|  |  |
| --- | --- |
| Criteria 1 | NP Agents – Short Acting Agents- Acetaminophen/Caffeine/Dihydrocodeine, Benzhydrocodone/Acetaminophen,  Butalbital/Acetaminophen/Caffeine/Codeine 50/300/40/30mg, Dsuvia, Hydrocodone/Acetaminophen 5-300, Hydrocodone/Acetaminophen 7.5-300, Hydrocodone/Acetaminophen 10-300mg, Hydrocodone/Ibuprofen, Levorphanol, Meperidine, Methadone, Oxycodone/Ibuprofen, Oxymorphone IR, Pentazocine/Naloxone, Seglentis, Tramadol Sol |
| Criteria 2 | NP Agents – Long Acting/Extended-Release Formulations-Belbuca, Buprenorphine TD Patch Weekly, Fentanyl, Hydrocodone Bitartrate ER 12HR Cap, Hydrocodone Bitartrate ER 24HR Tab, Hydromorphone ER, Morphine ER 24HR Cap, Oxycodone ER, Oxymorphone ER, Tramadol ER, Xtampza ER QL |
| Criteria 3 | Long Acting Preferred Agents- Butrans (BvG), Morphine ER Tab, Nucynta ER |
| Criteria 4 | NP Transmucosal Fentanyl Products |
| Criteria 5 | Preferred Agents – Short Acting Agents- Acetaminophen/Codeine, Butalbital/Acetaminophen/Caffeine/Codeine, Butalbital/Aspirin/Caffeine/Codeine, Butorphanol, Codeine, Hydrocodone/Acetaminophen, Hydromorphone IR, Morphine IR Tab, Morphine IR Sol, Nucynta IR, Oxycodone Cap, Oxycodone Sol, Oxycodone Tab, Oxycodone/Acetaminophen, Tramadol, Tramadol/Acetaminophen |

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria Title** | Analgesic Agents: Opioids | | |
| **Criteria Subtitle** | Non-Preferred Products- Short Acting | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE | 073169 | GCNSeqNo |
| BENZHYDROCODONE/ACETAMINOPHEN | 078222 | GCNSeqNo |
| BENZHYDROCODONE/ACETAMINOPHEN | 079488 | GCNSeqNo |
| BENZHYDROCODONE/ACETAMINOPHEN | 079489 | GCNSeqNo |
| BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE 50/300/40/30 mg | 071253 | GCNSeqNo |
| DSUVIA | 079437 | GCNSeqNo |
| HYDROCODONE/ACETAMINOPHEN 5-300, 7.5-300 and 10-300 mg | 057726 | GCNSeqNo |
| HYDROCODONE/ACETAMINOPHEN 5-300, 7.5-300 and 10-300 mg | 060338 | GCNSeqNo |
| HYDROCODONE/ACETAMINOPHEN 5-300, 7.5-300 and 10-300 mg | 060533 | GCNSeqNo |
| HYDROCODONE/IBUPROFEN | 034068 | GCNSeqNo |
| HYDROCODONE/IBUPROFEN | 054674 | GCNSeqNo |
| HYDROCODONE/IBUPROFEN | 063650 | GCNSeqNo |
| LEVORPHANOL | 004228 | GCNSeqNo |
| LEVORPHANOL | 079449 | GCNSeqNo |
| MEPERIDINE | 004049 | GCNSeqNo |
| MEPERIDINE | 004051 | GCNSeqNo |
| MEPERIDINE | 004053 | GCNSeqNo |
| MEPERIDINE | 059787 | GCNSeqNo |
| MEPERIDINE | 059790 | GCNSeqNo |
| MEPERIDINE | 059792 | GCNSeqNo |
| MEPERIDINE | 059793 | GCNSeqNo |
| MEPERIDINE | 059794 | GCNSeqNo |
| MEPERIDINE | 059797 | GCNSeqNo |
| MEPERIDINE | 059804 | GCNSeqNo |
| MEPERIDINE | 078735 | GCNSeqNo |
| MEPERIDINE | 078736 | GCNSeqNo |
| MEPERIDINE | 079737 | GCNSeqNo |
| METHADONE | 004235 | GCNSeqNo |
| METHADONE | 004237 | GCNSeqNo |
| METHADONE | 004238 | GCNSeqNo |
| METHADONE | 004239 | GCNSeqNo |
| METHADONE | 004240 | GCNSeqNo |
| METHADONE | 004242 | GCNSeqNo |
| METHADONE | 023767 | GCNSeqNo |
| METHADONE | 082101 | GCNSeqNo |
| OXYCODONE/IBUPROFEN | 058402 | GCNSeqNo |
| OXYMORPHONE IR | 061086 | GCNSeqNo |
| OXYMORPHONE IR | 061087 | GCNSeqNo |
| PENTAZOCINE/NALOXONE | 004292 | GCNSeqNo |
| SEGLENTIS | 082830 | GCNSeqNo |
| TRAMADOL SOL | 081474 | GCNSeqNo |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0009 |  | Select and Free Text | Is the patient new to (initial request) or continuing therapy with the requested product (re-authorization request)? | Initial request for product | 0010 |
| Continuation (re-authorization request) | 1001 |
| 2 | 0010 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0011 |
| N | 1235 |
| 3 | 0011 |  | Select | Does this request exceed 30 MED AND/OR exceed a 7 days supply (or 5 days supply if <18 years old)?  Patients with initial prescriptions for opioid therapy, defined as no rx opioid claims in the last 90 days, will be limited to 30 MED per day and a maximum of 7 days (or 5 days supply if <18 years old) per prescription. | Y | 0012 |
