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.

Length of Authorization:

7 to 30 days (except 12 months for end-of-life or cancer-related pain)

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 7 days.

Note:

- Patients on palliative care with a terminal diagnosis or with cancer-related pain (ICD10 C6900-C799; C800-C802) are exempt from this PA.
- This PA does not apply to pediatric use of codeine products, which is subject to separate clinical PA criteria.

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

Opioid	90 MME/day Dose	Notes
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.
Benzhydrocodone	73.5 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.

Approval Criteria	
1. What is the patient's diagnosis?	Record ICD10

2. Is the diagnosis funded by the OHP? Note: conditions such as fibromyalgia, TMJ, pelvic pain syndrome and tension headache are not funded by the OHP.	**Yes:** Go to #3	**No:** Pass to RPh. Deny; not funded by the OHP. For patients with a history of chronic opioid use, short-term approval may be considered if a patient-specific taper plan is documented or for up to 30 days to allow providers time to develop a taper plan. Subsequent approvals must document progress toward the taper. Note: Management of opioid dependence is funded by the OHP.
3. Is the requested medication a preferred agent?	**Yes:** Go to #5	**No:** Go to #4
4. 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 #5
5. Is the patient being treated for cancer-related pain (ICD10 G89.3) or under palliative care services (ICD10 Z51.5) with a life-threatening illness or severe advanced illness expected to progress toward dying?	**Yes:** Approve for up to 12 months.	**No:** Go to #6
6. 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 #7

7. 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 #8
8. 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 3 months the scheduled substances the patient has recently been prescribed from other providers?	**Yes:** Go to #9	**No:** Pass to RPh. Deny; medical appropriateness.
9. Did the patient's pain originate from acute injury, flare, or surgery that occurred in the last 6 weeks?	**Yes:** Go to #10	**No:** Go to #15
10. Has at least one non-opioid analgesic (e.g., NSAID, acetaminophen, and/or muscle relaxant) been tried and found to be ineffective or are contraindicated?	**Yes:** Go to #11	**No:** Pass to RPh. Deny; medical appropriateness
11. Is the opioid prescription for pain associated with a back or spine condition?	**Yes:** Go to #12	**No:** Approve for up to 30 days
12. 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, or acupuncture?	**Yes:** Go to #13	**No:** Pass to RPh. Deny; medical appropriateness
13. Is this the first opioid prescription the patient has received for this pain condition?	**Yes:** Approve for up to 7 days	**No:** Go to #14

14. 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, and MSPQ)?	**Yes:** Approve for up to 7 days	**No:** Pass to RPh. Deny; medical appropriateness.
15. Has the patient been prescribed opioid analgesics for more than 6 weeks?	**Yes:** Go to #16	**No:** Go to #10
16. 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:** Document tool used to measure pain and/or function. Go to #17	**No:** Pass to RPh. May approve for up to 30 days one time. For future claims without documentation: deny; medical appropriateness. Note: Management of opioid dependence is funded by the OHP.
17. 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 #18	**No:** Pass to RPh. Deny; medical appropriateness. Note: Management of opioid dependence is funded by the OHP.
18. Is the opioid prescription for pain associated with a back or spine condition?	**Yes:** Go to #19	**No:** Go to #20

19. Have any of the following therapies also been prescribed and utilized by the patient: spinal manipulation, physical therapy, yoga or acupuncture?	**Yes:** Document additional therapy. Approve for up to 7 days. Note: Risks outweigh benefits for back and spine conditions. OHP will not fund chronic use of opioids for back or spine conditions beginning 1/1/2018. Prescriber must develop a taper plan with the patient with a quit date before 1/1/2018. OHP funds treatment for patients who have become dependent or addicted to opioid analgesics.	**No:** Pass to RPh. Deny; medical appropriateness.
20. Does the total daily opioid dose exceed 90 MME (Table 1)?	**Yes:** Pass to RPh. May approve one time. For future claims: deny; medical appropriateness. For patients with a history of chronic opioid use, short-term approval may be considered if a patient-specific taper plan is documented or for up to 30 days to allow providers time to develop a taper plan. Subsequent approvals must document progress toward the taper. Note: Management of opioid dependence is funded by the OHP.	**No:** Approve for up to 30 days.

*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 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 rate of opioid taper should be based primarily on safety considerations, and special attention is needed for patients on high dose opioids, 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 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 the rate of taper based on safety considerations:
    a. Immediate discontinuation 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. Start with a taper of ≤10% of the original dose per week 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 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.
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.

Questions and answers about opioid coverage criteria effective August 21, 2017

Where can I find the new PA criteria for both short- and long-acting opioids?

On or after August 21, 2017, you can find the new PA criteria at www.orpdl.org/drugs under the "Analgesics" category.

Which opioids are restricted to 7 days or less for acute conditions?

Short-acting opioids such as hydrocodone/acetaminophen, oxycodone, and tramadol are restricted to 7 days or less for acute conditions. Long-acting opioids such as fentanyl and extended release morphine sulfate do not have this restriction.

You can find a comprehensive list of preferred and non-preferred short- and long-acting opioids on the Preferred Drug List (PDL) website.

- Short-acting: http://www.orpdl.org/drugs/drugclass.php?cid=1076.
- Long-acting: http://www.orpdl.org/drugs/drugclass.php?cid=1050.

Why are short-acting opioids restricted to 7 days or less for acute conditions?

This decision was based on the 2016 CDC guideline recommendations and will coincide with the Health Evidence Review Commission's 2014 coverage guidance.

What criteria apply to both short- and long-acting opioids?

Criteria for both short- and long-acting opioids require:

- A prescription that:
  - Is for a diagnosis which is funded by the OHP
  - Is not for pain associated with migraine or other type of headache, and
  - Does not exceed a total daily opioid dose of 90 morphine milligram equivalents (MME) per day.
- Documented verification that the patient:
  - Is not high-risk for opioid misuse or abuse,
  - Is not concurrently on other short- or long-acting opioids, and
  - Has sustained improvement of at least 30 percent in pain, function, or quality of life in the past 3 months (compared to baseline).

Do the new criteria apply to cancer-related pain or palliative care services?

No. Besides requiring an OHP-funded diagnosis, the additional new prior authorization criteria requirements do not apply if a patient is:

- Being treated for cancer-related pain (ICD-10 G89.3), or
- Under palliative care services (ICD-10 Z51.5) with a life-threatening illness or severe advanced illness expected to progress toward dying.

Providing the ICD-10 diagnosis code on the prescription order and submitting it on the pharmacy claim may expedite the approval process.

Questions?

- **About pharmacy point of sale and prior authorizations for fee-for-service prescriptions:** Call the Oregon Pharmacy Call Center at 1-888-202-2126.
- **About physical health prescriptions for patients in a coordinated care organization (CCO):** Contact the CCO.