*Pharmacy Policy*

# High Daily Morphine Milligram Equivalent

**Line of Business:** Both Lines of Business
**P&T Approval Date:** December 21, 2021 **Effective Date:** January 1, 2022

*This policy has been developed through review of medical literature, consideration of medical necessity, generally accepted medical practice standards, and was approved by the IEHP Pharmacy and Therapeutics Subcommittee.*

**» POLICY:**

This policy sets forth parameters to monitor the appropriate use of high dose opioids (MME>200mg). Prescription opioids are used primarily to treat pain and are available in different dosage forms and durations (short acting and long acting). Overutilization of high dose opioids has been linked to an increasing number of deaths due to overdose and has been identified as a safety signal by both CDC and CMS. To ensure the safety and appropriate use of these medications, IEHP has initiated a safety block on any opioid claims that exceed MME>200mg. Oncology, hospice care and long- term care facilities are exempted from this policy.

**Definitions:**

a. Total Morphine Milligram Equivalent (MME): The total cumulative dose of long acting and short acting opioids in a 24-hour period.
b. Chronic Pain: 3 months or more of persistent pain OR pain past the time of normal healing (Pain that persists even when the injury has healed).
c. Non-Pharmacologic Therapy: Defined as any therapy that does not involve a drug treatment for pain. Non-Pharmacologic Therapy consists of but not limited to:
    i. Physiotherapy
    ii. Acupuncture
    iii. Transcutaneous Electrical Nerve Stimulation (TENS)
    iv. Psychological Therapy
    v. Massage Therapy
    vi. Neurosurgical Procedures
d. Non-Opioid Pharmacologic Therapy: Defined as the use of medications not classified as an opioid. Non-Opioid Pharmacologic Therapy consists of but not limited to:
    i. NSAIDs (ex. Ibuprofen)
    ii. Acetaminophen (Over the counter and prescription)
    iii. Gabapentin
    iv. Pregabalin
    v. Duloxetine
    vi. Topical NSAIDS (diclofenac gel or patch)

**» CLINICAL GUIDELINES:**

**Guidelines for tapering opioid use:**

1. Long-acting Opioid: Decrease total daily dose by 5-10% of initial dose per week.
2. Short-acting Opioid: Decrease total daily dose by 5-15% per week.
3. Consider adjuvant therapy with non-pharmacological and non-opioid treatments.

**Guidelines for titration of opioid use:**

1. Member follow up within 2 to 4 weeks of dosage modifications or adjustments.
2. If needed, the daily dose may be increased by 25% - 100% at a time.
3. Do not increase the dose more frequently than the half-life of the drug.
4. If possible, only one drug should be titrated at a time.

***Tapering or titrating a member's therapy should be done on a case-by-case basis. The above are guidelines and the member needs are to be evaluated as a whole for other causes of pain.

**» PROCEDURE:**

**Requests for Total MME > 200mg/day for Chronic Pain:**

A Prior Authorization request will require the provider to submit supporting documentation of the following:

a. The member has an existing chronic pain condition that requires opioid management.
b. The member has tried and failed conservative pain management treatments such as non-pharmacologic therapy and non-opioid pharmacologic therapy within the past 3 months.
c. Previous titration history of opioids utilizing both short acting for breakthrough pain and long-acting agents for maintenance pain control.
d. Complete treatment plan with documentation of treatment goals and the date of anticipated goal achievement. Treatment goals must include plan for discontinuation if the benefits do not outweigh the risks.
e. A CURES report was reviewed and evaluated by the prescriber within 1 month of the prior authorization request.
f. A copy of pain contract initiated at start of opioid therapy including a urine drug screen (UDS).
g. The provider has discussed the risks and benefits of opioid therapy.
h. Above documentation will be reviewed by IEHP Clinical Staff.

