BlueCross BlueShield of Arizona
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PHARMACY COVERAGE GUIDELINES	**ORIGINAL EFFECTIVE DATE: 9/21/17**
SECTION: DRUGS	**LAST REVIEW DATE: 8/15/19**
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	ARCHIVE DATE:

OPIOIDS LIMITATION FOR QUANTITY AND DOSAGE

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

An **exception** request on an opioid medication limitation for quantity, or dosage greater than **21 days** requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

OPIOIDS LIMITATION FOR QUANTITY AND DOSAGE (cont.)

Criteria:

- An **exception** request on an opioid medication limitation for quantity, or dosage greater than **21 days** may be considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Individual is 18 years of age or older

2. A confirmed diagnosis of pain severe enough that is not controlled by the current quantity or dosage

3. Failure, contraindication, or intolerance to at least 2 Non-Opioid therapies as per diagnosis:
   - **MIGRAINES**:
     - PREVENTATIVE TREATMENTS
       - Anticonvulsant (Topiramate)
       - Beta-Blockers (Propranolol, Atenolol)
       - TCAs (Amitriptyline, Imipramine)
       - Calcium Channel Blockers (Amlodipine, Verapamil)
       - Non pharmacological treatments (Cognitive behavioral therapy, Relaxation, Biofeedback, Exercise therapy)
     - ACUTE TREATMENTS
       - Aspirin, Acetaminophen, NSAIDS (Naproxen, Ibuprofen, Meloxicam, Diclofenac) may be combined with caffeine
       - Anti-nausea medication (Ondansetron, Promethazine)
       - Triptans - migraine-specific (Rizatriptan, Sumatriptan)

   - **NEUROPATHIC PAIN**:
     - TCAs (Amitriptyline, Imipramine)
     - SNRIs (Duloxetine, Venlafaxine)
     - Gabapentin/Lyrica
     - Topical Aspercreme 4% cream or Patches
     - Non pharmacological treatments (Exercise, Weight loss, patient education)

   - **OSTEOARTHRITIS**:
     - FIRST LINE
       - Acetaminophen
       - Oral NSAIDs (Naproxen, Ibuprofen, Meloxicam, Diclofenac)
       - Topical NSAIDs (Diclofenac Gel)
     - SECOND LINE
       - Intra-articular hyaluronic acid (OA of the knee only)
       - Capsaicin

   - **FIBROMYALGIA**:
     - Duloxetine
     - Lyrica
     - Gabapentin
     - TCAs (Amitriptyline, Imipramine)

OPIOIDS LIMITATION FOR QUANTITY AND DOSAGE (cont.)

- Non pharmacological treatments (Low impact aerobic exercise such as brisk walking, swimming, water aerobics or bicycling. Cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation)

4. Documentation of the treatment plan and diagnosis that provides the rationale for the exception on medication limitation for quantity or dosage

5. Coordination of care will be performed between different prescribers for **ALL** controlled substances

6. **For non-cancer pain**: For **morphine equivalent dosing (MED) greater than 180mg/day**:
   - A dosing schedule to bring individual to a lower dosage of MED less than 180mg/day (titration schedule required)

7. **For non-cancer pain**: A **treatment plan,** including:
   - Pain intensity (scales or ratings)
   - Functional status (physical and psychosocial)
   - Patient's goal of therapy (level of pain acceptable and/or functional status)
   - Current non-pharmacological treatment

8. **For non-cancer pain**: Physician-patient **pain management contract** must be provided

9. **For non-cancer pain**: Individual must **NOT** be actively using **illicit substances** or **NOT** have a drug seeking behavior

10. **For non-cancer pain**: Documentation must be included for **random urine or blood tests** twice a year

11. **For non-cancer pain**: Documentation of **PDMP (Prescription Drug Monitoring Program) reviewed** by the prescriber every time a prescription for controlled substance is provided

12. **For non-cancer pain**: **One pharmacy (and another 24-hour closest pharmacy)** must be selected for all the controlled substances prescription services (limitation may vary by specific member's benefit plan*)

13. There is **NO** concomitant use with benzodiazepines-ex. clonazepam, lorazepam, diazepam etc. **OR** there is a treatment plan to taper use and to coordinate care among all prescribers

