Clinical Policy: Opioid Analgesics*

Reference Number: HIM.PA.139
Effective Date: 08.01.18
Last Review Date: 05.26
Line of Business: HIM/ICHRA

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Opioid analgesics exert their analgesic effect through opiate receptors distributed in tissues throughout the body.

This policy applies to all formulary long and short acting opioids requiring prior authorization (PA) or any non-formulary opioid request.

FDA Approved Indication(s)
Opioid analgesics are indicated for the management and treatment of moderate to severe pain.

Policy/Criteria
Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

I. Initial Approval Criteria
Please note: For HIM-Arkansas – if a member's covered prescription pain medication requires a prior authorization, then the prior authorization shall not be denied if the member has a terminal illness.

A. Cancer, Sickle Cell Disease, or Palliative Care (must meet all)**:**
1. Prescribed for pain associated with one of the following (a, b, or c):
   a. Cancer;
   b. Sickle cell disease;
   c. Palliative care (hospice or any terminal condition);
2. Member meets one of the following (a or b):*
   ** For Illinois HIM requests, the step therapy requirements below do not as of 1/1/2026 per IL HB 5395*
   a. Request is for treatment associated with cancer for a State with regulations against step therapy in certain oncology settings (see *Appendix E*);
   b. Member has failed an adequate trial of two formulary short-acting opioid analgesics that does not require PA, dosed around the clock, unless clinically significant adverse effects are experienced, or all are contraindicated;
3. Request does not exceed health plan-approved quantity limit, if applicable.

Approval duration: 12 months

B. Short-Acting Agents – Requests for ≤ a 14-day Supply (must meet all):
1. Prescribed for the treatment of pain unrelated to cancer, palliative care, or sickle cell disease;

2. Member has failed an adequate trial of two formulary short-acting opioids analgesics that does not require PA, dosed around the clock, unless clinically significant adverse effects are experienced, or all are contraindicated;*
   ** For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
3. For OHIO requests ONLY: Total opioid dose does not exceed 80 MME per day or for members who are stable (history of > 7 days of therapy) on doses higher than 80 MME per day, one of the following is met (a or b):
   a. Provider will initiate a dose taper;
      **Future approval will require decrease from current dose.*
   b. Documentation that a dose taper has been attempted within the past 6 months, with the reasons for taper failure;
4. For OHIO requests ONLY: If opioid is being prescribed concomitantly with a benzodiazepine, member meets both of the following (a and b):
   a. Documentation that the provider has acknowledged combined use of opioid medication and benzodiazepine;
   b. Prescribed for short term (< 3 months) use or provider will discontinue concurrent use of benzodiazepine and opioid therapy within a 3-month period;
      **Re-authorization request for concurrent use of opioid and benzodiazepine will not be approved.*
5. Request does not exceed health plan-approved quantity limit, if applicable.

Approval duration: 14 days

C. Long-Acting Agents OR Requests Exceeding a 14-day Supply Within 28 Days OR Requests Exceeding a 28-day Supply Within 90 Days (must meet all)**:**

1. Prescribed for the treatment of pain unrelated to cancer, palliative care, or sickle cell disease;
2. Member meets ALL of the following (a, b, and c), unless clinically significant adverse effects are experienced, or all are contraindicated:*
   ** For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*
   a. Failure ≥ 2 non-opioid ancillary treatments (e.g., non-steroidal anti-inflammatory drugs [NSAIDs], acetaminophen, anticonvulsants, antidepressants);
   b. For short-acting agent requests, one of the following (i or ii):
      i. Prescribed agent is a formulary short-acting agent that does not require PA;
      ii. Failure of an adequate trial of two formulary short-acting opioids analgesics, dosed around the clock;
   c. For long-acting agent requests, both of the following (i and ii):
      i. Except Louisiana ONLY, failure of an adequate trial of two short-acting opioids analgesics, dosed around the clock;
      ii. Failure of an adequate trial of two formulary long-acting agents*;
      **For Louisiana, if request is for an abuse deterrent formulation, substitution shall not be made to an extended-release medication that does not have defined abuse deterrent properties.*
3. For OHIO requests ONLY: Total opioid dose does not exceed 80 MME per day or for members who are stable (history of > 7 days of therapy) on doses higher than 80 MME per day, one of the following is met (a or b):
   a. Provider will initiate a dose taper;

**Future approval will require decrease from current dose.*

b. Documentation that a dose taper has been attempted within the past 6 months, with the reasons for taper failure;

4. For OHIO requests ONLY: If opioid is being prescribed concomitantly with a benzodiazepine, member meets both of the following (a and b):
   a. Documentation that the provider has acknowledged combined use of opioid medication and benzodiazepine;
   b. Prescribed for short term (< 3 months) use or provider will discontinue concurrent use of benzodiazepine and opioid therapy within a 3-month period;
5. Request does not exceed health plan-approved quantity limit, if applicable.

