KMAP GENERAL BULLETIN 18101

Opioid Products Indicated for Pain Management

Effective with dates of service on and after June 1, 2018, the **Opioid Products Indicated for Pain Management** prior authorization (PA) criteria will apply to all patients covered under Kansas Medicaid. This PA criteria are located on the KDHE website.

Short-Term/Acute Pain Opioid User

Patients who have received an opioid prescription(s) for less than 90 days in a look-back period of 4 months.

Chronic Opioid User

Patients who have received an opioid prescription(s) for greater than or equal to 90 days in a look-back period of 4 months.

PA will not be required for all short-acting opioid prescriptions that meet the following criteria:

- An initial fill limit of 7-day supply of short-acting opioid (immediate release formulation). Additionally, a limit of two fills (14-day supply total) is allowed within a 60-day look-back period (must be no more than a 7-day supply per prescription).
- Daily dosing limits cannot exceed the lesser of 90 morphine milligram equivalent (MME) or the Food & Drug Administration (FDA) maximum-approved dose.

PA will be required for all long-acting opioid prescriptions (extended-release formulations) and any short-acting opioid prescriptions exceeding the limits identified above.

Note: Patients with a cancer, sickle cell, or palliative care diagnosis will be EXEMPT from the 7-day supply and MME dosing limits. If an appropriate diagnosis code is documented in the medical record, prior authorization will not be required.

Note: Current opioid users exceeding the initial 14-day supply within 60 days and/or doses greater than 90MME or the FDA-approved doses will be grandfathered and PA for these opioid users will occur in a phased-in manner.

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Opioid Products Indicated for Pain Management continued

The following opioid prescriptions are included:

Buprenorphine*	Codeine	Dihydrocodeine	Fentanyl
Hydrocodone	Hydromorphone	Levorphanol	Meperidine
Methadone	Morphine	Oxycodone	Oxymorphone
Pentazocine	Tapentadol	Tramadol	

*products indicated for pain

A review of beneficiary claims for controlled drugs has been conducted. There are a number of Medicaid patients visiting more than one prescriber and using more than one pharmacy. If beneficiaries continue to receive prescriptions from several pharmacies and physicians, the member(s) may be placed in the Lock-In Program. This patient review and restriction program will limit the member to one pharmacy and one prescriber for controlled drugs.

Note: Buprenorphine products for opioid dependence (e.g. Suboxone®) are NOT affected by this policy.

Morphine equivalent dosing is a way to translate the dosages of different opioids to have a common standard. This helps to determine how much opioid a patient is taking when taking multiple pain medications. Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce the risk of overdose. The chart on the following pages shows the MME conversion factor for the associated medications. Sample MME calculators are on the AMDG and CDC websites.

If a provider believes that a patient should be approved for a higher dose than 90 MME or for longer than a 7-day supply, a PA form can be found on the KDHE website. All of the requested information must be provided including the form with all the fields and boxes completed and any additional clinical information pertinent to the request.

Helpful resources: CDC website and CMS website

Note: The effective date of the policy is June 1, 2018. The implementation of State policy by the KanCare managed care organizations (MCOs) may vary from the date noted in the Kansas Medical Assistance Program (KMAP) bulletins. The **KanCare Open Claims Resolution Log** on the KMAP Bulletins page documents the MCO system status for policy implementation and any associated reprocessing completion dates, once the policy is implemented.

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Opioid Oral Morphine Milligram Equivalent (MME) Conversion Factors[1, 2]

Type of Opioid (strength units)	**MME Conversion Factor**
Buprenorphine film/tablet[3] (mg)	30
Buprenorphine patch[4] (mcg/hr)	12.6
Buprenorphine film (mcg)	0.03
Butorphanol (mg)	7
Codeine (mg)	0.15
Dihydrocodeine (mg)	0.25
Fentanyl buccal or SL tablets, or lozenge/troche[5] (mcg)	0.13
Fentanyl film or oral spray[6] (mcg)	0.18
Fentanyl nasal spray[7] (mcg)	0.16
Fentanyl patch[8] (mcg)	7.2
Hydrocodone (mg)	1
Hydromorphone (mg)	4
Levorphanol tartrate (mg)	11
Meperidine hydrochloride (mg)	0.1
Methadone[9] (mg)	Methadone[9] (mg)
>0, <= 20	4
>20, <=40	8
>40, <=60	10
>60	12
Morphine (mg)	1
Opium (mg)	1
Oxycodone (mg)	1.5
Oxymorphone (mg)	3
Pentazocine (mg)	0.37
Tapentadol 10 (mg)	0.4
Tramadol (mg)	0.1

