Opioid Analgesics PA Request Provider Checklist

***** If possible, please include the following information with PA requests for opioid analgesics. Including the requested information does not guarantee PA approval but will decrease PA processing time.*****

All PA Requests for Opioids:

- Is the medication being used for the treatment of pain associated with terminal illness or cancer?
- Is the medication being used for the treatment of pain associated with an acute injury or surgery?
- Is there an established pain treatment agreement and material risk notice between patient and provider?
- Has patient tried and failed non-opioid treatment alternatives?
- Does the patient have a history of a suicide attempt?

Requests Exceeding a 120 mg Morphine Equivalent Dose (MED) per Day

- Has patient tried and failed treatment options under 120 mg MED per day?
- Has patient been evaluated by a pain management specialist or has provider had a consultation with a pain management specialist?

Requests for Continuation of Therapy and Requests for Over 90 Days of Treatment per Year

- Has patient been adherent to the established pain treatment agreement?
- Is there documentation that the requested medication has demonstrated improvement in patient's function and pain status?

Requests for Non-Formulary Opioid Analgesics

- Has patient tried and failed formulary options, or is there a reason why formulary options are contraindicated?

Requests for Methadone

- Has patient tried and failed formulary short-acting opioid treatment alternatives?
- Has patient tried and failed formulary long-acting opioid treatment alternative morphine sulfate ER tablets?

Requests for Fentanyl Transdermal Patches

- Is the patient opioid-tolerant?
- Is the medication being used for the treatment of chronic pain severe enough to require daily, around-the-clock, long-term opioid treatment for which alternative treatments are inadequate?

APPENDICES

Table of 120 mg Morphine Equivalent Doses (MED)

OPIOID	DOSE THRESHOLD
Codeine	800 mg per day
Fentanyl Transdermal Patches	50 mcg/hr patches
Hydrocodone	120 mg per day
Hydromorphone	30 mg per day
Methadone	40 mg per day
Oxycodone	80 mg per day
Oxymorphone	40 mg per day

Non-Opioid Formulary Treatment Alternatives

Antidepressants (DMAP benefit): Amitriptyline, Nortriptyline, Duloxetine, Venlafaxine
Anticonvulsants: Gabapentin capsules, Carbamazepine
Muscle Relaxants: Baclofen, Cyclobenzaprine, Methocarbamol, Tizanidine tablets
NSAIDs: Aspirin, Celebrex (PA required), Diclofenac, Diclofenac/Misoprostol, Etodolac, Ibuprofen, Indomethacin, Meloxicam, Nabumetone (PA required), Naproxen, Salsalate, Sulindac.
Non-Opioid Analgesics: Acetaminophen

Pain Treatment Agreements

Pain treatment agreements should include plans for random UAs, random pill counts, provider review of the prescription drug monitoring program (PDMP), patient use of a single pharmacy, a material risk notice (MRN), and patient abstinence from illegal drug use, marijuana use, and alcohol abuse.

Termination of Authorizations

WVCH reserves the right to revoke previously approved authorizations for the following:

- UA that is positive for illegal drugs, benzodiazepines, controlled substances that have not been prescribed to member, or marijuana.
- UA that is negative for prescribed medication despite regular fill history, refusal of UDS, or failure to perform UDS.
- High risk behavior: Multiple narcotics from multiple prescribers from multiple pharmacies, multiple overrides for lost/stolen controlled substances, evidence of medication diversion.

Non-Funded Conditions

Requests for patients with a history of chronic opioid use with no documentation of an OHP funded condition may be approved as amended to allow for dose tapering (approval of up to 60 days for history of chronic opioid therapy with short-acting opioids and approval of up to 6 months for history of chronic opioid therapy with long-acting opioids). Please include documentation of opioid dose tapering treatment plan.