Approval duration:
Short-acting agents – 3 months or duration of request (whichever is less)
Long-acting agents – 12 months

D. Diabetic Peripheral Neuropathy (must meet all)**:**

1. Request is for Nucynta ER;
2. Diagnosis of diabetic peripheral neuropathy;
3. Age ≥ 18 years;
4. Failure of gabapentin at ≥ 1,800 mg/day, unless contraindicated or clinically significant adverse effects are experienced;*
   ** For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
5. Failure of a formulary tricyclic antidepressant (TCA) (e.g., amitriptyline, nortriptyline, imipramine) at up to maximally indicated doses, unless clinically significant adverse effects are experienced, or all are contraindicated;*
   ** For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
6. Failure of a formulary serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g., duloxetine, venlafaxine) at up to maximally indicated doses, unless clinically significant adverse effects are experienced, or all are contraindicated;*
   ** For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
7. For Nucynta ER requests, member must use tapentadol ER, unless contraindicated or clinically significant adverse effects are experienced;
8. Dose does not exceed 500 mg per day;
9. Request does not exceed health plan-approved quantity limit, if applicable.

Approval duration: 6 months or duration of request (whichever is less)

E. Other diagnoses/indications – Not applicable

II. Continued Therapy

Please note: For HIM-Arkansas – if a member's covered prescription pain medication requires a prior authorization, then the prior authorization shall not be denied if the member has a terminal illness.

A. Cancer, Sickle Cell Disease, Palliative Care (must meet all)**:**
1. Currently receiving prescribed agent via Centene benefit for cancer, sickle cell disease, and palliative care or have previously met initial approval criteria;
2. Request does not exceed health plan-approved quantity limit, if applicable.

Approval duration: 12 months

B. Short-Acting Agents – Requests for ≤ a 14-day Supply (must meet all):
1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. For OHIO requests ONLY: Total opioid dose does NOT exceed 80 MME/day or if the current dose is higher than 80 MME/day, one of the following is met (a, b or c):
   a. Dose reduction has occurred since previous approval;
   b. A dose taper has been attempted within the past 6 months and was not successful; **Reason(s) for taper failure must be provided*
   c. Prescribed by or in consultation with a pain management specialist;
3. For OHIO requests ONLY: If the requested dose is for > 80 MME/day, an increase in dose has not occurred since previous approval;
4. For OHIO requests ONLY: If opioid is being prescribed concomitantly with a benzodiazepine, member meets all of the following (a, b, and c):
   a. Currently receiving concurrent opioid and benzodiazepine therapy via Centene benefit or member has previously met the initial approval criteria;
   b. Documentation supports that discontinuation of combination opioid and benzodiazepine therapy has been attempted in the last 3 months without success;
   c. Prescribed by or in consultation with a pain management specialist;
5. Request does not exceed health plan-approved quantity limit, if applicable.

Approval Duration: 14 days

C. Long-Acting Agents <u>OR</u> Requests Exceeding a 14-day Supply Within 28 Days <u>OR</u> 28-day Supply Within 90 Days (must meet all):
1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Has received more than a 14-day supply of opioid within 28 days or a 28-day supply within 90 days;
   **If member does not meet this requirement, please use the initial approval criteria to review this request*
3. Member continues to need opioid analgesics as evidenced by, including but not limited to <u>any</u> of the following:
   a. Provider submits medical justification;

b. Documentation of recent (within the last 6 months) office visit or office chart notes demonstrating follow-up with the member;
c. Attestation that provider has reviewed the treatment plan with the member and assessed the risks and benefits of opioid dose and duration;

4. For OHIO requests ONLY: Total opioid dose does NOT exceed 80 MME/day or if the current dose is higher than 80 MME/day, one of the following is met (a, b, or c):
   a. Dose reduction has occurred since previous approval;
   b. A dose taper has been attempted within the past 6 months and was not successful; **Reason(s) for taper failure must be provided*
   c. Prescribed by or in consultation with a pain management specialist;
5. For OHIO requests ONLY: If the requested dose is for > 80 MME/day, an increase in dose has not occurred since previous approval;
6. For OHIO requests ONLY: If opioid is being prescribed concomitantly with a benzodiazepine, member meets all of the following (a, b, and c):
   a. Currently receiving concurrent opioid and benzodiazepine therapy via Centene benefit or member has previously met the initial approval criteria;
   b. Documentation supports that discontinuation of combination opioid and benzodiazepine therapy has been attempted in the last 3 months without success;
   c. Prescribed by or in consultation with a pain management specialist;
7. Request does not exceed health plan-approved quantity limit, if applicable.

