

New Hampshire Medicaid Fee-for-Service Program Long-Acting Opioid Analgesic Criteria

Approval Date: August 7, 2020

Medications

Brand Names	Generic Names	Available Dosages	Abuse-Deterrent Formulation
Belbuca™	buprenorphine buccal	75, 150, 300, 450, 600, 750, and 900 mcg buccal film	No
Butrans®	buprenorphine transdermal	5, 7.5, 10, 15, 20 mcg/hr patches	No
Duragesic®	fentanyl transdermal	12, 25, 37.5, 50, 62.5, 75, 87.5, 100 mcg/hr patches	No
Hysingla® ER	hydrocodone ER	20, 30, 40, 60, 80, 120 mg tablets	Yes
Zohydro® ER	hydrocodone ER	10, 15, 20, 30, 40, 50 mg capsules	No
Exalgo®	hydromorphone ER	8, 12, 16, 32 mg tablets	No
MS Contin®	morphine sulfate CR	15, 30, 60, 100, 200 mg tablets	No
Arymo ER™	morphine sulfate extended-release	15 mg, 30 mg, and 60 mg tablets	Yes
Kadian®	morphine sulfate ER	10, 20, 30, 40, 50, 60, 80, 100, 200 mg capsules	No
Avinza®	morphine sulfate extended-release (generic available only)	30, 45, 60, 75, 90, 120 mg capsule	No
Morphabond™ ER	morphine sulfate extended-release	15 mg, 30 mg, 60 mg, and 100 mg tablets	Yes
OxyContin®	oxycodone CR	10, 15, 20, 30, 40, 60, 80 mg tablets	Yes

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Brand Names	Generic Names	Available Dosages	Abuse-Deterrent Formulation
Xtampza ER®	oxycodone extended-release	9 mg, 13.5 mg, 18 mg, 27 mg, and 36 mg capsules	Yes
Opana® ER	oxymorphone ER	5, 7.5, 10, 15, 20, 30, 40 mg biconcave tablets	No
Nucynta® ER	tapentadol ER	50, 100, 150, 200, 250 mg tablets	No
ConZip®	tramadol ER	100, 150 (generic only), 200, 300 mg capsules	No
Ultram® ER, Ryzolt®	tramadol ER	100, 200, 300 mg tablets	No

Criteria for Approval

*Hospice patients and end-of-life patients are **exempt** from prior authorization.*

1. Pain associated with cancer; **OR**
2. Pain associated with acute sickle cell disease (quantity limit: 10-day supply); **OR**
3. Patient is ≥ 18 years old who requires management of moderate to severe pain with a continuous around-the-clock analgesic for at least 10 days; **AND**
4. Failure on two other opioids for pain treatment for which the requested long-acting opioid is indicated; **AND**
5. Attestation that the New Hampshire Prescription Drug Monitoring Program (PDMP) has been reviewed within the last 60 days; **AND**
6. Confirmation that patient has a written pain agreement; **AND**
7. Confirmation that the patient will be prescribed concurrent naloxone.

Criteria for Denial

1. Criteria for approval not met; **OR**
2. Dosage greater than three times a day; **OR**
3. Concurrent long-acting opioid (two or more); **OR**
4. High starting dose without a prior history of opiate tolerance.

Length of Approval

Initial: Three months

Renewal: Six months

Non-preferred drugs on the Preferred Drug List (PDL) require additional Prior Authorization (PA).

Dispensing Limits: 34-day supply. In accordance with New Hampshire State Law (RSA 318-B: 9 IV).

References

Available upon request.

Revision History

Reviewed by	Reason for Review	Date Approved
Pharmacy & Therapeutic Committee	New	06/19/2008
Commissioner	New	07/22/2008
	RSA 318-B: 9 IV changes	01/01/2009
DUR Board	Update	06/22/2010
Commissioner	Approval	08/03/2010
DUR Board	Revision	06/18/2012
Commissioner	Approval	07/10/2012
DUR Board	Revision	05/31/2016
Commissioner	Approval	06/18/2016
DUR Board	Revision	09/27/2018
Commissioner Designee	Approval	11/27/2018
DUR Board	Revision	03/12/2019
Commissioner Designee	Approval	04/05/2019
DUR Board	Revision	06/30/2020
Commissioner Designee	Approval	08/07/2020