DURATION LIMIT WITH QUANTITY LIMIT AND POST LIMIT PRIOR AUTHORIZATION CRITERIA

DRUG CLASS **IMMEDIATE-RELEASE OPIOID ANALGESICS (BRAND AND GENERIC)***

generic name, dosage form

(codeine sulfate oral solution, tablets)

(hydromorphone hydrochloride oral solution, suppositories, tablets)

(levorphanol tartrate tablets)

(meperidine hydrochloride oral solution, tablets)

(morphine sulfate oral soln, oral soln concentrate, suppositories, tablets)

(oxycodone hydrochloride capsules, oral soln, oral soln concentrate, tabs)

(oxymorphone hydrochloride tablets)

(pentazocine/naloxone tablets)

(tapentadol oral solution, tablets)

(tramadol hydrochloride tablets)

Status: CVS Caremark Criteria
Type: Initial Step; Duration Limit; Initial Limit; Post Limit PA ***Ref # 2221-M***

** Drugs that are listed in the target drug box include both brand and generic and all dosage forms and strengths unless otherwise stated. OTC products are not included unless otherwise stated.*

FDA-APPROVED INDICATIONS

Codeine Sulfate

Oral Solution

Codeine sulfate oral solution is an opioid analgesic indicated for the management of mild to moderately severe pain where the use of an opioid analgesic is appropriate.

Tablets

Codeine sulfate tablets are indicated for the management of mild to moderate pain, where treatment with an opioid is appropriate and for which alternative treatments are inadequate.

Limitations of Use

Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve codeine sulfate tablets for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

Hydromorphone Hydrochloride

Oral Solution, Tablets

Hydromorphone hydrochloride oral solution and hydromorphone hydrochloride tablets are indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

Limitations of Use

Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve hydromorphone hydrochloride oral solution and hydromorphone hydrochloride tablets for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

Suppositories

Hydromorphone hydrochloride is indicated for the relief of moderate to severe pain such as that due to: Surgery, Trauma (soft tissue and bone), Burns, Cancer, Biliary Colic, Myocardial Infarction, Renal Colic.

Levorphanol Tartrate

Levorphanol Tartrate tablets are indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

Limitations of Use

Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve levorphanol tartrate tablets for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

Meperidine Hydrochloride

Oral Solution, Tablets

Meperidine hydrochloride oral solution and tablets are indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

Limitations of Use

Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve meperidine hydrochloride oral solution and tablets for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

Meperidine hydrochloride oral solution and tablets should not be used for treatment of chronic pain. Prolonged meperidine use may increase the risk of toxicity (e.g., seizures) from the accumulation of the meperidine metabolite, normeperidine.

Morphine Sulfate

Oral Solution

Morphine sulfate oral solution 10 mg per 5 mL and 20 mg per 5 mL are formulations of morphine, an opioid agonist, indicated for the relief of moderate to severe acute and chronic pain where use of an opioid analgesic is appropriate. Morphine sulfate oral solution 100 mg per 5 mL (20 mg/mL) is an opioid analgesic indicated for the relief of moderate to severe acute and chronic pain in opioid-tolerant patients.

Suppositories

Morphine suppositories are indicated for the relief of severe chronic pain and severe acute pain.

Tablets

Morphine sulfate tablets and suppositories are indicated for the management of acute and chronic pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

Limitations of Use

Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve morphine sulfate tablets for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

Nucynta (tapentadol)

Oral Solution and Tablets

Nucynta (tapentadol) oral solution and tablets are indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate in adults.

Limitations of Use

Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve Nucynta (tapentadol) oral solution and tablets for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

Oxaydo (oxycodone hydrochloride)

Oxaydo (oxycodone hydrochloride) is indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

Limitations of Use

Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve Oxaydo (oxycodone hydrochloride) for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

Oxycodone Hydrochloride

Capsules, Oral Concentrate, Oral Solution and Tablets

Oxycodone hydrochloride capsules, oral concentrate, oral solution and tablets are indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

Limitations of Use

Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve oxycodone hydrochloride capsules, oral concentrate, oral solution, and tablets for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

Oxymorphone Hydrochloride

Oxymorphone hydrochloride tablets are indicated for the management of acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

Limitations of Use

Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve oxymorphone hydrochloride tablets for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

Pentazocine/Naloxone

Pentazocine and naloxone tablets are indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

Limitations of Use
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve pentazocine and naloxone tablets for use in patients for whom alternative treatment options (e.g., non-opioid analgesics):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

RoxyBond (oxycodone hydrochloride)
RoxyBond (oxycodone hydrochloride) is indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.
Limitations of Use
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve RoxyBond (oxycodone hydrochloride) for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

Ultram (tramadol)
Ultram (tramadol) is indicated for the management of pain in adults that is severe enough to require an opioid analgesic and for which alternative treatments are inadequate.
Limitations of Use
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve Ultram (tramadol) for use in patients for whom alternative treatment options (e.g., non-opioid analgesics):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

COVERAGE CRITERIA
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

OR

- The patient can safely take the requested dose based on their history of opioid use. [Note: The lowest effective dosage should be prescribed for opioid naïve patients.]

AND

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

AND

- The requested drug is 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.]

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

OR

- The patient requires extended treatment beyond 7 days for moderate to severe ACUTE pain where use of an opioid analgesic is appropriate

Quantity Limits may apply.

RATIONALE

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. Codeine sulfate is indicated for the management of mild to moderate pain, where treatment with an opioid is appropriate and for which alternative treatments are inadequate. Hydromorphone hydrochloride, levorphanol tartrate, meperidine, oxycodone hydrochloride, pentazocine/naloxone, tapentadol, and tramadol are indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. Morphine sulfate is indicated for the management of acute and chronic pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. Oxymorphone hydrochloride is indicated for the relief of acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve immediate-release opioids for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products) 1) have not been tolerated or are not expected to be tolerated, or 2) have not provided adequate analgesia or are not expected to provide adequate analgesia.[1-22]

If the patient 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 (SCD) within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.

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 requested drug will be paid under that prescription benefit.

If the patient has an ICD 10 diagnosis code indicating cancer, sickle cell disease, or palliative care in their member health profile in the past 365 days, then the requested drug will be paid under that prescription benefit.

If a claim is submitted using a hospice patient residence code under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.

