	90 MME/day Dose	Notes
Benzhydrocodone	73.5 mg	
Codeine	600 mg	Codeine is not recommended for pediatric use; codeine is a prodrug of morphine and is subject to different rates of metabolism, placing certain populations at risk for overdose.
Dihydrocodeine	360 mg	
Hydrocodone bitartrate	90 mg	
Hydromorphone	22.5 mg	
Levorphanol tartrate	8 mg	
Meperidine	900 mg	Meperidine is not recommended for management of chronic pain due to potential accumulation of toxic metabolites.
Morphine	90 mg	
Oxycodone	60 mg	
Oxymorphone	30 mg	
Tapentadol	225 mg	
Tramadol	400 mg	400 mg/day is max dose and is not equivalent to 90 MME/day. Tramadol is not recommended for pediatric use as it is subject to different rates of metabolism placing certain populations at risk for overdose.

Approval Criteria

1. What is the patient's diagnosis?	Record ICD10	
2. Has the patient been prescribed any opioid analgesics (short or long-acting) for more than 6 weeks?	**Yes:** Go to **Renewal Criteria**	**No:** Go to #3
3. Is the diagnosis funded by the OHP? Note: Currently, conditions such as fibromyalgia, TMJ, pelvic pain syndrome, neuropathy, and tension headache are not funded by the OHP.	**Yes:** Go to #5	**No:** Current age ≥ 21 years: Pass to RPh. Deny; not funded by the OHP Current age < 21 years: Go to #4 Note: Management of opioid dependence is funded by the OHP.
4. Is there documentation that the condition is of sufficient severity that it impacts the patient's health (e.g., quality of life, function, growth, development, ability to participate in school, perform activities of daily living, etc)?	**Yes:** Go to #5	**No:** Pass to RPh. Deny; medical necessity.
5. Is the requested medication a preferred agent?	**Yes:** Go to #7	**No:** Go to #6
6. Will the prescriber change to a preferred product? Note: Preferred opioids are reviewed and designated as preferred agents by the Oregon Pharmacy & Therapeutics Committee based on published medical evidence for safety and efficacy.	**Yes:** Inform prescriber of covered alternatives in class.	**No:** Go to #7
7. Is the patient being treated for pain associated with sickle cell disease, severe burn injury or cancer-related pain or under palliative care services with a life-threatening illness or severe advanced illness expected to progress toward dying?	**Yes:** Approve for up to 12 months.	**No:** Go to #8
8. Is the prescription for a product containing codeine or tramadol in a patient less than 19 years of age? Note: Cold symptoms are not funded on the prioritized list	**Yes:** Deny for medical appropriateness	**No:** Go to #9

9. Is the prescription for a short-acting fentanyl product? Note: Short-acting transmucosal fentanyl products are designed for breakthrough cancer pain only. This PA does not apply to transdermal fentanyl patches.	**Yes:** Pass to RPh. Deny; medical appropriateness Note: Management of opioid dependence is funded by the OHP.	**No:** Go to #10
10. Is the opioid prescribed for pain related to migraine or other type of headache? Note: there is limited or insufficient evidence for opioid use for many pain conditions, including migraine or other types of headache.	**Yes:** Pass to RPh. Deny; medical appropriateness	**No:** Go to #11
11. Is the prescriber enrolled in the Oregon Prescription Drug Monitoring Program (www.orpdmp.com) and has the prescriber reviewed at least once in the past month and verified that opioid prescribing is appropriate?	**Yes:** Go to #12	**No:** Pass to RPh. Deny; medical appropriateness.
12. Is the patient currently taking a benzodiazepine or other central nervous system (CNS) depressant? Note: All opioids have a black box warning about the risks of profound sedation, respiratory depression, coma or death associated with concomitant use of opioids with benzodiazepines or other CNS depressants.	**Yes:** Pass to RPh. Deny; medical appropriateness	**No:** Go to #13
13. Within the past 6 weeks, has a 5-day trial of at least one non-opioid analgesic (e.g., NSAID, acetaminophen, and/or muscle relaxant) been tried for this indication at its maximum effective dose and found to be ineffective or are contraindicated?	**Yes:** Go to #14	**No:** Pass to RPh. Deny; medical appropriateness
14. Is the opioid prescription for pain associated with a back or spine condition?	**Yes:** Go to #15	**No:** Approve for up to 30 days not to exceed 90 MME
15. Has the prescriber also developed a plan with the patient to stay active (home or prescribed exercise regimen) and with consideration of additional therapies such as spinal manipulation, physical therapy, yoga, weight loss, massage therapy, or acupuncture?	**Yes:** Go to #16	**No:** Pass to RPh. Deny; medical appropriateness
16. Is this the first opioid prescription the patient has received for this pain condition?	**Yes:** Approve for up to 7 days not to exceed 90 MME	**No:** Go to #17

17. Can the prescriber provide documentation of sustained improvement in function of at least 30% compared to baseline with prior use of opioid analgesics (e.g., validated tools to assess function include: Oswestry, Neck Disability Index, SF-MPQ, 3-item PEG scale, and MSPQ)?	**Yes:** Approve for up to 7 days not to exceed 90 MME	**No:** Pass to RPh. Deny; medical appropriateness.