| N | 0013 |
| 4 | 0012 |  | Select and Free Text | Has the provider submitted documentation to support the need for exceeding 30 MED per day and/or a maximum of 7 days (or 5 days supply if <18 years old) per prescription?  If yes, please submit documentation. | Y | 0013 |
| N | 1235 |
| 5 | 0013 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 7 days of at least two unrelated preferred drugs of the same duration of action (SHORT-ACTING)?  If yes, please submit the medication trials and dates. | Y | 0015 |
| N | 0014 |
| 6 | 0014 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 0015 |
| N | 1236 |
| 7 | 0015 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred brand name that has a preferred generic product | Y | 0016 |
| N | 0017 |
| 8 | 0016 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation or inadequate clinical response or allergy of two or more generic labelers)? | Y | 0017 |
| N | 1235 |
| 9 | 0017 |  | Select and Free Text | Does the patient meet one of the following exemptions?  1) Diagnosis of active cancer treatment, palliative care, end-of-life/hospice care, sickle cell, severe burn, traumatic crushing of tissue, amputation, major orthopedic surgery  2) Prescriber attestation that patient is not opioid naïve (i.e., new to Medicaid or was on higher dose in hospital)  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 0018 |
| 10 | 0018 |  | Select and Free Text | Has the provider submitted documentation of the following?  1) Diagnosis code which must be for somatic type pain  2) Prescriber attestation that the benefits and risks of opioid therapy has been discussed with patient | Y | 0019 |
| N | 1235 |
| 11 | 0019 |  | Select | Does the provider attest that OARRS has been reviewed before initially prescribing or personally furnishing any controlled substance? | Y | 0020 |
| N | 1235 |
| 12 | 0020 |  | Select and Free Text | Has the provider submitted documentation of the patient’s indication, previous utilization, and requested length of therapy? | Y | 0021 |
| N | 1235 |
| 13 | 0021 |  | Select | Initial short-acting requests can be authorized up to 90 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1235 |
| 14 | 1001 |  | Select | Is the request for a dose escalation? | Y | 1002 |
| N | 1005 |
| 15 | 1002 |  | Select and Free Text | Has the provider submitted documentation of the following?  Prescriber attestation that dose escalation is likely to result in improved function or pain control. | Y | 1003 |
| N | 1235 |
| 16 | 1003 |  | Select | Is the request for a cumulative daily dose greater than 80 MED? | Y | 1004 |
| N | 1005 |
| 17 | 1004 |  | Select and Free Text | Is the medication being prescribed by or in consultation with a pain specialist, specialist in the area of the body affected by pain, or anesthesiologist?  If yes, please submit documentation. | Y | 1005 |
| N | 1235 |
| 18 | 1005 |  | Select and Free Text | Has the provider submitted documentation of the following?  1) Current treatment plan  2) Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screenings results reviewed, concerns addressed, and no serious adverse outcomes observed | Y | 1006 |
| N | 1235 |
| 19 | 1006 |  | Select | Subsequent short-acting and dose escalation requests can be authorized up to 180 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1235 |
| 20 | 1235 |  | Free Text | Please provide the rationale for the medication, dose, and duration being requested. | END (Pending Manual Review) |
| 21 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) |

LENGTH OF AUTHORIZATIONS: For the course of therapy, up to 180 days. Initial short-acting and long-acting requests may only be authorized for up to 90 days.