For patients 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, sickle cell disease, or palliative care in the member health profile in the past 365 days, or no hospice patient residence code submitted with their prescription claim:
If the patient has filled a prescription for at least a 7-day supply of an opioid agent indicated for the management of pain (immediate- or extended-release) within prescription claim history in the past 90 days under a prescription benefit administered by CVS Caremark, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below).

If the patient does not have at least a 7-day supply of an opioid agent indicated for the management of pain (immediate- or extended-release) within prescription claim history in the past 90 days (i.e., this is the patient's first fill of an opioid) and the incoming prescription drug is being filled for more than a 7-day supply, then the claim will reject with a message indicating that the patient can receive a 7-day supply or submit a prior authorization (PA) for additional quantities. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit. If the incoming prescription drug is being filled for less than a 7-day supply, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below).

The Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, sickle cell disease, palliative care, and end-of-life care.[26] The National Comprehensive Cancer Network (NCCN) guidelines for Adult Cancer Pain recommend for continuous pain, it is appropriate to give pain medication on a regular schedule with supplemental doses for breakthrough pain. Add an extended-release or long-acting formulation to provide background analgesia for control of chronic persistent pain controlled on stable doses of short-acting opioids.

When possible, use the same opioid for short-acting and extended-release forms. Allow rescue doses of short-acting opioids up to every 1 hour as needed.[24] The NCCN Palliative Care pain management recommendation is to treat according to NCCN guidelines for adult cancer pain.[23] For patients with no prescription claims of a cancer drug in the past 365 days, no ICD 10 diagnosis code indicating cancer or palliative care submitted with their prescription claim, no ICD 10 diagnosis code indicating cancer or palliative care in the member health profile in the past 365 days, or no hospice patient residence code submitted with their prescription claim who are identified through the prior authorization criteria as having cancer, a terminal condition, or pain being managed through hospice or palliative care, acute pain duration limits and post limit quantities will not apply.

According to the National Heart, Lung, and Blood Institute's (NHLBI) guidelines for Sickle Cell Disease (SCD), pain is the most common symptom of SCD. Pain can be acute, chronic, or an acute episode superimposed on chronic pain. Recurrent acute pain crises (also known as vaso-occlusive crises) are the most common manifestation of SCD. Chronic pain is also one of the most common chronic complications of SCD. Pain management must be guided by patient report of severity. No biomarkers or imaging studies can validate pain or assess its severity. Medications used to treat SCD-related pain should be tailored to the individual. For pain that is not relieved by nonsteroidal anti-inflammatory drugs (NSAIDs) or other measures, either short-acting or long-acting opioids may be used to manage pain in SCD.[28] For patients with no prescription claims of a sickle cell disease drug in the past 365 days, no ICD 10 diagnosis code indicating sickle cell disease submitted with their prescription claim, or no ICD 10 diagnosis code indicating sickle cell disease in the member health profile in the past 365 days who are identified through the prior authorization criteria as having sickle cell disease, acute pain duration limits and post limit quantities will not apply.

According to the CDC Guideline for Prescribing Opioids for Chronic Pain, long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should not prescribe a greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.[26] Coverage is provided for up to 7 days initially to provide an amount sufficient for the treatment of acute pain.

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, then clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.[26]

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should consider history of overdose, history of substance use disorder, higher opioid dosages [≥50 morphine milligram equivalents per day (MME/day)], or concurrent benzodiazepine use. [26]

The CDC Guideline for Prescribing Opioids for Chronic Pain recommends that when opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 MME/day, and avoid increasing the dosage to ≥90 MME/day or carefully justify a decision to titrate the dosage to ≥90 MME/day.[26] The immediate-release opioid drug initial quantity limits are set to encompass the usual/starting dosage and frequency range recommendations in labeling without exceeding a monthly quantity that corresponds to 90 MME/day. If the patient is requesting more than the initial quantity limit, then the system will reject with a message indicating that a prior authorization is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

The American Pain Society Opioid Treatment Guidelines state that a reasonable definition for high dose opioid therapy is >200 mg daily of oral morphine (or equivalent).[25] The immediate-release opioid drug post limit quantities are set to encompass the usual dosage and frequency range recommendations in labeling, or up to 1.5 times the initial quantity limit, without exceeding a monthly quantity that corresponds to 200 MME/day to promote optimization of pain management, safe and effective use, and to reduce misuse, abuse, and overdose.

Although meperidine is commonly used for acute pain relief, use of this drug as first-line opiate therapy is discouraged because of central excitatory toxicity of the metabolite (normeperidine). Because of extensive first-pass metabolism in the liver of normeperidine, the risk of excitatory toxicity is increased with oral administration of meperidine. Therefore, oral therapy is discouraged. Use of meperidine for chronic pain is discouraged because of its short duration of effect and risk of accumulation. Meperidine should be limited to short-term (i.e., a few days) because of the risk of accumulation of the toxic normeperidine metabolite with repeated or large doses.[21] The initial quantity limit for meperidine will be set at a quantity that corresponds to a 72 hour supply (allows for weekend coverage, if necessary). The post limit quantity will be set at a quantity that corresponds to a 96 hour supply, allowing one additional day of therapy beyond the initial quantity limit.

The limit for codeine is set reflective of its questionable role in chronic or moderate to severe pain management as compared to other opioid medications. When prescribing codeine, healthcare providers should choose the lowest effective dose for the shortest period of time. The initial quantity limit for codeine will be set at a quantity that corresponds to a one week supply. The post limit quantity will be set at a quantity that corresponds to a two-week supply.

Pentazocine is not commonly used in clinical practice due to the occurrence of dysphoric reactions and its relatively short duration of action.[27] According to the NCCN Guidelines for Adult Cancer Pain, mixed agonist-antagonist drugs (including pentazocine) have limited usefulness and are not recommended for the treatment of cancer pain.[24] The one month and three months limit for pentazocine/naloxone are set as the same based on these significant safety concerns.

PROGRAM DESCRIPTION*

Neither acute pain duration limits nor quantity limits apply if the patient 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, neither acute pain duration limits nor quantity limits will 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, sickle cell disease, or palliative care in their member health profile in the past 365 days, or if a prescription claim is submitted using a hospice patient residence code.

Acute Pain Duration Limit

If a patient has filled a prescription for at least a 7-day supply of an opioid agent indicated for the management of pain (immediate- or extended-release) within prescription claim history in the past 90 days, then the immediate-release opioid will adjudicate for up to the initial quantity limit.

