John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

MEMORANDUM

DATE: July 3, 2017

TO: All Louisiana Medicaid Providers

FROM: Jen Steele, Medicaid Director

SUBJECT: Louisiana Fee for Service (FFS) Medicaid Short-acting Opioid 7-day Quantity Limit and MME per Day Limit

Effective July 10, 2017, the Louisiana Department of Health (LDH) Pharmacy Program in conjunction with the Louisiana Medicaid Drug Utilization Review (DUR) Board will implement new opioid policies for opioid prescription drugs reimbursed by Fee for Service (FFS) Medicaid. Short-acting opioids will be limited to a 7-day supply for opioid-naïve recipients. Also, each time an opioid prescription claim is submitted for a recipient, the Morphine Milligram Equivalent (MME) per day for all active opioid prescriptions for that recipient will be calculated. For each recipient, the cumulative daily MME for all active opioid prescriptions will be limited to a maximum of 120 MME per day.

EXEMPTIONS: Short-acting Opioid 7-day Quantity limit and MME per day
There are exemptions to the edits for quantity limits and maximum daily MME limits for opioids. All Schedule II opioid prescriptions require a valid diagnosis code to process. Pharmacy claims for opioid products will not be subject to the short-acting opioid quantity limit or the 120 MME per day limit when the recipient has a diagnosis of cancer or palliative care. The appropriate diagnosis code must be submitted at Point of Sale (POS) in **NCPDP field 424-DO**.

Diagnosis codes which will bypass short-acting opioid 7-day quantity limits and MME limits:

Diagnosis	ICD-10-CM Diagnosis Code(s)
Cancer	C00.*-C96.*
Palliative Care	Z51.5

*any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Short-Acting Opioids 7-Day Quantity Limit

Short-acting opioids will be limited to a 7-day supply for opioid-naïve recipients. For this edit, opioid-naïve recipients are defined as those who have not had an opioid claim paid within the last 90 days. Refer to the following chart for a list of the short-acting opioids and corresponding quantity limits for opioid-naïve recipients.

Pharmacy claims which exceed the quantity limit for short-acting opioids for opioid-naïve recipients will deny with:

> **NCPDP rejection code 76** (Quantity and/or days supply exceeds program maximum) mapped to
> **EOB code 062** (Quantity Exceeds Maximum – MD Fax *Opioid Analgesic Treatment Worksheet* to 1-866-797-2329.)

(See **EXEMPTIONS** to Short-acting Opioid 7-day Quantity Limit on page 1 of this memo.)

Description	Dosage Form	Units/7 days	Representative Brand
Codeine/Acetaminophen	Tablet	28	Tylenol® with Codeine
Hydrocodone/Acetaminophen	Tablet	28	Lortab®, Vicodin®
Hydrocodone/Ibuprofen	Tablet	28	Vicoprofen®
Hydromorphone HCl	Tablet	28	Dilaudid®
Meperidine	Tablet	28	Demerol®
Morphine Sulfate	Tablet	28	
Oxycodone	Tablet/ Capsule	28	Roxicodone®
Oxycodone/Acetaminophen			Endocet®, Percocet®, Roxicet®
Oxycodone/Aspirin			
Oxycodone/Ibuprofen			
Oxymorphone HCl	Tablet	28	Opana®
Tapentadol	Tablet	28	Nucynta®
Tramadol	Tablet	28	Ultram®
Tramadol/Acetaminophen			Ultracet®

Morphine Milligram Equivalent (MME) Per Day Limit
Opioid pharmacy claims causing the recipient to exceed 120 MME per day will deny with:

> **NCPDP rejection code 88** (DUR Reject Error) mapped to
> **EOB code 322** (>120 MME/day – Pharmacist Override Allowed After Review)

Authorization to override is a TWO-STEP process.

STEP 1-Pharmacist
Pharmacists are encouraged to review the recipient's opioid prescription profile and the Prescription Monitoring Program (PMP) to view the cumulative MME prior to dispensing the medication.

