

ALASKA MEDICAID

EXTENDED RELEASE OPIOIDS (all strengths)

NO PRIOR AUTHORIZATION REQUIRED*

Morphine ER tablets (generic MS Contin) and fentanyl transdermal patches (generic Duragesic)

PRIOR AUTHORIZATION REQUIRED*

All claims for the following medications will require prior authorization: Duragesic (brand), Hydromorphone ER (Exalgo), Morphine ER capsules (Avinza and Kadian), Methadone, MS Contin (brand), Nucynta ER, Oxycodone ER (Opana ER), and Oxycodone ER (Oxycontin)

* Quantity limits and therapeutic duplication edits apply. Requests to exceed the maximum dispensing limits (<http://dhss.alaska.gov/dhcs/Documents/pharmacy/pdfs/maxunitsall.pdf>) and requests for the use of duplicate extended release opioids will require additional prior authorization. Requests to exceed the dispensing limit or requests for duplicate extended release opioids will be evaluated by the Department on a case-by-case basis.

CRITERIA FOR APPROVAL:

1. Morphine ER tablets (generic MS Contin) and fentanyl transdermal patches (generic Duragesic) do not require prior authorization.*
2. All request for extended release opioids must clearly document that the patient is opioid tolerant and has taken at least 60mg oral morphine per day, 25mcg transdermal fentanyl/hour, 30mg oral oxycodone per day, 8mg oral hydromorphone per day, 25mg oral oxycodone, or an equianalgesic dose of another opioid for a week or longer; **AND**
3. All requests for extended release opioids must be accompanied by a letter of medical necessity documenting the need for an around-the-clock opioid analgesic and a opioid agreement (aka “pain contract”); **AND**
4. All other extended release opioids require a trial of morphine ER tablets or fentanyl transdermal patches at an equivalent therapeutic dose that resulted in a documented adverse drug reaction, treatment failure, or other medical complication within the past year; **OR**
5. The prescriber must submit documentation of the medical rationale for the non-trial with morphine ER tablets or fentanyl transdermal.

LENGTH OF AUTHORIZATION:

Coverage may be approved for up to 6 months

DISPENSING LIMIT:

Maximum dispensing limits apply. See the Maximum Units List available online at: <http://dhss.alaska.gov/dhcs/Documents/pharmacy/pdfs/maxunitsall.pdf> for additional information.