14. Absence of **ALL** contraindications
    - **Contraindications:**
      - Significant Respiratory depression
      - Acute or severe bronchial asthma
      - Known or suspected paralytic ileus or other GI obstruction
      - Moderate to severe hepatic impairment
      - Allergic reaction to opioid medication prescribed

*For Qualified Health Plans (**QHP**) for Individuals/Families and Small Groups:
"Narcotics Designated Network Program" is a program that requires certain members taking narcotic medications to obtain prescriptions for all covered narcotic medications from one designated eligible

OPIOIDS LIMITATION FOR QUANTITY AND DOSAGE (cont.)

physician or other provider and to obtain all covered narcotic medications from one network pharmacy designated by BCBSAZ and/or the PBM.

Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. **ONE** of the following:
   - Individual's pain is controlled with these products
   - Medication Assisted Treatment (MAT)

2. There is documentation that coordination of care is being performed between different prescribers for **ALL** controlled substances

3. The condition has not progressed or worsened while on therapy and no development of severe side effects like:
   - Apnea, dyspnea, epistaxis, hemoptysis, hyperventilation, hypoxia, upper respiratory infection etc.
   - Confusion/speech disturbance
   - Dehydration
   - Atrial fibrillation/arrhythmia/chest pain
   - Ascites

4. **For non-cancer pain**: A **treatment plan**, including:
   - Pain intensity (scales or ratings)
   - Functional status (physical and psychosocial)
   - Patient's goal of therapy (level of pain acceptable and/or functional status)
   - Current non-pharmacological treatment

5. **For non-cancer pain**: Physician-patient **pain management contract** must be provided

6. **For non-cancer pain**: Documentation must be included for **random urine or blood tests** twice a year

7. **For non-cancer pain**: Documentation of **PDMP reviewed** by the prescriber every time a prescription for controlled substance is provided

8. **For non-cancer pain**: **One pharmacy (and another 24-hour closest pharmacy)** must be selected for all the controlled substances prescription services (limitation may vary by specific member's benefit plan*)

9. **For non-cancer pain**: Individual has been evaluated and must **not** have an active addiction to illicit substances or prescription drugs or a drug seeking behavior

10. There is **NO** concomitant use with benzodiazepines-ex. clonazepam, lorazepam, diazepam etc. **OR** there is a treatment plan to taper use and to coordinate care among all prescribers

Renewal approval duration: 12 months

OPIOIDS LIMITATION FOR QUANTITY AND DOSAGE (cont.)

- **Patients should be tapered off or lower the dosage if any of the following apply: See "Definitions" section for Tapering guidelines**
  - The patient has committed serious or repeated drug seeking behavior
  - The patient makes no progress toward therapeutic goals

- **For all patients receiving more than 200 mg morphine or equivalent per 24 hours: See "Definitions" section for Tapering guidelines**
  - Taper patient to a lower dosage
  - Provide a Naloxone prescription to avoid side effects
  - Initiate/augment non-opioid treatments
  - Provide BH/Case management support to help with the taper

Description:

Medications are subject to limitations, including but not limited to, quantity, age, gender, and dosage. BCBSAZ determines which medications are subject to limitations based upon medication product labeling, nationally recognized compendia or guidelines, and established clinical trials that have been published in peer reviewed professional medical journals. Medication limitations are subject to change at any time without prior notice.

Providers may submit an exception request when medication limitations are exceeded or not met. However, a request is not a guarantee of coverage. Applicable benefit limitations and exclusions of the member's specific benefit plan may apply.

Definitions:

CDC Recommendations for Opioid Prescribing for Chronic Pain:

A. Determining when to initiate or continue opioids for chronic pain

1. Opioids are not first-line or routine therapy for chronic pain
2. Establish and measure goals for pain and function
3. Discuss benefits and risks and availability of non-opioid therapies with patient

B. Opioid selection, dosage, duration, follow-up, and discontinuation

1. Use immediate-release opioids when starting
2. Start low and go slow-Use caution at any dose and avoid increasing to high dosages
3. When opioids are needed for acute pain, prescribe no more than needed
   - Do NOT prescribe ER/LA opioids for acute pain
4. Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if opioids cause harm or are not helping

C. Assessing risk and addressing harms of opioid use

1. Evaluate risk factors for opioid-related harms

OPIOIDS LIMITATION FOR QUANTITY AND DOSAGE (cont.)