Approval duration:
Short-acting agents – 3 months or duration of request (whichever is less)
Long-acting agents – 12 months

D. Diabetic Peripheral Neuropathy (must meet all)**:**

1. Request is for Nucynta ER;
2. Currently receiving Nucynta ER for the diagnosis of diabetic peripheral neuropathy or member has met initial approval criteria;
3. Member continues to need Nucynta ER as evidenced by, including but not limited to any of the following:
   a. Provider submits medical justification;
   b. Documentation of recent (within the last 6 months) office visit or office chart notes demonstrating follow-up with the member;
   c. Attestation that provider has reviewed the treatment plan with the member and assessed the risks and benefits of Nucynta ER;
4. For Nucynta ER requests, member must use tapentadol ER, unless contraindicated or clinically significant adverse effects are experienced;
5. If request is for a dose increase, new dose does not exceed 500 mg per day;
6. Request does not exceed health plan-approved quantity limit, if applicable.

Approval duration: 6 months or duration of request (whichever is less)

E. Other diagnoses/indications – Not applicable

III. Diagnoses/Indications for which coverage is NOT authorized – Not applicable

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
MME: morphine milligram equivalents
NSAID: non-steroidal anti-inflammatory drug
PA: prior authorization
REMS: Risk Evaluation and Mitigation Strategy
SNRI: serotonin-norepinephrine reuptake inhibitor
TIRF: transmucosal immediate-release fentanyl
TCA: tricyclic antidepressant

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): significant respiratory depression; acute or severe bronchial asthma; gastrointestinal obstruction, including paralytic ileus; hypersensitivity to the opioid active ingredient, salts, or any component of the product; concurrent use of monoamine oxidase inhibitors or use of these within the last 14 days (Nucynta ER only).
- Boxed warning(s): potential for addiction, abuse, and misuse; Risk Evaluation and Mitigation Strategy (REMS); life-threatening respiratory depression; accidental ingestion; neonatal opioid withdrawal syndrome; cytochrome P450 3A4 interactions; risks from concomitant use with benzodiazepines or other CNS depressants.

Appendix D: General Information

Opioid Oral MME Conversion Factors	
Type of Opioid (strength units)	**MME Conversion Factor**
Codeine (mg)	0.15
Dihydrocodeine (mg)	0.25
Fentanyl buccal or SL tablets, or lozenge/troche (mcg)	0.13
Fentanyl film or oral spray (mcg)	0.18
Fentanyl nasal spray (mcg)	0.16
Fentanyl patch (mcg)	7.2
Hydrocodone (mg)	1
Hydromorphone (mg)	4
Levorphanol tartrate (mg)	11
Meperidine hydrochloride (mg)	0.1
Methadone (mg)	
> 0, ≤ 20	4
> 20, ≤ 40	8
> 40, ≤ 60	10
> 60	12
Morphine (mg)	1
Opium (mg)	1

Opioid Oral MME Conversion Factors	
Oxycodone (mg)	1.5
Oxymorphone (mg)	3
Pentazocine (mg)	0.37
Tapentadol (mg)	0.4
Tramadol (mg)	0.1

Appendix E: States with Regulations against Redirections in Cancer

State	Step Therapy Prohibited?	Notes
FL	Yes	For stage 4 metastatic cancer and associated conditions
GA	Yes	For stage 4 metastatic cancer. Redirection does not refer to review of medical necessity or clinical appropriateness
IA	Yes	For standard of care stage 4 cancer drug use, supported by peer-reviewed, evidence-based literature, and approved by FDA
IN	Yes	For advanced, metastatic cancer and associated conditions
LA	Yes≠	For stage 4 advanced, metastatic cancer or associated conditions. ≠Exception if clinically equivalent therapy, contains identical active ingredient(s), and proven to have same efficacy
MS	Yes	For advanced metastatic cancer and associated conditions
NV	Yes	Stage 3 and stage 4 cancer patients for a prescription drug to treat the cancer or any symptom thereof of the covered person
OH	Yes	For stage 4 metastatic cancer and associated conditions
OK	Yes	For advanced metastatic cancer and associated conditions
PA	Yes	For stage 4 advanced, metastatic cancer
TN	Yes^	For advanced metastatic cancer, metastatic blood cancer, and associated conditions ^ Exception if step therapy is for AB-rated generic equivalent, interchangeable biologic product, or biosimilar product to the equivalent brand drug
TX	Yes	For stage 4 advanced, metastatic cancer and associated conditions

V. Dosage and Administration

There are numerous opioid analgesics, please refer to the package insert of your drug of interest for information on appropriate dosage and administration.