MED Guide			
Generic Name	Strength	Dosage Form	Qty/day for 120 mg MED
CODEINE SULFATE	15 MG	TABLET	53.33
CODEINE SULFATE	30 MG	TABLET	26.67
CODEINE SULFATE	60 MG	TABLET	13.33
FENTANYL	12.5 MCG/HR	PATCH	1.2
FENTANYL	25 MCG/HR	PATCH	0.6
FENTANYL	50 MCG/HR	PATCH	0.3
HYDROCODONE/APAP	10MG-325MG	TABLET	12
HYDROMORPHONE HCL	2 MG	TABLET	15
HYDROMORPHONE HCL	4 MG	TABLET	7.5
HYDROMORPHONE HCL	8 MG	TABLET	3.75
METHADONE HCL	5 MG	TABLET	8
METHADONE HCL	10 MG	TABLET	4
MORPHINE SULFATE	10 MG/5 ML	SOLN	60
MORPHINE SULFATE	100 MG/5 ML	SOLN	6
MORPHINE SULFATE	15 MG	TABLET	8
MORPHINE SULFATE	30 MG	TABLET	4
MORPHINE SULFATE	15 MG	TABLET ER	8
MORPHINE SULFATE	30 MG	TABLET ER	4
MORPHINE SULFATE	60 MG	TABLET ER	2
OXYCODONE HCL	100 MG/5 ML	SOLN	4
OXYCODONE HCL	5 MG	TABLET	16
OXYCODONE HCL	7.5 MG	TABLET	12
OXYCODONE HCL	10 MG	TABLET	8
OXYCODONE HCL	15 MG	TABLET	5.33
OXYCODONE HCL	20 MG	TABLET	4
OXYCODONE HCL	30 MG	TABLET	2.67

Formulary Listing

Name	Fill Restriction
APAP/Codeine 120/12 mg per 5 mL sol	QL of 240 mL. Max of 1 fill per 180 days.
APAP/Codeine 300/15 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year.
APAP/Codeine 300/30 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year.
APAP/Codeine 300/60 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year.
Codeine Sulfate 15 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Codeine Sulfate 30 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Codeine Sulfate 60 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Fentanyl 25 mcg/hr patches	PA required.
Fentanyl 50 mcg/hr patches	PA required.
Hydrocodone/APAP 7.5/325 mg per 15 mL sol	QL of 240 mL. Max of 1 fill per 180 days.
Hydrocodone/APAP 5/325 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year.
Hydrocodone/APAP 7/325 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year.
Hydrocodone/APAP 10/325 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year.
Hydrocodone/Ibuprofen 7.5/200 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year.
Hydromorphone 2 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Hydromorphone 4 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Hydromorphone 8 mg tabs	QL per time of 90 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Methadone 5 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18 and for all new starts
Methadone 10 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18 and for all new starts

Name	Fill Restriction
Morphine IR 15 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Morphine IR 30 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Morphine ER 15 mg tabs	QL per time of 90 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Morphine ER 30 mg tabs	QL per time of 90 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Morphine ER 60 mg tabs	QL per time of 60 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Oxycodone 5 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Oxycodone 10 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Oxycodone 15 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Oxycodone 20 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Oxycodone 30 mg tabs	QL per time of 60 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Oxycodone/APAP 5/325 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Oxycodone/APAP 7.5/325 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.
Oxycodone/APAP 10/325 mg tabs	QL per time of 120 tabs in 25 days. Max of 90 days per year. PA required for patients under 18.

Short-Acting Opioid (SAO) PA Criteria

*****Continuation of therapy requests that do not meet criteria may be approved as amended for up to 60 days to allow for PA criteria compliance or dose tapering*****

1. Is the patient being treated for an OHP funded condition?
    a. If Yes, move to question #2.
    b. If No, review documentation for relevant comorbid conditions. If there are relevant comorbid conditions, move to question #2. If there are no relevant comorbid conditions, Cat. 1 denial.

2. Is the requested medication on the formulary?
    a. If Yes, move to question #4.
    b. If No, move to question #3.

3. Has patient tried and failed formulary options?
    a. If Yes, more to questions #4.
    b. If No, Cat. 15 denial.

4. Is the requested medication being used for the treatment of pain associated with cancer or a terminal illness?
    a. If Yes, **Approve for 12 months**.
    b. If No, move to questions #5.

5. Is the requested medication being used for the treatment of acute pain associated with a recent injury or surgery?
    a. If Yes, **Approve for up to 90 days**.
    b. If No, move to questions #6.

6. Has the patient tried and failed (or is the patient currently using) non-opioid treatment alternatives?
   See page 2 for examples of non-opioid treatment alternatives.
    a. If Yes, move to question #7.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

7. Does the patient have a history of a suicide attempt within the last 2 years or a suicide attempt using pills anytime?
    a. If Yes, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).
    b. If No, move to question #8.

8. Does the dosing of the medication exceed a 120 mg morphine equivalent dose (MED) per day?
    a. If Yes, move to question #9.
    b. If No, move to question #11.