2. Check CSPMP for high dosages and prescriptions from other providers at the beginning of the treatment and at least quarterly while on the opioid treatment
3. Use urine drug testing to identify prescribed substances and undisclosed use
4. Avoid concurrent benzodiazepine and opioid prescribing
5. Arrange treatment for opioid use disorder if needed

Prescriber Education:

- Guidelines for Prescribing Opioids for Chronic Pain
  https://www.cdc.gov/drugoverdose/pdf/TurnTheTide_PocketGuide-a.pdf
  http://www.agencymeddirectors.wa.gov/Files/FY16-288SummaryAMDGOpioidGuideline_FINAL.pdf
  https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf

- Checklist for prescribing opioids for chronic pain
  https://www.cdc.gov/drugoverdose/pdf/PDO_Checklist-a.pdf
- Tapering Opioids for Chronic Pain
  https://www.cdc.gov/drugoverdose/pdf/Clinical_Pocket_Guide_Tapering-a.pdf

- Non-Opioid Treatments
  https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf

- Assessing Benefits and Harms of Opioid
  https://www.cdc.gov/drugoverdose/pdf/Assessing_Benefits_Harms_of_Opioid_Therapy-a.pdf

- Calculating Total Daily Dose of Opioids for Safer Dosage
  https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

- Checking Controlled Substances Prescription Monitoring Program (CSPMP)
  https://arizona.pmpaware.net/login
  https://pharmacypmp.az.gov/

- Educational Webinar Series for Prescribers
  https://www.cdc.gov/drugoverdose/pdf/COCA-webinar-series-allslides-a.pdf
  https://www.cdc.gov/drugoverdose/prescribing/trainings.html
  http://www.coperems.org/

- CDC Guideline for Prescribing Opioids for Chronic Pain
  https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html

- Washington State Opioid Taper Plan Calculator
  www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

- Tapering Long-Term Opioid Therapy in Chronic Non-cancer Pain
  www.mayoclinicproceedings.org/article/S0025-6196(15)00303-1/fulltext

OPIOIDS LIMITATION FOR QUANTITY AND DOSAGE (cont.)

- UpToDate
  https://www-uptodate-com.mwu.idm.oclc.org/contents/overview-of-the-treatment-of-chronic-non-cancer-pain?source=search_result&search=non-cancer%20pain&selectedTitle=1~150

Opioid Risk Assessment Tool:

Score each that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disorders		
ADD,OCD, Bipolar, Schizophrenia	2	2
Depression	1	1
Total score		
Assessment of risk		
Low risk for abuse	≤ 3	
Moderate risk for abuse	4-7	
High risk for abuse	≥ 8	
Definitions of risk		
Low = unlikely to abuse Moderate = as likely will as will not abuse High = likely to abuse		

- **Warnings and Precautions**:
  - Simultaneous use with another long-acting opioid drug
  - Used on an as needed basis
  - Used during immediate post-operative period
  - Used for the treatment of mild pain
  - Used for pain not expected to persist for an extended period of time
  - Simultaneous use with opioid antagonist or opioid agonist-antagonist
  - Simultaneous use with monoamine oxidase inhibitors (MAOIs) or within 14 days of stopping an MAOI
  - Woman who is breast feeding an infant or child

Resources:

OPIOIDS LIMITATION FOR QUANTITY AND DOSAGE (cont.)

Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.

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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Opioid Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information			
Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:
Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:		Office Fax:
Dispensing Pharmacy Information			
Pharmacy Name:	Pharmacy Phone:		Pharmacy Fax:
Requested Medication Information			
Medication Name:	Strength:		Dosage Form:
Directions for Use:	Quantity:	Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: _____ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. Select all applicable diagnoses below.