|  |  |
| --- | --- |
| **Last Approved** | 9/21/2023 |
| **Other** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria Title** | Analgesic Agents: Opioids | | |
| **Criteria Subtitle** | Non-Preferred Products- Long Acting | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| BELBUCA | 075050 | GCNSeqNo |
| BELBUCA | 075051 | GCNSeqNo |
| BELBUCA | 075052 | GCNSeqNo |
| BELBUCA | 075053 | GCNSeqNo |
| BELBUCA | 075054 | GCNSeqNo |
| BELBUCA | 075055 | GCNSeqNo |
| BELBUCA | 075056 | GCNSeqNo |
| BUPRENORPHINE TD PATCH WEEKLY | 059589 | GCNSeqNo |
| BUPRENORPHINE TD PATCH WEEKLY | 059590 | GCNSeqNo |
| BUPRENORPHINE TD PATCH WEEKLY | 059591 | GCNSeqNo |
| BUPRENORPHINE TD PATCH WEEKLY | 071432 | GCNSeqNo |
| BUPRENORPHINE TD PATCH WEEKLY | 072673 | GCNSeqNo |
| FENTANYL 25 MCG/HR PATCH | 015880 | GCNSeqNo |
| FENTANYL 50 MCG/HR PATCH | 015881 | GCNSeqNo |
| FENTANYL 75 MCG/HR PATCH | 015882 | GCNSeqNo |
| FENTANYL 100 MCG/HR PATCH | 015883 | GCNSeqNo |
| FENTANYL 12 MCG/HR PATCH | 059102 | GCNSeqNo |
| FENTANYL 62.5 MCG/HR PATCH | 073524 | GCNSeqNo |
| FENTANYL 87.5 MCG/HR PATCH | 073525 | GCNSeqNo |
| FENTANYL 37.5 MCG/HR PATCH | 073532 | GCNSeqNo |
| HYDROCODONE BITARTRATE ER 12 HR CAP | 073621 | GCNSeqNo |
| HYDROCODONE BITARTRATE ER 12 HR CAP | 073622 | GCNSeqNo |
| HYDROCODONE BITARTRATE ER 12 HR CAP | 073623 | GCNSeqNo |
| HYDROCODONE BITARTRATE ER 12 HR CAP | 073624 | GCNSeqNo |
| HYDROCODONE BITARTRATE ER 12 HR CAP | 073625 | GCNSeqNo |
| HYDROCODONE BITARTRATE ER 12 HR CAP | 073626 | GCNSeqNo |
| HYDROCODONE BITARTRATE ER 24HR TAB | 073176 | GCNSeqNo |
| HYDROCODONE BITARTRATE ER 24HR TAB | 073177 | GCNSeqNo |
| HYDROCODONE BITARTRATE ER 24HR TAB | 073179 | GCNSeqNo |
| HYDROCODONE BITARTRATE ER 24HR TAB | 073180 | GCNSeqNo |
| HYDROCODONE BITARTRATE ER 24HR TAB | 073181 | GCNSeqNo |
| HYDROCODONE BITARTRATE ER 24HR TAB | 073182 | GCNSeqNo |
| HYDROCODONE BITARTRATE ER 24HR TAB | 073183 | GCNSeqNo |
| HYDROMORPHONE ER | 066200 | GCNSeqNo |
| HYDROMORPHONE ER | 069860 | GCNSeqNo |
| HYDROMORPHONE ER | 069889 | GCNSeqNo |
| HYDROMORPHONE ER | 069890 | GCNSeqNo |
| MORPHINE ER 24HR CAP | 050220 | GCNSeqNo |
| MORPHINE ER 24HR CAP | 050221 | GCNSeqNo |
| MORPHINE ER 24HR CAP | 050222 | GCNSeqNo |
| MORPHINE ER 24HR CAP | 064739 | GCNSeqNo |
| MORPHINE ER 24HR CAP | 064740 | GCNSeqNo |
| MORPHINE ER 24HR CAP | 050219 | GCNSeqNo |
| MORPHINE ER 24HR CAP | 060355 | GCNSeqNo |
| MORPHINE ER 24HR CAP | 060356 | GCNSeqNo |
| MORPHINE ER 24HR CAP | 060357 | GCNSeqNo |
| MORPHINE ER 24HR CAP | 060358 | GCNSeqNo |
| MORPHINE ER 24HR CAP | 061722 | GCNSeqNo |
| MORPHINE ER 24HR CAP | 061748 | GCNSeqNo |
| MORPHINE ER 24HR CAP | 061749 | GCNSeqNo |
| MORPHINE ER 24HR CAP | 062358 | GCNSeqNo |
| OXYCODONE ER | 072862 | GCNSeqNo |
| OXYCODONE ER | 072863 | GCNSeqNo |
| OXYCODONE ER | 072864 | GCNSeqNo |
| OXYCODONE ER | 072865 | GCNSeqNo |
| OXYCODONE ER | 072866 | GCNSeqNo |
| OXYCODONE ER | 072867 | GCNSeqNo |
| OXYCODONE ER | 072868 | GCNSeqNo |
| OXYMORPHONE ER | 061091 | GCNSeqNo |
| OXYMORPHONE ER | 061092 | GCNSeqNo |
| OXYMORPHONE ER | 061093 | GCNSeqNo |
| OXYMORPHONE ER | 061094 | GCNSeqNo |
| OXYMORPHONE ER | 063782 | GCNSeqNo |
| OXYMORPHONE ER | 063783 | GCNSeqNo |
| OXYMORPHONE ER | 063784 | GCNSeqNo |
| TRAMADOL ER | 043536 | GCNSeqNo |
| TRAMADOL ER | 043537 | GCNSeqNo |
| TRAMADOL ER | 060274 | GCNSeqNo |
| TRAMADOL ER | 063422 | GCNSeqNo |
| TRAMADOL ER | 063423 | GCNSeqNo |
| TRAMADOL ER | 063424 | GCNSeqNo |
| TRAMADOL ER | 067760 | GCNSeqNo |
| TRAMADOL ER | 067761 | GCNSeqNo |
| TRAMADOL ER | 067762 | GCNSeqNo |
| XTAMPZA ER | 076031 | GCNSeqNo |
| XTAMPZA ER | 076032 | GCNSeqNo |
| XTAMPZA ER | 076033 | GCNSeqNo |
| XTAMPZA ER | 076034 | GCNSeqNo |
| XTAMPZA ER | 076035 | GCNSeqNo |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0001 |  | Select and Free Text | Is the patient new to (initial request) or continuing therapy with the requested product (re-authorization request)? | Initial request for product | 0002 |
| Continuation (re-authorization request) | 1001 |
| 2 | 0002 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0003 |
| N | 1235 |
| 3 | 0003 |  | Select | Is the request for any of the following products:  Buprenorphine TD Patch Weekly (generic Butrans), Morphine ER 24HR Cap (generic Kadian) | Y | 0004 |
| N | 0009 |
| 4 | 0004 |  | Select | What product is being requested? | Buprenorphine TD Patch Weekly (generic Butrans) | 0005 |