If the patient does not have at least a 7-day supply of an opioid agent indicated for the management of pain (immediate- or extended-release) within prescription claim history in the past 90 days (i.e., this is the patient's first fill of an opioid) , then coverage is provided for up to a 7-day supply of the immediate-release opioid. Prior authorization review is required to determine coverage for a quantity necessary for treatment beyond 7 days. For patients 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, sickle cell disease, or palliative care in the member health profile in the past 365 days, or no hospice patient residence code submitted with their prescription claim who are identified through the prior authorization criteria as having cancer, sickle cell disease, a terminal condition, or pain being managed through hospice or palliative care, acute pain duration limits will not apply.

Quantity Limit/Post Limit

Plans implementing morphine milligram equivalent (MME)-based quantity limits on immediate-release opioids are providing coverage for an initial amount of a monthly quantity that corresponds to 90 MME or less per day. Coverage is provided for up to the initial quantity limit per Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below.

Prior authorization review is required to determine coverage for additional quantities above the initial limit.

Post limit quantities are set not to exceed a monthly quantity that corresponds to 200 MME/day. For patients 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, sickle cell disease, or palliative care in the member health profile in the past 365 days, or no hospice patient residence code submitted with their prescription claim who are identified through the prior authorization criteria as having cancer, sickle cell disease, a terminal condition, or pain being managed through hospice or palliative care, post limit quantities will not apply.

**Acute Pain Duration Limit logic will apply first, followed by initial quantity limit logic.*

REFERENCES

1. Codeine Sulfate oral solution [package insert]. Columbus, OH: Roxane Laboratories, Inc.; June 2011.
2. Codeine Sulfate tablets [package insert]. Philadelphia, PA: Lannett Company, Inc.; October 2018.
3. Dilaudid oral solution, tablets [package insert]. Coventry, RI: Rhodes Pharmaceuticals L.P.; September 2018.
4. Hydromorphone HCl oral solution, tablets [package insert] Eatontown, NJ: Westward Pharmaceuticals Corp; November 2017.
5. Hydromorphone HCl suppositories [package insert]. Minneaoplis, MN: Perrigo; November 2018.
6. Levorphanol Tartrate [package insert]. Solana Beach, CA: Sentynl Therapeutics, Inc.; September 2018.
7. Meperidine Hydrochloride oral solution, tablets [package insert]. Eatontown, NJ: West-Ward Pharmaceuticals Corp.; September 2017.
8. Morphine Sulfate 10 mg/5 mL, 20 mg/5 mL, 100 mg/5 mL (20 mg/mL) oral solution [package insert]. Bryan, OH: Nostrum Laboratories, Inc.; December 2018.
9. Morphine Sulfate suppositories [package insert]. Minneapolis, MN: Perrigo; November 2018.
10. Morphine Sulfate tablets [package insert]. Eatontown, NJ: West-Ward Pharmaceuticals Corp.; April 2017.
11. Nucynta oral solution [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc; November 2017.
12. Nucynta tablets [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc; December 2016.
13. Oxaydo [package insert]. Wayne, PA: Egalet US Inc.; September 2018.
14. Oxycodone Hydrochloride tablets [package insert]. Brookhaven, NY: Amneal Pharmaceuticals of NY LLC; October 2018.
15. Oxycodone Hydrochloride capsules [package insert]. Philadelphia, PA: Lannett Company, Inc.; July 2018.
16. Oxycodone Hydrochloride 5 mg/5 mL, 100 mg/5 mL (20 mg/mL) oral solution [package insert]. Newtown, PA: KVK-TECH, Inc.; December 2018.
17. Oxymorphone [package insert]. Newtown, PA: KVK-TECH, Inc.; December 2018.
18. Pentazocine and Naloxone [package insert]. Parsipanny, NJ: Actavis Pharma, Inc; July 2018.
19. RoxyBond [package insert]. Basking Ridge, NJ: Daiichi Sankyo, Inc.; December 2018.
20. Ultram [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc ; September 2018.
21. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Hudson, OH: Wolters Kluwer Clinical Drug Information, Inc. http://online.lexi.com/. Accessed January 2019.
22. Micromedex (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. http://www.micromedexsolutions.com/. Accessed January 2019.
23. Palliative Care. NCCN Guidelines version 1.2019. Available at: http://www.nccn.org/professionals/physician_gls/pdf/palliative.pdf. Accessed January 2019.
24. Adult Cancer Pain. NCCN Guidelines version 2.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/pain.pdf. Accessed January 2019.
25. Chou R, Fanciullo G, Fine P, et al. Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain The Journal of Pain 2009;10:113-130.

26. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65:1–49. Available at: http://dx.doi.org/10.15585/mmwr.rr6501e1. Accessed January 2019.
27. Clinical Pharmacology [database online]. Tampa, FL: Elsevier/Gold Standard; http://clinicalpharmacology.com/ [available with subscription]. Accessed March 2019.
28. National Heart, Lung, and Blood Institute. Evidence-Based Management of Sickle Cell Disease: Expert Panel Report, 2014. Available at: https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%20020816_0.pdf. Accessed March 2019.

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INITIAL STEP THERAPY

If the patient 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 requested drug will be paid under that prescription benefit.

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 requested drug will be paid under that prescription benefit.

If the patient has an ICD 10 diagnosis code indicating cancer, sickle cell disease, or palliative care in their member health profile in the past 365 days, then the requested drug will be paid under that prescription benefit.

If a claim is submitted using a hospice patient residence code under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.

For patients 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, sickle cell disease, or palliative care in the member health profile in the past 365 days, or no hospice patient residence code submitted with their prescription claim:
If the patient has filled a prescription for at least a 7-day supply of an opioid agent indicated for the management of pain (immediate- or extended-release) within prescription claim history in the past 90 days under a prescription benefit administered by CVS Caremark, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below).

If the patient does not have at least a 7-day supply of an opioid agent indicated for the management of pain (immediate- or extended-release) within prescription claim history in the past 90 days (i.e., this is the patient's first fill of an opioid) and the incoming prescription drug is being filled for more than a 7-day supply, then the claim will reject with a message indicating that the patient can receive a 7-day supply or submit a prior authorization (PA) for additional quantities. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit. If the incoming prescription drug is being filled for less than a 7-day supply, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below).

LIMIT CRITERIA*

Neither acute pain duration limits nor quantity limits apply if the patient 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, neither acute pain duration limits nor quantity limits will 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, sickle cell disease, or palliative care in their member health profile in the past 365 days, or if a prescription claim is submitted using a hospice patient residence code.

