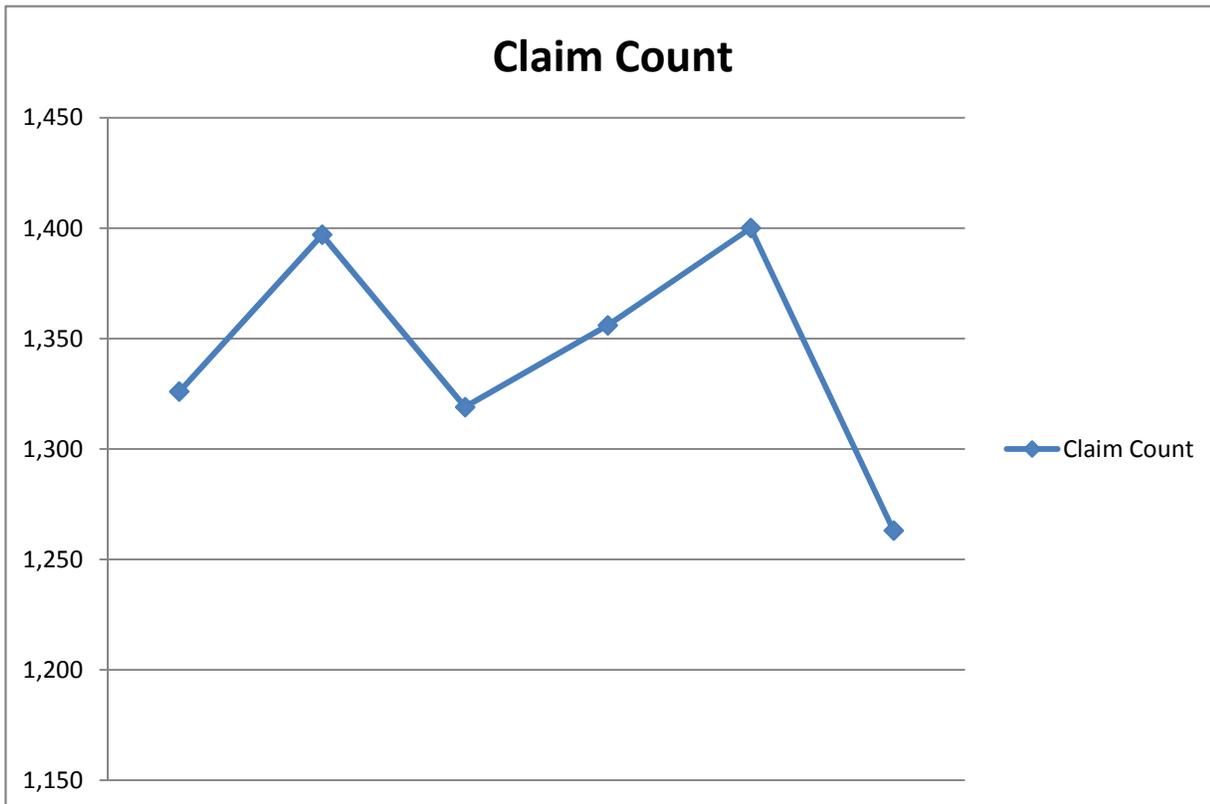


Short Acting Opioids Utilization 2012 Q2 & 2012 Q3 - Top 10

Drug Label Name	Sum of Claim Count	Sum of Quantity Dispensed
OXYCODONE TAB 30MG	8061	999669
TRAMADOL HCL TAB 50MG	6591	532532
OXYCODONE TAB 15MG	3394	401697
MORPHINE SUL INJ 5MG/ML	2635	12402
OXYCODONE TAB 5MG	1757	136283
HYDROMORPHON INJ 2MG/ML	1600	9493
OXYCODONE TAB 10MG	914	96049
HYDROMORPHON INJ 1MG/ML	895	11310
HYDROMORPHON TAB 4MG	658	67576
HYDROMORPHON TAB 2MG	653	42754
Grand Total	27158	2309765

