

**NC Division of Medical Assistance
 Outpatient Pharmacy
 Prior Approval Criteria
 Narcotic Analgesics**

**Medicaid and Health Choice
 Effective Date: March 4, 2002
 Amended Date: June 16, 2016**

Therapeutic Class Code: H3A,H3N

Therapeutic Class Description: Analgesics, Narcotics; Analgesics, Narcotic Agonist, NSAID
 Combination

Medication (Short Acting)	Generic Code Number(s)	NDC Number(s)
Abstral	16178, 16179, 16181-16184	
Actiq and generic	19191-19194, 19204, 19206	
codeine	16240-16242	
oxycodone and ibuprofen	23827	
Demerol and generic	15990-15991	
Dilaudid and generic	16143, 16141, 16144, 20251	
Endodan	26836	
Fentora	97280-97281, 97283-97285	
Lazanda	27648, 29146	
Levorphanol	16350	
Magnacet	97873- 97876	
Morphine	16070-16071, 16051-16053, 16060, 16062, 16063	
Nucynta	26163-26165	
Onsolis	27545-27549	
Opana and generic	27243-27244	
Oxecta (Oxaydo)	31256, 32047	
oxycodone capsules	16285	
Percocet and generic	14965-14966, 50756, 50766, 70491-70492	
Percodan and Generic	26836	
PrimLev	26953-26956	
Roxicodone and generic	16280-16281, 16290, 20091-20092	
Tylox	70500	
Subsys	31187, 31188, 31189, 31192, 31193, 31196, 31197	

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Medication (Long Acting)	Generic Code Number(s)	NDC Number(s)
Avinza	17189, 17191-17193, 16212-16213	
Belbuca	39959, 39965, 39966, 39967, 39968, 39969, 39975	
Butrans	25308-25309, 25312, 35214, 36946	
Duragesic and generic	19200-19203, 24635	
Embeda	37685, 37686, 37687, 37688, 37689, 37692	
Exalgo	28427, 33088, 33142, 33143	
Hysingla ER	37539, 37541, 37543, 37544, 37545, 37546, 37547	
Kadian	26490, 26492-26494, 97534-97535, 97508, 98135, 33158, 33159, 33162, 33164	
Nucynta ER	29787, 29788, 29789, 29791, 29792	
MS Contin and generic	16078, 16640-16643	
Opana ER	27247-27249, 27253, 99492-99494, 33915, 33916, 33917, 33918, 33919, 33832, 33833	
Oxycontin and generic	16282-16284, 16286, 99238-99240	
Dolophine and generic	16420, 16422	
Zohydro ER Capsules	35365, 35504, 35505, 35506, 35507, 35525, 38057, 38058, 38059, 38061, 38062, 38063	

Eligible Beneficiaries

NC Medicaid (Medicaid) beneficiaries shall be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

NC Health Choice (NCHC) beneficiaries, ages 6 through 18 years of age, shall be enrolled on the date of service to be eligible, and must meet policy coverage criteria, unless otherwise specified. **EPSDT does not apply to NCHC beneficiaries.**

EPSDT Special Provision: Exception to Policy Limitations for Beneficiaries under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiaries under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed clinician). This means

EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. Additional information on EPSDT guidelines may be accessed at <http://www.ncdhhs.gov/dma/epsdt/>.

A maximum of 750mg/day of morphine (or similar morphine equivalent dose for non-morphine Schedule II narcotics) may be authorized for single ingredient products. A maximum of 4gm/day of acetaminophen or aspirin may be authorized for combination products with acetaminophen or aspirin.

Exemptions: Prior authorization is not required for beneficiaries with a diagnosis of pain secondary to cancer.

Criteria

Short-Acting Non-preferred Narcotic Analgesics

- Documented failure within the past year of a 30-day trial of a preferred narcotic analgesic at a dose equivalent to the brand being prescribed. The nature of treatment failure must be clearly documented in the chart.
- OR**
- Beneficiary has a known documented contraindication to one or more of the preferred ingredients (i.e. dye).
- AND**
- Length of therapy may be approved for up to 12months.
 - Prescribing clinician has reviewed the North Carolina Medical Board statement on use of controlled substances for the treatment of pain (<http://www.ncmedboard.org/Clients/NCBOM/Public/NewsandForum/mgmt.htm>), and is adhering as medically appropriate to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate.

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Long-Acting narcotic analgesics

- Beneficiary shall have a diagnosis of chronic pain syndrome of at least four weeks duration. Length of therapy shall be approved for up to 12months.

AND

- Prescribing clinician has reviewed the North Carolina Medical Board statement on use of controlled substances for the treatment of pain (http://www.ncmedboard.org/position_statements/detail/policy_for_the_use_of_controlled_substances_for_the_treatment_of_pain/) and is adhering as medically appropriate to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate.

Non-Preferred Agents

- Documented failure within the past year of a 30-day trial of a preferred long- acting narcotic analgesic at a dose equivalent to the non-preferred narcotic analgesic being prescribed. The nature of treatment failure must be clearly documented in the chart.

OR

- Beneficiary has a contraindication or allergy to the preferred long acting narcotic analgesics.

Zohydro

- Documented failure of ALL preferred and non-preferred agents (unique product only) required before Zohydro may be utilized.

Procedures

- Changes in strength will not require prior authorization.
- Prior authorization request forms will be accepted when submitted by facsimile telecommunication methods only.

Equipotent Dosing Charts (based on morphine sulfate 750mg/day):

Description	Equipotent Dose
Fentanyl	200mcg/hr
Fentanyl Citrate	7,500 mcg/d
Hydromorphone HCl	187.5mg/d
Levophanoltartrate	25mg/d
Meperidine HCl	7,500mg/d
Methadone HCl	100mg/d
Morphine sulfate	750mg/d
Oxycodone HCl	500mg/d
Oxymorphone HCl	250mg/d

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Description	Maximum Daily Quantity based on APAP OR ASA
Oxycodone HCl/Acetaminophen 10mg-300mg tablet	13 tablets
Oxycodone HCl/Acetaminophen 10mg-325mg tablet	12 tablets
Oxycodone HCl/Acetaminophen 10mg-650mg tablet	6 tablets
Oxycodone HCl/Acetaminophen 2.5mg-300mg tablet	13 tablets
Oxycodone HCl/Acetaminophen 2.5mg-325mg tablet	12 tablets
Oxycodone HCl/Acetaminophen 5mg-300mg tablet	13 tablets
Oxycodone HCl/Acetaminophen 5mg-325mg tablet	12 tablets
Oxycodone HCl/Acetaminophen 5mg-500mg capsule	8 capsules
Oxycodone HCl/Acetaminophen 7.5mg-300mg tablet	13 tablets
Oxycodone HCl/Acetaminophen 7.5mg-325mg tablet	12 tablets
Oxycodone HCl/Acetaminophen 7.5mg-500mg tablet	8 tablets
Oxycodone HCl/Aspirin 4.8355mg-325mg tablet	12 tablets

References

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