ACUTE PAIN DURATION LIMIT:

The acute pain duration limit portion of this program applies to patients identified with potential first fills of immediate-release opioid prescriptions for the treatment of non-cancer and non-sickle cell related pain. A first fill is defined as at least a 7-day supply of an opioid agent indicated for the management of pain (immediate- or extended-release) within prescription claim history during the past 90 days.

If the patient does not have at least a 7-day supply of an opioid agent indicated for the management of pain (immediate- or extended-release) within prescription claim history in the past 90 days (i.e., this is the patient's first fill of an opioid) and the incoming prescription drug is being filled for more than a 7-day supply, then the claim will reject with a message indicating that the patient can receive a 7-day supply or submit a prior authorization (PA) for additional quantities. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit. If the incoming prescription drug is being filled for less than a 7-day supply, then the initial quantity limit criteria will apply (see Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below).

INITIAL QUANTITY LIMIT:

Morphine milligram equivalent (MME) quantity limits for immediate-release opioids provide coverage for an initial amount of a monthly quantity that corresponds to 90 MME or less per day. Coverage is provided for up to the initial quantity limit per Column A and Column B in the Opioid Analgesics IR Quantity Limits Chart below. Prior authorization review is required to determine coverage for additional quantities above the initial limit.

**Acute Pain Duration Limit logic will apply first, followed by initial quantity limit logic.*

CRITERIA FOR APPROVAL

1	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
2	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.]	Yes	No
3	Has the patient been evaluated and will the patient be monitored regularly for the development of opioid use disorder?	Yes	No
4	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 6.]	Yes	No

5	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? [If yes, then skip to question 7.]	Yes	No
6	Does the patient require extended treatment beyond 7 days for moderate to severe ACUTE pain where use of an opioid analgesic is appropriate? [If yes, then skip to question 8.] [If no, then no further questions.]	Yes	No

7 Which drug is being requested (applies to brand or generic)?
[Note: Please check the drug being requested (applies to brand or generic).]

[] codeine oral solution or tablets (if checked, go to 9)
[] hydromorphone oral solution, suppositories, or tablets (if checked, go to 10)
[] levorphanol tablets (if checked, go to 11)
[] meperidine oral solution or tablets (if checked, go to 12)
[] morphine sulfate oral concentrate or oral solution (if checked, go to 13)
[] morphine sulfate suppositories (if checked, go to question 14)
[] morphine sulfate tablets (if checked, go to question 15)
[] oxycodone, Oxaydo, or RoxyBond capsules or tablets (if checked, go to question 16)
[] oxycodone oral concentrate or oral solution (if checked, go to 17)
[] oxymorphone tablets (if checked, go to question 18)
[] pentazocine/naloxone tablets (if checked, go to 19)
[] tapentadol oral solution or tablets (Nucynta) (if checked, go to 20)
[] tramadol tablets (if checked, go to 21)

8 Which drug is being requested (applies to brand or generic)?
[Note: Please check the drug being requested (applies to brand or generic).]

[] codeine oral solution or tablets (if checked, go to 22)
[] hydromorphone oral solution, suppositories, or tablets (if checked, go to 23)
[] levorphanol tablets (if checked, go to 24)
[] meperidine oral solution or tablets (if checked, go to 25)
[] morphine sulfate oral concentrate or oral solution (if checked, go to 26)
[] morphine sulfate suppositories (if checked, go to question 27)
[] morphine sulfate tablets (if checked, go to question 28)
[] oxycodone, Oxaydo, or RoxyBond capsules or tablets (if checked, go to question 29)
[] oxycodone oral concentrate or oral solution (if checked, go to 30)
[] oxymorphone tablets (if checked, go to question 31)
[] pentazocine/naloxone tablets (if checked, go to 32)
[] tapentadol oral solution or tablets (Nucynta) (if checked, go to 33)
[] tramadol tablets (if checked, go to 34)

9	Does the patient require use of MORE than the plan allowance of 840 mL (quantity sufficient for a 14-day supply) in a one month period of codeine sulfate oral solution OR MORE than the plan allowance of 84 tablets (quantity sufficient for a 14-day supply) in a one month period of codeine sulfate tablets? [No further questions.]	Yes	No

	[RPh Note: If yes, then deny and enter a partial approval for 840 mL/month of codeine sulfate oral solution OR 84 tablets/month of codeine sulfate tablets.]		
10	Does the patient require use of MORE than the plan allowance PER MONTH of any of the following: A) 1500 mL of hydromorphone oral solution, B) 180 suppositories of hydromorphone suppositories, C) 270 tablets of hydromorphone 2 mg tablets, D) 225 tablets of hydromorphone 4 mg tablets, E) 90 tablets of hydromorphone 8 mg tablets? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 1500 mL/month of hydromorphone oral solution, B) 180 suppositories/month of hydromorphone suppositories, C) 270 tablets/month of hydromorphone 2 mg tablets, D) 225 tablets/month of hydromorphone 4 mg tablets, E) 90 tablets/month of hydromorphone 8 mg tablets.]	Yes	No
11	Does the patient require use of MORE than the plan allowance PER MONTH of 180 levorphanol tablets? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 180 levorphanol tablets/ month.]	Yes	No
12	Does the patient require use of MORE than the plan allowance of 120 mL (quantity sufficient for a 4-day supply) in a one month period of meperidine oral solution OR MORE than the plan allowance of 24 tablets/month (quantity sufficient for a 4-day supply) of meperidine tablets in a one month period? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 120 mL/month of meperidine oral solution OR 24 tablets/month of meperidine tablets.]	Yes	No
13	Does the patient require use of MORE than the plan allowance PER MONTH of 270 mL of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution OR MORE than the plan allowance PER MONTH of 1350 mL of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 270 mL/month of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution OR 1350 mL/month of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution.]	Yes	No
14	Does the patient require use of MORE than the plan allowance PER MONTH of 270 suppositories of morphine sulfate suppository 5 mg, 10 mg, 20 mg OR MORE than the plan allowance PER MONTH of 180 suppositories of morphine sulfate suppository 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 270 suppositories/month of morphine sulfate suppository 5 mg, 10 mg, 20 mg OR 180 suppositories/month of morphine sulfate suppository 30 mg.]	Yes	No

