DURATION LIMIT WITH QUANTITY LIMIT AND POST LIMIT PRIOR AUTHORIZATION CRITERIA

DRUG CLASS **IMMEDIATE-RELEASE OPIOID ANALGESICS (BRAND AND GENERIC)**

Prior authorization applies only to patients ≤ 25 years of age.

generic name, dosage form

(codeine sulfate tablets)

(hydromorphone hydrochloride oral solution, suppositories, tablets)

(levorphanol tartrate tablets)

(meperidine hydrochloride oral solution, tablets)

(morphine sulfate oral soln, oral soln concentrate, suppositories, tablets)

(oxycodone hydrochloride capsules, oral soln, oral soln concentrate, tabs)

(oxymorphone hydrochloride tablets)

(pentazocine/naloxone tablets)

(tapentadol oral solution, tablets)

(tramadol hydrochloride oral solution, tablets)

Status: CVS Caremark Criteria
Type: Duration Limit; Initial Limit; Post Limit PA ***Ref # C21407-M***

SCREENOUT LOGIC
If the patient is ≤ 25 years of age and has filled a prescription for at least a 1-day supply of a drug indicating the patient is being treated for cancer or sickle cell disease within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.

If a claim is submitted with an ICD 10 diagnosis code indicating cancer, sickle cell disease, or palliative care under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.

If the patient has an ICD 10 diagnosis code indicating cancer or palliative care in their member health profile in the past 365 days, then the requested drug will be paid under that prescription benefit.

If the patient has any history of an ICD 10 diagnosis code indicating sickle cell disease in their member health profile, then the requested drug will be paid under that prescription benefit.

If a claim is submitted using a hospice patient residence code under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.

For patients ≤ 25 years of age with no prescription claims of a cancer drug or a sickle cell disease drug in the past 365 days, no ICD 10 diagnosis code indicating cancer, sickle cell disease, or palliative care submitted with their prescription claim, no ICD 10 diagnosis code indicating cancer or palliative care in their member health profile in the past 365 days, no history of an ICD 10 diagnosis code indicating sickle cell disease in their member health profile, or no hospice patient residence code submitted with their prescription claim:
If the patient is ≤ 25 years of age and has filled a prescription for at least an 8-day supply of an immediate-release (IR) or extended-release (ER) opioid agent indicated for the management of pain within prescription claim history in the past 90 days under a prescription benefit administered by CVS Caremark, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below).

If the patient is ≤ 25 years of age and does not have at least an 8-day supply of an IR or ER opioid agent indicated for the management of pain within prescription claim history in the past 90 days and the incoming prescription drug is being filled for more than a 3-day supply, then the claim will reject with a message indicating that the patient can receive a 3-day supply (until 7-days of therapy in a 90-day period have been filled) or submit a prior authorization (PA) for additional quantities. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit. If the incoming prescription drug is being filled for less than a 3-day supply, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below).

LIMIT CRITERIA**
Neither acute pain duration limits nor quantity limits apply if the patient is ≤ 25 years of age and has a drug in claims history in the past year that indicates the patient is being treated for cancer or sickle cell disease. In addition, neither acute pain duration limits nor quantity limits will apply if a prescription claim is submitted with an ICD 10 diagnosis code indicating cancer, sickle cell disease, or palliative care, if the patient has an ICD 10 diagnosis code indicating cancer or palliative care in their member health profile in the past 365 days, if the patient has a history of an ICD 10 diagnosis code indicating sickle cell disease in their member health profile, or if a prescription claim is submitted using a hospice patient residence code.

ACUTE PAIN DURATION LIMIT*:
The acute pain duration limit portion of this program applies to patients ≤ 25 years of age and are identified with potential first fills of immediate-release opioid prescriptions for the treatment of non-cancer, non-sickle cell, non-hospice, and non-palliative care related pain. Patients are limited to a maximum of a 3-day supply per fill up to 7 days of therapy in a 90-day period.

If the patient is ≤ 25 years of age and does not have at least an 8-day supply of an IR or ER opioid agent indicated for the management of pain within prescription claim history in the past 90 days and the incoming prescription drug is being filled for more than a 3-day supply, then the claim will reject with a message indicating that the patient can receive a 3-day supply (until 7-days of therapy in a 90-day period have been filled) or submit a prior authorization (PA) for additional quantities. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit. If the incoming prescription drug is being filled for less than a 3-day supply, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below).