Oxycodone 30mg Tab Utilization 2012 Q2 & 2012 Q3

Month Claim Submitted	Drug Label Name	Claim Count	Quantity Dispensed	Days Supply	Dispensing Fee	Total Amount Paid
April 2012	OXYCODONE TAB 30MG	1,326	168,700	36,513	\$4,875.34	\$81,337.21
May 2012	OXYCODONE TAB 30MG	1,397	173,728	38,394	\$5,184.74	\$84,525.36
June 2012	OXYCODONE TAB 30MG	1,319	163,347	36,340	\$4,937.22	\$79,731.29
July 2012	OXYCODONE TAB 30MG	1,356	167,889	37,638	\$5,127.62	\$82,766.50
August 2012	OXYCODONE TAB 30MG	1,400	171,841	38,801	\$5,434.46	\$86,687.23
September 2012	OXYCODONE TAB 30MG	1,263	154,164	34,846	\$4,827.74	\$77,234.70



Therapeutic Class Overview

Short-acting Opioids

Therapeutic Class

- **Overview/Summary:** Pain is one of the most common and debilitating patient complaints, with persistent pain having the potential to lead to functional impairment, disability, psychological distress and sleep deprivation. Pain can be categorized as being either nociceptive or neuropathic, and the treatments for each are specific. Nociceptive pain is caused by damage to tissues and can further be divided into somatic (pain arising from injury to body tissues) and visceral pain (pain arising from the internal organs). Visceral pain is often described as poorly localized, deep, dull, and cramping. In contrast, neuropathic pain arises from abnormal neural activity secondary to disease, injury, or dysfunction of the nervous system.¹ Pharmacologic therapy should not be the sole focus of pain treatment; however, it is the most widely utilized option to manage chronic pain. Combining pharmacologic therapies may result in improved analgesia, and because lower doses of each agent can be used, patients may experience fewer treatment-emergent adverse events. Response to pharmacologic therapies will vary between individual patients, and currently no one approach has been demonstrated to be appropriate for all patients. Treatment decisions are largely based on the type of pain (e.g., neuropathic, nociceptive), comorbidities, concurrent medications, pharmacokinetic/pharmacodynamic properties of the agent and anticipated adverse events.²

As a class, opioid analgesics encompass a group of naturally occurring, semisynthetic, and synthetic drugs that stimulate opiate receptors and effectively relieve pain without producing loss of consciousness.³⁻²¹ These agents primarily produce intense analgesia via their agonist actions at mu receptors, which are found in large numbers within the central nervous system. The binding of these agents to mu receptors produces a variety of other effects including bradycardia, sedation, euphoria, physical dependence and respiratory depression.³ Unlike other analgesic classes, opioids have well-accepted equianalgesic doses, which allows clinicians to convert between agents and between routes of administration. Pure opioid agonists do not have a ceiling effect as other analgesics do; therefore, additional analgesia may be obtained by increasing the opioid dose. Close monitoring after an opioid conversion or dosage change is required to evaluate the need for further dosage adjustments.² Combination therapy has been widely used for the clinical management of acute pain; by combining two agents with different mechanisms of action, the combination therapy provides additive analgesic effects while reducing the risk of adverse effects. Moreover, combination therapies overcome the “ceiling effects” of their individual components. Opioids are found in combination products along with aspirin, acetaminophen, ibuprofen, caffeine and butalbital.³

In patients who experience chronic pain, it is recommended that once a stable short-acting (immediate release) opioid dose is reached, the patient then be converted to a long-acting agent.² The long-acting opioid should be used on a scheduled basis, with as-needed short-acting medications prescribed for breakthrough pain. Patients who routinely require frequent breakthrough doses within a dosing interval may benefit from an increase in their scheduled medication. Due to their known potential for abuse, opioids are classified as controlled substances.³⁻²¹ It is important to recognize that tolerance and physical dependence are potential and common physiologic changes that occur in most patients who receive opioids for a sustained amount of time. Tolerance is defined as the need for increased dosage to produce the same effect, or a reduced effect is observed with a constant dose. Physical dependence occurs when the body becomes accustomed to receiving opioids due to neuroadaptation. Psychological dependence, or addiction, indicates that the patient is using an agent for its psychiatric effects. This occurrence is not a characteristic of the drug class alone, but is a combined effect of biochemical, societal and psychological factors affecting the patient.²²