15	Does the patient require use of MORE than the plan allowance PER MONTH of 270 tablets of morphine sulfate 15 mg tablets OR MORE than the plan allowance PER MONTH of 180 tablets of morphine sulfate 30 mg tablets? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 270 tablets/month of morphine sulfate 15 mg tablets OR 180 tablets/month of morphine sulfate 30 mg tablets.]	Yes	No
16	Does the patient require use of MORE than the plan allowance PER MONTH of any of the following: A) 270 capsules or tablets of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 180 tablets of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg C) 120 tablets of oxycodone 30 mg or RoxyBond 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 270 capsules or tablets/month of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 180 tablets/month of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg C) 120 tablets/month of oxycodone 30 mg or RoxyBond 30 mg.]	Yes	No
17	Does the patient require use of MORE than the plan allowance PER MONTH of 180 mL of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate OR MORE than the plan allowance PER MONTH of 2700 mL of oxycodone 5 mg/5 mL oral solution? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 180 mL/month of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate OR 2700 mL/month of oxycodone 5 mg/5 mL oral solution.]	Yes	No
18	Does the patient require use of MORE than the plan allowance PER MONTH of 360 tablets of oxymorphone 5 mg OR MORE than the plan allowance PER MONTH of 180 tablets of oxymorphone 10 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 360 tablets/month of oxymorphone 5 mg OR 180 tablets/month of oxymorphone 10 mg.]	Yes	No
19	Does the patient require use of MORE than the plan allowance PER MONTH of 300 pentazocine/naloxone tablets? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 300 pentazocine/naloxone tablets/month.]	Yes	No
20	Does the patient require use of MORE than the plan allowance PER MONTH of any of the following: A) 240 tablets of Nucynta (tapentadol) 50 mg tablets, B) 180 tablets of Nucynta (tapentadol) 75 mg tablets, C) 120 tablets of Nucynta (tapentadol) 100 mg tablets, D) 700 mL of Nucynta (tapentadol) oral solution? [No further questions.]	Yes	No

	[RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 240 tablets/month of Nucynta (tapentadol) 50 mg tablets, B) 180 tablets/month of Nucynta (tapentadol) 75 mg tablets, C) 120 tablets/month of Nucynta (tapentadol) 100 mg tablets, D) 700 mL/month of Nucynta (tapentadol) oral solution.]		
21	Does the patient require use of MORE than the plan allowance PER MONTH of 240 tablets of tramadol? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 240 tablets/month of tramadol.]	Yes	No
22	Does the patient require use of MORE than the plan allowance of 840 mL (quantity sufficient for a 14-day supply) in a one month period of codeine sulfate oral solution OR MORE than the plan allowance of 84 tablets (quantity sufficient for a 14-day supply) in a one month period of codeine sulfate tablets? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 840 mL/month of codeine sulfate oral solution OR 84 tablets/month of codeine sulfate tablets.]	Yes	No
23	Does the patient require use of MORE than the plan allowance PER MONTH of any of the following: A) 1500 mL of hydromorphone oral solution, B) 180 suppositories of hydromorphone suppositories, C) 270 tablets of hydromorphone 2 mg tablets, D) 225 tablets of hydromorphone 4 mg tablets, E) 90 tablets of hydromorphone 8 mg tablets? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 1500 mL/month of hydromorphone oral solution, B) 180 suppositories/month of hydromorphone suppositories, C) 270 tablets/month of hydromorphone 2 mg tablets, D) 225 tablets/month of hydromorphone 4 mg tablets, E) 90 tablets/month of hydromorphone 8 mg tablets.]	Yes	No
24	Does the patient require use of MORE than the plan allowance PER MONTH of 180 levorphanol tablets? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 180 levorphanol tablets/ month.]	Yes	No
25	Does the patient require use of MORE than the plan allowance of 120 mL (quantity sufficient for a 4-day supply) in a one month period of meperidine oral solution OR MORE than the plan allowance of 24 tablets/month (quantity sufficient for a 4-day supply) of meperidine tablets in a one month period? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 120 mL/month of meperidine oral solution OR 24 tablets/month of meperidine tablets.]	Yes	No
26	Does the patient require use of MORE than the plan allowance PER MONTH of 270 mL	Yes	No

	of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution OR MORE than the plan allowance PER MONTH of 1350 mL of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 270 mL/month of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution OR 1350 mL/month of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution.]		
27	Does the patient require use of MORE than the plan allowance PER MONTH of 270 suppositories of morphine sulfate suppository 5 mg, 10 mg, 20 mg OR MORE than the plan allowance PER MONTH of 180 suppositories of morphine sulfate suppository 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 270 suppositories/month of morphine sulfate suppository 5 mg, 10 mg, 20 mg OR 180 suppositories/month of morphine sulfate suppository 30 mg.]	Yes	No
28	Does the patient require use of MORE than the plan allowance PER MONTH of 270 tablets of morphine sulfate 15 mg tablets OR MORE than the plan allowance PER MONTH of 180 tablets of morphine sulfate 30 mg tablets? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 270 tablets/month of morphine sulfate 15 mg tablets OR 180 tablets/month of morphine sulfate 30 mg tablets.]	Yes	No
29	Does the patient require use of MORE than the plan allowance PER MONTH of any of the following: A) 270 capsules or tablets of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 180 tablets of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg C) 120 tablets of oxycodone 30 mg or RoxyBond 30 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 270 capsules or tablets/month of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 180 tablets/month of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg C) 120 tablets/month of oxycodone 30 mg or RoxyBond 30 mg.]	Yes	No
30	Does the patient require use of MORE than the plan allowance PER MONTH of 180 mL of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate OR MORE than the plan allowance PER MONTH of 2700 mL of oxycodone 5 mg/5 mL oral solution? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 180 mL/month of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate OR 2700 mL/month of oxycodone 5 mg/5 mL oral solution.]	Yes	No
31	Does the patient require use of MORE than the plan allowance PER MONTH of 360 tablets of oxymorphone 5 mg OR MORE than the plan allowance PER MONTH of 180 tablets of oxymorphone 10 mg?	Yes	No

[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for 360 tablets/month of oxymorphone 5 mg OR 180 tablets/month of oxymorphone 10 mg.]

32 Does the patient require use of MORE than the plan allowance PER MONTH of 300 pentazocine/naloxone tablets? Yes No
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for 300 pentazocine/naloxone tablets/month.]