| Morphine ER 24HR Cap (generic Kadian) | 0007 |
| Other | 0009 |
| 5 | 0005 |  | Select and Free Text | Has the brand medication been attempted and failed or is the brand medication contraindicated?  If yes, please submit documentation. | Y | 0006 |
| N | 1235 |
| 6 | 0006 |  | Select and Free Text | Has the provider submitted documentation for doses greater than 5mcg/hour an inadequate clinical response with at least one opioid formulation taken for at least 60 of the last 90 days? | Y | 0009 |
| N | 1235 |
| 7 | 0007 |  | Select and Free Text | Is this request being used for cancer pain, palliative care, or end-of-life/hospice care?  If yes, please submit documentation. | Y | 0009 |
| N | 0008 |
| 8 | 0008 |  | Select and Free Text | Has the provider submitted documentation of an inadequate clinical response of at least one opioid formulation taken for at least 60 of the last 90 days?  If yes, please submit the medication trials and dates. | Y | 0009 |
| N | 1235 |
| 9 | 0009 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 7 days of at least two unrelated preferred drugs of the same duration of action (LONG-ACTING)?  If yes, please submit the medication trials and dates. | Y | 0011 |
| N | 0010 |
| 10 | 0010 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 0011 |
| N | 1236 |
| 11 | 0011 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred brand name that has a preferred generic product | Y | 0012 |
| N | 0013 |
| 12 | 0012 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation or inadequate clinical response or allergy of two or more generic labelers)? | Y | 0013 |
| N | 1235 |
| 13 | 0013 |  | Select and Free Text | Does the patient meet the following exemption?  Patient is receiving long-acting opioids for cancer pain, palliative care, or end-of-life hospice care  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 0014 |
| 14 | 0014 |  | Select and Free Text | Has the provider submitted documentation of the following?   1. Request is a daily dose equivalent of less than or equal to 80 MED 2. Inadequate clinical response to both non-opioid pharmacologic and non-pharmacologic treatments 3. Current use of opioids for greater than or equal to 60 of the last 90 days 4. Treatment plan including risk assessment, substance abuse history, concurrent therapies, and requirements for random urine screenings (baseline urine drug tests must be submitted) 5. Pain and function scores at each visit 6. Opioid contract required to be in place and submitted with PA form | Y | 0015 |
| N | 1235 |
| 15 | 0015 |  | Select | Does the provider attest that OARRS has been reviewed before initially prescribing or personally furnishing any controlled substance? | Y | 0016 |
| N | 1235 |
| 16 | 0016 |  | Select | Initial long-acting requests can be authorized up to 90 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1235 |
| 17 | 1001 |  | Select | Is the request for a dose escalation? | Y | 1002 |
| N | 1005 |
| 18 | 1002 |  | Select and Free Text | Has the provider submitted documentation of the following?  Prescriber attestation that dose escalation is likely to result in improved function or pain control. | Y | 1003 |
| N | 1235 |
| 19 | 1003 |  | Select | Is the request for a cumulative daily dose greater than 80 MED? | Y | 1004 |
| N | 1005 |
| 20 | 1004 |  | Select and Free Text | Is the medication being prescribed by or in consultation with a pain specialist, specialist in the area of the body affected by pain, or anesthesiologist?  If yes, please submit documentation. | Y | 1005 |
| N | 1235 |
| 21 | 1005 |  | Select and Free Text | Has the provider submitted documentation of the following?  1) Current treatment plan  2) Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screenings results reviewed, concerns addressed, and no serious adverse outcomes observed | Y | 1006 |
| N | 1235 |
| 22 | 1006 |  | Select | Subsequent long-acting and dose escalation requests can be authorized up to 180 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1235 |
| 23 | 1235 |  | Free Text | Please provide the rationale for the medication, dose, and duration being requested. | END (Pending Manual Review) | |
| 24 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: For the course of therapy, up to 180 days. Initial short-acting and long-acting requests may only be authorized for up to 90 days.