Table 1. Current Medications Available in Therapeutic Class⁴⁻²¹

Generic (Trade Name)	Food and Drug Administration Approved Indications	Dosage Form/Strength	Generic Availability
Single-Entity Agents			
Codeine	Treatment of mild to moderate pain	Injection (phosphate): 15 mg/mL 30 mg/mL Oral solution (sulfate): 30 mg/5 mL Tablet (sulfate): 15 mg 30 mg 60 mg	a
Hydromorphone (Dilaudid ^{®*})	Treatment of moderate to severe pain and treatment of postoperative pain	Injection, powder for reconstitution: 250 mg Injection, solution: 1 mg/mL 2 mg/mL 4 mg/mL 10 mg/mL Oral liquid: 1 mg/mL Suppository: 3 mg Tablet: 2 mg 4 mg 8 mg	a
Levorphanol (Levo-dromoran ^{®*})	Treatment of moderate to severe pain	Tablet: 2 mg	a
Meperidine (Demerol ^{®*} , Meperitab ^{®*})	Treatment of moderate to severe pain	Injection: 10 mg/mL 25 mg/mL 50 mg/mL 75 mg/mL 100 mg/mL Oral solution: 50 mg/5 mL Tablet: 50 mg 100 mg	a
Morphine (MSIR ^{®*} , Roxanol ^{®*})	Treatment of moderate to severe pain	Injection: 0.5 mg/mL 1 mg/mL 2 mg/mL	a

Generic (Trade Name)	Food and Drug Administration Approved Indications	Dosage Form/Strength	Generic Availability
		4 mg/mL 5 mg/mL 8 mg/mL 10 mg/mL 15 mg/mL 25 mg/mL 50 mg/mL Oral solution: 10 mg/5 mL 20 mg/5 mL 20 mg/mL Suppository: 5 mg 10 mg 20 mg 30 mg Tablet: 15 mg 30 mg	
Oxycodone (Oxecta [®] , Oxy IR [®] , Oxydose [®] , OxyFast [®] , Roxicodone [®])	Treatment of moderate to severe pain	Capsules: 5 mg Oral solution: 5 mg/5 mL 20 mg/mL Tablets: 5 mg 7.5 mg 10 mg 15 mg 20 mg 30 mg	a
Oxymorphone (Opana [®])	Treatment of moderate to severe pain	Injection: 1 mg/mL Tablet: 5 mg 10 mg	a
Tapentadol (Nucynta [®])	Treatment of moderate to severe pain	Tablet: 50 mg 75 mg 100 mg	-
Combination Products			
Codeine/ acetaminophen (Capital [®] with Codeine, Cocet [®] ,	Treatment of mild to moderate pain and treatment of moderate to severe pain	Oral solution: 12 mg/120 mg per 5 mL Tablet:	a

Generic (Trade Name)	Food and Drug Administration Approved Indications	Dosage Form/Strength	Generic Availability
Tylenol [®] with Codeine*, Vopac [®])		15 mg/300 mg 30 mg/300 mg 60 mg/300 mg 30 mg/650 mg	
Codeine/acetaminophen/caffeine/butalbital (Fioricet [®] with Codeine*)	Treatment of tension headache	Capsule: 30 mg/325 mg/40 mg/50 mg	a
Codeine/aspirin/caffeine/butalbital (Fiorinal [®] with Codeine*)	Treatment of tension headache	Capsule: 30 mg/325 mg/40 mg/50 mg	a
Dihydrocodeine/acetaminophen/caffeine (Panlor [®] DC*, Panlor [®] SS*, Trezix [®] , ZerLor [®] *)	Treatment of moderate to severe pain	Capsule: 16 mg/356.4 mg/30 mg	a
Dihydrocodeine/aspirin/caffeine (Synalgos [®] DC)	Treatment of moderate to severe pain	Capsule: 16 mg/356.4 mg/30 mg Tablet: 32 mg/712.8 mg/60 mg	-
Hydrocodone/acetaminophen (Anexsia [®] *, Bancap-HC [®] *, Co-Gesic [®] *, Hydrocet [®] *, Hydrogesic [®] *, Hycet [®] *, Lorcet [®] *, Lortab [®] *, Margesic [®] *, Maxidone [®] *, Norco [®] *, Polygesic [®] *, Stagesic [®] *, Vanacet [®] *, Vicodin [®] *, Vicodin [®] HP*, Xodol [®] *, Zamiset [®] *, Zolvit [®] , Zydone [®])	Treatment of moderate to severe pain	Capsule: 5 mg/500 mg Oral solution: 10 mg/300 mg per 15 mL 7.5 mg/325 mg per 15 mL 10 mg/325 mg per 15 mL 7.5 mg/500 mg per 15 mL 10 mg/500 mg per 15 mL Tablet: 5 mg/300 mg 7.5 mg/300 mg 10 mg/300 mg 5 mg/325 mg 7.5 mg/325 mg 10 mg/325 mg 5 mg/400 mg 7.5 mg/400 mg 10 mg/400 mg 2.5 mg/500 mg 5 mg/500 mg 7.5 mg/500 mg 10 mg/500 mg 7.5 mg/650 mg 10 mg/650 mg 10 mg/660 mg 7.5 mg/750 mg	a

