DURATION LIMIT CRITERIA

DRUG CLASS **ACETAMINOPHEN/ASPIRIN/IBUPROFEN CONTAINING OPIOID ANALGESICS (BRAND AND GENERIC)**

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

(generic)

(acetaminophen and benzhydrocodone)

(acetaminophen and codeine)

(acetaminophen and hydrocodone)

(acetaminophen and oxycodone)

(acetaminophen and tramadol)

(acetaminophen, caffeine, and dihydrocodeine)

(aspirin and oxycodone)

(ibuprofen and hydrocodone)

(ibuprofen and oxycodone)

Status: CVS Caremark Criteria
Type: Duration Limit; Post Limit Criteria* ***Ref # C21408-E***

***C21408-E will be used in combination with Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H. The Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H will be coded separately.*

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 claim will proceed to the subsequent initial quantity limit criteria Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H.

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 claim will proceed to the subsequent initial quantity limit criteria Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H.

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 claim will proceed to the subsequent initial quantity limit criteria Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H.

If the patient has any history of an ICD 10 diagnosis code indicating sickle cell disease in their member health profile, then the claim will proceed to the subsequent initial quantity limit criteria Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H.

If a claim is submitted using a hospice patient residence code under a prescription benefit administered by CVS Caremark, then the claim will proceed to the subsequent initial quantity limit criteria Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H.

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 claim will proceed to the subsequent initial quantity limit criteria Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H.

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). The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit. The subsequent initial quantity limits from the Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H would then apply. If the incoming prescription drug is being filled for less than a 3-day supply, then the claim will proceed to the subsequent initial quantity limit criteria Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H.

LIMIT CRITERIA (DAY SUPPLY)**
Acute pain duration limits do not 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, acute pain duration limits will not 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. The subsequent initial quantity limits from the Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H would then apply to all patients regardless of concomitant conditions (e.g., active cancer treatment, palliative care, and end-of-life care) due to the non-opioid components.

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 claim will proceed to the subsequent initial quantity limit criteria Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H.

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 days supply. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit. The subsequent initial quantity limits from the Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H would then apply. If the incoming prescription drug is being filled for less than a 3-day supply, then the claim will proceed to

the subsequent initial quantity limit criteria Opioids IR APAP-ASA-IBU Combo Products Limit 1365-H.

For hydrocodone/ibuprofen tablets, oxycodone/ibuprofen tablets, tramadol/acetaminophen tablets:
A quantity of 28 tablets/month of oxycodone/ibuprofen tablets, 40 tablets/month of tramadol/acetaminophen tablets, or 50 tablets/month of hydrocodone/ibuprofen tablets is provided upon approval of the PA to allow coverage consistent with product labeling.

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CRITERIA FOR APPROVAL

1	Which opioid combination product (brand or generic) is being requested? Please check the drug being requested. [] benzhydrocodone/ACETAMINOPHEN (Apadaz) (if checked, go to 2) [] codeine/ACETAMINOPHEN (if checked, go to 2) [] dihydrocodeine/caffeine/ACETAMINOPHEN (if checked, go to 2) [] hydrocodone/ACETAMINOPHEN (if checked, go to 2) [] hydrocodone/IBUPROFEN (if checked, go to 8) [] oxycodone/ACETAMINOPHEN (if checked, go to 2) [] oxycodone/ASPIRIN (if checked, go to 2) [] oxycodone/IBUPROFEN (if checked, go to 8) [] tramadol/ACETAMINOPHEN (if checked, go to 8)		
2	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
3	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
4	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
5	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
6	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? [No further questions.]	Yes	No
7	Does the patient require extended treatment for ongoing management of ACUTE pain?	Yes	No

[No further questions.]

8	Does the patient require use of MORE than the plan allowance of any of the following: A) 5 tablets per day OR 50 tablets per month (quantity sufficient for a 10-day supply) of hydrocodone/IBUPROFEN tablets, B) 8 tablets per day OR 40 tablets per month quantity sufficient for a 5-day supply) of tramadol/ACETAMINOPHEN tablets, C) 4 tablets per day OR 28 tablets per month quantity sufficient for a 7-day supply)of oxycodone/IBUPROFEN tablets? [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 5 tablets per day and 50 tablets per month (quantity sufficient for a 10-day supply) of hydrocodone/IBUPROFEN tablets, B) 8 tablets per day and 40 tablets per month quantity sufficient for a 5-day supply) of tramadol/ACETAMINOPHEN tablets, C) 4 tablets per day and 28 tablets per month quantity sufficient for a 7-day supply)of oxycodone/IBUPROFEN tablets.]	Yes	No

Mapping Instructions		
	Yes	**No**
1.	1=2; 2=2; 3=2; 4=2; 5=8; 6=2; 7=2; 8=8; 9=8	N/A
2.	Approve, 12 months	Go to 3
3.	Go to 4	Deny
4.	Go to 5	Deny
5.	Go to 6	Go to 7
6.	Approve, 6 months	Deny
7.	Approve, 1 month	Deny
8.	Deny	Approve, 1 month - 5 tablets/day AND 50 tablets/month of hydrocodone/ibuprofen tablets or - 8 tablets/day AND 40 tablets/month of tramadol/APAP tablets or - 4 tablets/day AND 28 tablets/month of oxycodone/ibuprofen tablets

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