UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2020 P 4000-7
Program	Opioid Overutilization Cumulative Drug Utilization Review Criteria (including individual long-acting opioid supply limits.)
Medication	All salt forms, single and combination ingredient products, all long- and short-acting formulations, and all brand and generic formulations: including but not limited to codeine, buprenorphine (for pain)[1], dihydrocodeine, fentanyl, methadone, meperidine, morphine, hydrocodone, hydromorphone, levorphanol, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol
P&T Approval Date	8/2016, 2/2017, 9/2017, 4/2018, 6/2018, 9/2018, 4/2019, 4/2020
Effective Date	7/1/2020; Oxford only: 7/1/2020

1. Background:

The Center for Disease Control (CDC) recommends that clinicians should prescribe the lowest effective dosage when opioids are started. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to 50 morphine milligram equivalents (MME) or more per day, and should avoid increasing dosage to 90 MME or more per day or carefully justify a decision to titrate dosage to 90 MME or more per day.

According to the CDC, if a patient's opioid dosage for all sources of opioids combined reaches or exceeds 50 MME per day, clinicians should implement additional precautions, including increased frequency of follow-up and considering offering naloxone. Clinicians should avoid increasing opioid dosages to 90 MME or more per day or should carefully justify a decision to increase dosage to 90 MME or more per day based on individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to harms as dosages approach 90 MME per day, other treatments and effectiveness, and recommendations based on consultation with pain specialists. If patients do not experience improvement in pain and function at 90 MME or more per day, or if there are escalating dosage requirements, clinicians should discuss other approaches to pain management, consider working with patients to taper opioids to a lower dosage, consider discontinuation of some or all opioids, and evaluate patients for opioid use disorder

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2. Coverage Criteria[a]:

A. Individual Long-Acting Supply Limits

1. **Cancer or End of Life (defined as a < 2 year life expectancy) related pain for individual long-acting supply limits**

a. Coverage will be approved based on the following criterion:

(1) Patient requires treatment with opioids due to active cancer diagnosis or end of life related pain (document cancer diagnosis or for end of life, expectancy of < 2 years.)

Authorization for cancer or end of life pain will be issued for 24 months for a quantity of 9999 to prevent further disruption in therapy if the patient's dose is increased. If the patient is <u>currently</u> taking a high dose opioid regimen where the supply limit is exceeded and does not meet the authorization criteria requirements for approval, a denial will be issued and a transition authorization of 90 days may be issued one time up to the current quantity with up to one additional transition authorization (total of 2 transition authorizations).

2. **Non-cancer and Non-End of Life Pain for individual long-acting supply limits (Initial Authorization)**

a. Coverage will be approved based on **<u>ALL</u>** of the following:

(1) Prescriber attests to **<u>ALL</u>** of the following:

(a) The information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided.
(b) Treatment goals are defined, including estimated duration of treatment.
(c) Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention
(d) If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression.
(e) Patient has been screened for substance abuse/opioid dependence.

-AND-

(2) The opioid regimen is not being used in combination with buprenorphine containing products for opioid dependence.

-AND-

(3) Document **BOTH** of the following:

(a) The total daily desired morphine milligram equivalent requested for the patient.
(b) The diagnosis associated with the need for pain management.

-AND-

(4) State prescription drug monitoring program (PDMP), if available, has been reviewed to identify any concurrently prescribed controlled substances

-AND-

(5) **BOTH** of the following:

(a) Patient has tried and failed non-opioid pain medication (document drug name and date of trial)
(b) Have used opioid medications in lower doses and did not adequately control pain (document drug regimen or MME and dates of therapy)

Authorization will be issued for 6 months for the requested quantity up to the maximum ceiling limit. If the patient is currently taking a high dose opioid regimen where the supply limit is exceeded and does not meet the authorization criteria requirements for approval, a denial will be issued and a transition authorization of 90 days may be issued one time up to the current quantity with up to one additional transition authorization (total of 2 transition authorizations).

3. **Non-cancer and Non-End of Life Pain for individual long-acting supply limits (Reauthorization)**

a. **ALL** of the following:

(1) Prescriber attests to **ALL** of the following:

(a) The information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to

verify the accuracy of the information provided.
(b) Treatment goals are defined, including estimated duration of treatment.
(c) Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention
(d) If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression.
(e) Patient has been screened for substance abuse/opioid dependence.