Renewal Criteria		
1. What is the patient's diagnosis?	Record ICD10 code	
2. Is the request for a patient already established on opioid treatment for >6 weeks (long-term treatment)?	**Yes**: Go to #3	**No**: Go to **Approval Criteria**
3. Does the request document a taper plan for the patient?	**Yes:** Document taper plan and approve for duration of taper or 3 months whichever is less.	**No:** Go to #4
4. Is there documentation indicating it is **unsafe** to initiate a taper at this time?	**Yes:** Go to #5 Document provider attestation and rationale	**No:** Pass to RPh. Deny; medical appropriateness
5. Is the prescriber enrolled in the Oregon Prescription Drug Monitoring Program (www.orpdmp.com) and has the prescriber verified at least once in the past 1 month that opioid prescribing is appropriate?	**Yes:** Go to #6	**No:** Pass to RPh. Deny. Medical appropriateness
6. Has the patient had a urinary drug screen (UDS) within the past year to verify absence of illicit drugs and non-prescribed opioids?	**Yes:** Go to #7	**No:** Pass to RPh. Deny. Medical appropriateness
7. Can the prescriber provide documentation of sustained improvement of at least 30% in pain, function, or quality of life in the past 3 months compared to baseline? Note: Pain control, quality of life, and function can be quickly assessed using the 3-item PEG scale. *	**Yes:** Go to #9 Document tool used and score vs. baseline: _____	**No:** Go to #8
8. Has the patient been referred for alternative non-pharmacologic modalities of pain treatment (e.g., physical therapy, supervised exercise, spinal manipulation, yoga, or acupuncture)?	**Yes:** Go to #9	**No:** Pass to RPh. Deny. Medical appropriateness

9. Is the request for an increased cumulative daily dose compared to previously approved therapy or average dose in the past 6 weeks?	**Yes:** Go to #10	**No:** Go to #12
10. Does the total cumulative daily opioid dose exceed 90 MME (see Table 1)?	**Yes:** Pass to RPh. Deny; medical appropriateness	**No:** Go to #11
11. Is there documented rationale (e.g., new acute injury) to support the increase in dose?	**Yes:** Go to #12	**No:** Pass to RPh; deny; medical appropriateness
12. Does the patient have any of the following risk factors for overdose? a. Concomitant CNS depressants (benzodiazepines, muscle relaxants, sedating antipsychotics, etc) b. Total daily opioid dose > 90 MME c. Recent urine drug screen indicating illicit or non-prescribed opioids d. Concurrent short- and long-acting opioid use e. Diagnosis of opioid use disorder	**Yes:** Go to #13 Document number of risk factors	**No:** Go to #14
13. Has the member been prescribed or have access to naloxone?	**Yes:** Go to #14	**No:** Pass to RPh. Deny. Medical appropriateness
14. Does the patient have a pain contract on file with the prescriber?	**Yes:** Approved duration is based on the number of identified risk factors for overdose or length of treatment (whichever is less): Risk factors: >=3: 2 month 1-2: 4 months 0: 6 months	**No:** Pass to RPh. Deny; medical appropriateness

*The PEG is freely available to the public http://www.agencymeddirectors.wa.gov/Files/AssessmentTools/1-PEG%203%20item%20pain%20scale.pdf.
Citation of the original publication:
Krebs EE, Lorenz KA, Bair MJ, Damush TA, Wu J, Sutherland JM, Asch SM, Kroenke K. Development and initial validation of the PEG, a 3-item scale assessing pain intensity and interference. *Journal of General Internal Medicine*. 2009 Jun; 24:733-738

Clinical Notes:

How to Discontinue Opioids.

Adapted from the following guidelines on opioid prescribing:

- The Washington State Interagency Guideline on Prescribing Opioids for Pain; Agency Medical Directors' Group, June 2015. Available at http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf.