Authorization to override EOB code 322 may be done by the pharmacist by submitting the following codes at POS:

> **NCPDP 439-E4 field** (Reason for Service Code) – HD (High Dose)
> **NCPDP 440-E5 field** (Professional Service Code) – R0 (Pharmacist Consulted)
> **NCPDP 441-E6 field** (Result of Service Code) – 1B (Filled, Prescription As Is)

The pharmacist must document override codes on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

STEP 2-Prescriber
If the prescriber deems that it is medically necessary for the recipient to exceed the maximum 120 MME per day limit, the prescriber must complete the *Opioid Analgesic Treatment Worksheet* and fax the completed signed worksheet to the Prior Authorization Unit housed at the University of Louisiana at Monroe (ULM) at 1-866-797-2329 for clinical review.

If there is not an approved prescriber request for override, the claim will deny at POS with:

> **NCPDP rejection code 88** (DUR reject error) mapped to
> **EOB code 305** (Over 120 MME/day – MD Fax *Opioid Analgesic Treatment Worksheet* to 1-866-797-2329.)

(See **EXEMPTIONS** to MME per day limit on page 1 of this memo.)

When the pharmacist cannot reach the prescriber OR when the RxPA Center is closed (the RxPA Center is open 8am-6pm Monday through Saturday and is closed on Sunday), the pharmacist, using his/her professional judgment, may deem the filling of the prescription for these edits to be an 'emergency.' In these emergency cases, the

pharmacist must indicate 'Emergency Prescription' and document the emergency on the hardcopy prescription or in the pharmacy's electronic recordkeeping system. The pharmacist may override the pharmacy claim at POS by:

Placing '03' in NCPDP field 418-DI (Level of Service).

Please forward this notice to other providers to assist with notification. The Department's ultimate goal is to ensure appropriate and medically necessary utilization of opioids while decreasing the risk of overutilization and diversion.

Your continued cooperation and support of the Louisiana Medicaid Program efforts to coordinate care and improve health are greatly appreciated.

If you have questions about the contents of this memo, you may contact the Molina Point of Sale (POS) Help Desk (800) 648-0790 or Fee for Service (FFS) Pharmacy Help Desk at (800) 437-9101 or refer to www.lamedicaid.com.

JS/MBW/GJS

c: Healthy Louisiana Plans
Melwyn B. Wendt
Molina

Opioid Analgesic Treatment Worksheet

☐ **Aetna Better Health of Louisiana**
Fax: 1-844-699-2889
www.aetnabetterhealth.com/louisiana/providers/pharmacy

☐ **Amerigroup**
Fax: 1-888-346-0102
www.myamerigroup.com/la/pages/medicaid.aspx

☐ **AmeriHealth Caritas Louisiana**
Fax: 1-855-452-9131
www.amerihealthcaritasla.com/pharmacy/index.aspx

☐ **Fee for Service (FFS) Louisiana Legacy Medicaid**
Fax: 1-866-797-2329
www.lamedicaid.com

☐ **LA Healthcare Connections**
Fax: 1-866-399-0929
www.louisianahealthconnect.com/for-members/pharmacy-services/

☐ **UnitedHealthcare**
Fax: 1-866-940-7328
www.uhccommunityplan.com/health-professionals/la/pharmacy.html

Please fax the completed form to the appropriate plan using the designated fax number provided above.

Please note: An approval is not a guarantee of payment. All edits will apply when medication is processed at point-of-sale. Payment on a claim will only be made when the claim is billed correctly and all conditions for payment are met.

Recipient Name:	FFS / MCO ID #:	Recipient DOB:	
EPSDT Support Coordinator (Name/Address): *(optional)*	Medication Allergies:	Recipient Weight (kg):	Recipient Height (ft/in):
Prescriber Name:	Prescriber Specialty:	Medicaid Provider ID # or NPI#:	
Call-Back Phone#:	Office Fax#:	Office Contact:	
DRUG INFORMATION (one drug per request)			

Drug Name / Dosage Form:_____ Strength:_____

This medication is a PREFERRED / NON-PREFERRED Agent. (CIRCLE ONE)

If request is for a non-preferred agent, list preferred agents tried:_____
If not, explain why recipient is unable to use a preferred agent:_____
_____
_____

Is this request for medication prescribed for treatment of pain related to cancer, palliative care, or end-of-life care? _____***Yes*** _____***No***

IF NO, SKIP THIS SECTION AND CONTINUE.