Copied from CMS.gov

1 The MME conversion factor is intended only for analytic purposes where prescription data is used to calculate daily MME. It is to be used in the formula: Strength per Unit X (Number of Units/Day Supply) X MME conversion factor = MME/Day. This value does not constitute clinical guidance or recommendations for converting patients from one form of opioid analgesic to another. Please consult the manufacturer's full prescribing information for such guidance. Use of this file for the purposes of any clinical decision-making warrants caution.

2 National Center for Injury Prevention and Control. CDC compilation of benzodiazepines, muscle relaxants, stimulants, zolpidem, and opioid analgesics with oral morphine milligram equivalent conversion factors, 2016 version. Atlanta, GA: Centers for Disease Control and Prevention; 2016. Available at https://www.cdc.gov/drugoverdose/media/. For more information, send an email to Mbohm@cdc.gov.

3 Buprenorphine formulations with a FDA approved indication for Medication Assisted Treatment (MAT) are excluded from Medicare's Overutilization Monitoring System's opioid overutilization reporting.

4 The MME conversion factor for buprenorphine patches is based on the assumption that one milligram of parenteral buprenorphine is equivalent to 75 milligrams of oral morphine and that one patch delivers the dispensed micrograms per hour over a 24 hour day. Example: 5 micrograms/hour buprenorphine patch X 24 hours = 120 micrograms/day buprenorphine = 0.12mg/day = 9 mg/day oral MME. In other words, the conversion factor not accounting for days of use would be 9/5 or 1.8. However, since the buprenorphine patch remains in place for 7 days, we have multiplied the conversion factor by 7 (1.8 X 7= 12.6). In this example, MME/day for four 5 microgram/hour buprenorphine patches dispensed for use over 28 days would work out as follows: Example: 5 microgram/hour buprenorphine patch X (4patches/28days) X 12.6 = 9 MME/day. Please note that because this allowance has been made based on the typical dosage of one buprenorphine patch per 7 days, you should first change all Day Supply in your prescription data to follow this standard, i.e. Day Supply for buprenorphine patches = # patches X 7.

5 The MME conversion factor for fentanyl buccal tablets, sublingual tablets, and lozenges/troche is 0.13. This conversion factor should be multiplied by the number of micrograms in a given tablet or lozenge/troche.

6 The MME conversion factor for fentanyl film and oral spray is 0.18. This reflects a 40% greater bioavailability for films compared to lozenges/tablets and 38% greater bioavailability for oral sprays compared to lozenges/tablets.

7 The MME conversion factor for fentanyl nasal spray is 0.16, which reflects a 20% greater bioavailability for sprays compared to lozenges/tablets.

8 The MME conversion factor for fentanyl patches is based on the assumption that one milligram of parenteral fentanyl is equivalent to 100 milligrams of oral morphine and that one patch delivers the dispensed micrograms per hour over a 24 hour day. Example: 25 micrograms/hour fentanyl patch X 24 hours = 600 micrograms/day fentanyl = 60 milligrams/day oral morphine milligram equivalent. In other words, the conversion factor not accounting for days of use would be 60/25 or 2.4. However, since the fentanyl patch remains in place for 3 days, we have multiplied the conversion factor by 3 (2.4 X 3 = 7.2). In this example, MME/day for ten 25 micrograms/hour fentanyl patches dispensed for use over 30 days would work out as follows: Example: 25 microgram/hour fentanyl patch X (10 patches/30 days) X 7.2 = 60 MME/day. Please note that because this allowance has been made based on the typical dosage of one fentanyl patch per 3 days, you should first change all Day Supply in your prescription data to follow this standard, i.e., Day Supply for fentanyl patches = # of patches X 3.

9 https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

10 Tapentadol is a mu receptor agonist and norepinephrine reuptake inhibitor. Oral MMEs are based on degree of mu-receptor agonist activity, but it is unknown if this drug is associated with overdose in the same dose-dependent manner as observed with medications that are solely mu receptor agonists.