33 Does the patient require use of MORE than the plan allowance PER MONTH of any of the following: A) 240 tablets of Nucynta (tapentadol) 50 mg tablets, B) 180 tablets of Nucynta (tapentadol) 75 mg tablets, C) 120 tablets of Nucynta (tapentadol) 100 mg tablets, D) 700 mL of Nucynta (tapentadol) oral solution? Yes No
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 240 tablets/month of Nucynta (tapentadol) 50 mg tablets, B) 180 tablets/month of Nucynta (tapentadol) 75 mg tablets, C) 120 tablets/month of Nucynta (tapentadol) 100 mg tablets, D) 700 mL/month of Nucynta (tapentadol) oral solution.]

34 Does the patient require use of MORE than the plan allowance PER MONTH of 240 tablets of tramadol? Yes No
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for 240 tablets/month of tramadol.]

Mapping Instructions			
	Yes	**No**	**DENIAL REASONS – DO NOT USE FOR MEDICARE PART D**
1.	Approve, 12 months, No set post limit quantity [Enter approval for quantity of 999999.]	Go to 2	
2.	Go to 3	Deny	You do not meet the requirements of your plan. Your plan covers this drug when you can safely take the drug based on your history of opioid use. Your request has been denied based on the information we have. [Short Description: Patient cannot safely take requested dose.]
3.	Go to 4	Deny	You do not meet the requirements of your plan. Your plan covers this drug when you will be monitored regularly. Your request has been denied

			based on the information we have. [Short Description: Patient not monitored regularly for opioid use disorder.]
4.	Go to 5	Go to 6	
5.	Go to 7	Deny	You do not meet the requirements of your plan. Your plan covers this drug when you meet all of these conditions: - Your pain will be checked by your doctor the first month after your initial prescription or after a dose increase and every 3 months after that - The benefits outweigh the risks of taking the medication Your request has been denied based on the information we have. [Short Description: Patient's pain is not being reassessed.]
6.	Go to 8	Deny	You do not meet the requirements of your plan. Your plan covers this drug when you have one of these conditions: - Pain due to cancer, sickle cell disease, or a terminal condition - Pain being managed through hospice or palliative care - Moderate to severe chronic pain that requires treatment with an opioid - Moderate to severe acute pain that requires treatment with an opioid for more than seven days Your request has been denied based on the information we have. [Short Description: No approvable diagnosis.]
7.	1=9; 2=10; 3=11; 4=12; 5=13; 6=14; 7=15; 8=16; 9=17; 10=18; 11=19; 12=20; 13=21	N/A	
8.	1=22; 2=23; 3=24; 4=25; 5=26; 6=27; 7=28; 8=29; 9=30; 10=31; 11=32; 12=33; 13=34	N/A	
9.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 12 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 840 mL of codeine sulfate oral solution in a one month period - 84 tablets of codeine sulfate tablets in a one month period You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
10.	Deny RPh Note: For the denial verbiage, only include the	Approve, 12 months See Opioid	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 1500 mL/month of hydromorphone oral solution - 180 suppositories/month hydromorphone suppositories

	requested drug. Remove all the other drugs from the verbiage.	Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	- 270 tablets/month of hydromorphone 2 mg tablets - 225 tablets/month of hydromorphone 4 mg tablets - 90 tablets/month of hydromorphone 8 mg tablets You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
11.	Deny	Approve, 12 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to 180 tablets/month of the requested drug and strength. You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
12.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 12 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 120 mL of meperidine oral solution in a one month period - 24 tablets of meperidine tablets in a one month period You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
13.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 12 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 270 mL/month of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution - 1350 mL/month of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
14.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 12 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 270 suppositories/month of morphine sulfate suppository 5 mg, 10 mg, or 20 mg - 180 suppositories/month of morphine sulfate suppository 30 mg You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied.

		D for a 3 month supply)	[Short Description: Over max quantity.]
15.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 12 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 270 tablets/month of morphine sulfate 15 mg tablets - 180 tablets/month of morphine sulfate 30 mg tablets You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
16.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 12 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 270 capsules or tablets/month of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg - 180 tablets/month of oxycodone 15 mg, 20 mg or RoxyBond 15 mg - 120 tablets/month of oxycodone 30 mg or RoxyBond 30 mg You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
17.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 12 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 180 mL/month of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate - 2700 mL/month of oxycodone 5 mg/5 mL oral solution You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
18.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 12 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 360 tablets/month of oxymorphone 5 mg - 180 tablets/month of oxymorphone 10 mg You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
19.	Deny	Approve, 12	You have requested more than the maximum quantity allowed by your

		months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply)	plan. Current plan approved criteria cover up to 300 tablets/month of the requested drug and strength. You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
20.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 12 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 240 tablets/month of Nucynta (tapentadol) 50 mg tablets - 180 tablets/month of Nucynta (tapentadol) 75 mg tablets - 120 tablets/month of Nucynta (tapentadol) 100 mg tablets - 700 mL/month of Nucynta (tapentadol) oral solution You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
21.	Deny	Approve, 12 months See Opioid Analgesics IR Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to 240 tablets/month of the requested drug and strength. You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
22.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 840 mL of codeine sulfate oral solution in a one month period - 84 tablets of codeine sulfate tablets in a one month period You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
23.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 1500 mL/month of hydromorphone oral solution - 180 suppositories/month hydromorphone suppositories - 270 tablets/month of hydromorphone 2 mg tablets - 225 tablets/month of hydromorphone 4 mg tablets - 90 tablets/month of hydromorphone 8 mg tablets You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the

			requested drug and strength has been denied. [Short Description: Over max quantity.]
24.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to 180 tablets/month of the requested drug and strength. You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
25.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 120 mL of meperidine oral solution in a one month period - 24 tablets of meperidine tablets in a one month period You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
26.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 270 mL/month of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution - 1350 mL/month of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
27.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 270 suppositories/month of morphine sulfate suppository 5 mg, 10 mg, or 20 mg - 180 suppositories/month of morphine sulfate suppository 30 mg You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
28.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 270 tablets/month of morphine sulfate 15 mg tablets - 180 tablets/month of morphine sulfate 30 mg tablets You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]

