

ALASKA MEDICAID

Morphine SR / Oxymorphone ER

Avinza[®], Kadian[®], MS Contin[®], Oramorph SR[®], Opana ER[®]
(These criteria do not apply to Oxycontin[®])

Preferred Drugs:

Kadian[®], Morphine Sulfate Tablet SA, Oramorph SR[®]

Non-Preferred Drugs:

Avinza[®]

INDICATION:

Sustained Release Oral Opioid Agonists are indicated for the management of moderate to severe intractable chronic pain when continuous around the clock analgesia is needed for a period of time greater than 10 days, or for postoperative pain, except that: **AVINZA[®]** is not indicated for postoperative use.¹ **KADIAN[®]** is only indicated for postoperative use if the patient is already receiving the drug prior to surgery or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time.² **OPANA ER[®]** is not indicated for pain in the post-operative period if the pain is mild or not expected to persist for an extended period of time.³

CRITERIA FOR APPROVAL:

1. The dispensing pharmacy may override PA for patients in hospice, or who have cancer, or who are in LTC facilities.
2. The medication must have been prescribed for the management of moderate to severe intractable chronic pain when continuous around the clock analgesia is needed for a period of time greater than 10 days. If the medication has been prescribed for the management of acute post-surgical pain, it may be approved if prescribed in accord with the indications listed in the “INDICATION” section above; **AND**
3. Treatment with at least one “first line”⁴ medication has been less than optimal, or is Inappropriate; **AND**
4. The patient can not be safely or effectively treated with a combination opioid analgesic that also contains either acetaminophen, aspirin, or ibuprofen.
5. For therapy which extends beyond 30 days, the patient must enter an “opioid agreement”, (a plan of action addressing continued medical monitoring and a written, signed agreement for therapy), with the prescriber. This agreement must include consent for random urine drug toxicology screening, and should be kept on file by the prescriber.

CRITERIA CAUSING DENIAL:

Coverage will be denied if any one or more of the following conditions are met:

1. The medication is dosed on an as needed or “PRN” schedule instead of around-the clock.
2. The average daily opioid dose from all sources exceeds an average daily morphine equivalent dose, (MED),⁵ of 360mg.
3. The patient is currently taking any other long acting opioid (including Oxycontin[®]).
4. The patient has an approved PA on file for any other long acting opioid (including Oxycontin[®]).

LENGTH OF AUTHORIZATION:

1. Coverage may be approved for up to 6 months.

DISPENSING LIMIT:

1. The dispensing limit is a 30 day supply of medication.

REFERENCES / FOOTNOTES:

¹ Avinza[®] Package Insert, available at:
<http://www.fda.gov/medwatch/safety/2005/avinza_PI.pdf>
Accessed 06/18/2007

² Kadian[®] Package Insert, available at:
<<http://www.kadian.com/pages/getfile.aspx?id=1C6197AB-8F83-43E7-B239-D4615293989B>>
Accessed 06/18/2007

³ Opana ER[®] Package Insert, available at:
<http://www.opana.com/pdfs/opana_er_pi.pdf>
Accessed 06/18/2007

⁴ Alaska Medicaid Opioid Guidelines, available on the PA page.

⁵ An opioid dose calculator can be downloaded at:
<<http://www.agencymeddirectors.wa.gov/opioiddosing.asp>>
Accessed 06/18/2007