|  |  |
| --- | --- |
| **Last Approved** | 9/21/2023 |
| **Other** |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Criteria Title** | | | Analgesic Agents: Opioids | | | | | | |
| **Criteria Subtitle** | | | Butrans, Morphine Sulfate ER Tab, Nucynta | | | | | | |
| **Approval Level** | | | GCNSeqNo | | | | | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | | | Drug Name | | | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) | | |
| BUTRANS | | | 059589 | GCNSeqNo | | |
| BUTRANS | | | 059590 | GCNSeqNo | | |
| BUTRANS | | | 059591 | GCNSeqNo | | |
| BUTRANS | | | 071432 | GCNSeqNo | | |
| BUTRANS | | | 072673 | GCNSeqNo | | |
| MORPHINE ER TAB | | | 004096 | GCNSeqNo | | |
| MORPHINE ER TAB | | | 004097 | GCNSeqNo | | |
| MORPHINE ER TAB | | | 011886 | GCNSeqNo | | |
| MORPHINE ER TAB | | | 011887 | GCNSeqNo | | |
| MORPHINE ER TAB | | | 016522 | GCNSeqNo | | |
| NUCYNTA ER | | | 067266 | GCNSeqNo | | |
| NUCYNTA ER | | | 067267 | GCNSeqNo | | |
| NUCYNTA ER | | | 067268 | GCNSeqNo | | |
| NUCYNTA ER | | | 067270 | GCNSeqNo | | |
| NUCYNTA ER | | | 067271 | GCNSeqNo | | |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | | **Question Type** | **Question Text** | | | **Choice Text** | **Next Question ID** | |
| 1 | 0001 |  | | Select and Free Text | Is the patient new to (initial request) or continuing therapy with the requested product (re-authorization request)? | | | Initial request for product | 0002 | |
| Continuation (re-authorization request) | 1001 | |
| 2 | 0002 |  | | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | | | Y | 0003 | |
| N | 1235 | |
| 3 | 0003 |  | | Select | What product is being requested? | | | Butrans | 0004 | |
| Morphine Sulfate ER Tab (generic MS Contin) | 0005 | |
| Nucynta ER | 0005 | |
| Other | 0007 | |
| 4 | 0004 |  | | Select and Free Text | Has the provider submitted documentation for doses greater than 5mcg/hour an inadequate clinical response with at least one opioid formulation taken for at least 60 of the last 90 days?  If yes, please submit the medication trials and dates. | | | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 5 | 0005 |  | | Select and Free Text | Is this request being used for cancer pain, palliative care, or end-of-life/hospice care?  If yes, please submit documentation. | | | Y | END (Pending Manual Review) | |
| N | 0006 | |
| 6 | 0006 |  | | Select and Free Text | Has the provider submitted documentation of an inadequate clinical response of at least one opioid formulation taken for at least 60 of the last 90 days?  If yes, please submit the medication trials and dates. | | | Y | 0007 | |
| N | 1235 | |
| 7 | 0007 |  | | Select and Free Text | Does the patient meet the following exemption?  Patient is receiving long-acting opioids for cancer pain, palliative care, or end-of-life/hospice care.  If yes, please submit documentation. | | | Y | END (Pending Manual Review) | |
| N | 0008 | |
| 8 | 0008 |  | | Select and Free Text | Has the provider submitted documentation of the following?  1) Request is a daily dose equivalent of less than or equal to 80 MED  2) Inadequate clinical response to both non-opioid pharmacologic and non-pharmacologic treatments  3) Current use of opioids for greater than or equal to 60 of the last 90 days  4) Treatment plan including risk assessment, substance abuse history, concurrent therapies, and requirements for random urine screenings (baseline urine drug tests must be submitted)  5) Pain and function scores at each visit  6) Opioid contract required to be in place and submitted with PA form | | | Y | 0009 | |
| N | 1235 | |
| 9 | 0009 |  | | Select | Does the provider attest that OARRS has been reviewed before initially prescribing or personally furnishing any controlled substance? | | | Y | 0010 | |
| N | 1235 | |
| 10 | 0010 |  | | Select | Initial long-acting requests can be authorized up to 90 days. Does this request meet this requirement? | | | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 11 | 1001 |  | | Select | Is the request for a dose escalation? | | | Y | 1002 | |
| N | 1005 | |
| 12 | 1002 |  | | Select and Free Text | Has the provider submitted documentation of the following?  Prescriber attestation that dose escalation is likely to result in improved function or pain control. | | | Y | 1003 | |
| N | 1235 | |
| 13 | 1003 |  | | Select | Is the request for a cumulative daily dose greater than 80 MED? | | | Y | 1004 | |
| N | 1005 | |
| 14 | 1004 |  | | Select and Free Text | Is the medication being prescribed by or in consultation with a pain specialist, specialist in the area of the body affected by pain, or anesthesiologist?  If yes, please submit documentation. | | | Y | 1005 | |
| N | 1235 | |
| 15 | 1005 |  | | Select and Free Text | Has the provider submitted documentation of the following?  1) Current treatment plan  2) Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screenings results reviewed, concerns addressed, and no serious adverse outcomes observed | | | Y | 1006 | |
| N | 1235 | |
| 16 | 1006 |  | | Select | Subsequent long-acting and dose escalation requests can be authorized up to 180 days. Does this request meet this requirement? | | | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 17 | 1235 |  | | Free Text | Please provide the rationale for the medication, dose, and duration being requested. | | | END (Pending Manual Review) | | |

LENGTH OF AUTHORIZATIONS: For the course of therapy, up to 180 days. Initial short-acting and long-acting requests may only be authorized for up to 90 days.

