BlueCross BlueShield
Federal Employee Program
Federal Employee Program®
750 9th St NW
Washington, D.C. 20001
202.942.1000
Fax 202.942.1125

5.70.061

Section:	Prescription Drugs	**Effective Date:**	April 1, 2024
Subsection:	Analgesics and Anesthetics	**Original Policy Date:**	January 1, 2018
Subject:	Opioid Drugs	**Page:**	1 of 17

Last Review Date: March 8, 2024

Opioid Drugs

Description

Benzhydrocodone-acetaminophen (Apadaz*)
Buprenorphine (Belbuca)
Buprenorphine (Buprenex)
Buprenorphine patch (Butrans)
Butorphanol
Butorphanol (Stadol)
Butorphanol powder
Celecoxib-tramadol (Seglentis)
Codeine
Codeine-acetaminophen
Codeine powder
Dihydrocodeine-caffeine-acetaminophen (Trezix)
Dihydrocodeine-caffeine-acetaminophen* (Dvorah*)
Fentanyl
Fentanyl patch (Duragesic patch)
Hydrocodone-acetaminophen
Hydrocodone-acetaminophen solution 10-325mg*
Hydrocodone-ibuprofen
Hydrocodone ER (Hysingla ER, Zohydro ER)
Hydrocodone powder
Hydromorphone
Hydromorphone IR (Dilaudid IR)
Hydromorphone ER (Exalgo)
Hydromorphone powder
Levorphanol*
Levorphanol powder
Meperidine (Demerol)
Meperidine powder
Morphine
Morphine IR
Morphine powder
Morphine sulfate ER (Arymo ER, Avinza, Kadian, MorphaBond, MS Contin)

Morphine sulfate/naltrexone ER (Embeda)
Nalbuphine
Oxycodone-acetaminophen
Oxycodone-acetaminophen* (Nalocet*, Primlev*, Prolate*)
Oxycodone-aspirin
Oxycodone-ibuprofen
Oxycodone ER (OxyContin, Xtampza ER)
Oxycodone IR
Oxycodone powder
Oxymorphone IR (Opana IR)
Oxymorphone ER (Opana ER)
Oxymorphone powder
Pentazocine-Naloxone
Tapentadol IR (Nucynta IR)
Tapentadol ER (Nucynta ER)
Tramadol IR (Qdolo, Ultram)
Tramadol IR 25mg tablets*
Tramadol IR 100mg tablets*
Tramadol-acetaminophen
Tramadol ER (Conzip*, Ultram)

*Prior authorization for certain non-covered formulations applies only to formulary exceptions.

Background
Opioid drugs are medications that are used in the management of pain.

The intent of the criteria is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines. Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, opioids should be reserved for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.

- **Maximum daily limit of any combination of opioid medications without a PA is 90 MME/day.**
- **Maximum daily limit of any combination of opioid medications with a PA is 200 MME/day for patients age 18 and older or 90 MME/day for patients age 17 and under.**
- **There is no maximum daily limit for patients with pain associated with anesthesia, cancer, pain associated with sickle cell disease, or treatment associated with hospice, palliative, or end-of-life care.**

Regulatory Status
FDA-approved indications:

1. Opioid drugs are indicated for the management of pain.
2. Butorphanol Tartrate Injection: as a preoperative or pre-anesthetic medication, as a supplement to balanced anesthesia, for the relief of pain during labor, and for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate
3. Demerol (meperidine) Injection: for preoperative medication, support of anesthesia, for obstetrical analgesia, and for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate
4. Fentanyl Injection: analgesic action of short duration during the anesthetic periods, premedication, induction and maintenance, and in the immediate postoperative period (recovery room) as the need arises; use as an opioid analgesic supplement in general or regional anesthesia; administration with a neuroleptic as an anesthetic premedication, for the induction of anesthesia and as an adjunct in the maintenance of general and regional anesthesia; use as an anesthetic agent with oxygen in selected high risk patients, such as those undergoing open heart surgery or certain complicated neurological or orthopedic procedures

Opioids have boxed warnings for the following:

- Respiratory depression is the chief hazard of opioid agonists, which if not immediately recognized and treated, may lead to respiratory arrest and death. Risk is increased in patients receiving concurrent CNS depressants (including alcohol), patients with chronic obstructive pulmonary disease, orthostatic hypotension, increased intracranial pressure, biliary tract diseases, and seizure disorders. To reduce the risk of respiratory depression, proper dosing, titration, and monitoring are essential.
- All patients treated with opioids require careful monitoring for signs of abuse and addiction, since use of opioid analgesic products carries the risk of addiction even under appropriate medical use.
- Accidental ingestion of extended-release opioids, especially in children, can result in fatal opioid overdose.
- Prolonged use of opioid agonists during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening.
- Concomitant use of opioids with benzodiazepines or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death.

The Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain recommends that when opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day. The extended-release opioid drug initial quantity limits are set to encompass the usual/starting dosage and frequency range recommendations in labeling without exceeding 90 MME per day (16).

CDC guidelines find that concurrent use of benzodiazepines and opioids might put patients at greater risk for potentially fatal overdose. Three studies of fatal overdose deaths found evidence of concurrent benzodiazepine use in 31%–61% of decedents (16). The FDA also states that benzodiazepines “are also commonly abused and misused, often together with opioid pain relievers and other medicines” (22).

The CDC Guideline for Prescribing Opioids for Chronic Pain states that when starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting opioids. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids (16).

The American Pain Society Opioid Treatment Guidelines state that a reasonable definition for high dose opioid therapy is >200 mg daily of oral morphine (or equivalent). The Institute for Clinical Systems Improvement Chronic Pain Guideline states that among patients receiving opioids for non-malignant pain, the daily dose is strongly associated with opioid-related mortality. An average dose of 200 mg or more morphine (or equivalent) was associated with a nearly nine-fold increase in the risk of overdose relative to low doses (<20 mg of morphine or equivalent) (15-18).

FDA warns that opioids can interact with antidepressants and migraine medicines to cause a serious central nervous system reaction called serotonin syndrome, in which high levels of the chemical serotonin build up in the brain and cause toxicity (see Appendix 1 for list of drugs) (17).

Centers for Medicare and Medicaid Services have a chart that includes buprenorphine MME conversion factors (21).

The FDA has determined that a Risk Evaluation and Mitigation Strategy (REMS) is necessary for all opioid analgesics intended for outpatient use to ensure that the benefits of these drugs continue to outweigh the risks. The Opioid Analgesic REMS is a strategy to reduce the risk of abuse, misuse, addiction, overdose, and deaths due to prescription opioid analgesics. Prescribers should counsel patients and caregivers about the use of naloxone for opioid overdose and consider prescribing naloxone if clinically indicated (21).

Related policies
Abstral, Actiq, Buprenorphine and Methadone Powders, Fentanyl Powder, Fentora, Methadone, Suboxone Drug Class, Subsys

Policy

This policy statement applies to clinical review performed for pre-service (Prior Approval, Precertification, Advanced Benefit Determination, etc.) and/or post-service claims.

Opioid drugs may be considered **medically necessary** if the conditions indicated below are met.

Opioid drugs may be considered **investigational** for all other indications.

Prior-Approval Requirements

Prior authorization is not required if prescribed by an oncologist and/or the member has paid pharmacy claims for an oncology medication(s) in the past 6 months

Diagnoses

Patient must have **ONE** of the following:

1. Pain associated with cancer
2. Pain associated with sickle cell disease
3. Treatment associated with hospice, palliative, or end-of-life care

Diagnoses

Patient must have **ONE** of the following:

1. Pain
    a. Alternative treatment options have been ineffective, not tolerated, or inadequate for controlling the pain (i.e., non-opioid analgesics and immediate release analgesics)
    b. Prescriber agrees to assess the benefits of pain control (i.e., care plan, signs of abuse, severity of pain) after 3 months of therapy
    c. Age 18 and older **only**: **NO** cumulative morphine milligram equivalent (MME) over 200 MME/day
    d. Age 17 and younger **only**: **NO** cumulative morphine milligram equivalent (MME) over 90 MME/day

    (e.g., https://www.mdcalc.com/morphine-milligram-equivalents-mme-calculator, https://www.cdc.gov/opioids/providers/prescribing/app.html)

2. **Butorphanol injection, Demerol (meperidine) injection, and Fentanyl injection ONLY:** Induction or maintenance of anesthesia

