**Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction**

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| Criteria 1 | Buprenorphine (NP) |
| Criteria 2 | Lucemyra (NP, QL) |

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| **Criteria Title** | Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction | | |
| **Criteria Subtitle** | Buprenorphine | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| BUPRENORPHINE 2 MG SL TAB | 029312 | GCNSeqNo |
| BUPRENORPHINE 8 MG SL TAB | 029313 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0997 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0998 |
| Continuation (re-authorization request) | 1220 |
| 2 | 0998 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0999 |
| N | 1235 |
| 3 | 0999 |  | Select | Is the patient currently pregnant? | Y | 1003 |
| N | 1000 |
| 4 | 1000 |  | Select | Is the patient currently breastfeeding? | Y | 1003 |
| N | 1001 |
| 5 | 1001 |  | Select and Free Text | Does the patient have an allergy or other contraindication to preferred products?  If yes, please provide documentation to support. | Y | 1002 |
| N | 1235 |
| 6 | 1002 |  | Select | Has the patient been explained the difference between an allergic reaction and symptoms of opioid withdraw? | Y | 1003 |
| N | 1235 |
| 7 | 1003 |  | Select | Has the physician reviewed the OARRS report within 7 days prior to the prior authorization request? | Y | 1004 |
| N | 1235 |
| 8 | 1004 |  | Select and Free Text | Has the provider submitted documentation of the patient’s diagnosis and ICD-10 Code?  Please note that requests are not approvable for pain. | Y | 1005 |
| N | 1235 |
| 9 | 1005 |  | Select | Has the patient been referred to counseling for addiction treatment? | Y | 1006 |
| N | 1235 |
| 10 | 1006 |  | Select | Has the patient been offered a prescription for a naloxone kit? | Y | 1007 |
| N | 1235 |
| 11 | 1007 |  | Select | Is the dose greater than 16 mg buprenorphine equivalents per day?  Please note: Doses greater than 24mg/day will not be authorized. | Y | 1008 |
| N | 1009 |
| 12 | 1008 |  | Select and Free Text | Has the provider submitted rationale to support why 16 mg buprenorphine equivalents per day is being exceeded?  Please note: Doses greater than 24mg/day will not be authorized. | Y | 1009 |
| N | 1235 |
| 13 | 1009 |  | Select and Free Text | Has the provider submitted documentation of the patient’s next appointment to assess induction therapy?  Please provide date of appointment. | Y | 1010 |
| N | 1235 |
| 14 | 1010 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least two preferred drugs?  If yes, please submit the medication trials and dates. | Y | 1012 |
| N | 1011 |
| 15 | 1011 |  | 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 | 1012 |
| N | 1236 |
| 16 | 1012 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1013 |
| N | END (Pending Manual Review) |
| 17 | 1013 |  | 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, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 18 | 1220 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | 1221 |
| N | 1235 |
| 19 | 1221 |  | Select | Is the patient currently pregnant? | Y | 1225 |
| N | 1222 |
| 20 | 1222 |  | Select | Is the patient currently breastfeeding? | Y | 1225 |
| N | 1223 |
| 21 | 1223 |  | Select | Does the patient have an allergy or other contraindication to naloxone? | Y | 1224 |
| N | 1235 |
| 22 | 1224 |  | Select | Has the patient been explained the difference between an allergic reaction and symptoms of opioid withdrawal? | Y | 1225 |
| N | 1235 |
| 23 | 1225 |  | Select | Has the provider submitted documentation of the current duration of treatment as of the date of this request? | Y | 1226 |
| N | 1235 |
| 24 | 1226 |  | Select | Has the provider submitted documentation of the frequency of physician meetings? | Y | 1227 |
| N | 1235 |
| 25 | 1227 |  | Select and Free Text | Has the patient been actively participating in counseling AND has been compliant with all sessions? Has the provider submitted documentation of the date of last counseling? | Y | 1228 |
| N | 1235 |
| 26 | 1228 |  | Select | Has the dose been reduced in the past 6 months? | Y | 1230 |
| N | 1229 |
| 27 | 1229 |  | Select and Free Text | Has the provider submitted documentation of why there has not been an evaluation for the dose reduction since the previous PA request? | Y | 1230 |
| N | 1235 |
| 28 | 1230 |  | Select | Has the physician reviewed the OARRS report within 7 days prior to the PA request? | Y | 1231 |
| N | 1235 |
| 29 | 1231 |  | Select | Has the patient received opioids, benzodiazepines, sedative hypnotics, carisoprodol or tramadol? | Y | 1232 |
| N | 1234 |
| 30 | 1232 |  | Select | Has the physician coordinated with all prescribers of controlled substances and determined treatment should continue? | Y | 1233 |
| N | 1235 |
| 31 | 1233 |  | Select and Free Text | Has an addiction specialist recommended to continue substance abuse treatment?  Please documentation of the addiction specialist consulted, phone number, and date. | Y | 1234 |
| N | 1235 |
| 32 | 1234 |  | Select and Free Text | Has the provider submitted documentation of lab testing requirements being met (at least twice per quarter for first year of treatment; once per quarter thereafter)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 33 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 34 | 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: 180 days

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| **Last Approved** | 4/20/2023 |
| **Other** |  |

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| **Criteria Title** | Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction | | |
| **Criteria Subtitle** | Lucemyra | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| LUCEMYRA | 019113 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 2 | 1000 |  | Select and Free Text | Has the provider submitted documentation that the drug was initiated in an inpatient setting? | Y | 1003 |
| N | 1001 |
| 3 | 1001 |  | Select and Free Text | Has the provider submitted medical justification supporting why an opioid taper (such as with buprenorphine or methadone) cannot be used?  If yes, please submit documentation. | Y | 1002 |
| N | 1235 |
| 4 | 1002 |  | Select and Free Text | Has the patient had an inadequate clinical response or contraindication to clonidine?  If yes, please submit documentation. | Y | 1003 |
| N | 1235 |
| 5 | 1003 |  | Select | Has the physician reviewed the OARRS report within 7 days prior to the prior authorization request? | Y | 1004 |
| N | 1235 |
| 6 | 1004 |  | Select and Free Text | Has the provider submitted documentation of the patient’s diagnosis and ICD-10 Code?  Please note that requests are not approvable for pain. | Y | 1005 |
| N | 1235 |
| 7 | 1005 |  | Select | Has the patient been referred to counseling for addiction treatment? | Y | 1006 |
| N | 1235 |
| 8 | 1006 |  | Select | Has the patient been offered a prescription for a naloxone kit? | Y | 1007 |
| N | 1235 |
| 9 | 1007 |  | Select and Free Text | Has the provider submitted documentation of the patient’s next appointment to assess induction therapy?  Please provide date of appointment. | Y | 1008 |
| N | 1235 |
| 10 | 1008 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least two preferred drugs?  If yes, please submit the medication trials and dates. | Y | 1010 |
| N | 1009 |
| 11 | 1009 |  | 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 | 1010 |
| N | 1236 |
| 12 | 1010 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1011 |
| N | END (Pending Manual Review) |
| 13 | 1011 |  | 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, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 14 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 15 | 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: 14 Days

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| --- | --- |
| **Last Approved** | 4/20/2023 |
| **Other** |  |