

DRUG QUANTITY MANAGEMENT POLICY – PER RX

POLICY: Opioids – Short-Acting Products DQM Policy (All Ages) – Per Rx

Note: This is not an inclusive list. As new products become available, they will roll into this policy and the list will be updated periodically.

- Alfentanil injectable
- Benzhydrocodone combination oral tablets
- Buprenorphine injectable
- Butorphanol injectable, nasal solution
- Codeine oral tablets, combination product oral tablets/capsules, combination product oral solution
- Dihydrocodeine combination oral tablets/capsules
- Fentanyl transmucosal lozenges, buccal tablets, nasal solution, sublingual spray, sublingual tablet, injectable, transdermal patches
- Hydrocodone combination product oral tablets, combination product oral solution
- Hydromorphone injectable, oral tablets, oral solution, rectal suppositories
- Levorphanol oral tablets
- Meperidine oral tablets, oral solution, injectable
- Morphine oral tablets, oral solution, injectable, rectal suppositories
- Nalbuphine injectable
- Opium/Belladonna rectal suppositories
- Oxycodone oral tablets, oral capsules, oral solution, combination product oral tablets, combination product oral solution
- Oxymorphone oral tablets
- Pentazocine/naloxone oral tablets
- Remifentanil injectable
- Sufentanil injectable
- Tapentadol oral tablets
- Tramadol oral tablets, combination product oral tablets

REVIEW DATE: 02/01/2023

OVERVIEW

Short-acting opioids are indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.¹

Guidelines

In 2022, the **Centers for Disease Control and Prevention (CDC)** published an updated guideline for prescribing opioids for pain.¹ Nonopioid therapies are at least as effective as opioids for many common types of acute pain, and nonopioid therapies are preferred for subacute and chronic pain. Clinicians should maximize the use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Multiple noninvasive nonpharmacologic interventions (e.g., aerobic, aquatic, or resistance exercises, weight loss, psychological therapy, spinal manipulation, low-level laser therapy, massage, mindfulness-based stress reduction, yoga, tai chi, qigong, acupuncture, cognitive behavioral therapy, and spinal manipulation) are associated with improvements in pain, function, or both, that are sustained after treatment and are not associated with serious harms. Non-

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opioid drugs (e.g., tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitor [SNRI] antidepressants, duloxetine, selected antiseizure medications (e.g., pregabalin, gabapentin, oxcarbazepine), capsaicin and lidocaine patches, and nonsteroidal anti-inflammatory drugs [NSAIDs]) are associated with small to moderate improvements in chronic pain and function for certain chronic pain conditions.

Before initiating opioid therapy for patients with pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy.¹ Before starting ongoing opioid therapy for patients with subacute or chronic pain, clinicians should work with patients to establish treatment goals for pain and function and consider how opioid therapy will be discontinued if benefits do not outweigh risks. When opioids are initiated, clinicians should prescribe the lowest effective dosage of immediate-release opioids for no longer than needed for the expected duration of pain severe enough to require opioids. During ongoing opioid therapy, clinicians should collaborate with patients to evaluate and carefully weigh the benefits and risks of continuing opioid therapy and exercise care when increasing, continuing, or reducing opioid dosage.

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate the risk for opioid-related harms and should work with patients to incorporate relevant strategies to mitigate risk, including offering naloxone and reviewing potential interactions with any other prescribed medications or substances used.¹ When prescribing initial opioid therapy and periodically during opioid therapy, clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose. When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances.

The 2020 **American Society of Hematology** guideline for the management of acute and chronic pain in patients with sickle cell disease states that pain causes significant morbidity for those living with sickle cell disease and manifests as acute intermittent pain, chronic daily pain, and acute-on-chronic pain.² For adults and children with chronic pain who are receiving chronic opioid therapy, are functioning well, and have perceived benefit, the guideline suggests shared decision making for continuation of chronic opioid therapy. For adults and children with chronic pain who are receiving chronic opioid therapy, are functioning poorly, or are at high risk for aberrant opioid use or toxicity, the guideline suggests against continuation of chronic opioid therapy.