9. Has patient tried and failed medication doses under 120 mg MED per day?
    a. If Yes, move to question #10.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

10. Has patient been evaluated by a pain management specialist or has provider had a consultation with a pain management specialist?
    a. If Yes, move to question #11.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

11. Is there an established pain treatment agreement between patient and provider?
    See page 2 for pain treatment agreement recommendations.
    a. If Yes, move to question #12.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

12. Does the request represent a new start or a continuation of therapy?
    a. If request is a New Start, **Approve for up to 90 days.**
    b. If request is a continuation of therapy, move to question #13.

13. Does the provider submitted documentation indicate that medication use has demonstrated an improvement in patient's function and pain status?
    a. If Yes, move to question #14.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

14. Has the patient been adherent to their established pain treatment agreement?
    a. If Yes, **Approve for 6 months.**
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

Long-Acting Opioid (LAO) PA Criteria

*****Continuation of therapy requests that do not meet criteria may be approved as amended for up to 6 months to allow for PA criteria compliance or dose tapering*****

1. Is the patient being treated for an OHP funded condition?
    a. If Yes, move to question #2.
    b. If No, review documentation for relevant comorbid conditions. If there are relevant comorbid conditions, move to question #2. If there are no relevant comorbid conditions, Cat. 1 denial.

2. Is the requested medication on the formulary?
    a. If Yes, move to question #4.
    b. If No, move to question #3.

3. Has patient tried and failed formulary options?
    a. If Yes, more to questions #4.
    b. If No, Cat. 15 denial.

4. Is the requested medication being used for the treatment of pain associated with cancer or a terminal illness?
    a. If Yes, **Approve for 12 months**.
    b. If No, move to questions #5.

5. Has the patient tried and failed (or is the patient currently using) non-opioid treatment alternatives?
   See page 2 for examples of non-opioid treatment alternatives.
    a. If Yes, move to question #6.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

6. Does the patient have a history of a suicide attempt within the last 2 years or a suicide attempt using pills anytime?
    a. If Yes, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).
    b. If No, move to question #7.

7. Does the patient's total opioid use (IR and ER products) exceed a 120 mg morphine equivalent dose (MED) per day?
    a. If Yes, move to question #8.
    b. If No, move to question #10.

8. Has patient tried and failed medication doses under 120 mg MED per day?
    a. If Yes, move to question #9.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

9. Has patient been evaluated by a pain management specialist or has provider had a consultation with a pain management specialist?
    a. If Yes, move to question #10.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

10. Is there an established pain treatment agreement between patient and provider?
See page 2 for pain treatment agreement recommendations.
    a. If Yes, move to question #11.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

11. Does the request represent a new start or a continuation of therapy?
    a. If request is a New Start, **Approve for up to 90 days.**
    b. If request is a continuation of therapy, move to question #12.

12. Does the provider submitted documentation indicate that medication use has demonstrated an improvement in patient's function and pain status?
    c. If Yes, move to question #13.
    d. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

13. Has the patient been adherent to their established pain treatment agreement?
    a. If Yes, **Approve for 6 months.**
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

Methadone PA Criteria

*****Continuation of therapy requests that do not meet criteria may be approved as amended for up to 6 months to allow for PA criteria compliance or dose tapering*****

1. Is the patient being treated for an OHP funded condition?
    a. If Yes, move to question #2.
    b. If No, review documentation for relevant comorbid conditions. If there are relevant comorbid conditions, move to question #2. If there are no relevant comorbid conditions, Cat. 1 denial.

2. Is the requested medication on the formulary?
    a. If Yes, move to question #4.
    b. If No, move to question #3.

3. Has the patient tried and failed formulary options?
    a. If Yes, more to questions #4.
    b. If No, Cat. 15 denial.

4. Is the requested medication being used for the treatment of pain associated with cancer or a terminal illness?
    a. If Yes, **Approve for 12 months**.
    b. If No, move to questions #5.

5. Has the patient tried and failed non-opioid treatment alternatives, short-acting opioids, and morphine sulfate ER tablets?
See page 2 for examples of non-opioid treatment alternatives.
    a. If Yes, move to question #6.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

6. Does the patient have a history of a suicide attempt within the last 2 years or a suicide attempt using pills anytime?
    a. If Yes, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).
    b. If No, move to question #7.