If yes, FOR FFS AND AMERIHEALTH CARITAS, this form is not required. Pharmacist must enter diagnosis code at Point of Sale.
If yes, FOR ALL OTHER PLANS, STOP HERE AND complete all information above this section AND state diagnosis:_____
AND prescriber's signature:_____AND fax to appropriate plan above.

Requested medication is short-acting / long-acting. (CIRCLE ONE) Directions:_____

Quantity Requested: _____ DOES THIS EXCEED THE MAXIMUM QUANTITY LIMIT PER DAY? YES / NO (CIRCLE ONE)

Request is for: _____Initiation of therapy _____Continuation of Therapy

For continuation of therapy, is the dose currently being tapered? _____Yes _____No

If no, explain: _____

Recipient's current *CUMULATIVE* MORPHINE EQUIVALENT DOSE (MED)/DAY: _____ (include MED for medication being requested)

Note: The Louisiana Prescription Monitoring Program (PMP) provides the cumulative MED for all of the recipient's controlled medications. Information is current through the previous day (the day before the PMP is accessed).

DOES THIS EXCEED THE MAXIMUM MED ALLOWED PER DAY? YES / NO (CIRCLE ONE)

TREATMENT INFORMATION

This medication is being used for: _____acute condition _____chronic condition (check one only)

Is this medication being used for moderate to severe neuropathic pain or fibromyalgia? _____Yes _____No

Is this medication being used for postoperative pain? _____Yes _____No If yes, date of surgery:_____

Diagnoses for which the opioid is prescribed (include primary and secondary diagnoses applicable to this request, ICD code and description):

Diagnosis:_____ Diagnosis:_____
Date of Diagnosis:_____ Date of Diagnosis:_____

List other **treatments that have been tried or are currently being given** for this condition, both pharmacological and non-pharmacological:

Pharmacological Treatments

Drug / Strength	Directions	Start Date / End Date (or Current)	Reason for Discontinuation (if applicable)

Non-pharmacological Treatments

Treatment	Start Date / End Date (or Current)

For **quantity limit override OR MED override**, explain in detail the need for requested quantity/MED: _____

PRESCRIBER ATTESTATION

Please indicate YES/True or NO/False for each of the following attestations. Explanation is required for each 'NO/False' answer in order for the request to be considered for approval. For short-acting opioids, complete A – G; for long-acting opioids, complete A – L.

	YES (True)	NO (False)	THE PRESCRIBER ATTESTS TO THE FOLLOWING:
SHORT AND LONG-ACTING OPIOIDS			A. A complete **assessment** for pain and function was performed for this patient and **documentation is attached.**
			B. The patient has been **screened for substance abuse / opioid dependence** and **documentation is attached.** *(Not required for recipients in long-term care facility)*
			C. The **PMP** (Prescription Monitoring Program) will be accessed **each** time a controlled prescription is written for this patient.
			D A **treatment plan** which includes current and previous goals of therapy for both pain and function has been developed for this patient.
			E. **Criteria** for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient.
			F. **Benefits and potential harms** of opioid use have been discussed with this patient. In addition, if the patient has concurrent comorbidities or is taking medications that could potentially cause drug-drug interactions, an assessment of increased risk for respiratory depression has been completed and discussed with the patient. The risk of combining opioids with other central nervous system depressants, such as benzodiazepines, alcohol, or illicit drugs such as heroin, has also been specifically addressed. The level of risk for opioid abuse/overdose with the dose/duration prescribed to the patient has also been discussed.
			G An **Opioid Treatment Agreement** signed by both the patient and prescriber is on file. *(Not required for recipients in long-term care facility)*