Generic (Trade Name)	Food and Drug Administration Approved Indications	Dosage Form/Strength	Generic Availability
		10 mg/750 mg	
Hydrocodone/ ibuprofen (Ibudone ^{®*} , Reprexain ^{®*} , Vicoprofen ^{®*})	Short-term treatment of acute pain	Tablet: 2.5 mg/200 mg 5 mg/200 mg 7.5 mg/200 mg 10 mg/200 mg	a
Oxycodone/ acetaminophen (Endocet ^{®*} , Lynox [®] , Magnacet [®] , Percocet ^{®*} , Tylox ^{®*} , Xolox [®])	Treatment of moderate to severe pain	Capsule: 5 mg/500 mg Oral solution: 5 mg/325 mg per 5 mL Tablet: 5 mg/300 mg 7.5 mg/300 mg 10 mg/300 mg 2.5 mg/325 mg 5 mg/325 mg 7.5 mg/325 mg 10 mg/325 mg 5 mg/400 mg 7.5 mg/400 mg 10 mg/400 mg 5 mg/500 mg 7.5 mg/500 mg 10 mg/500 mg 10 mg/650 mg	a
Oxycodone/aspirin (Endodan ^{®*} , Percodan ^{®*})	Treatment of moderate to severe pain	Tablet: 4.8355 mg/325 mg	a
Oxycodone/ ibuprofen (Combunox ^{®*})	Treatment of moderate to severe pain and short-term treatment of acute pain	Tablet: 5 mg/400 mg	a

*Generic is available in at least one dosage form or strength.

Evidence-based Medicine

- Systematic reviews and meta-analyses have demonstrated similar safety and level of analgesia between hydromorphone, morphine, oxycodone and oxymorphone in the management of chronic cancer, chronic non-cancer and acute pain.²³⁻²⁸
- Meperidine appears to have comparable analgesic effect as morphine and oxycodone but may be associated with higher incidence of adverse events.^{25,29}
- In one double-blind, randomized controlled trial involving patients who underwent total hip or knee replacement surgery, patients were significantly more likely to achieve a pain relief of at least 50% following administration of oxymorphone 10 or 20 mg compared to placebo, but not with oxymorphone 30 mg or oxycodone 10 mg. A direct comparison between oxymorphone and oxycodone was not performed.³⁰
- Several placebo- and active-controlled, randomized studies have demonstrated immediate-release tapentadol to be noninferior to oxycodone in the management of postoperative pain and pain associated with degenerative joint disease, low back pain or osteoarthritis.³¹⁻³⁴ Results from these studies also demonstrate that therapy with tapentadol may have a more favorable adverse effect

profile, specifically in terms of the incidence of gastrointestinal adverse events, compared to immediate-release oxycodone.³⁵⁻³⁷

- The results of randomized controlled trials have generally demonstrated a comparable level of analgesia between codeine/acetaminophen, hydrocodone/acetaminophen, hydrocodone/ibuprofen and oxycodone/acetaminophen in the management of acute pain.³⁸⁻⁴⁰ One randomized controlled trial also showed similar efficacy between codeine/acetaminophen and hydrocodone/acetaminophen in the management of chronic cancer pain.⁴¹ A randomized controlled trial showed that oxycodone/ibuprofen may provide greater total pain relief than hydrocodone/acetaminophen or oxycodone/acetaminophen in pediatric patients who underwent dental procedure.⁴²
- Head-to-head trials involving codeine, levorphanol, butalbital-containing products, dihydrocodeine-containing products or oxycodone/aspirin are not available.
- A meta-analysis of 35 double-blind, randomized controlled trials showed that a single dose of codeine 60 mg produced significantly greater pain relief compared to placebo in patients with postoperative pain.⁴³ When compared to ibuprofen and acetaminophen in children with acute musculoskeletal injury, codeine 1 mg/kg achieved a level of analgesia that was comparable to acetaminophen 15 mg/kg but less than that of ibuprofen 10 mg/kg.⁴⁴
- An observational study demonstrated that levorphanol was shown to be effective in relieving chronic non-cancer pain in patients whose pain was not adequately relieved by other strong opioids.⁴⁵