☐ Confirmed diagnosis of pain severe enough that is not controlled by the current dosage
☐ Confirmed diagnosis of Migraines
☐ Confirmed diagnosis of Neuropathic Pain
☐ Confirmed diagnosis of Osteoarthritis
☐ Confirmed diagnosis of Fibromyalgia
☐ Other diagnosis: _____ ICD-10 Code(s): _____

2. What is the quantity requested per day? _____

3. What is the reason for exceeding the plan limitations? Please specify below (if applicable).

_____

4. For Migraines: Check all applicable non-opioid therapies failed, intolerated, or contraindicated.

PREVENTATIVE TREATMENTS

☐ Anticonvulsants (Topiramate)
☐ Beta-Blockers (Propranolol, Atenolol)
☐ TCAs (Amitriptyline, Imipramine)
☐ Calcium Channel Blockers (Amlodipine, Verapamil)
☐ Non pharmacological treatments (Cognitive behavioral therapy, Relaxation, Biofeedback, Exercise therapy)

ACUTE TREATMENTS

☐ Aspirin, Acetaminophen, NSAIDS (Naproxen, Ibuprofen, Meloxicam, Diclofenac) may be combined with caffeine
☐ Anti-nausea medication (Ondansetron, Promethazine)
☐ Triptans - migraine-specific (Rizatriptan, Sumatriptan)

5. For Neuropathic Pain: Check all applicable non-opioid therapies failed, intolerated, or contraindicated.

☐ TCAs (Amitriptyline, Imipramine)
☐ SNRIs (Duloxetine, Venlafaxine)
☐ Gabapentin/Lyrica
☐ Topical Aspercreme 4% cream or Patches
☐ Non pharmacological treatments (Exercise, Weight loss, patient education)

Opioid Prior Authorization Request Form

6. For Osteoarthritis: Check all applicable non-opioid therapies failed, intolerated, or contraindicated.

FIRST LINE

- ☐ Acetaminophen
- ☐ Oral NSAIDs (Naproxen, Ibuprofen, Meloxicam, Diclofenac)
- ☐ Topical NSAIDs (Diclofenac Gel)

SECOND LINE

- ☐ Intra-articular hyaluronic acid (OA of the knee only)
- ☐ Capsaicin

7. For Fibromyalgia: Check all applicable non-opioid therapies failed, intolerated, or contraindicated.

- ☐ Duloxetine
- ☐ Lyrica
- ☐ Gabapentin
- ☐ TCAs (Amitriptyline, Imipramine)
- ☐ Non pharmacological treatments (Low impact aerobic exercise such as brisk walking, swimming, water aerobics or bicycling. Cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation)

8. ☐ Yes ☐ No **For non-cancer pain**: For **morphine equivalent dosing (MED) greater than 180mg/day**:
A dosing schedule to bring individual to a lower dosage of MED less than 180mg/day (titration schedule required)

9. ☐ Yes ☐ No **A treatment plan must be submitted with this request form that includes ALL of the following:**

- Pain intensity (scales or ratings)
- Functional status (physical and psychosocial)
- Patient's goal of therapy (level of pain acceptable and/or functional status)
- Current non-pharmacological treatment

10. ☐ Yes ☐ No **A physician-patient pain management contract must be submitted with this request form.**

11. ☐ Yes ☐ No **Individual must not be actively using illicit substances or NOT have a drug seeking behavior.**

12. ☐ Yes ☐ No **Results from random urine or blood test twice a year must be submitted with this request form.**

13. ☐ Yes ☐ No **Has the state's Prescription Drug Monitoring Program (PDMP) been reviewed for this individual every time a prescription for controlled substance is provided?**

14. What other controlled substances is the patient currently receiving? Please specify below.

_____

15. One pharmacy (plus one closest 24 hour pharmacy) must be selected for all the controlled substances prescription services. Please specify:

_____

16. ☐ Yes ☐ No **There is NO concomitant use with benzodiazepines-ex. clonazepam, lorazepam, diazepam etc.**

17. ☐ Yes ☐ No **There is absence of ALL contraindications.**

18. What medication(s) has the individual tried and failed for this diagnosis? Please specify below.
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

19. Are there any supporting labs or test results? Please specify below.

Date	Test	Value

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Opioid Prior Authorization Request Form

20. Is there any additional information the prescribing provider feels is important to this review? Please specify below.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature: Date:

Please note: Some medications may require completion of a drug-specific request form.

Incomplete forms or forms without the chart notes will be returned.

Office notes, labs, and medical testing relevant to the request that show medical justification are required.