|  |  |
| --- | --- |
| **Last Approved** | 9/21/2023 |
| **Other** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria Title** | Analgesic Agents: Opioids | | |
| **Criteria Subtitle** | Transmucosal Fentanyl Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| FENTANYL CITRATE OTFC 200 MCG | 022358 | GCNSeqNo |
| FENTANYL CITRATE OTFC 400 MCG | 022360 | GCNSeqNo |
| FENTANYL CITRATE OTFC 600 MCG | 041339 | GCNSeqNo |
| FENTANYL CITRATE OTFC 800 MCG | 041340 | GCNSeqNo |
| FENTANYL CIT OTFC 1,200 MCG | 041341 | GCNSeqNo |
| FENTANYL CIT OTFC 1,600 MCG | 041342 | GCNSeqNo |
| FENTANYL CIT 100 MCG BUCCAL TB | 061492 | GCNSeqNo |
| FENTANYL CIT 200 MCG BUCCAL TB | 061493 | GCNSeqNo |
| FENTANYL CIT 400 MCG BUCCAL TB | 061495 | GCNSeqNo |
| FENTANYL CIT 600 MCG BUCCAL TB | 061496 | GCNSeqNo |
| FENTANYL CIT 800 MCG BUCCAL TB | 061497 | GCNSeqNo |
| SUBSYS 100 MCG SPRAY | 068412 | GCNSeqNo |
| SUBSYS 400 MCG SPRAY | 068413 | GCNSeqNo |
| SUBSYS 200 MCG SPRAY | 068414 | GCNSeqNo |
| SUBSYS 600 MCG SPRAY | 068415 | GCNSeqNo |
| SUBSYS 800 MCG SPRAY | 068416 | GCNSeqNo |
| SUBSYS 1200 MCG SPRAY | 068756 | GCNSeqNo |
| SUBSYS 1600 MCG SPRAY | 068757 | GCNSeqNo |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0009 |  | Select and Free Text | Is the patient new to (initial request) or continuing therapy with the requested product (re-authorization request)? | Initial request for product | 0010 |
| Continuation (re-authorization request) | 1001 |
| 2 | 0010 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0011 |
| N | 1235 |
| 3 | 0011 |  | Select | Does this request exceed 30 MED AND/OR exceed a 7 days (or 5 days supply if <18 years old) supply?  Patients with initial prescriptions for opioid therapy, defined as no rx opioid claims in the last 90 days, will be limited to 30 MED per day and a maximum of 7 days (or 5 days supply if <18 years old) per prescription. | Y | 0012 |
| N | 0013 |
| 4 | 0012 |  | Select and Free Text | Has the provider submitted documentation to support the need for exceeding 30 MED per day and/or a maximum of 7 days (or 5 days supply if <18 years old) per prescription?  If yes, please submit documentation. | Y | 0013 |
| N | 1235 |
| 5 | 0013 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 7 days of at least two unrelated preferred drugs of the same duration of action (SHORT-ACTING)?  If yes, please submit the medication trials and dates. | Y | 0015 |
| N | 0014 |
| 6 | 0014 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 0015 |
| N | 1236 |
| 7 | 0015 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred brand name that has a preferred generic product | Y | 0016 |
| N | 0017 |
| 8 | 0016 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation or inadequate clinical response or allergy of two or more generic labelers)? | Y | 0017 |
| N | 1235 |
| 9 | 0017 |  | Select | Is the medication being prescribed by an oncologist, pain specialist, or hospice/palliative prescriber? | Y | 0018 |
| N | 1235 |
| 10 | 0018 |  | Select | Is the patient concurrently taking a long-acting opioid at a therapeutic dose of any of the following for at least 7 days without adequate pain relief:   1. Greater than or equal to 60 mg oral morphine/day 2. Greater than or equal to 8 mg oral hydromorphone/day 3. Greater than or equal to 25 mcg/hr transdermal fentanyl 4. Greater than or equal to 25 mg oral oxymorphone/day 5. Greater than or equal to 30 mg oral oxycodone/day 6. Equianalgesic dose of another opioid | Y | 0019 |
| N | 1235 |
| 11 | 0019 |  | Select | Ohio Medicaid covers up to 4 doses per day for Transmucosal Fentanyl. Does this request meet this requirement? | Y | 0020 |
| N | 1237 |
| 12 | 0020 |  | Select and Free Text | Does the patient meet one of the following exemptions?   1. Diagnosis of active cancer treatment, palliative care, end-of-life/hospice care, sickle cell, severe burn, traumatic crushing of tissue, amputation, major orthopedic surgery 2. Prescriber attestation that patient is not opioid naïve (i.e., new to Medicaid or was on higher dose in hospital)   If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 0021 |
| 13 | 0021 |  | Select and Free Text | Has the provider submitted documentation of the following?  1) Diagnosis code which must be for somatic type pain  2) Prescriber attestation that the benefits and risks of opioid therapy has been discussed with patient | Y | 0022 |
| N | 1235 |
| 14 | 0022 |  | Select | Does the provider attest that OARRS has been reviewed before initially prescribing or personally furnishing any controlled substance? | Y | 0023 |