Key Points within the Medication Class

- According to Current Clinical Guidelines:
 - The World Health Organization suggests that patients with pain be started on acetaminophen or a nonsteroidal anti-inflammatory drug (NSAID). If sufficient pain relief is not achieved, patients should be escalated to a “weak opioid” and then to a “strong opioid”, such as morphine.^{46,47}
 - Opioid naïve patients (those not chronically receiving opioid therapy on a daily basis) experiencing severe pain should receive rapid titration of short-acting opioids.^{46,47}
 - Opioid-naïve patients whose pain intensity is moderate at presentation, the pathways are quite similar to those for severe pain, with slower titration of short-acting opioids.^{46,47}
 - Opioid-naïve patients experiencing mild pain intensity should receive nonopioid analgesics, such as NSAIDs or acetaminophen or treatment with consideration of slower titration of short-acting opioids.^{46,47}
 - Patients with chronic persistent pain controlled by stable doses of short-acting opioids should be provided with “around-the-clock” extended release or long acting formulation opioids with provision of a ‘rescue dose’ to manage break-through or transient exacerbations of pain.^{46,47}
 - Opioids with rapid onset and short duration are preferred as rescue doses. The repeated need for rescue doses per day may indicate the necessity to adjust the baseline treatment.^{46,47}
 - Rescue doses of short-acting opioids should be provided for pain that is not relieved by regularly scheduled, “around the clock” doses. Opioids administered on an “as needed” basis are for patients who have intermittent pain with pain-free intervals.^{46,47}
 - Clinicians may consider using a written chronic opioid therapy management plan to document patient and clinician responsibilities and expectations and assist in patient education.^{46,47}
- Other Key Facts:
 - Generic products are available for all products with the exception of tapentadol (Nucynta[®]) and dihydrocodeine/aspirin/caffeine (Synalgos[®] DC).³

References

1. Smith HS. Definition and pathogenesis of chronic pain. In: Basow DS (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2010 [cited 2012 Jul]. Available from: <http://www.utdol.com/utd/index.do>.
2. American Pain Society. Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain. 5th ed. American Pain Society, Glenview, IL, 2003.
3. Drug Facts and Comparisons 4.0 [database on the Internet]. St. Louis: Wolters Kluwer Health, Inc.; 2012 [cited 2012 Jul 26]. Available from: <http://online.factsandcomparisons.com>.
4. Codeine tablet [package insert]. Columbus (OH): Roxane Laboratories, Inc.; 2010 Aug.
5. Dilaudid[®] [package insert]. Stamford (CT): Purdue Pharma; 2009 Oct.

