Clinical Policy: Chronic Use of Opioid Analgesics

Reference Number: NE.PMN.97
Effective Date: 12/6/2018
Last Review Date:10/10/2023
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Opioid analgesics exert their analgesic effect through opiate receptors distributed in tissues throughout the body. Prescribing of opioids in Nebraska is addressed in state documentation.[1,2] This policy outlines need for prior authorization in the prescription of opioids when criteria set forth in the foregoing documents are exceeded.

FDA Approved Indication(s)

Opioid analgesics are indicated for the management and treatment of moderate to severe pain.

Policy/Criteria

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Nebraska Total Care that use of opioid analgesics in excess of State determined limits are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria for opioid therapy in excess of morphine milligram equivalents (MME) State limitations

A. Cancer or Palliative Care (must meet all):

1. Prescribed for pain associated with cancer or palliative care;
2. Request is for a preferred drug, unless member has previously failed, is intolerant to or has contraindications to preferred drug options, according to criteria set by the Nebraska Medicaid Preferred Drug List. **Methadone will be approved only in pain control OR end-of-life care. Trial of preferred agent not required for end-of-life care.* **Approval duration: 12 months, per state recommendation**

B. B. Non-cancer related pain

1. Prescribed for the treatment of non-cancer/non-malignant pain and defined by claims history of opioid use in excess of state limitation within prior 30 days;
2 Request is for a preferred drug, unless member has previously failed, is intolerant to or has contraindications to two or more preferred drugs as identified by the Nebraska State Preferred Drug List. **Methadone will be approved only in pain control OR end-of-life care. Trial of preferred agent not required for end-of-life care.*
1. Member will be maintained on no more than 2 opioid analgesics concurrently;
2. Request includes either

a. Provider attestation that a dose taper will be attempted during the ensuing prescription duration; or
b. Documentation that a dose taper has been attempted within the past 6 months with reason(s) for taper failure. **Provider will be advised that doses higher than the current dose will not be approved in the future*

3. Provider agrees to continuously assess the member's pain management regimen for possible discontinuation or dosage decrease of opioid therapy;
4. Documentation that the provider has reviewed the Prescription Drug Monitoring Program (PDMP) to identify concurrently prescribed controlled substances.

Approval duration: 6 months.

C. C. Other diagnoses/indications – Not applicable

II. Continued Therapy

A. Cancer or Palliative Care (must meet all):

1. Currently receiving therapy for pain associated with cancer or palliative care;
2. If member is receiving more than 2 opioid analgesics concurrently, at least one of the following requirements has been met (a or b):
   a. Prescriber previously provided a documented clinical rationale for the use of > 2 opioid analgesics concurrently;
   b. Prescriber provides a documented clinical rationale supporting that addition of an extended release agent or upward titration of existing opioid analgesics is inappropriate or contraindicated;

Approval duration: 12 months

B. Non-cancer related pain (must meet all):

1. Currently receiving long term (defined as a history of chronic opioid use in the 3 months preceding the request) opioid therapy via Nebraska Total Care benefit or documentation supports that member is currently receiving opioids and has received this medication for at least 28 days in last 90 days;
2. Request is for a preferred drug, unless member has previously failed, is intolerant to or has contraindications to two or more preferred drugs; **Methadone will be approved only in pain control OR end-of-life care. Trial of preferred agent not required for end-of-life care.*
3. Prescriber provides documentation supporting inability to discontinue opioid therapy;
4. Member will not be maintained on > 2 opioid analgesics concurrently;
5. Member will have a random urine drug test performed at least every 180 days.
6. Member will have a pain contract executed by provider.
7. If total opioid dose is above the State 90 MME/day Limit, one of the following is met (a, b, c or d):
   a. Dose reduction has occurred since previous approval, if applicable;
   b. A dose taper has been attempted within the past 6 months and was not successful; *Reason(s) for taper failure must be provided.*

c. Medical justification why a taper should not be attempted or for any dose increase that has occurred since previous approval, if applicable;
d. Prescribed by or in consultation with a pain management specialist

8. Documentation that the provider has reviewed the PDMP to identify concurrently prescribed controlled substances:
Approval duration: 12 months.

C. Other diagnoses/indications – Not applicable

III. Diagnoses/Indications for which coverage is NOT authorized:
Not applicable

IV. Dosage and Administration
There are numerous narcotic analgesics, please refer to the package insert of your drug of interest for information on appropriate dosage and administration.

V. Product Availability
There are numerous narcotic analgesics, please refer to the package insert of your drug of interest for product availability information.

VI. References
1. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain--United States, 2016. JAMA. 2016 Apr 19; 315(15):1624-45.
2. Initial and Continued Approval follow-up periods based on the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain – 2016. www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf
3. Kampman K, Jarvis M. American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. J Addict Med. 2015 Sep-Oct;9(5):358-67.
4. Nebraska Medicaid Preferred Drug List Class criteria for Analgesics, Opioid Long-Acting and Analgesics, Opioid Short-Acting.
5. Nebraska Medicaid Summary of Drug Limitations document.
6. Nebraska Pain Management Guidance Document v3.2 – October 2017

Reviews, Revisions, and Approvals	Date
Initiation of policy	12/6/18
Formatting updates, no content changes	01/28/20
Removed State MME taper schedule, change length of initial approval from 3 to 6 months, change length of continuing approval from 3 to 12 months	03/26/21
Additional information regarding approval of methadone as non-preferred agent	12/1/21
Updated typo regarding use of methadone in certain patient populations	3/14/22
Removed requirement to notify Nebraska Total Care of approval, edited continued therapy for non-cancer pain to be more succinct.	4/3/23

Reviews, Revisions, and Approvals	Date
Removed requirement of having one opioid be long-acting and one opioid be short-acting.	10/10/2023

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.