POLICY STATEMENT

This Drug Quantity Management program has been developed to restrict the initial days' supply of short-acting opioids to 7 days, thus decreasing the quantity dispensed to align with current guidelines and prevent stockpiling and/or misuse. A quantity sufficient for a 7-day supply will be covered without prior authorization. Additional quantities for greater than a 7-day supply will require coverage review. If the Drug Quantity Management rule is not met for the requested product at the point of service, coverage will be determined by the Criteria below. All approvals are provided for 1 year in duration.

Note: This policy includes multiple formulations of the medications listed on page 1; the list is not inclusive. As new products become available, they will roll into this policy and the list will be updated periodically. Point of sale alerts also manage the quantity of opioid product distribution. Those point of sale alerts occur prior to any Utilization Management edits.

Automation: This policy targets new users of short-acting opioid products only. A patient with a history of any opioid within the 130-day look-back period is excluded from Drug Quantity Management. If the patient has a prescription for a cancer medication (see Appendix A) within a 180-day period, the claim will

adjudicate. When available, the ICD-10 codes for cancer will be used as part of automation to allow approval of the requested medication (see Appendix B).

CRITERIA

1. Approve the requested quantity if the patient meets ONE of the following criteria (A, B, C, or D):
 - A) Patient has a cancer diagnosis; OR
 - B) Patient is in hospice program, end-of-life care, or palliative care; OR
 - C) Patient meets BOTH of the following criteria (i and ii):
 - i. Patient has a diagnosis of sickle cell disease; AND
 - ii. Medication is being prescribed by or in consultation with a hematologist; OR
 - D) Patient meets ALL of the following criteria (i, ii, iii, iv, and v):
 - i. Non-opioid therapies (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs], acetaminophen) have provided an inadequate response or are inappropriate according to the prescriber; AND
 - ii. Patient’s of controlled substance prescriptions has been checked using the state prescription drug monitoring program (PDMP), according to the prescriber; AND
 - iii. Risks (e.g., addiction, overdose) and realistic benefits of opioid therapy have been discussed with the patient according to the prescriber; AND
 - iv. Need for a naloxone prescription has been assessed and naloxone has been ordered, if necessary, according to the prescriber; AND
 - v. Need for periodic scheduled toxicology testing has been assessed and ordered, if necessary, according to the prescriber.

REFERENCES

1. Dowell D, Ragan KR, Jones CM, et al. CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022. *MMWR Recomm Rep.* 2022;71(3):1-95.
2. Brandow AM, Carroll CP, Creary S, et al. American Society of Hematology 2020 guidelines for sickle cell disease: management of acute and chronic pain. *Blood Adv.* 2020;4(12):2656-2701.

Type of Revision	Summary of Changes	Review Date
Annual Revision	The following products were removed from the policy (no longer available): codeine combination product oral suspension, oxymorphone injection, pentazocine injection. Automation for ICD-9 codes removed from the policy (ICD-10 codes remain in place).	06/30/2022
Early Annual Revision	A note was added to state “Point of sale alerts also manage the quantity of opioid product distribution. Those point of sale alerts occur prior to any Utilization Management edits.” New override criteria were added to approve the quantity requested if the patient has a diagnosis of sickle cell disease and the medication is prescribed by or in consultation with a hematologist. Added criterion that the need for a naloxone prescription has been assessed and naloxone has been ordered, if necessary, according to the prescriber. Added criterion that the need for periodic toxicology testing has been assessed and ordered, if necessary, according to the prescriber.	02/01/2023

APPENDIX A

Note: This list is not inclusive. As new STCs become available, they will roll into this policy and the list will be updated periodically.