6. Levorphanol [package insert]. Columbus (OH): Roxane Laboratories, Inc.; 2011 Jul.
7. Demerol[®] [package insert]. New York (NY): Sanofi-aventis U.S. LLC; 2011 Oct.
8. Morphine sulfate tablet [package insert]. Columbus (OH): Roxane Laboratories, Inc.; 2010 Jan.
9. Oxecta[®] [package insert]. Bristol (TN) King Pharmaceuticals Inc.; 2011 Jun.
10. Opana[®] [package insert]. Chadds Ford (PA): Endo Pharmaceuticals Inc.; 2011 Aug.
11. Nucynta[®] [package insert]. Titusville (NJ): Janssen Pharmaceuticals, Inc.; 2011 Jul.
12. Tylenol[®] with Codeine [package insert]. Raritan (NJ): PriCara; 2011 Sep.
13. Butalbital, Acetaminophen, Caffeine and Codeine Phosphate [package insert]. Corona (CA): Watson Laboratories, Inc.; 2011 Jun.
14. Fiorinal[®] with Codeine [package insert]. Morristown (NJ): Watson Pharma, Inc.; 2009 Jun.
15. Acetaminophen, Caffeine and Dihydrocodeine Bitartrate [package insert]. Coral Springs (FL): Boca Pharmacal, Inc.; 2011 May.
16. Synalgos[®]-DC [package insert]. Detroit (MI): Caraco Pharmaceutical Laboratories, Ltd.; 2009 Oct.
17. Vicodin[®] [package insert]. North Chicago (IL): Abbott Laboratories; 2011 Sep.
18. Vicoprofen[®] [package insert]. North Chicago (IL): Abbott Laboratories; 2009 Oct.
19. Percocet[®] [package insert]. Chadds Ford (PA): Endo Pharmaceuticals Inc.; 2011 May.
20. Percodan[®] [package insert]. Chadds Ford (PA): Endo Pharmaceuticals Inc.; 2010 Jul.
21. Oxycodone and Ibuprofen [package insert]. Elizabeth (NJ): Actavis Elizabeth LLC; 2011 Aug.
22. Federation of State Medical Boards. Model policy for the use of controlled substances for the treatment of pain [document on the Internet]. Euless (TX): Federation of State Medical Boards of the United States, Inc.; 2004 [accessed 2012 Jul 26].
23. Felden L, Walter C, Harder S, Treede RD, Kayser H, Drover D, Geisslinger G, Lötsch J. Comparative clinical effects of hydromorphone and morphine: a meta-analysis. *Br J Anaesth*. 2011 Sep;107(3):319-28.
24. Pigni A, Brunelli C, Caraceni A. The role of hydromorphone in cancer pain treatment: a systematic review. *Palliat Med*. 2011 Jul;25(5):471-7.
25. Quigley C. Hydromorphone for acute and chronic pain. *Cochrane Database Syst Rev*. 2002;(1):CD003447.
26. Wiffen PJ, McQuay HJ. Oral morphine for cancer pain. *Cochrane Database Syst Rev*. 2007 Oct;(4):CD003868.
27. King SJ, Reid C, Forbes K, Hanks G. A systematic review of oxycodone in the management of cancer pain. *Palliat Med*. 2011 Jul;25(5):454-70.
28. Bekkering GE, Soares-Weiser K, Reid K, Kessels AG, Dahan A, Treede RD, et al. Can morphine still be considered to be the standard for treating chronic pain? A systematic review including pair-wise and network meta-analyses. *Curr Med Res Opin*. 2011 Jul;27(7):1477-91.
29. Eisenberg E, McNicol E, Carr DB. Opioids for neuropathic pain. *Cochrane Database Syst Rev*. 2006 Jul;(3):CD006146.
30. Gimbel J, Ahdiel H. The efficacy and safety of oral immediate-release oxymorphone for postsurgical pain. *Anesth Analg*. 2004; 99:1472-7.
31. Hatrick C, Van Hove I, Stegman JU, Oh C, Upmalis D. Efficacy and tolerability of tapentadol immediate release and oxycodone HCl immediate release in patients awaiting primary joint replacement surgery for end-stage joint disease: a 10-day, Phase III, randomized, double-blind, active- and placebo-controlled study. *Clin Ther*. 2009;31(2):260-71.
32. Stegman JU, Weber H, Steup A, Okamoto A, Upmalis D, Daniels S. The efficacy and tolerability of multiple-dose tapentadol immediate release for the relief of acute pain following orthopedic (bunionectomy) surgery. *Curr Med Res Opin*. 2008;24(11):3185-96.
33. Daniels SE, Upmalis D, Okamoto A, Lange C, Haeussler J. A randomized, double-blind, phase III study comparing multiple doses of tapentadol IR, oxycodone IR, and placebo for postoperative (bunionectomy) pain. *Curr Med Res Opin*. 2009;25(3):765-76.
34. Daniels S, Casson E, Stegmann JU, Oh C, Okamoto A, Rauschkolb C, et al. A randomized, double-blind, placebo-controlled phase 3 study of the relative efficacy and tolerability of tapentadol IR and oxycodone IR for acute pain. *Curr Med Res Opin*. 2009 Jun;25(6):1551-61.
35. Hale M, Upmalis D, Okamoto A, Lange C, Rauschkolb C. Tolerability of tapentadol immediate release in patients with lower back pain or osteoarthritis of the hip or knee over 90 days: a randomized, double-blind study. *Curr Med Res Opin*. 2009 May;25(5):1095-104.
36. Etropolski M, Kelly K, Okamoto A, Rauschkolb C. Comparable efficacy and superior gastrointestinal tolerability (nausea, vomiting, constipation) of tapentadol compared to oxycodone hydrochloride. *Adv Ther*. 2011 May;28(5):401-17.
37. Vorsanger G, Xiang J, Okamoto A, Upmalis D, Moskovitz B. Evaluation of study discontinuations with tapentadol immediate release and oxycodone immediate release in patients with low back or osteoarthritis pain [abstract]. *J Opioid Manag*. 2010 May-Jun;6(3):169-79.
38. Corsinovi L, Martinelli E, Fonte G, Astengo M, Sona A, Gatti A, et al. Efficacy of oxycodone/acetaminophen and codeine/acetaminophen vs conventional therapy in elderly women with persistent, moderate to severe osteoarthritis-related pain. *Arch Gerontol Geriatr*. 2009 Nov-Dec;49(3):378-82.
39. Marco CA, Plewa MC, Buderer N, Black C, Roberts A. Comparison of oxycodone and hydrocodone for the treatment of acute pain associated with fractures; A double-blind, randomized, controlled trial. *Acad Emerg Med*. 2005;12(4):282-8.
40. Litkowski LJ, Christensen SE, Adamson DN, VanDyke T, Han S, Newman KB. Analgesic efficacy and tolerability of oxycodone 5 mg/Ibuprofen 400 mg compared to those of oxycodone 5 mg/acetaminophen 325 mg and hydrocodone 7.5 mg/acetaminophen 500 mg in patients with moderate to severe postoperative pain: a randomized, double-blind, placebo-controlled, single-dose, parallel-group study in a dental pain model. *Clin Ther*. 2005;27(4):418-29.
41. Rodriguez RF, Castillo JM, Del Pilar Castillo M, Nunez PD, Rodriguez MF, Restrepo JM, et al. Codeine/acetaminophen and hydrocodone/acetaminophen combination tablets for the management of chronic cancer pain in adults: a 23-day, prospective, double-blind, randomized, parallel-group study. *Clin Ther*. 2007;29(4):581-7.
42. Palangio M, Wideman GL, Keffer M, Landau CJ, Morris E, Doyle RT Jr, et al. Combination hydrocodone and ibuprofen vs combination oxycodone and acetaminophen in the treatment of postoperative obstetric or gynecologic pain. *Clin Ther*. 2000;22(7):600-12.