INITIAL QUANTITY LIMIT:
Morphine milligram equivalent (MME) quantity limits for IR opioids provide coverage for an initial amount of a monthly

quantity that corresponds to 90 MME or less per day. Coverage is provided for up to the initial quantity limit per Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below. Prior authorization review is required to determine coverage for additional quantities above the initial limit.

**Acute Pain Duration Limit logic will apply first, followed by initial quantity limit logic.*

CRITERIA FOR APPROVAL

1	Is the requested drug being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through hospice or palliative care? [If yes, then no further questions.]	Yes	No
2	Can the patient safely take the requested dose based on their history of opioid use? [Note: The lowest effective dosage should be prescribed for opioid naïve patients.] [If no, then no further questions.]	Yes	No
3	Has the patient been evaluated and will the patient be monitored regularly for the development of opioid use disorder? [If no, then no further questions.]	Yes	No
4	Is the requested drug being prescribed for moderate to severe CHRONIC pain where use of an opioid analgesic is appropriate? [Note: Chronic pain is generally defined as pain that typically lasts greater than 3 months.] [If no, then skip to question 7.]	Yes	No
5	Will the patient's pain be reassessed in the first month after the initial prescription or any dose increase AND every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety? [If no, then no further questions.]	Yes	No
6	Which drug is being requested (applies to brand or generic)? [Note: Please check the drug being requested (applies to brand or generic).] [] codeine tablets (if checked, go to 9) [] hydromorphone oral solution, suppositories, or tablets (if checked, go to 10) [] levorphanol tablets (if checked, go to 11) [] meperidine oral solution or tablets (if checked, go to 12) [] morphine sulfate oral concentrate or oral solution (if checked, go to 13) [] morphine sulfate suppositories (if checked, go to question 14) [] morphine sulfate tablets (if checked, go to question 15) [] oxycodone, Oxaydo, or RoxyBond capsules or tablets (if checked, go to 16) [] oxycodone oral concentrate or oral solution (if checked, go to 17) [] oxymorphone tablets (if checked, go to 18) [] pentazocine/naloxone tablets (if checked, go to 19) [] tapentadol oral solution or tablets (Nucynta) (if checked, go to 20)		

[] tramadol oral solution or tablets (if checked, go to 21)

7	Does the patient require extended treatment beyond 3 days for moderate to severe ACUTE pain where use of an opioid analgesic is appropriate? [If no, then no further questions.]	Yes	No
8	Which drug is being requested (applies to brand or generic)? [Note: Please check the drug being requested (applies to brand or generic).] [] codeine tablets (if checked, go to 22) [] hydromorphone oral solution, suppositories, or tablets (if checked, go to 23) [] levorphanol tablets (if checked, go to 24) [] meperidine oral solution or tablets (if checked, go to 25) [] morphine sulfate oral concentrate or oral solution (if checked, go to 26) [] morphine sulfate suppositories (if checked, go to question 27) [] morphine sulfate tablets (if checked, go to question 28) [] oxycodone, Oxaydo, or RoxyBond capsules or tablets (if checked, go to 29) [] oxycodone oral concentrate or oral solution (if checked, go to 30) [] oxymorphone tablets (if checked, go to 31) [] pentazocine/naloxone tablets (if checked, go to 32) [] tapentadol oral solution or tablets (Nucynta) (if checked, go to 33) [] tramadol oral solution or tablets (if checked, go to 34)		
9	Does the patient require use of MORE than the plan allowance of 6 tablets per day OR MORE than 84 tablets in a one month period (quantity sufficient for a 14-day supply) of codeine? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 6 tablets per day and 84 tablets per month of codeine.]	Yes	No
10	Does the patient require use of MORE than the plan allowance of any of the following: A) 50 mL per day of hydromorphone oral solution, B) 6 hydromorphone suppositories per day, C) 9 tablets per day of hydromorphone 2 mg, D) 7.5 tablets per day of hydromorphone 4 mg, E) 3 tablets per day of hydromorphone 8 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 50 mL per day of hydromorphone oral solution, B) 6 hydromorphone suppositories per day, C) 9 tablets per day of hydromorphone 2 mg, D) 7.5 tablets per day of hydromorphone 4 mg, E) 3 tablets per day of hydromorphone 8 mg.]	Yes	No
11	Does the patient require use of MORE than the plan allowance of 6 levorphanol tablets per day? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 6 levorphanol tablets per day.]	Yes	No
12	Does the patient require use of MORE than the plan allowance of any of the following: A)	Yes	No