VI. Product Availability

There are numerous opioid analgesics, please refer to the package insert of your drug of interest for product availability information.

VII. References

1. Nucynta ER Prescribing Information. Stoughton, MA: Collegium Pharmaceutical, Inc.; December 2025. Available at: https://www.nucynta.com/. Accessed January 23, 2026.

2. Dowell D, Ragan KR, Jones CM, Baldwin GT, and Chou R. CDC clinical practice guideline for prescribing opioids for pain – United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1-95.
3. Kampman K, Jarvis M. American Society of Addiction Medicine (ASAM) national practice guideline for the use of medications in the treatment of addiction involving opioid use. J Addict Med. 2015 Sep-Oct;9(5):358-67.
4. Price R, Smith D, Franklin G, et al. Oral and topical treatment of painful diabetic polyneuropathy: Practice guideline update summary. Report of the AAN Guideline Subcommittee. Neurology 2022;98(1): 31-43.
5. American Diabetes Association Professional Practice Committee. 12. Retinopathy, neuropathy, and foot care: Standards of Care in Diabetes—2025. Diabetes Care 2025;48(Suppl. 1): S252–S265.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: no significant changes; references reviewed and updated.	11.23.21	02.22
Removed reference to HIM.PA.103; aligned step therapy verbiage in sections IA,B,C with NF criteria in HIM.PA.103; For section IB (short-acting agents), removed "requiring PA" from title; For diabetic peripheral neuropathy, revised approval duration from 180 days to 6 months for initial therapy and 30 days to 6 months for continued therapy, removed drug specific (Nucynta ER) call out in title, and moved criteria to end of sections I and II.	07.18.22	
For section IC, clarified trial and failure language for short-acting and long-acting agent requests. Template changes applied to continued therapy section.	09.06.22	
Ad hoc update added Louisiana state specific regulations to section I.C.2.C.i-ii.	11.23.22	
1Q 2023 annual review: added sickle cell disease; for continued therapy for short-acting agents changed approval duration from 7 days to 1 month; references reviewed and updated.	12.01.22	02.23
For long acting agents or request exceeding 14-day supply within 28 days or 28-day supply within 90 days section, removed disclaimer for "if member is new to Centene benefit…"; for section II.C.2 changed day supply requirement from "7-day supply of opioid in last 90 days" to "14-day supply of opioid within 28 days or 28-day supply within 90 days"; for section II.C II.D, added additional options to allow "documentation of recent (within the last 6 months) office visit or office chart notes demonstrating follow-up with the member" and "attestation that the provider has reviewed the treatment plan with the member and assessed the risks and benefits of the opioid dose and duration" to support need of opioid analgesics	03.02.23	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
for member; for cancer, sickle cell disease, palliative care, removed Ohio specific 80 MME/day requirement.		
1Q 2024 annual review: for short-acting agents changed approval duration to 14 days; references reviewed and updated.	10.19.23	02.24
2Q 2024 annual review: no significant changes; references reviewed and updated.	01.19.24	05.24
2Q 2025 annual review: added by-passing of redirection if state regulations do not allow step therapy in certain oncology settings along with Appendix E; references reviewed and updated. Added step therapy bypass for IL HIM per IL HB 5395.	04.08.25	05.25
For diabetic peripheral neuropathy, added step therapy bypass for IL HIM per IL HB 5395. For all other indications for IL HIM 5395 bypass, updated language with removal of do not apply to "formulary agents requiring PA" from statement.	06.29.25	
Added criterion that request does not exceed health plan-approved quantity limit, if applicable to all indications.	10.03.25	
2Q 2026 annual review: removed disclaimers directing to CP.PMN.127 for fentanyl IR products due to policy retirement; updated Appendix D with revised language and exception for Tennessee; references reviewed and updated. Updated Appendix E to include Indiana. Added ICHRA line of business.	03.26.26	05.26
For brand Nucynta ER, added requirement that member must use generic tapentadol ER.	05.07.26	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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