43. Derry S, Moore RA, McQuay HJ. Single dose oral codeine, as a single agent, for acute postoperative pain in adults. Cochrane Database Syst Rev. 2010 Apr 14;(4):CD008099.
44. Clark E, Plint AC, Correll R, Gaboury I, Passi B. A randomized, controlled trial of acetaminophen, ibuprofen, and codeine for acute pain relief in children with musculoskeletal trauma. Pediatrics. 2007; 119:460-7.
45. McNulty JP. Can levorphanol be used like methadone for intractable refractory pain? J Palliat Med. 2007 Apr;10(2):293-6.
46. Chou R, Fanciullo GJ, Fine PG, Adler JA, Ballantyne JC, Davies P, et al. American Pain Society: Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. The Journal of Pain. 2009;10(2):113-30.
47. National Comprehensive Cancer Network (NCCN). NCCN clinical practice guidelines in oncology: adult cancer pain. Fort Washington (PA): 2012.version 1 [cited 2012 Jul]. Available from: http://www.nccn.org/professionals/physician_gls/pdf/pain.pdf.

DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID
DRUG USE REVIEW (DUR) BOARD
PROPOSED PRIOR AUTHORIZATION CRITERIA

Short-acting opioid analgesics exceeding the quantity limit are a covered benefit of Nevada Medicaid for recipients who meet the criteria for coverage.

1. Coverage and Limitations:

Authorization will be given if the following criteria are met and documented:

- a. The recipient is unable to achieve adequate analgesia despite attempts to titrate the dose of the short-acting opioid analgesic.

OR

- b. The requested dose cannot be obtained through dose consolidation of the short-acting opioid analgesic.

AND

- c. If the recipient is currently receiving a long-acting opioid analgesic, the prescriber provides an appropriate clinical rationale for not titrating the dose.

OR

- d. The prescriber provides a clinical rationale for why a long-acting opioid analgesic is not appropriate for the recipient at this time.

2. PA Guidelines:

Prior Authorization approval will be 6 months.

3. Quantity Limitations:

Codeine sulfate: 180 units of a single strength/30 days

Hydromorphone: 180 units of a single strength/30 days

Levorphanol: 120 units of a single strength/30 days

Meperidine: 240 units of a single strength/30 days

Morphine sulfate: 180 units of a single strength/30 days

Oxycodone: 180 units of a single strength/30 days

Oxymorphone: 180 units of a single strength/30 days

Tapentadol: 180 units of a single strength/30 days