	30 mL per day OR 120 mL in a one month period (quantity sufficient for a 4-day supply) of meperidine oral solution, B) 6 tablets per day OR 24 tablets in a one month period (quantity sufficient for a 4-day supply) of meperidine tablets? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for A) 30 mL per day and 120 mL in a one month period (quantity sufficient for a 4-day supply) of meperidine oral solution, B) 6 tablets per day and 24 tablets in a one month period (quantity sufficient for a 4-day supply) of meperidine tablets.]		
13	Does the patient require use of MORE than the plan allowance of 45 mL per day of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution OR MORE than the plan allowance of 9 mL per day of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 45 mL/day of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution OR 9 mL/day of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution.]	Yes	No
14	Does the patient require use of MORE than the plan allowance of 9 suppositories per day of morphine sulfate 5 mg, 10 mg, 20 mg OR MORE than the plan allowance of 6 suppositories per day of morphine sulfate 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 9 suppositories per day of morphine sulfate 5 mg, 10 mg, 20 mg OR 6 suppositories per day of morphine sulfate 30 mg.]	Yes	No
15	Does the patient require use of MORE than the plan allowance of 9 tablets per day of morphine sulfate 15 mg OR MORE than the plan allowance of 6 tablets per day of morphine sulfate 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 9 tablets per day of morphine sulfate 15 mg OR 6 tablets per day of morphine sulfate 30 mg.]	Yes	No
16	Does the patient require use of MORE than the plan allowance of any of the following: A) 9 capsules or tablets per day of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 6 tablets per day of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg C) 4 tablets per day of oxycodone 30 mg or RoxyBond 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 9 capsules or tablets per day of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 6 tablets per day of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg C) 4 tablets per day of oxycodone 30 mg or RoxyBond 30 mg.]	Yes	No
17	Does the patient require use of MORE than the plan allowance of 90 mL per day of oxycodone 5 mg/5 mL oral solution OR MORE than the plan allowance of 6 mL per day of	Yes	No

	oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 90 mL/day of oxycodone 5 mg/5 mL oral solution OR 6 mL/day of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate.]		
18	Does the patient require use of MORE than the plan allowance of 12 tablets per day of oxymorphone 5 mg OR MORE than the plan allowance of 6 tablets per day of oxymorphone 10 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 12 tablets per day of oxymorphone 5 mg OR 6 tablets per day of oxymorphone 10 mg.]	Yes	No
19	Does the patient require use of MORE than the plan allowance of 10 pentazocine/naloxone tablets per day? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 10 pentazocine/naloxone tablets per day.]	Yes	No
20	Does the patient require use of MORE than the plan allowance of any of the following: A) 23.33 mL per day of Nucynta (tapentadol) oral solution, B) 8 tablets per day of Nucynta (tapentadol) 50 mg tablets, C) 6 tablets per day of Nucynta (tapentadol) 75 mg tablets, D) 4 tablets per day of Nucynta (tapentadol) 100 mg tablets? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the followingA) 23.33 mL per day of Nucynta (tapentadol) oral solution, B) 8 tablets per day of Nucynta (tapentadol) 50 mg tablets, C) 6 tablets per day of Nucynta (tapentadol) 75 mg tablets, D) 4 tablets per day of Nucynta (tapentadol) 100 mg tablets.]	Yes	No
21	Does the patient require use of MORE than the plan allowance of any of the following: A) 80 mL per day of tramadol 5 mg/mL oral solution, B) 8 tablets per day of tramadol 50 mg, C) 4 tablets per day of tramadol 100 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 80 mL per day of tramadol 5 mg/mL oral solution, B) 8 tablets per day of tramadol 50 mg, C) 4 tablets per day of tramadol 100 mg.]	Yes	No
22	Does the patient require use of MORE than the plan allowance of 6 tablets per day OR MORE than 84 tablets in a one month period (quantity sufficient for a 14-day supply) of codeine? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 6 tablets per day and 84 tablets per month of codeine.]	Yes	No