AND ALL of the following for diagnosis of Pain:

a. Prescriber agrees to evaluate patient's response to therapy before changing dose or adding additional opioid medications
b. Prescriber agrees to assess patient for signs and symptoms of serotonin syndrome
c. Prescriber agrees to participate in the Opioid Analgesic REMS program and to monitor for abuse, misuse, addiction, and overdose and discontinue if necessary (*https://opioidanalgesicrems.com*)
d. **NO** dual therapy with opioid addiction treatment or methadone
e. **NO** dual therapy with an anti-anxiety benzodiazepine(s)
    i. Alprazolam (Xanax)
    ii. Clonazepam (Klonopin)
    iii. Diazepam (Valium)
    iv. Lorazepam (Ativan)
    v. Oxazepam (Serax)
    vi. Chlordiazepoxide (Librium)
    vii. Clorazepate dipotassium (Tranxene)

Prior – Approval *Renewal* Requirements

Prior authorization is not required if prescribed by an oncologist and/or the member has paid pharmacy claims for an oncology medication(s) in the past 6 months

Diagnoses

Patient must have **ONE** of the following:

1. Pain associated with cancer
2. Pain associated with sickle cell disease
3. Treatment associated with hospice, palliative, or end-of-life care

Diagnoses

Patient must have **ONE** of the following:

1. Pain
    a. Prescriber agrees to continue to assess the benefits of pain control (i.e., care plan, signs of abuse, severity of pain) after 3 months of therapy
    b. Age 18 and older **only: NO** cumulative morphine milligram equivalent (MME) over 200 MME/day
    c. Age 17 and younger **only**: **NO** cumulative morphine milligram equivalent (MME) over 90 MME/day
    (e.g., https://www.mdcalc.com/morphine-milligram-equivalents-mme-calculator, https://www.cdc.gov/opioids/providers/prescribing/app.html)

2. **Butorphanol injection, Demerol (meperidine) injection, and Fentanyl injection ONLY**: Induction or maintenance of anesthesia

AND ALL of the following for the diagnosis of Pain:

a. Prescriber agrees to evaluate patient's response to therapy before changing dose or adding additional opioid medications
b. Prescriber agrees to assess patient for signs and symptoms of serotonin syndrome
c. Prescriber agrees to participate in the Opioid Analgesic REMS program and to monitor for abuse, misuse, addiction, and overdose and discontinue if necessary (*https://opioidanalgesicrems.com*)
d. **NO** dual therapy with opioid addiction treatment or methadone
e. **NO** dual therapy with an anti-anxiety benzodiazepine(s)
    i. Alprazolam (Xanax)
    ii. Clonazepam (Klonopin)
    iii. Diazepam (Valium)

iv. Lorazepam (Ativan)
v. Oxazepam (Serax)
vi. Chlordiazepoxide (Librium)
vii. Clorazepate dipotassium (Tranxene)

Policy Guidelines

Pre - PA Allowance

Prior authorization is not required if prescribed by an oncologist and/or the member has paid pharmacy claims for an oncology medication(s) in the past 6 months

Quantity

- Patients aged 18 years or older will be eligible for the Pre-PA Allowance for Extended-Release (ER) opioids after they have filled at least a 10-day supply of immediate-release (IR) opioid therapy in the last 180 days, unless switching from another ER opioid.
- Patients aged 18 years or older will be able to fill the Pre-PA Allowance of IR opioids/IR Combo opioids after they have filled an initial 7-day supply of IR opioid therapy or if they have been on IR or ER opioid therapy in the last 180 days.
- Patients aged 17 or under will require a PA after they have filled a 3-day supply of the Pre-PA Allowance in the last 180 days.
- Patients using dual therapy with opioid addiction treatment or methadone in the last 30 days will not be eligible for Pre-PA Allowance.
- **Maximum daily limit of any combination of opioid medications without a PA is 90 MME/day.**

IR Opioids Tablets & Suppositories: ≤ 90 MME/day

Medication	Strength	Quantity Limit
Butorphanol	10 mg/mL nasal spray	0.34 mL per day (Max: 12 units per 90 days)
Meperidine	50mg, 100mg	1 unit per day (Max: 90 units per 90 days)
Hydromorphone	8mg	2 units per day (Max: 180 units per 90 days)
Oxycodone/Roxybond	30mg	
Tapentadol	100mg	
Morphine sulfate	30mg, 30mg supp	3 units per day (Max: 270 units per 90 days)
Oxycodone	20mg	
Oxymorphone	10mg	
Tapentadol	75mg	

Codeine	15mg, 30mg, 60mg	4 units per day (Max: 360 units per 90 days)
Hydromorphone	2mg, 4mg, 3mg supp	
Morphine sulfate	15mg, 5mg supp, 10mg supp, 20mg supp	
Oxycodone/Roxybond/ Oxaydo	5mg cap, 5mg tab, 7.5mg, 10mg, 15mg	
Oxymorphone	5mg	
Pentazocine/naloxone	50/0.5mg	
Tapentadol	50mg	
Tramadol	50mg	6 units per day (Max: 540 units per 90 days)