-AND-

(2) The opioid regimen is not being used in combination with buprenorphine containing products for opioid dependence.

-AND-

(3) Identify rationale for not tapering and discontinuing opioid (Document rationale).

-AND-

(4) Patient demonstrates meaningful improvement in pain and function (Document improvement in function or pain score improvement).

-AND-

(5) Document **BOTH** of the following:

(a) The total daily desired morphine milligram equivalent requested for the patient.
(b) The diagnosis associated with the need for pain management.

-AND-

(6) State prescription drug monitoring program (PDMP), if available, has been reviewed to identify any concurrently prescribed controlled substances

Authorization will be issued for 6 months for the requested quantity up to the maximum ceiling limit. If the patient is currently taking a high dose opioid regimen where the supply limit is exceeded and does not meet the authorization criteria requirements for approval, a denial will be issued and a transition authorization of 90 days may be issued one time up to the current

quantity with up to one additional transition authorization (total of 2 transition authorizations).

B. Cumulative MMELIMIT (MEDLIMIT)^.

1. **Cancer or End of Life (defined as a < 2 year life expectancy) related pain for MMELIMIT (MEDLIMIT)**

    a. Cumulative doses exceeding 180 morphine milligram equivalents (MME) will be approved based on the following criteria:

        (1) Patient is being treated for active cancer diagnosis or end of life related pain (document cancer diagnosis or for end of life, expectancy of < 2 years.)

Authorization for cancer or end of life pain will be issued for 24 months for an MME of 9999 to prevent further disruption in therapy if the patient's dose is increased. If the patient is <u>currently</u> taking a high dose opioid regimen where the MME exceeds 180 and does not meet the authorization criteria requirements for cumulative opioid overutilization, a denial will be issued and a transition authorization of 90 days may be issued one time up to the current MME with up to one additional transition authorization (total of 2 transition authorizations). A transition authorization should not be granted to patients <u>currently</u> at or below the180 MME threshold.

2. **Non-cancer and Non-End of Life Pain for MMELIMIT (MEDLIMIT)- (Initial Authorization)**

    a. Coverage will be approved based on the following:

        (1) Required to meet all criteria for individual long-acting supply limits above (Section 2)

Authorization will be issued for 6 months up to the current requested MME plus 90 MME up to a maximum of 990. If the patient is <u>currently</u> taking a high dose opioid regimen where the MME exceeds 180 and does not meet the authorization criteria requirements for cumulative opioid overutilization, a denial will be issued and a transition authorization of 90 days may be issued one time up to the current MME with up to one additional transition authorization (total of 2 transition authorizations). A transition authorization should not be granted to patients <u>currently</u> at or below the180 MME threshold.

3. **Non-cancer and Non-End of Life Pain for MMELIMIT (MEDLIMIT)**

(Reauthorization)

a. Coverage will be approved based on all of the following:

(1) Required to meet all criteria for individual long-acting supply limits above (Section 3)

Authorization will be issued for 6 months up to the current requested MME plus 90 MME up to a maximum of 990. If the patient is currently taking a high dose opioid regimen where the MME exceeds 180 and does not meet the authorization criteria requirements for cumulative opioid overutilization, a denial will be issued and a transition authorization of 90 days may be issued one time up to the current MMME with up to one additional transition authorization (total of 2 transition authorizations). A transition authorization should not be granted to patients currently at or below the 180 MME threshold.

***If in Ohio, prescribers should reference the Ohio Guidelines created by the Governor's Cabinet Opiate Action Team when the dose exceeds 80 MME.**

Supply Limit Grid[1]:

Drugs Strength	CDC Max MME (90 MME equivalent*)	Supply Limit/Month	Supply Limit Ceiling Limit for Non-Cancer/ End of Life Pain**
Arymo ER 15 mg	90 mg/day	93	93 (3/day)
Arymo ER 30 mg	90 mg/day	93	93 (3/day)
Arymo ER 60 mg	90 mg/day	31	124 (4/day)
Avinza 30 mg	90 mg/day	31	31 (1/day)
Avinza 45 mg	90 mg/day	31	31 (1/day)
Avinza 60 mg	90 mg/day	31	31 (1/day)
Avinza 75 mg	90 mg/day	31	93 (3/day)
Avinza 90 mg	90 mg/day	31	62 (2/day)
Avinza 120 mg	90 mg/day	0	62 (2/day)
Dolophine 10mg	22.5 mg/day	62	186 (6/day)
Dolophine 5 mg	22.5 mg/day	124	124 tablets (4/day)
Duragesic 12 mcg/hr	50 mcg q 72 hrs (1/2 patch/day equivalent)	15	15 (0.5/day)
Duragesic 25 mcg/hr	50 mcg q 72 hrs (1/2 patch/day equivalent)	15	15 (0.5/day)
Duragesic 50 mcg/hr	50 mcg q 72 hrs (1/2 patch/day equivalent)	10	15 (0.5/day)

Duragesic 75 mcg/hr	50 mcg q 72 hrs (1 patch/day equivalent)	10	10 (0.33/day)
Duragesic 100 mcg/hr	50 mcg q 72 hrs (1 patch/day equivalent)	10	10 (0.33/day)
Exalgo 8 mg	24 mg/day	31	31 (1/day)
Exalgo 12 mg	24 mg/day	62	62 (2/day)
Exalgo 16 mg	24 mg/day	31	93 (3/day)
Exalgo 32 mg	24 mg/day	0	31 (1/day)
Fentanyl Patch 37.5 mcg/hr^	50 mcg q 72 hrs (1/2 patch/day equivalent)	10	15 (0.5/day)
Fentanyl Patch 62.5 mcg/hr^	50 mcg q 72 hrs (1 patch/day equivalent)	10	15 (0.5/day)
Fentanyl Patch 87.5 mcg/hr^	50 mcg q 72 hrs (1 patch/day equivalent)	10	10 (0.33/day)
Hysingla ER 20 mg	90 mg/day	31	31 (1/day)
Hysingla ER 30 mg	90 mg/day	31	31 (1/day)
Hysingla ER 40 mg	90 mg/day	31	31 (1/day)
Hysingla ER 60 mg	90 mg/day	31	31 (1/day)
Hysingla ER 80 mg	90 mg/day	31	93 (3/day)
Hysingla ER 100 mg	90 mg/day	0	62 (2/day)
Hysingla ER 120 mg	90 mg/day	0	62 (2/day)
Kadian 10 mg	90 mg/day	62	62 (2/day)
Kadian 20 mg	90 mg/day	62	62 (2/day)
Kadian 30 mg	90 mg/day	62	62 (2/day)
Kadian 40 mg	90 mg/day	62	62 (2/day)
Kadian 50 mg	90 mg/day	31	62 (2/day)
Kadian 60 mg	90 mg/day	31	62 (2/day)
Kadian 70 mg	90 mg/day	31	62 (2/day)
Kadian 80 mg	90 mg/day	31	93 (3/day)
Kadian 100 mg	90 mg/day	0	62 (2/day)
Kadian 130 mg	90 mg/day	0	31 (1/day)
Kadian 150 mg	90 mg/day	0	31 (1/day)
Kadian 200 mg	90 mg/day	0	31 (1/day)
Methadone 10/5 mL	22.5 mg/day	350 mL	930mL (30 mL/day)
Methadone 5/5mL	22.5 mg/day	700 mL	1860 mL (60 mL/ day)
Methadone 10/1 mL	22.5 mg/day	186 mL	186 mL (6 mL/day)
Methadone 40 mg tablet for oral suspension	22.5 mg/day	45 tablets	45 tablets (1.5 tablets/day)