23	Does the patient require use of MORE than the plan allowance of any of the following: A) 50 mL per day of hydromorphone oral solution, B) 6 hydromorphone suppositories per day, C) 9 tablets per day of hydromorphone 2 mg, D) 7.5 tablets per day of hydromorphone 4 mg, E) 3 tablets per day of hydromorphone 8 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 50 mL per day of hydromorphone oral solution, B) 6 hydromorphone suppositories per day, C) 9 tablets per day of hydromorphone 2 mg, D) 7.5 tablets per day of hydromorphone 4 mg, E) 3 tablets per day of hydromorphone 8 mg.]	Yes	No
24	Does the patient require use of MORE than the plan allowance of 6 levorphanol tablets per day? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 6 levorphanol tablets per day.]	Yes	No
25	Does the patient require use of MORE than the plan allowance of any of the following: A) 30 mL per day OR 120 mL in a one month period (quantity sufficient for a 4-day supply) of meperidine oral solution, B) 6 tablets per day OR 24 tablets in a one month period (quantity sufficient for a 4-day supply) of meperidine tablets? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for A) 30 mL per day and 120 mL in a one month period (quantity sufficient for a 4-day supply) of meperidine oral solution, B) 6 tablets per day and 24 tablets in a one month period (quantity sufficient for a 4-day supply) of meperidine tablets.]	Yes	No
26	Does the patient require use of MORE than the plan allowance of 45 mL per day of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution OR MORE than the plan allowance of 9 mL per day of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 45 mL/day of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution OR 9 mL/day of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution.]	Yes	No
27	Does the patient require use of MORE than the plan allowance of 9 suppositories per day of morphine sulfate 5 mg, 10 mg, 20 mg OR MORE than the plan allowance of 6 suppositories per day of morphine sulfate 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 9 suppositories per day of morphine sulfate 5 mg, 10 mg, 20 mg OR 6 suppositories per day of morphine sulfate 30 mg.]	Yes	No
28	Does the patient require use of MORE than the plan allowance of 9 tablets per day of morphine sulfate 15 mg OR MORE than the plan allowance of 6 tablets per day of	Yes	No

	morphine sulfate 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 9 tablets per day of morphine sulfate 15 mg OR 6 tablets per day of morphine sulfate 30 mg.]		
29	Does the patient require use of MORE than the plan allowance of any of the following: A) 9 capsules or tablets per day of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 6 tablets per day of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg C) 4 tablets per day of oxycodone 30 mg or RoxyBond 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 9 capsules or tablets per day of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 6 tablets per day of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg C) 4 tablets per day of oxycodone 30 mg or RoxyBond 30 mg.]	Yes	No
30	Does the patient require use of MORE than the plan allowance of 90 mL per day of oxycodone 5 mg/5 mL oral solution OR MORE than the plan allowance of 6 mL per day of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 90 mL/day of oxycodone 5 mg/5 mL oral solution OR 6 mL/day of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate.]	Yes	No
31	Does the patient require use of MORE than the plan allowance of 12 tablets per day of oxymorphone 5 mg OR MORE than the plan allowance of 6 tablets per day of oxymorphone 10 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 12 tablets per day of oxymorphone 5 mg OR 6 tablets per day of oxymorphone 10 mg.]	Yes	No
32	Does the patient require use of MORE than the plan allowance of 10 pentazocine/naloxone tablets per day? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 10 pentazocine/naloxone tablets per day.]	Yes	No
33	Does the patient require use of MORE than the plan allowance of any of the following: A) 23.33 mL per day of Nucynta (tapentadol) oral solution, B) 8 tablets per day of Nucynta (tapentadol) 50 mg tablets, C) 6 tablets per day of Nucynta (tapentadol) 75 mg tablets, D) 4 tablets per day of Nucynta (tapentadol) 100 mg tablets? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the followingA) 23.33 mL per day of Nucynta (tapentadol) oral solution, B) 8 tablets per day of Nucynta (tapentadol) 50 mg tablets, C) 6 tablets per day of Nucynta (tapentadol) 75 mg tablets, D)	Yes	No

4 tablets per day of Nucynta (tapentadol) 100 mg tablets.]

34 Does the patient require use of MORE than the plan allowance of any of the following: A) 80 mL per day of tramadol 5 mg/mL oral solution, B) 8 tablets per day of tramadol 50 mg, C) 4 tablets per day of tramadol 100 mg?
[No further questions.]

Yes No

[RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 80 mL per day of tramadol 5 mg/mL oral solution, B) 8 tablets per day of tramadol 50 mg, C) 4 tablets per day of tramadol 100 mg.]