IR Opioids Solutions: ≤ 90 MME/day

Medication / Strength	Quantity Limit
Hydromorphone liquid 5mg/5mL (1mg/mL)	18 units per day (Max: 1620 mL per 90 days)
Meperidine oral soln 50mg/5mL	4 units per day (Max: 360 mL per 90 days)
Morphine sulfate oral soln 10mg/5mL	30 units per day (Max: 2700 mL per 90 days)
Oxycodone soln 5mg/5mL	
Morphine sulfate oral soln 20mg/5mL	22.5 units per day (Max: 2025 mL per 90 days)
Morphine sulfate (conc) oral soln 20mg/mL (100mg/5mL)	4.5 units per day (Max: 405 mL per 90 days)
Oxycodone oral concentrate 20mg/mL (100mg/5mL)	3 units per day (Max: 270 mL per 90 days)
Qdolo (tramadol IR) oral solution 5mg/mL	60 units per day (Max: 5400 mL per 90 days)

IR Opioid Combo Tablets or Capsules: ≤ 50 MME/day

Medication	Strength	Quantity Limit
Codeine/APAP soln	120-12 mg/5 mL	5400 mL per 90 days
Hydrocodone/APAP soln	7.5/325 mg/15 mL	
Hydrocodone/APAP elixir	10/300 mg/15 mL	
Oxycodone/APAP soln	5-325 mg/5 mL	3000 mL per 90 days
Hydrocodone/ibuprofen	5/200 mg, 7.5/200 mg, 10/200 mg	270 units per 90 days
Oxycodone/ibuprofen	5/400 mg	
Oxycodone/APAP	10/325 mg	
Codeine/APAP	60/300 mg	360 units per 90 days
Hydrocodone/APAP	7.5/300 mg, 7.5/325 mg, 10/300 mg, 10/325 mg	
Oxycodone/APAP	7.5/325 mg	

Dihydrocodeine/APAP/caffeine	16/320.5/30 mg	450 units per 90 days
Codeine/APAP	15/300 mg, 30/300 mg	540 units per 90 days
Hydrocodone/APAP	2.5/325 mg, 5/300 mg, 5/325 mg	
Oxycodone/APAP	2.5/325 mg, 5/325 mg	
Oxycodone/ASA	4.8355/325 mg	
Tramadol/APAP	37.5/325 mg	
Celecoxib/tramadol	56/44 mg	None (requires PA)

ER Opioids Tablets or Capsules: ≤ 90 MME/day

Medication	Strength	Quantity Limit
Avinza (morphine)	60mg, 75mg, 90mg	1 unit per day (Max: 90 units per 90 days)
Embeda (morphine /naltrexone)	50/2mg, 60/2.4mg, 80/3.2mg	
Exalgo (hydromorphone)	8mg, 12mg, 16mg	
Kadian (morphine)	50mg, 60mg, 80mg	
Avinza (morphine)	45mg	2 units per day (Max: 180 units per 90 days)
Embeda (morphine /naltrexone)	20/0.8mg, 30/1.2mg,	
Kadian (morphine)	10mg, 20mg, 30mg, 40mg	
MorphaBond (morphine)	15mg, 30mg	
Nucynta ER (tapentadol)	50mg, 100mg	
Opana ER (oxymorphone)	5mg, 7.5mg, 10mg, 15mg	
OxyContin (oxycodone)	10mg, 15mg, 20mg, 30mg	
Xtampza ER (oxycodone)	9mg, 13.5mg, 18mg, 27mg	
Avinza (morphine)	30mg	3 units per day (Max: 270 units per 90 days)
Arymo ER (morphine)	15mg, 30mg	
MS Contin (morphine)	15mg, 30mg	

ER Tramadol: ≤ 30 MME/day

Medication	Strength	Quantity Limit
Ultram ER (tramadol)	100mg, 150mg, 200mg, 300mg	1 unit per day (Max: 90 units per 90 days)

ER Butrans Patches: ≤ 90 MME/day

Strength	Quantity Limit	Morphine Milligram Equivalent Daily Dosing
5 mcg/hr	0.15 units per day (Max: 12 patches per 84 days)	9 MME/day
7.5 mcg/hr		13.5 MME/day
10 mcg/hr		18 MME/day
15 mcg/hr		27 MME/day
20 mcg/hr		36 MME/day