**Reassessment Criteria:**

a. The member is currently on a stable regimen and on target with treatment plan to achieve pain goals.
b. If their previous treatment goal has changed, supporting documentation of new treatment goals and date of anticipated goal achievement.
c. For Chronic pain members, documentation of active pain contract within the past year.
d. A CURES report that was reviewed and evaluated by the prescriber in the last month.
e. An updated urine drug screen (UDS) that was reviewed and evaluated in the past 12 months.
f. Must be reviewed by IEHP Clinical Staff.

**References:**


1. Centers for Disease Control and Prevention. CDC Guideline for Prescribing Opioids for Chronic Pain. March 18, 2016. Available at: https://www.cdc.gov/drugoverdose/prescribing/guideline.html. Accessed August 6, 2019.

2. Department of Veterans Affairs. VA/DOD Clinical Practice Guideline For Management Of Opioid Therapy For Chronic Pain. VA, Washington, DC. May 2010. Available at: http://www.va.gov/painmanagement/docs/cpg_opioidtherapy_summary.pdf. Accessed August 6, 2019.

3. Oregon Pain Guidance. Pain Treatment Guidelines. Opioid Prescribing Guidelines – A Provider and Community Resource. May 2016. Available at: http://www.oregonpainguidance.org/app/content/uploads/2016/05/OPG_Guidelines_2016.pdf. Accessed August 6, 2019.


| Change Control | | |
|---|---|---|
| **Date** | **Change** | **Author** |
| 12/13/2021 | • Updated P&T Approval Date and Effective Date | JM |
| 11/22/2021 | • Line of Business updated to include Medicare<br>• Removed at point of sale to monitor opioid claims for both pharmacy and medical claims | TL |
| 08/06/2021 | • Renew with no changes | VM |
| 08/20/2020 | • Renew with no changes | RR |
| 08/21/2019 | • Update format | ND |
| 05/15/2019 | • Renew with no change | ND |

# IEHP Pain Assessment & Treatment Plan

**Patient Name:** **Member ID:**

**Date of Birth:** **Diagnosis**

***** Please complete ALL sections of this form. Incomplete forms will not be accepted. *****

## Section A:
## Member Medication Regimen

**Current Analgesic Regimen:**

| Drug Name | Strength | Frequency | Quantity | Duration | D/C date |
|---|---|---|---|---|---|
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| | | | | | |
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**Past Analgesic Regimen (within last 6 months):**

| Drug Name | Strength | Frequency | Quantity | Duration | D/C date |
|---|---|---|---|---|---|
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## Section B:
## Supporting documents for current treatment plan

___Chart notes documenting titration up to current dose.

___Documentation indicating that the risk and benefits of opioid therapy have been discussed with the patient.

___Documentation indicating treatment plan for discontinuation if benefits do not outweigh the risks.

__Documentation indicating a Prescription Drug Monitoring Report (CURES) has been reviewed within the past 30 days.
**Date CURES report was accessed: _____**

___Pain Contract signed and dated within the past 12 months.
**Date Pain Contract was signed: _____**

___Urine Drug Screen within the past 6 months.
**Date Urine Drug Screen was taken**: _____
**Test Results: _____**

# IEHP Pain Assessment & Treatment Plan

**Patient Name:** **Member ID:**

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| **Section C: Treatment Assessment Questions** | |
|---|---|
| Has the patient tried the most optimal non-opioid containing analgesic drug regimen? | Yes __ No__ |
| Does the patient have any history of substance abuse? If yes, please identify the substance and past treatment | Yes __ No__ |
| Please provide any additional medical justification relevant to adding this medication to the patient's pain regimen. | Yes __ No__ |

| **Section D: Pain Assessment (0 = no pain, 10 = worst)** |
|---|
| **Current Pain:**<br>On a scale of 0-10, how would you assess patient's current pain.<br>Please circle one: 0 1 2 3 4 5 6 7 8 9 10<br>Comments: |
| **Treatment Goal:**<br>On a scale of 0-10, what is the pain scale goal for this patient.<br>Please circle one: 0 1 2 3 4 5 6 7 8 9 10<br>Comments: |