Mapping Instructions		
	Yes	**No**
1.	Approve, 12 months, No set post limit quantity [Enter approval for quantity of 999999.]	Go to 2
2.	Go to 3	Deny
3.	Go to 4	Deny
4.	Go to 5	Go to 7
5.	Go to 6	Deny
6.	1=9; 2=10; 3=11; 4=12; 5=13; 6=14; 7=15; 8=16; 9=17; 10=18; 11=19; 12=20; 13=21	N/A
7.	Go to 8	Deny
8.	1=22; 2=23; 3=24; 4=25; 5=26; 6=27; 7=28; 8=29; 9=30; 10=31; 11=32; 12=33; 13=34	N/A
9.	Deny	Approve, 6 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply)
10.	Deny	Approve, 6 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)
11.	Deny	Approve, 6 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)
12.	Deny	Approve, 6 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply)
13.	Deny	Approve, 6 months

		See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)
14.	Deny	Approve, 6 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)
15.	Deny	Approve, 6 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)
16.	Deny	Approve, 6 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)
17.	Deny	Approve, 6 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)
18.	Deny	Approve, 6 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)
19.	Deny	Approve, 6 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply)
20.	Deny	Approve, 6 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)
21.	Deny	Approve, 6 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)
22.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)
23.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)

24.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)
25.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)
26.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)
27.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)
28.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)
29.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)
30.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)
31.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)
32.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)
33.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)
34.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)

Opioid Analgesics IR Quantity Limits Chart
Coverage is provided without prior authorization (for patients not identified as potential first fills) for a 30-day or 90-day supply of an immediate-release opioid for a quantity that corresponds to ≤ 90 MME/day. Coverage for quantities that correspond to ≤ 200 MME/day for a 30-day or 90-day supply is provided through prior authorization when criteria for approval are met.

These quantity limits should accumulate across all drugs of the same unit limit (i.e., drugs with 30 units accumulate together, drugs with 60 units accumulate together, etc).

		COLUMN A	COLUMN B	COLUMN C	COLUMN D
Drug/Strength**	**Labeled Dosing**	**Initial 1 Month Limit* ≤ 90 MME/day (per 25 days)**	**Initial 3 Month Limit* ≤ 90 MME/day (per 75 days)**	**Post 1 Month Limit* ≤ 200 MME/day (per 25 days)**	**Post 3 Month Limit* ≤ 200 MME/day (per 75 days)**
Codeine sulfate tab 15 mg	q4h, Max Daily Dose 360 mg	42 tabs/month‡ 6 tabs/day (13.5 MME/day)	Does Not Apply‡	84 tabs/month‡ 6 tabs/day (13.5 MME/day)	Use Column C
Codeine sulfate tab 30 mg	q4h, Max Daily Dose 360 mg	42 tabs/month‡ 6 tabs/day (27 MME/day)	Does Not Apply‡	84 tabs/month‡ 6 tabs/day (27 MME/day)	Use Column C
Codeine sulfate tab 60 mg	q4h, Max Daily Dose 360 mg	42 tabs/month‡ 6 tabs/day (54 MME/day)	Does Not Apply‡	84 tabs/month‡ 6 tabs/day (54 MME/day)	Use Column C
Hydromorphone oral soln 5 mg/5 mL (1 mg/mL)	q3-6h	600 mL/month 20 mL/day (80 MME/day)	1800 mL/3 months 20 mL/day (80 MME/day)	1500 mL/month 50 mL/day (200 MME/day)	4500 mL/3 months 50 mL/day (200 MME/day)
Hydromorphone supp 3 mg	q6-8h	120 supps/month 4 supps/day (48 MME/day)	360 supps/3 months 4 supps/day (48 MME/day)	180 supps/month 6 supps/day (72 MME/day)	540 supps/3 months 6 supps/day (72 MME/day)
Hydromorphone tab 2 mg	q4-6h	180 tabs/month 6 tabs/day (48 MME/day)	540 tabs/3 months 6 tabs/day (48 MME/day)	270 tabs/month 9 tabs/day (72 MME/day)	810 tabs/3 months 9 tabs/day (72 MME/day)
Hydromorphone tab 4 mg	q4-6h	150 tabs/month 5 tabs/day (80 MME/day)	450 tabs/3 months 5 tabs/day (80 MME/day)	225 tabs/month 7.5 tabs/day (120 MME/day)	675 tabs/3 months 7.5 tabs/day (120 MME/day)
Hydromorphone tab 8 mg	q4-6h	60 tabs/month 2 tabs/day (64 MME/day)	180 tabs/3 months 2 tabs/day (64 MME/day)	90 tabs/month 3 tabs/day (96 MME/day)	270 tabs/3 months 3 tabs/day (96 MME/day)
Levorphanol tab 1 mg	q6-8h	120 tabs/month 4 tabs/day (44 MME/day)	360 tabs/3 months 4 tabs/day (44 MME/day)	180 tabs/month 6 tabs/day (66 MME/day)	540 tabs/3 months 6 tabs/day (66 MME/day)
Levorphanol tab 2 mg	q6-8h	120 tabs/month 4 tabs/day (88 MME/day)	360 tabs/3 months 4 tabs/day (88 MME/day)	180 tabs/month 6 tabs/day (132 MME/day)	540 tabs/3 months 6 tabs/day (132 MME/day)
Levorphanol tab 3 mg	q6-8h	60 tabs/month 2 tabs/day (66 MME/day)	180 tabs/3 months 2 tabs/day (66 MME/day)	180 tabs/month 6 tabs/day (198 MME/day)	540 tabs/3 months 6 tabs/day (198 MME/day)
Meperidine oral soln 50 mg/5 mL	q3-4h	90 mL/month**** 30 mL/day (30 MME/day)	Does Not Apply****	120 mL/month**** 30 mL/day (30 MME/day)	Use Column C
Meperidine tab 50 mg	q3-4h	18 tabs/month**** 6 tabs/day (30 MME/day)	Does Not Apply****	24 tabs/month**** 6 tabs/day (30 MME/day)	Use Column C
Meperidine tab 100 mg	q3-4h	18 tabs/month**** 6 tabs/day (60 MME/day)	Does Not Apply****	24 tabs/month**** 6 tabs/day (60 MME/day)	Use Column C
Morphine sulfate (conc) oral soln 20	q4h	135 mL/month 4.5 mL/day	405 mL/3 months 4.5 mL/day	270 mL/month 9 mL/day	810 mL/3 months 9 mL/day