STC*	STC Description
0470	ANTINEOPLASTIC - ALKYLATING AGENTS
0471	ANTINEOPLASTIC - ANTIMETABOLITES
0472	ANTINEOPLASTIC - VINCA ALKALOIDS
0473	ANTIBIOTIC ANTINEOPLASTICS
0475	ANTINEOPLASTICS, MISCELLANEOUS
6323	ANTINEOPLASTIC - ANTIANDROGENIC AGENTS
7235	ANTINEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES
7977	ANTINEOPLASTIC IMMUNOMODULATOR AGENTS
8254	ANTINEOPLASTIC LHRH(GNRH) AGONIST, PITUITARY SUPPR.
8460	ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS
8569	ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY
8585	ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY
9150	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS
B759	ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS
C232	ANTINEOPLASTIC - MTOR KINASE INHIBITORS
C370	ANTINEOPLASTIC - EPOTHILONES AND ANALOGS
C532	ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS
C593	ANTINEOPLASTIC - AROMATASE INHIBITORS
D426	ANTINEOPLASTIC - IMMUNOTHERAPY, THERAPEUTIC VAC
D560	ANTINEOPLASTIC - MICROTUBULE INHIBITORS
D687	CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY
E039	ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS
E150	ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR
E600	ANTINEOPLASTIC - VEGF-A,B AND PLGF INHIBITORS
F495	ANTINEOPLASTIC - INTERLEUKIN-6(IL-6)INHIB,ANTIBODY
F501	ANTINEOPLASTIC - VEGFR ANTAGONIST
F665	ANTINEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB
G545	ANTINEOPLASTIC - IMMUNOTHERAPY, VIRUS-BASED AGENTS
G575	ANTINEOPLASTIC - MEK1 AND MEK2 KINASE INHIBITORS
G590	ANTINEOPLASTIC - ANTI-CD38 MONOCLONAL ANTIBODY
G607	ANTINEOPLASTIC - ANTI-SLAMF7 MONOCLONAL ANTIBODY
G802	ANTINEOPLASTIC- B CELL LYMPHOMA-2(BCL-2) INHIBITORS
G857	ANTI-PROGRAMMED CELL DEATH-LIGAND 1 (PD-L1) MAB
H018	ANTINEOPLASTIC, PDGFR-ALPHA BLOCKER MC ANTIBODY
H214	ANTINEOPLASTIC COMB-KINASE AND AROMATASE INHIBIT
H289	ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS
H309	ANTINEOPLASTIC – ANTIBIOTIC AND ANTIMETABOLITE
H317	ANTINEOPLASTIC – CD22 ANTIBODY-CYTOTOXIC ANTIBIOTIC
H324	ANTINEOPLASTIC- CD19 DIR. CAR-T CELL IMMUNOTHERAPY
H329	ANTINEOPLASTIC – CD33 ANTIBODY-CYTOTOXIC ANTIBIOTIC
H617	ANTINEOPLASTIC – BRAF KINASE INHIBITORS
H768	ANTINEOPLASTIC-CD22 DIRECT ANTIBODY/CYTOTOXIN CONJ
H868	ANTINEOPLASTIC-CD123-DIRECTED CYTOTOXIN CONJUGATE
I054	ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)
I264	ANTINEOPLASTIC – PROTEIN METHYLTRANSFERASE INHIBITORS
I482	ANTINEOPLASTIC – CD19 (B LYMPHOCYTE) MC ANTIBODY
I738	ANTINEOPLASTIC – EGFR AND MET RECEPTOR INHIB, MAB
I746	ANTINEOPLASTIC – KRAS INHIBITOR
I832	ANTINEOPLASTIC – HYPOXIA INDUCIBLE FACTOR (HIF) INH
I938	ANTINEOPLASTIC – IMMUNOTHERAPY, T-CELL ENGAGER
I996	ANTINEOPLASTIC – IMMUNOTHERAPY CHECKPOINT INHIB COMB

* Excluding topical products.

APPENDIX B

*Indicates the inclusion of subheadings.