| N | 1235 |
| 15 | 0023 |  | Select and Free Text | Has the provider submitted documentation of the patient’s indication, previous utilization, and requested length of therapy? | Y | 0024 |
| N | 1235 |
| 16 | 0024 |  | Select | Initial short-acting requests can be authorized up to 90 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1235 |
| 17 | 1001 |  | Select | Is the request for a dose escalation? | Y | 1002 |
| N | 1005 |
| 18 | 1002 |  | Select and Free Text | Has the provider submitted documentation of the following?  Prescriber attestation that dose escalation is likely to result in improved function or pain control. | Y | 1003 |
| N | 1235 |
| 19 | 1003 |  | Select | Is the request for a cumulative daily dose greater than 80 MED? | Y | 1004 |
| N | 1005 |
| 20 | 1004 |  | Select and Free Text | Is the medication being prescribed by or in consultation with a pain specialist, specialist in the area of the body affected by pain, or anesthesiologist?  If yes, please submit documentation. | Y | 1005 |
| N | 1235 |
| 21 | 1005 |  | Select and Free Text | Has the provider submitted documentation of the following?  1) Current treatment plan  2) Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screenings results reviewed, concerns addressed, and no serious adverse outcomes observed | Y | 1006 |
| N | 1235 |
| 22 | 1006 |  | Select | Subsequent short-acting and dose escalation requests can be authorized up to 180 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1235 |
| 23 | 1235 |  | Free Text | Please provide the rationale for the medication, dose, and duration being requested. | END (Pending Manual Review) | |
| 24 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |
| 25 | 1237 |  | Free Text | Please provide the rationale for the dose and frequency being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: For the course of therapy, up to 180 days. Initial short-acting and long-acting requests may only be authorized for up to 90 days.

|  |  |
| --- | --- |
| **Last Approved** | 9/21/2023 |
| **Other** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria Title** | Analgesic Agents: Opioids | | |
| **Criteria Subtitle** | Preferred Products- Short Acting | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ACETAMINOPHEN/CODEINE | 004163 | GCNSeqNo |
| ACETAMINOPHEN/CODEINE | 004165 | GCNSeqNo |
| ACETAMINOPHEN/CODEINE | 004169 | GCNSeqNo |
| ACETAMINOPHEN/CODEINE | 045155 | GCNSeqNo |
| ACETAMINOPHEN/CODEINE | 070212 | GCNSeqNo |
| ACETAMINOPHEN/CODEINE | 070224 | GCNSeqNo |
| BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE | 004149 | GCNSeqNo |
| BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE | 071253 | GCNSeqNo |
| BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE | 004120 | GCNSeqNo |
| BUTORPHANOL | 004287 | GCNSeqNo |
| BUTORPHANOL | 004288 | GCNSeqNo |
| BUTORPHANOL | 016674 | GCNSeqNo |
| CODEINE | 004185 | GCNSeqNo |
| CODEINE | 004186 | GCNSeqNo |
| CODEINE | 004187 | GCNSeqNo |
| HYDROCODONE/ACETAMINOPHEN | 030623 | GCNSeqNo |
| HYDROCODONE/ACETAMINOPHEN | 047430 | GCNSeqNo |
| HYDROCODONE/ACETAMINOPHEN | 047431 | GCNSeqNo |
| HYDROCODONE/ACETAMINOPHEN | 053582 | GCNSeqNo |
| HYDROCODONE/ACETAMINOPHEN | 066836 | GCNSeqNo |
| HYDROCODONE/ACETAMINOPHEN | 068600 | GCNSeqNo |
| HYDROCODONE/ACETAMINOPHEN | 071384 | GCNSeqNo |
| HYDROCODONE/ACETAMINOPHEN | 071385 | GCNSeqNo |
| HYDROMORPHONE IR | 004110 | GCNSeqNo |
| HYDROMORPHONE IR | 004112 | GCNSeqNo |
| HYDROMORPHONE IR | 015190 | GCNSeqNo |
| HYDROMORPHONE IR | 016156 | GCNSeqNo |
| HYDROMORPHONE IR | 004108 | GCNSeqNo |
| MORPHINE IR TAB, SOL | 004087 | GCNSeqNo |
| MORPHINE IR TAB, SOL | 004089 | GCNSeqNo |
| MORPHINE IR TAB, SOL | 004090 | GCNSeqNo |
| MORPHINE IR TAB, SOL | 004091 | GCNSeqNo |
| MORPHINE IR TAB, SOL | 004092 | GCNSeqNo |
| MORPHINE IR TAB, SOL | 071396 | GCNSeqNo |
| NUCYNTA IR 50 MG TAB | 065319 | GCNSeqNo |
| NUCYNTA IR 75 MG TAB | 065320 | GCNSeqNo |
| NUCYNTA IR 100 MG TAB | 065321 | GCNSeqNo |
| OXYCODONE CAP, SOL, TAB | 004224 | GCNSeqNo |
| OXYCODONE CAP, SOL, TAB | 004225 | GCNSeqNo |
| OXYCODONE CAP, SOL, TAB | 013467 | GCNSeqNo |
| OXYCODONE CAP, SOL, TAB | 015065 | GCNSeqNo |
| OXYCODONE CAP, SOL, TAB | 024507 | GCNSeqNo |
| OXYCODONE CAP, SOL, TAB | 045298 | GCNSeqNo |
| OXYCODONE CAP, SOL, TAB | 046474 | GCNSeqNo |
| OXYCODONE CAP, SOL, TAB | 046475 | GCNSeqNo |
| OXYCODONE CAP, SOL, TAB | 069101 | GCNSeqNo |
| OXYCODONE CAP, SOL, TAB | 076361 | GCNSeqNo |
| OXYCODONE CAP, SOL, TAB | 078532 | GCNSeqNo |