mg/mL (100 mg/5 mL)		(90 MME/day)	(90 MME/day)	(180 MME/day)	(180 MME/day)
Morphine sulfate oral soln 10 mg/5 mL	q4h	900 mL/month 30 mL/day (60 MME/day)	2700 mL/3 months 30 mL/day (60 MME/day)	1350 mL/month 45 mL/day (90 MME/day)	4050 mL/3 months 45 mL/day (90 MME/day)
Morphine sulfate oral soln 20 mg/5 mL	q4h	675 mL/month 22.5 mL/day (90 MME/day)	2025 mL/3 months 22.5 mL/day (90 MME/day)	1350 mL/month 45 mL/day (180 MME/day)	4050 mL/3 months 45 mL/day (180 MME/day)
Morphine sulfate supp 5 mg	q4h	180 supps/month 6 supps/day (30 MME/day)	540 supps/3 month 6 supps/day (30 MME/day)	270 supps/month 9 supps/day (45 MME/day)	810 supps/3 months 9 supps/day (45 MME/day)
Morphine sulfate supp 10 mg	q4h	180 supps/month 6 supps/day (60 MME/day)	540 supps/3 month 6 supps/day (60 MME/day)	270 supps/month 9 supps/day (90 MME/day)	810 supps/3 months 9 supps/day (90 MME/day)
Morphine sulfate supp 20 mg	q4h	120 supps/month 4 supps/day (80 MME/day)	360 supps/month 4 supps/day (80 MME/day)	270 supps/month 9 supps/day (180 MME/day)	810 supps/month 9 supps/day (180 MME/day)
Morphine sulfate supp 30 mg	q4h	90 supps/month 3 supps/day (90 MME/day)	270 supps/3 months 3 supps/day (90 MME/day)	180 supps/month 6 supps/day (180 MME/day)	540 supps/3 months 6 supps/day (180 MME/day)
Morphine sulfate tab 15 mg	q4h	180 tabs/month 6 tabs/day (90 MME/day)	540 tabs/3 months 6 tabs/day (90 MME/day)	270 tabs/month 9 tabs/day (135 MME/day)	810 tabs/3 months 9 tabs/day (135 MME/day)
Morphine sulfate tab 30 mg	q4h	90 tabs/month 3 tabs/day (90 MME/day)	270 tabs/3 months 3 tabs/day (90 MME/day)	180 tabs/month 6 tabs/day (180 MME/day)	540 tabs/3 months 6 tabs/day (180 MME/day)
Oxaydo 5 mg	q4-6h	180 tabs/month 6 tabs/day (45 MME/day)	540 tabs/3 months 6 tabs/day (45 MME/day)	270 tabs/month 9 tabs/day (67.5 MME/day)	810 tabs/3 months 9 tabs/day (67.5 MME/day)
Oxaydo 7.5 mg	q4-6h	180 tabs/month 6 tabs/day (67.5 MME/day)	540 tabs/3 months 6 tabs/day (67.5 MME/day)	270 tabs/month 9 tabs/day (101.25 MME/day)	810 tabs/3 months 9 tabs/day (101.25 MME/day)
Oxycodone cap 5 mg	q4-6h	180 caps/month 6 caps/day (45 MME/day)	540 caps/3 months 6 caps/day (45 MME/day)	270 caps/month 9 caps/day (67.5 MME/day)	810 caps/3 months 9 caps/day (67.5 MME/day)
Oxycodone oral concentrate 100 mg/5 mL (20 mg/mL)	q4-6h	90 mL/month 3 mL/day (90 MME/day)	270 mL/3 months 3 mL/day (90 MME/day)	180 mL/month 6 mL/day (180 MME/day)	540 mL/3 months 6 mL/day (180 MME/day)
Oxycodone soln 5 mg/5 mL	q4-6h	900 mL/month 30 mL/day (45 MME/day)	2700 mL/3 months 30 mL/day (45 MME/day)	2700 mL/ month 90 mL/day (135 MME/day)	8100 mL/3 months 90 mL/day (135 MME/day)
Oxycodone tab 5 mg	q4-6h	180 tabs/month 6 tabs/day (45 MME/day)	540 tabs/3 months 6 tabs/day (45 MME/day)	270 tabs/month 9 tabs/day (67.5 MME/day)	810 tabs/3 months 9 tabs/day (67.5 MME/day)
Oxycodone tab 10 mg	q4-6h	180 tabs/month 6 tabs/day (90 MME/day)	540 tabs/3 months 6 tabs/day (90 MME/day)	270 tabs/month 9 tabs/day (135 MME/day)	810 tabs/3 months 9 tabs/day (135 MME/day)
Oxycodone tab 15 mg	q4-6h	120 tabs/month 4 tabs/day (90 MME/day)	360 tabs/3 months 4 tabs/day (90 MME/day)	180 tabs/month 6 tabs/day (135 MME/day)	540 tabs/3 months 6 tabs/day (135 MME/day)
Oxycodone tab 20 mg	q4-6h	90 tabs/month 3 tabs/day (90 MME/day)	270 tabs/3 months 3 tabs/day (90 MME/day)	180 tabs/month 6 tabs/day (180 MME/day)	540 tabs/3 months 6 tabs/day (180 MME/day)
Oxycodone tab 30 mg	q4-6h	60 tabs/month 2 tabs/day (90 MME/day)	180 tabs/3 months 2 tabs/day (90 MME/day)	120 tabs/month 4 tabs/day (180 MME/day)	360 tabs/3 months 4 tabs/day (180 MME/day)