ER Duragesic Patches: ≤ 90 MME/day

Strength	Quantity Limit	Morphine Milligram Equivalent Daily Dosing
12.5 mcg	0.34 units per day (Max: 30 patches per 90 days)	30 MME/day
25 mcg		60 MME/day
37.5 mcg		90 MME/day

ER Opioid Films: ≤ 90 MME/day

Medication	Strength	Quantity Limit
Belbuca (buprenorphine)	75mcg, 150mcg, 300mcg, 450mcg	1 unit per day (Max: 90 units per 90 days)

Prior - Approval Limits

Quantity

- The diagnoses of induction/maintenance of anesthesia, pain associated with cancer, pain associated with sickle cell disease, or treatment associated with hospice, palliative, or end-of-life care **ONLY** are not subject to the maximum MME daily limit
- Patients aged 18 years or older will be eligible for the PA Allowance for Extended-Release (ER) opioids after they have filled at least a 10-day supply of immediate-release (IR) opioid therapy in the last 180 days, unless switching from another ER opioid, and meet the above PA approval requirements.
- Patients aged 18 years or older will be eligible to fill the PA Allowance of IR opioids/IR Combo opioids after they have filled an initial 7-day supply of IR opioid therapy or if they have been on IR or ER opioid therapy in the last 180 days and meet the above PA approval requirements.
- Patients aged 17 or under will be eligible for the PA allowance after they have filled a 3-day supply in the last 180 days and meet the above PA approval requirements.
- Duragesic: Patients may not change patches more often than every 72 hours. Patch changes of every 48 hours may be approved if a higher strength has been inadequate when used every 72 hours. Maximum limit of any combination of Duragesic patches is 75 mcg.
- Seglentis: Maximum daily dose limit is 4 tablets/day.
- **Adults: Maximum daily limit of any combination of opioid medications with a PA is 200 MME/day.**

- **Pediatrics: Maximum daily limit of any combination of opioid medications with a PA is 90 MME/day.**

Opioid medications

Opioid	Morphine Milligram Equivalent (MME) Conversion Factor*
Butorphanol	7.0
Buprenorphine film/tablet	30.0
Buprenorphine patch (mcg/hr)	12.6
Buprenorphine film (mcg)	0.03
Codeine	0.15
Dihydrocodeine	0.25
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1.0
Hydromorphone	5.0
Levorphanol	11.0
Meperidine	0.1
Methadone	4.7
Morphine	1.0
Oxycodone	1.5
Oxycodone (Xtampza ER only)	1.67
Oxymorphone	3.0
Pentazocine	0.37
Tapentadol	0.4
Tramadol	0.2

***Multiply the dose for each opioid by the conversion factor to determine the dose in MMEs.

Duration 6 months

12 months for pain associated with cancer, pain associated with sickle cell disease, or treatment associated with hospice, palliative, or end-of-life care

Prior – Approval *Renewal* Limits

Same as above

Rationale

Summary
Opioid drugs are medications that are indicated for the management of pain. In addition, Butorphanol, Demerol and fentanyl injections are also indicated for pre-operative anesthesia. Because of the risks of addiction, abuse, and misuse with opioids, the CDC Guidelines recommends patients should receive treatment that provides the greatest benefits relative to the risks associated with that treatment in order to optimize patient outcomes.

Prior approval is required to ensure the safe, clinically appropriate, and cost-effective use of opioid drugs while maintaining optimal therapeutic outcomes.

References

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7. FDA News Release. FDA Drug Safety Communication: FDA requiring labeling changes for benzodiazepines. September 23, 2020.
8. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95.