Morphabond ER 15 mg	90 mg/day	93	93 (3/day)
Morphabond ER 30 mg	90 mg/day	93	93(3/day)
Morphabond ER 60 mg	90 mg/day	0	124 (4/day)
Morphabond ER 100 mg	90 mg/day	0	62 (2/day)
MS Contin 15 mg	90 mg/day	93	93 (3/day)
MS Contin 30 mg	90 mg/day	93	93 (3/day)
MS Contin 60 mg	90 mg/day	0	124 (4/day)
MS Contin 100 mg	90 mg/day	0	62 (2/day)
MS Contin 200 mg	90 mg/day	0	31 (1/day)
Nucynta ER 50 mg	225 mg/day	62	62 (2/day)
Nucynta ER 100 mg	225 mg/day	62	62 (2/day)
Nucynta ER 150 mg	225 mg/day	0	93(3/day)
Nucynta ER 200 mg	225 mg/day	0	62 (2/day)
Nucynta ER 250 mg	225 mg/day	0	62 (2/day)
Opana ER 5 mg	30 mg/day	62	62 (2/day)
Opana ER 7.5 mg	30 mg/day	62	62 (2/day)
Opana ER 10 mg	30 mg/day	62	62 (2/day)
Opana ER 15 mg	30 mg/day	62	62 (2/day)
Opana ER 20 mg	30 mg/day	0	62 (2/day)
Opana ER 30 mg	30 mg/day	0	62 (2/day)
Opana ER 40 mg	30 mg/day	0	62 (2/day)
OxyContin/ oxycodone extended-release authorized generic 10 mg	60 mg/day	62	62 (2/day)
OxyContin/ oxycodone extended-release authorized generic 15 mg	60 mg/day	62	62 (2/day)
OxyContin/ oxycodone extended-release authorized generic 20 mg	60 mg/day	62	62 (2/day)
OxyContin/ oxycodone extended-release authorized generic 30 mg	60 mg/day	62	62 (2/day)
OxyContin/ oxycodone extended-release authorized	60 mg/day	0	62 (2/day)

generic 40 mg			
OxyContin/ oxycodone extended-release authorized generic 60 mg	60 mg/day	0	62 (2/day)
OxyContin/ oxycodone extended-release authorized generic 80 mg	60 mg/day	0	62 (2/day)
Xtampza ER 9 mg	54 mg/day	62	62 (2/day)
Xtampza ER 13.5 mg	54 mg/day	62	62 (2/day)
Xtampza ER 18 mg	54 mg/day	62	62 (2/day)
Xtampza ER 27 mg	54 mg/day	62	155 (5/day)
Xtampza ER 36 mg	54 mg/day	0	124 (4/day)
Zohydro ER 10 mg	90 mg/day	62	62 (2/day)
Zohydro ER 15 mg	90 mg/day	62	62 (2/day)
Zohydro ER 20 mg	90 mg/day	62	62 (2/day)
Zohydro ER 30 mg	90 mg/day	62	62 (2/day)
Zohydro ER 40 mg	90 mg/day	62	186 (6/day)
Zohydro ER 50 mg	90 mg/day	0	124 (4/day)

1 For buprenorphine pain product supply limit please see Butrans or Belbuca criteria
^ MMELIMIT (MEDLIMIT) refers to Cumulative MME of 180
**** Ceiling limit is based on dose optimization and a maximum of 240 MME**

3. Additional Clinical Programs:
Medical Necessity and Step Therapy may also be in place.

4. References:
1. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. JAMA. Published online March 2016.

Program	Opioid Overutilization Cumulative Drug Utilization Review Criteria
Change Control	
8/2016	New program
2/2017	Added dihydrocodeine and table with morphine equivalent doses. Removed requirement for submission of request on opioid overutilization fax form. Enhanced open ended clinical questions to align with long-acting opioid reauthorization criteria. Added requirement that opioid regimen is not being used in combination with buprenorphine containing products. Increased authorization duration to 12 months. Added allowance to provide a 90 day transition authorization for those who do not meet criteria.
9/2017	Combined cancer and end of life criteria. Removed attestation from cancer and end of life section. Added override to maximum MED threshold to cancer and end of life section. Aligned open ended response criteria with long-acting opioid medical necessity criteria. Added threshold level approvals to minimize member disruption with dose increases. Decreased non cancer authorization from 12 months to 6 months. Removed requirement to consult with a pain management specialist
4/2018	Revised criteria for cancer/end of life. Increased authorization period to 24 months. Updated transition authorization to note a maximum of two transition authorizations. Revised non-cancer/end of life to include attestation requirements. Added requirement for trial/failure of non-opioid pain medications and trial of MED <180. Added reauthorization criteria.
6/2018	Added criteria for Supply Limit Review including supply limit table. Added ceiling limits for non-cancer/end of life pain. Separated out MEDLIMIT from supply limit.
9/2018	Revised supply limit for Morphabond.
4/2019	Updated MED to MME. Removed submission of medical records requirement for cancer or end of life diagnosis.
4/2020	Annual review. Removed Embeda from supply limit criteria.