Oxymorphone tab 5 mg	q4-6h	180 tabs/month 6 tabs/day (90 MME/day)	540 tabs/3 months 6 tabs/day (90 MME/day)	360 tabs/month 12 tabs/day (180 MME/day)	1080 tabs/3 months 12 tabs/day (180 MME/day)
Oxymorphone tab 10 mg	q4-6h	90 tabs/month 3 tabs/day (90 MME/day)	270 tabs/3 months 3 tabs/day (90 MME/day)	180 tabs/month 6 tabs/day (180 MME/day)	540 tabs/3 months 6 tabs/day (180 MME/day)
Pentazocine/naloxone 50/0.5 mg	q3-4h, Total daily dose should not exceed 12 tablets.	120 tabs/month*** 4 tabs/day (74 MME/day)	Does Not Apply ***	300 tabs/month*** 10 tabs/day (185 MME/day)	Use Column C
RoxyBond 5 mg	q4-6h	180 tabs/month 6 tabs/day (45 MME/day)	540 tabs/3 months 6 tabs/day (45 MME/day)	270 tabs/month 9 tabs/day (67.5 MME/day)	810 tabs/3 months 9 tabs/day (67.5 MME/day)
RoxyBond 15 mg	q4-6h	120 tabs/month 4 tabs/day (90 MME/day)	360 tabs/3 months 4 tabs/day (90 MME/day)	180 tabs/month 6 tabs/day (135 MME/day)	540 tabs/3 months 6 tabs/day (135 MME/day)
RoxyBond 30 mg	q4-6h	60 tabs/month 2 tabs/day (90 MME/day)	180 tabs/3 months 2 tabs/day (90 MME/day)	120 tabs/month 4 tabs/day (180 MME/day)	360 tabs/3 months 4 tabs/day (180 MME/day)
Tapentadol oral soln 20 mg/mL†	q4-6h, Max daily dose is 700 mg on the first day and 600 mg on subsequent days.	300 mL/month 10 mL/day (80 MME/day)	900 mL/3 months 10 mL/day (80 MME/day)	700 mL/month 23.33 mL/day (186.7 MME/day)	2100 mL/3 months 23.33 mL/day (186.7 MME/day)
Tapentadol tab 50 mg	q4-6h, Max daily dose is 700 mg on the first day and 600 mg on subsequent days.	120 tabs/month 4 tabs/day (80 MME/day)	360 tabs/3 months 4 tabs/day (80 MME/day)	240 tabs/month 8 tabs/day (160 MME/day)	720 tabs/3 months 8 tabs/day (160 MME/day)
Tapentadol tab 75 mg	q4-6h, Max daily dose is 700 mg on the first day and 600 mg on subsequent days.	90 tabs/month 3 tabs/day (90 MME/day)	270 tabs/3 months 3 tabs/day (90 MME/day)	180 tabs/month 6 tabs/day (180 MME/day)	540 tabs/3 months 6 tabs/day (180 MME/day)
Tapentadol tab 100 mg	q4-6h, Max daily dose is 700 mg on the first day and 600 mg on subsequent days.	60 tabs/month 2 tabs/day (80 MME/day)	180 tabs/3 months 2 tabs/day (80 MME/day)	120 tabs/month 4 tabs/day (160 MME/day)	360 tabs/3 months 4 tabs/day (160 MME/day)
Tramadol oral soln 5 mg/mL	q4-6h, Max Daily Dose 400 mg	1800 mL/month 60 mL/day (30 MME/day)	5400 mL/3 months 60 mL/day (30 MME/day)	2400 mL/month 80 mL/day (40 MME/day)	7200 mL/month 80 mL/day (40 MME/day)
Tramadol 50 mg	q4-6h, Max Daily Dose 400 mg	180 tabs/month 6 tabs/day (30 MME/day)	540 tabs/3 months 6 tabs/day (30 MME/day)	240 tabs/month 8 tabs/day (40 MME/day)	720 tabs/3 months 8 tabs/day (40 MME/day)
Tramadol 100 mg	q4-6h, Max Daily Dose 400 mg	90 tabs/month 3 tabs/day (30 MME/day)	270 tabs/3 months 3 tabs/day (30 MME/day)	120 tabs/month 4 tabs/day (40 MME/day)	360 tabs/3 months 4 tabs/day (40 MME/day)