| OXYCODONE CAP, SOL, TAB | 078533 | GCNSeqNo |
| OXYCODONE/ACETAMINOPHEN | 004221 | GCNSeqNo |
| OXYCODONE/ACETAMINOPHEN | 004222 | GCNSeqNo |
| OXYCODONE/ACETAMINOPHEN | 013998 | GCNSeqNo |
| OXYCODONE/ACETAMINOPHEN | 048976 | GCNSeqNo |
| OXYCODONE/ACETAMINOPHEN | 048977 | GCNSeqNo |
| TRAMADOL | 023139 | GCNSeqNo |
| TRAMADOL | 044978 | GCNSeqNo |
| TRAMADOL/ACETAMINOPHEN | 048456 | GCNSeqNo |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0009 |  | Select and Free Text | Is the patient new to (initial request) or continuing therapy with the requested product (re-authorization request)? | Initial request for product | 0010 |
| Continuation (re-authorization request) | 1001 |
| 2 | 0010 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0011 |
| N | 1235 |
| 3 | 0011 |  | Select | Does this request exceed 30 MED AND/OR exceed a 7 days supply (or 5 days supply if <18 years old)?  Patients with initial prescriptions for opioid therapy, defined as no rx opioid claims in the last 90 days, will be limited to 30 MED per day and a maximum of 7 days (or 5 days supply if <18 years old) per prescription. | Y | 0012 |
| N | 1237 |
| 4 | 0012 |  | Select and Free Text | Has the provider submitted documentation to support the need for exceeding 30 MED per day and/or a maximum of 7 days (or 5 days supply if <18 years old) per prescription?  If yes, please submit documentation. | Y | 0013 |
| N | 1235 |
| 5 | 0013 |  | Select and Free Text | Does the patient meet one of the following exemptions?  1) Diagnosis of active cancer treatment, palliative care, end-of-life/hospice care, sickle cell, severe burn, traumatic crushing of tissue, amputation, major orthopedic surgery  2) Prescriber attestation that patient is not opioid naïve (i.e., new to Medicaid or was on higher dose in hospital)  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 0014 |
| 6 | 0014 |  | Select and Free Text | Has the provider submitted documentation of the following?  1) Diagnosis code which must be for somatic type pain  2) Prescriber attestation that the benefits and risks of opioid therapy has been discussed with patient | Y | 0015 |
| N | 1235 |
| 7 | 0015 |  | Select | Does the provider attest that OARRS has been reviewed before initially prescribing or personally furnishing any controlled substance? | Y | 0016 |
| N | 1235 |
| 8 | 0016 |  | Select and Free Text | Has the provider submitted documentation of the patient’s indication, previous utilization, and requested length of therapy? | Y | 0017 |
| N | 1235 |
| 9 | 0017 |  | Select | Initial short-acting requests can be authorized up to 90 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1235 |
| 10 | 1001 |  | Select | Is the request for a dose escalation? | Y | 1002 |
| N | 1005 |
| 11 | 1002 |  | Select and Free Text | Has the provider submitted documentation of the following?  Prescriber attestation that dose escalation is likely to result in improved function or pain control. | Y | 1003 |
| N | 1235 |
| 12 | 1003 |  | Select | Is the request for a cumulative daily dose greater than 80 MED? | Y | 1004 |
| N | 1005 |
| 13 | 1004 |  | Select and Free Text | Is the medication being prescribed by or in consultation with a pain specialist, specialist in the area of the body affected by pain, or anesthesiologist?  If yes, please submit documentation. | Y | 1005 |
| N | 1235 |
| 14 | 1005 |  | Select and Free Text | Has the provider submitted documentation of the following?  1) Current treatment plan  2) Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screenings results reviewed, concerns addressed, and no serious adverse outcomes observed | Y | 1006 |
| N | 1235 |
| 15 | 1006 |  | Select | Subsequent short-acting and dose escalation requests can be authorized up to 180 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1235 |
| 16 | 1235 |  | Free Text | Please provide the rationale for the medication, dose, and duration being requested. | END (Pending Manual Review) | |
| 17 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |
| 18 | 1237 |  | Free Text | Prior Authorization for a preferred short-acting opioid is only required if the initial request (defined as no opioids in the previous 90 days) exceeds 30 MED AND/OR exceeds a 7 days supply (or 5 days supply if <18 years old). | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: For the course of therapy, up to 180 days. Initial short-acting and long-acting requests may only be authorized for up to 90 days.

|  |  |
| --- | --- |
| **Last Approved** | 9/21/2023 |
| **Other** |  |