curative

Opioids Prior Authorization

Drug(s) Applied:	**fentanyl transdermal patch, hydrocodone/acetaminophen 7.5-325mg/15mL solution, oxycodone 5mg/5mL solution**

Criteria:
Drug(s) Applied will be approved when the requested medication is being used for an FDA approved indication and all of the following criteria are met:

I. Initial Therapy Criteria
- **A. Chronic Pain** as indicated by chart notes within past 90 days
  1. ONE of the following:
     a) Diagnosis of chronic cancer pain due to an active malignancy **or**
     b) Patient is eligible for hospice or palliative care **or**
     c) Diagnosis of sickle cell disease **or**
     d) Diagnosis of chronic non-cancer pain **and**
        (1) Requested agent is not prescribed as an as-needed (prn) analgesic, or for acute/intermittent/breakthrough pain, postoperative pain, or mild pain **and**
        (2) Chart notes indicate patient is opioid-tolerant with a medication history of taking opioids for at least 7 days (i.e., at least 60 mg oral morphine per day, 25 mcg transdermal fentanyl per hour, 30 mg oral oxycodone per day, 8 mg oral hydromorphone per day, 25 mg oral oxymorphone per day, 60 mg oral hydrocodone per day, or an equianalgesic dose of another opioid) **and**
        (3) Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., pain management, oncology)

  Approval Duration: 3 months

- **B. Acute Pain** as indicated by chart notes within past 90 days
  1. The requested agent is hydrocodone/acetaminophen solution or oxycodone solution **and**
  2. ONE of the following
     a) Patient cannot swallow a pill, **or**
     b) Patient had a recent oral or throat procedure limiting the ability to swallow, **or**

c) Patient has a condition or had a recent procedure that could impact absorption or tolerability of a pill (e.g. gastric bypass, bowel resection, ulcer, or gastroparesis)

Approval Duration: 1 month

II. Continued Therapy Criteria

A. Chronic Pain as indicated by chart notes within past 90 days

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization process or meets the initial therapy criteria above **and**
2. Documented clinical benefit since starting the requested agent (i.e., improvement or stabilization of pain from baseline **and**
3. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., pain management, oncology)

Approval Duration: 6 months

B. Acute Pain as indicated by chart notes within past 90 days

1. Review under Initial Therapy Criteria

Approval Duration: N/A

Policy Owned by: Curative PBM team