**The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing. Limits are set up both as quantity versus time and daily dose edits.*

***The limit criteria apply to both brand and generic, if available.*

**** This drug is indicated for short-term acute use; therefore, the 30-day limit will be the same as the 90-day limit. The intent is for prescriptions of the requested drug to be filled one month at a time, even if filled at mail order; there should be no 3 month supplies filled.*

*****Due to risk of accumulation, the initial quantity limit will be set at a quantity that corresponds to a 3-day supply. The post limit quantity will be set at a quantity that corresponds to a 4-day supply. This drug is indicated for short-term acute use; therefore, the 30-*

day limit will be the same as the 90-day limit. The intent is for prescriptions of the requested drug to be filled one month at a time, even if filled at mail order; there should be no 3 month supplies filled.
†*Available in 100 mL and 200 mL bottles. It is the discretion of the dispensing pharmacy to fill quantities per package size up to these quantity limits. In such cases the filling limit and day supply may be less than what is indicated.*
‡ *The initial quantity limit for codeine will be set at a quantity that corresponds to a one-week supply. The post limit quantity will be set at a quantity that corresponds to a two-week supply. This drug is indicated for short-term acute use; therefore, the 30-day limit will be the same as the 90-day limit. The intent is for prescriptions of the requested drug to be filled one month at a time, even if filled at mail order; there should be no 3 month supplies filled.*

REFERENCES

1. State of Tennessee Prior Authorization Approval Policy.

Written by: UM Development (DS)
Date Written: 07/2021
Revised:
Reviewed: Medical Affairs: (DNC) 08/2021

The Participating Group signed below hereby accepts and adopts as its own the criteria for use with Prior Authorization, as administered by CVS Caremark.

_____ _____
Signature Date

_____
Client Name