Policy History

Date	Action

December 2017	Annual review Addition to PA for January 1, 2018 Merge of ER opioids from policy numbers 5.70.25, 5.70.30, 5.70.33, 5.70.34, 5.70.35, 5.70.36, 5.70.38, 5.70.39, 5.70.47
January 2018	Addition of Opana ER and removal of MS Contin 60mg from pre-PA Allowance
March 2018	Annual editorial review Addition of Avinza
September 2018	Addition of Tramadol ER to criteria
October 2018	Addition of Opioid Analgesic REMS requirement. Targiniq ER, Troxyca ER, Vantrela ER, and Xartemis XR removed from market
November 2018	Annual review and reference update. Addition of Opioid Analgesic REMS link per SME
February 2019	Addition of Pre-PA opioids chart
March 2019	Annual review
December 2019	Annual review. Addition of requirement of no cumulative MME over 300. Revised quantity limit for MS Contin 200mg from 180/90 to 90/90 to fall within the MME allowance
March 2020	Annual editorial review. Updated Opioid Analgesic REMS link
December 2020	Annual review. Increased the SA for Belbuca 75mcg, 150mcg, 300mcg, 450mcg to 90/90 from 60/90 per FEP. Conzip requires formulary exception + PA
March 2021	Annual editorial review and reference update
December 2021	Annual review. Per FEP, decreased the requirement that cumulative MME cannot exceed 200 MME/day from 300 MME/day. Removed requirements “no other opioid at PA limits” and “no dual therapy with another long-acting opioid” due to blanket MME. Added requirement “Prescriber agrees to evaluate patient’s response to therapy before changing dose or adding additional opioid medications.” Revised PA quantity chart to remove quantity limits and add MME per unit. Changed requirement of “previous IR opioid therapy for 10 days in the last 90 days to “previous IR opioid therapy for 10 days in the last 180 days.”
February 2022	Updated Pre-PA allowance with oncology step edit statement. Per FEP: added “Prescribers should counsel patients and caregivers about the use of naloxone for opioid overdose” under regulatory status, and added MME calculating links

March 2022	Annual review. Updated Xtampza ER MME per unit value to align with RxClaim system update (1.5 conversion factor to 1.667)
May 2023	Per SME, addition to regulatory status that prescriber should consider prescribing naloxone if clinically indicated. Changed policy number to 5.70.061. Adjusted MME for hydromorphone and tramadol per CDC update
September 2023	Annual review
December 2023	Annual review. Combined with policies for consistency and clarity: 5.70.070 Opioid IR Drug Class, 5.70.067 IR Opioid Combo Drugs, 5.70.031 Duragesic patch, 5.70.043 Butrans, 5.70.064 Opioid powders (minus buprenorphine and methadone powders), 5.70.080 Opioid injectables. Streamlined requirements and quantity charts
February 2024	Added tramadol IR 25mg as a product requiring a formulary exception
March 2024	Annual review

Keywords

This policy was approved by the FEP® Pharmacy and Medical Policy Committee on March 8, 2024 and is effective on April 1, 2024.

Appendix 1 - List of Serotonergic Medications

Selective Serotonin Reuptake Inhibitors (SSRIs)

paroxetine	Paxil, Paxil CR, Pexeva, Brisdelle
fluvoxamine	Luvox, Luvox CR
fluoxetine	Prozac, Prozac Weekly, Sarafem, Selfemra, Symbyax
sertraline	Zoloft
citalopram	Celexa
escitalopram	Lexapro

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

venlafaxine	Effexor XR
desvenlafaxine	Pristiq, Khedezla
duloxetine	Cymbalta
milnacipran	Savella

Tricyclic Antidepressants (TCAs)

amitriptyline	No brand name currently marketed
desipramine	Norpramin
clomipramine	Anafranil
imipramine	Tofranil, Tofranil PM
nortriptyline	Pamelor, Aventyl
protriptyline	Vivactil
doxepin	Zonalon, Silenor
trimipramine	Surmontil

Monoamine Oxidase Inhibitors (MAOIs)

isocarboxazid	Marplan
phenelzine	Nardil
selegiline	Emsam, Eldepryl, Zelapar
tranylcypromine	Parnate

Other Psychiatric Medicines

amoxapine	No brand name currently marketed
maprotiline	No brand name currently marketed
nefazodone	No brand name currently marketed
trazodone	Oleptro
buspirone	No brand name currently marketed
vilazodone	Viibryd
mirtazapine	Remeron, Remeron Soltab
llthium	Lithobid

Migraine Medicines

almotriptan	Axert
frovatriptan	Frova
naratriptan	Amerge
rizatriptan	Maxalt, Maxalt-MLT
sumatriptan	Imitrex, Imitrex Statdose, Alsuma, Sumavel Dosepro, Zecuity, Treximet
zolmitriptan	Zomig, Zomig-ZMT

Antiemetics

ondansetron	Zofran, Zofran ODT, Zuplenz
granisetron	Kytril, Sancuso
dolasetron	Anzemet
palonosetron	Aloxi

Other Serotonergic Medicines

dextromethorphan	Bromfed-DM, Delsym, Mucinex DM, Nuedexta
linezolid	Zyvox
cyclobenzaprine	Amrix
methylene blue	
St. John’s wort	
tryptophan	