7. Does the patient's total opioid use (IR and ER products) exceed a 120 mg morphine equivalent dose (MED) per day?
    a. If Yes, move to question #8.
    b. If No, move to question #10.

8. Has patient tried and failed medication doses under 120 mg MED per day?
    a. If Yes, move to question #9.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

9. Has patient been evaluated by a pain management specialist or has provider had a consultation with a pain management specialist?
    a. If Yes, move to question #10.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

10. Is there an established pain treatment agreement between patient and provider?
    See page 2 for pain treatment agreement recommendations.
    a. If Yes, move to question #11.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

11. Does the request represent a new start or a continuation of therapy?
    a. If request is a New Start, **Approve for up to 90 days.**
    b. If request is a continuation of therapy, move to question #12.

12. Does the provider submitted documentation indicate that medication use has demonstrated an improvement in patient's function and pain status?
    e. If Yes, move to question #13.
    f. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

13. Has the patient been adherent to their established pain treatment agreement?
    a. If Yes, **Approve for 6 months.**
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

* Special consideration may be given to patients currently on chronic opioid therapy with methadone in whom dose decreases or medication discontinuation may result in destabilization, and patient "grandfathering" may be approved. Providers may contact a WVP HA pharmacist to have the coverage of methadone by the plan continued for patients with a history of chronic methadone use.

Fentanyl Transdermal Patch PA Criteria

*****Continuation of therapy requests that do not meet criteria may be approved as amended for up to 6 months to allow for PA criteria compliance or dose tapering*****

1. Is the patient being treated for an OHP funded condition?
    a. If Yes, move to question #2.
    b. If No, review documentation for relevant comorbid conditions. If there are relevant comorbid conditions, move to question #2. If there are no relevant comorbid conditions, Cat. 1 denial.

2. Is the patient opioid-tolerant?
    Opioid-tolerant is defined as patients who are taking at least 60 mg/day of oral morphine, transdermal fentanyl 25 mcg/hour, oral oxycodone 30 mg/day, oral hydromorphone 8 mg/day, oral oxymorphone 25 mg/day, or equianalgesic dose of another opioid for ***at least one week****.*
    a. If Yes, move to question #3.
    b. If No, Cat. 3 denial and Cat. 5 denial.
    Fentanyl transdermal patches are not indicated for opioid-naïve patients.

3. Is the medication being used for the treatment of chronic pain severe enough to require daily, around-the-clock, long-term opioid treatment for which alternative treatments are inadequate?
    a. If Yes, move to question #4.
    b. If No, Cat. 3 denial and Cat. 5 denial.
    Fentanyl transdermal patches are only indicated for the treatment of chronic pain that meets this criteria.

4. Is the medication being used for the treatment of pain associated with cancer or a terminal illness?
    a. If Yes, **Approve for 12 months.**
    b. If No, move to questions #5.

5. Does the dosing of the medication exceed the 50 mcg/hr patches?
    a. If Yes, move to question #6.
    b. If No, move to question #8.

6. Has patient tried and failed medication doses under the 50 mcg/hr patches?
    a. If Yes, move to question #7.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

7. Has patient been evaluated by a pain management specialist or has provider had a consultation with a pain management specialist?
    a. If Yes, move to question #8.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

8. Is the medication dosing interval within the FDA approved dosing?
    FDA approved dosing interval for fentanyl transdermal patches is every 48 to 72 hours.
    a. If Yes, move to question #9.
    b. If No, Cat. 3 denial and Cat. 5 denial.

9. Is there an established pain treatment agreement between patient and provider?
    See page 2 for pain treatment agreement recommendations.
    a. If Yes, move to question #10.
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

10. Does the request represent a new start or a continuation of therapy?
    a. If request is a New Start, **Approve for up to 90 days.**
    b. If request is a continuation of therapy, move to question #11.

11. Does the provider submitted documentation indicate that medication use has demonstrated an improvement in patient's function and pain status?
    g. If Yes, move to question #12.
    h. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

12. Has the patient been adherent to their established pain treatment agreement?
    a. If Yes, **Approve for 6 months.**
    b. If No, forward to Medical Director to assess medical appropriateness (Possible Cat. 5 denial).

Guide to Denial Categories	Reason for Denial
Category 1	The condition is not on a funded line
Category 3	The use of the medication is considered experimental/ investigational (usually applies to off-label use of a medication)
Category 5	Not medically appropriate
Category 15	Formulary medications have not been exhausted