29.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 270 capsules or tablets/month of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg - 180 tablets/month of oxycodone 15 mg, 20 mg or RoxyBond 15 mg - 120 tablets/month of oxycodone 30 mg or RoxyBond 30 mg You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
30.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 180 mL/month of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate - 2700 mL/month of oxycodone 5 mg/5 mL oral solution You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
31.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 360 tablets/month of oxymorphone 5 mg - 180 tablets/month of oxymorphone 10 mg You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
32.	Deny	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to 300 tablets/month of the requested drug and strength. You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
33.	Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.	Approve, 1 month See Opioid Analgesics IR Quantity Limits Chart (Column C)	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to: - 240 tablets/month of Nucynta (tapentadol) 50 mg tablets - 180 tablets/month of Nucynta (tapentadol) 75 mg tablets - 120 tablets/month of Nucynta (tapentadol) 100 mg tablets - 700 mL/month of Nucynta (tapentadol) oral solution You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]
34.	Deny	Approve, 1 month	You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to 240 tablets/month of the

		See Opioid Analgesics IR Quantity Limits Chart (Column C)	requested drug and strength. You have been approved for the maximum quantity that your plan covers for a duration of 1 month. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]

Opioid Analgesics IR Quantity Limits Chart

Coverage is provided without prior authorization (for patients not identified as potential first fills) for a 30-day or 90-day supply of an immediate-release opioid for a quantity that corresponds to ≤ 90 MME/day. Coverage for quantities that correspond to ≤ 200 MME/day for a 30-day or 90-day supply is provided through prior authorization when criteria for approval are met.

These quantity limits should accumulate across all drugs of the same unit limit (i.e., drugs with 30 units accumulate together, drugs with 60 units accumulate together, etc).

		COLUMN A	COLUMN B	COLUMN C	COLUMN D
Drug/Strength**	**Labeled Dosing**	**Initial 1 Month Limit* ≤ 90 MME/day (per 25 days)**	**Initial 3 Month Limit* ≤ 90 MME/day (per 75 days)**	**Post 1 Month Limit* ≤ 200 MME/day (per 25 days)**	**Post 3 Month Limit* ≤ 200 MME/day (per 75 days)**
Codeine sulfate oral soln 30 mg/5 mL	15 to 60 mg (2.5 mL to 10 mL) q4h. Max Daily Dose 360 mg.	210 mL‡ (27 MME/day)	210 mL‡ (27 MME/day)	840 mL‡ (54 MME/day)	Use Column C
Codeine sulfate tab 15 mg	15 to 60 mg q4h. Max Daily Dose 360 mg.	42 tabs‡ (13.5 MME/day)	42 tabs‡ (13.5 MME/day)	84 tabs‡ (13.5 MME/day)	Use Column C
Codeine sulfate tab 30 mg	15 to 60 mg q4h. Max Daily Dose 360 mg.	42 tabs‡ (27 MME/day)	42 tabs‡ (27 MME/day)	84 tabs‡ (27 MME/day)	Use Column C
Codeine sulfate tab 60 mg	15 to 60 mg q4h. Max Daily Dose 360 mg.	42 tabs‡ (54 MME/day)	42 tabs‡ (54 MME/day)	84 tabs‡ (54 MME/day)	Use Column C
Hydromorphone oral soln 5 mg/5 mL (1 mg/mL)	2.5 mg – 10 mg (2.5 mL to 10 mL) q3-6h	600 mL (80 MME/day)	1800 mL (80 MME/day)	1500 mL (200 MME/day)	4500 mL (200 MME/day)
Hydromorphone supp 3 mg	1 supp q6-8h	120 supps (48 MME/day)	360 supps (48 MME/day)	180 supps (72 MME/day)	540 supps (72 MME/day)
Hydromorphone tab 2 mg	2-4 mg q4-6h	180 tabs (48 MME/day)	540 tabs (48 MME/day)	270 tabs (72 MME/day)	810 tabs (72 MME/day)
Hydromorphone tab 4 mg	2-4 mg q4-6h	150 tabs (80 MME/day)	450 tabs (80 MME/day)	225 tabs (120 MME/day)	675 tabs (120 MME/day)
Hydromorphone tab 8 mg	2-4 mg q4-6h	60 tabs (64 MME/day)	180 tabs (64 MME/day)	90 tabs (96 MME/day)	270 tabs (96 MME/day)
Levorphanol tab 1 mg	1-3 mg q6-8h	120 tabs (44 MME/day)	360 tabs (44 MME/day)	180 tabs (66 MME/day)	540 tabs (66 MME/day)
Levorphanol tab 2 mg	1-3 mg q6-8h	120 tabs (88 MME/day)	360 tabs (88 MME/day)	180 tabs (132 MME/day)	540 tabs (132 MME/day)
Levorphanol tab 3 mg	1-3 mg q6-8h	60 tabs (66 MME/day)	180 tabs (66 MME/day)	180 tabs (198 MME/day)	540 tabs (198 MME/day)
Meperidine oral soln 50 mg/5 mL	50-150 mg (5-15 mL) q3-4h	90 mL**** (30 MME/day)	90 mL**** (30 MME/day)	120 mL**** (30 MME/day)	Use Column C
Meperidine tab 50 mg	50-150 mg q3-4h	18 tabs**** (30 MME/day)	18 tabs**** (30 MME/day)	24 tabs**** (30 MME/day)	Use Column C

