AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Extended-Release Opioid Analgesics	Page:	1 of 4
Effective Date:	4/1/2025	Last Review Date:	6/6/2024

Applies to:	☒Illinois	☐Florida	☒Florida Kids
	☐New Jersey	☐Maryland	☐Michigan
	☒Pennsylvania Kids	☐Virginia	☐Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for extended-release opioid analgesics under the patient's prescription drug benefit.

Description:

The intent of the criteria is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines for extended-release opioid analgesics. The American Pain Society Opioid Treatment Guidelines state that a reasonable definition for high dose opioid therapy is greater than 200 mg daily of oral morphine (or equivalent). Requests to exceed these limits and those for any non-preferred product are subject to the criteria in this policy. Medications requested for more than 200 Morphine Milligram Equivalents (MME) per day will require a Medical Director Review.

Applicable Drug List:

Fentanyl Transdermal Patch

Hydrocodone bitartrate 12 Hour ER Capsule

Hydrocodone bitartrate 24 Hour ER Tablet
(Generic Hysingla ER)

Hydromorphone HCL 24 Hour ER Tablet
(Generic Exalgo)

Methadone HCL Tablet

Methadone HCL Oral Solution

Methadone HCL Oral Concentrate
(Generic Methadose)

Morphine Sulfate 12 Hour ER Tablet
(Generic MS Contin)

Morphine Sulfate 24 Hour ER Capsule
(Generic Kadian)

Morphine Sulfate 24-hour ER Beads Capsule
(Generic Avinza)

Xtampza (oxycodone 12 Hour ER Capsule)

Oxycodone HCL 12 Hour ER Tablet
(Generic oxycontin)

Oxymorphone HCL 12-hour ER Tablet
(Generic Opana ER)

Nucynta ER (tapentadol HCL 12-hour ER Tablet)

Tramadol HCL 24-hour Biphasic Release Capsule
(Generic Conzip)

Tramadol HCL 24 Hour ER Tablet
(Generic Ultram ER)

Tramadol HCL 24 Hour Biphasic Release Tablet

Buprenorphine Transdermal Patch
(Generic Butrans)

Buprenorphine HCL Buccal Film
(Generic Belbuca)

Policy/Guideline:

The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through hospice or palliative care

  AND
- If the request is for a nonpreferred extended-release opioid analgesic, the patient is unable to take the required number of formulary alternatives for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

OR

- The requested drug is being prescribed for CHRONIC pain severe and persistent enough to require an extended treatment period with a daily opioid analgesic in a patient who has been taking an opioid [Note: Chronic pain is generally defined as pain that typically lasts greater than 3 months.]

  AND
- The patient can safely take the requested dose based on their history of opioid use

AND

- The patient has been evaluated and the patient will be monitored regularly for the development of opioid use disorder

AND

- The patient's pain will 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

AND

- This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days **OR**
- The patient has taken an immediate-release opioid for at least one week

AND

- If the request is for a methadone product, then it is NOT being prescribed for detoxification treatment or as part of a maintenance treatment plan for opioid/substance abuse or addiction

AND

- If the request is for a nonpreferred extended-release opioid analgesic, the patient is unable to take the required number of formulary alternatives for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

[Note: These drugs should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.]

Quantity Limits may apply.

Approval Duration and Quantity Restrictions:

For pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through hospice or palliative care: Approve: 12 months

Chronic pain: Approve: 6 months

Quantity Level Limit: Reference Formulary for drug specific quantity level limits

References:

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