Selecting the optimal timing and approach to tapering depends on multiple factors. The decision to taper should be based on shared decision making between the patient and provider based on risks and benefits of therapy. Involving the patient in the decision to

taper helps establish trust with the patient, ensures patient-focused tapering, incorporates the patient's values into the taper plan, provides education on the risks of opioid use, and establishes realistic goals and expectations. Avoid insisting on opioid tapering or discontinuation when opioid use may be warranted. The rate of opioid taper should be based primarily on safety considerations, and special attention is needed for patients on high dose opioids or with significant long-term use, as too rapid a taper may precipitate withdrawal symptoms or drug-seeking behavior. In addition, behavioral issues or physical withdrawal symptoms can be a major obstacle during an opioid taper. Patients who feel overwhelmed or desperate may try to convince the provider to abandon the taper. Although there are no methods for preventing behavioral issues during taper, strategies implemented at the beginning of chronic opioid therapy such as setting clear expectations, allowing for pauses during the taper, and development of an exit strategy are most likely to prevent later behavioral problems if a taper becomes necessary.

1. Consider sequential tapers for patients who are on chronic benzodiazepines and opioids. Coordinate care with other prescribers (e.g. psychiatrist) as necessary. In general, taper off opioids first, then the benzodiazepines.
2. Do not use ultra-rapid detoxification or antagonist-induced withdrawal under heavy sedation or anesthesia (e.g. naloxone or naltrexone with propofol, methohexital, ketamine or midazolam).
3. Establish an individualized rate of taper based on safety considerations and patient history. Common tapers have a dose reduction of 5% to 20% per month:
    a. Assess for substance use disorder and transition to appropriate medication assisted treatment if there is diversion or non-medical use,
    b. Rapid taper (over a 2 to 3 week period) if the patient has had a severe adverse outcome such as overdose or substance use disorder, or
    c. Slow taper for patients with no acute safety concerns. May consider starting with a taper of ≤10% of the original dose per month and assess the patient's functional and pain status at each visit.
4. Adjust the rate, intensity, and duration of the taper according to the patient's response (e.g. emergence of opioid withdrawal symptoms (see Table below)).
5. Watch for signs of unmasked mental health disorders (e.g. depression, PTSD, panic disorder) during taper, especially in patients on prolonged or high dose opioids. Consult with specialists to facilitate a safe and effective taper. Use validated tools to assess conditions.
6. Consider the following factors when making a decision to continue, pause or discontinue the taper plan:
    a. Assess the patient behaviors that may be suggestive of a substance use disorder
    b. Address increased pain with use of non-opioid pharmacological and non-pharmacological options.
    c. Evaluate patient for mental health disorders.
    d. If the dose was tapered due to safety risk, once the dose has been lowered to an acceptable level of risk with no addiction behavior(s) present, consider maintaining at the established lower dose if there is a clinically meaningful improvement in function, reduced pain and no serious adverse outcomes.
7. Do not reverse the taper; it must be unidirectional. The rate may be slowed or paused while monitoring for and managing withdrawal symptoms.
8. Increase the taper rate when opioid doses reach a low level (e.g. <15 mg/day MED), since formulations of opioids may not be available to allow smaller decreases.
9. Use non-benzodiazepine adjunctive agents to treat opioid abstinence syndrome (withdrawal) if needed. Unlike benzodiazepine withdrawal, opioid withdrawal symptoms are rarely medically serious, although they may be extremely unpleasant. Symptoms of mild opioid withdrawal may persist for 6 months after opioids have been discontinued (see Table below).
10. Refer to a crisis intervention system if a patient expresses serious suicidal ideation with plan or intent, or transfer to an emergency room where the patient can be closely monitored.
11. Do not start or resume opioids or benzodiazepines once they have been discontinued, as they may trigger drug cravings and a return to use. Counsel the patient on the increased risk of overdose with abrupt return to a previously prescribed higher dose. Provide opioid overdose education and consider offering naloxone.
12. Consider inpatient withdrawal management if the taper is poorly tolerated.

Symptoms and Treatment of Opioid Withdrawal.

Adapted from the Washington State Interagency Guideline on Prescribing Opioids for Pain; Agency Medical Directors' Group, June 2015. Available at http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf)

Restlessness, sweating or tremors	Clonidine 0.1-0.2 mg orally every 6 hours or transdermal patch 0.1-0.2 mg weekly (If using the patch, oral medication may be needed for the first 72 hours) during taper. Monitor for significant hypotension and anticholinergic side effects.
Nausea	Anti-emetics such as ondansetron or prochlorperazine
Vomiting	Loperamide or anti-spasmodics such as dicyclomine

Muscle pain, neuropathic pain or myoclonus	NSAIDs, gabapentin or muscle relaxants such as cyclobenzaprine, tizanidine or methocarbamol
Insomnia	Sedating antidepressants (e.g. nortriptyline 25 mg at bedtime or mirtazapine 15 mg at bedtime or trazodone 50 mg at bedtime). Do not use benzodiazepines or sedative-hypnotics.

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