Meperidine tab 100 mg	50-150 mg q3-4h	18 tabs**** (60 MME/day)	18 tabs**** (60 MME/day)	24 tabs**** (60 MME/day)	Use Column C
Morphine sulfate (conc) oral soln 20 mg/mL (100 mg/5 mL)	10-20 mg q4h	135 mL (90 MME/day)	405 mL (90 MME/day)	270 mL (180 MME/day)	810 mL (180 MME/day)
Morphine sulfate oral soln 10 mg/5 mL	10-20 mg q4h	900 mL (60 MME/day)	2700 mL (60 MME/day)	1350 mL (90 MME/day)	4050 mL (90 MME/day)
Morphine sulfate oral soln 20 mg/5 mL	10-20 mg q4h	675 mL (90 MME/day)	2025 mL (90 MME/day)	1350 mL (180 MME/day)	4050 mL (180 MME/day)
Morphine sulfate supp 5 mg	10-20 mg q4h	180 supps (30 MME/day)	540 supps (30 MME/day)	270 supps (45 MME/day)	810 supps (45 MME/day)
Morphine sulfate supp 10 mg	10-20 mg q4h	180 supps (60 MME/day)	540 supps (60 MME/day)	270 supps (90 MME/day)	810 supps (90 MME/day)
Morphine sulfate supp 20 mg	10-20 mg q4h	120 supps (80 MME/day)	360 supps (80 MME/day)	270 supps (180 MME/day)	810 supps (180 MME/day)
Morphine sulfate supp 30 mg	10-20 mg q4h	90 supps (90 MME/day)	270 supps (90 MME/day)	180 supps (180 MME/day)	540 supps (180 MME/day)
Morphine sulfate tab 15 mg	15-30 mg q4h	180 tabs (90 MME/day)	540 tabs (90 MME/day)	270 tabs (135 MME/day)	810 tabs (135 MME/day)
Morphine sulfate tab 30 mg	15-30 mg q4h	90 tabs (90 MME/day)	270 tabs (90 MME/day)	180 tabs (180 MME/day)	540 tabs (180 MME/day)
Oxycodone cap 5 mg	5-15 mg q4-6h	180 caps (45 MME/day)	540 caps (45 MME/day)	270 caps (67.5 MME/day)	810 caps (67.5 MME/day)
Oxycodone oral concentrate 100 mg/5 mL (20 mg/mL)	5-15 mg q4-6h	90 mL (90 MME/day)	270 mL (90 MME/day)	180 mL (180 MME/day)	540 mL (180 MME/day)
Oxycodone soln 5 mg/5 mL	5-15 mg q4-6h	900 mL (45 MME/day)	2700 mL (45 MME/day)	2700 mL (135 MME/day)	8100 mL (135 MME/day)
Oxaydo 5 mg	5-15 mg q4-6h	180 tabs (45 MME/day)	540 tabs (45 MME/day)	270 tabs (67.5 MME/day)	810 tabs (67.5 MME/day)
Oxaydo 7.5 mg	5-15 mg q4-6h	180 tabs (67.5 MME/day)	540 tabs (67.5 MME/day)	270 tabs (101.25 MME/day)	810 tabs (101.25 MME/day)
Oxycodone tab 5 mg	5-15 mg q4-6h	180 tabs (45 MME/day)	540 tabs (45 MME/day)	270 tabs (67.5 MME/day)	810 tabs (67.5 MME/day)
Oxycodone tab 10 mg	5-15 mg q4-6h	180 tabs (90 MME/day)	540 tabs (90 MME/day)	270 tabs (135 MME/day)	810 tabs (135 MME/day)
Oxycodone tab 15 mg	5-15 mg q4-6h	120 tabs (90 MME/day)	360 tabs (90 MME/day)	180 tabs (135 MME/day)	540 tabs (135 MME/day)
Oxycodone tab 20 mg	5-15 mg q4-6h	90 tabs (90 MME/day)	270 tabs (90 MME/day)	180 tabs (180 MME/day)	540 tabs (180 MME/day)
Oxycodone tab 30 mg	5-15 mg q4-6h	60 tabs (90 MME/day)	180 tabs (90 MME/day)	120 tabs (180 MME/day)	360 tabs (180 MME/day)
Oxymorphone tab 5 mg	10-20 mg q4-6h	180 tabs (90 MME/day)	540 tabs (90 MME/day)	360 tabs (180 MME/day)	1080 tabs (180 MME/day)
Oxymorphone tab 10 mg	10-20 mg q4-6h	90 tabs (90 MME/day)	270 tabs (90 MME/day)	180 tabs (180 MME/day)	540 tabs (180 MME/day)
Pentazocine/naloxone 50/0.5 mg	1-2 tabs q3-4h. Total daily dose should not exceed 12 tablets.	120 tabs*** (74 MME/day)	120 tabs*** (74 MME/day)	300 tabs*** (185 MME/day)	Use Column C
RoxyBond 5 mg	5-15 mg q4-6h	180 tabs (45 MME/day)	540 tabs (45 MME/day)	270 tabs (67.5 MME/day)	810 tabs (67.5 MME/day)
RoxyBond 15 mg	5-15 mg q4-6h	120 tabs (90 MME/day)	360 tabs (90 MME/day)	180 tabs (135 MME/day)	540 tabs (135 MME/day)
RoxyBond 30 mg	5-15 mg q4-6h	60 tabs (90 MME/day)	180 tabs (90 MME/day)	120 tabs (180 MME/day)	360 tabs (180 MME/day)

Tapentadol oral soln 20 mg/mL†	50 mg (2.5 mL) to 100 mg (5 mL) every 4 to 6 hours. Max daily dose is 700 mg on the first day and 600 mg on subsequent days.	300 mL (80 MME/day)	900 mL (80 MME/day)	700 mL (186.7 MME/day)	2100 mL (186.7 MME/day)
Tapentadol tab 50 mg	50 mg, 75 mg, or 100 mg every 4 to 6 hours. Max daily dose is 700 mg on the first day and 600 mg on subsequent days.	120 tabs (80 MME/day)	360 tabs (80 MME/day)	240 tabs (160 MME/day)	720 tabs (160 MME/day)
Tapentadol tab 75 mg	50 mg, 75 mg, or 100 mg every 4 to 6 hours. Max daily dose is 700 mg on the first day and 600 mg on subsequent days.	90 tabs (90 MME/day)	270 tabs (90 MME/day)	180 tabs (180 MME/day)	540 tabs (180 MME/day)
Tapentadol tab 100 mg	50 mg, 75 mg, or 100 mg every 4 to 6 hours. Max daily dose is 700 mg on the first day and 600 mg on subsequent days.	60 tabs (80 MME/day)	180 tabs (80 MME/day)	120 tabs (160 MME/day)	360 tabs (160 MME/day)
Tramadol 50 mg	50-100 mg q4-6h, MAX = 400 mg/day	180 tabs (30 MME/day)	540 tabs (30 MME/day)	240 tabs (40 MME/day)	720 tabs (40 MME/day)

**The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing. Limits are set up as quantity versus time edits.*

***The limit criteria apply to both brand and generic, if available.*

****This drug is indicated for short-term acute use; therefore, the 30-day limit will be the same as the 90-day limit.*

*****Due to risk of accumulation, the 30-day and 90-day initial limit allows a quantity that corresponds to a 3-day supply only and the 30-day and 90-day post limit allows a quantity that corresponds to a 4-day supply only.*

†*Available in 100 mL and 200 mL bottles. It is the discretion of the dispensing pharmacy to fill quantities per package size up to these quantity limits. In such cases the filling limit and day supply may be less than what is indicated.*

‡*This drug is indicated for short-term acute use; therefore, the 30-day limit will be the same as the 90-day limit. The initial quantity limit for codeine will be set at a quantity that corresponds to a one week supply. The post limit quantity will be set at a quantity that corresponds to a two week supply.*