LONG-ACTING OPIOIDS	YES (True)	NO (False)	THE PRESCRIBER ATTESTS TO THE FOLLOWING:
			H The patient requires continuous **around the clock** analgesic therapy for which alternative treatment options have been inadequate or have not been tolerated.
			I. Patient previously utilized at least two weeks of short-acting opioids for this condition. Please enter drug(s), dose, duration and date of trial in *Pharmacological Treatment Section* on page 1.
			J. Medication has **not** been prescribed to treat acute pain, mild pain, or pain that is not expected to persist for an extended period of time.
			K. Medication has **not** been prescribed for use as an as-needed (PRN) analgesic.
			L. Prescribing information for requested product has been **thoroughly reviewed** by prescriber.

*IF NO FOR **ANY** OF THE ABOVE (A-L), PLEASE EXPLAIN:*

THIS SECTION APPLIES TO **AETNA BETTER HEALTH OF LOUISIANA** RECIPIENTS ONLY.

Aetna

Does the Opioid Treatment Agreement include All of the following? _____Yes _____No

- Consequences of lost medication or taking more than prescribed
- Consequences of obtaining controlled substances from other prescribers
- Member agreement to only use one pharmacy

Is the request for Nucynta ER for the treatment of **diabetic peripheral neuropathy**? _____Yes _____No

- If yes, has the patient had an inadequate response or intolerance to duloxetine AND tramadol AND at least one additional formulary medication (e.g., gabapentin, amitriptyline, nortriptyline, or topical capsaicin)? _____Yes _____No
- If yes, were the trials of the formulary agents at least 4 weeks and at maximum tolerated doses? _____Yes _____No

Worksheet required for all requests / approvals. For questions only, please call 1-855-242-0802.

THIS SECTION APPLIES TO **AMERIGROUP** RECIPIENTS ONLY.

Amerigroup

For long-acting opioids, the following must also be met:

☐ Yes ☐ No	Has individual had a trial and inadequate response or intolerance to two preferred long-acting agents (preferred agents – morphine sulfate ER [specifically, generic MS Contin], fentanyl patch)?
☐ Yes ☐ No	Has individual completed titration and is already maintained on a stable dose of the requested drug?
☐ Yes ☐ No	Are the preferred long-acting opioids not acceptable due to concomitant clinical situations, such as but not limited to known hypersensitivity to any ingredient which is not also in the requested non-preferred agent?
☐ Yes ☐ No	Does individual require a non-preferred abuse deterrent agent (OxyContin, Hysingla ER, Targiniq ER, Embeda, MorphaBond, and Xtampza ER, Troxyca ER, Vantrela ER, Arymo ER) based upon a history of substance abuse disorder OR individual's family member or household resident has active substance abuse disorder or a history of substance abuse disorder?
☐ Yes ☐ No	Does individual require Butrans (buprenorphine transdermal patch) or Belbuca (buprenorphine buccal film) due to concern for abuse or dependence with pure opioid agents?

Amerigroup

Approval duration for both short-acting and long-acting opioids, if criteria above are met:

Palliative care and cancer pain: 12 months

All other pain conditions:

Initial request: 3 months

Maintenance requests: 6 months

For questions, please call 1-800-454-3730.

THIS SECTION APPLIES TO **AMERIHEALTH CARITAS** LOUISIANA RECIPIENTS ONLY.

AmeriHealth Caritas

AmeriHealth Caritas

AmeriHealth Caritas

Please note:

For short-acting opioids, if these criteria are met, the request will be approved with up to 3 months duration. For long-acting opioids, if these criteria are met, the request will be approved with up to 6 months duration. Also, if this request for is for a medication prescribed for treatment of pain related to cancer, palliative care, or end-of-life care, no further review is necessary as it will pay at POS with appropriate diagnosis code.

1. If this request is for a non-formulary opioid drug, patient must also try and fail up to 3 formulary alternatives before approving non-formulary opioids. If yes, list formulary agents tried:_____

2. For requests to exceed the quantity limits for **short-acting opioids**:
   a. Has the patient tried and failed (or is the patient currently using) 2 or more of the following:
   Non-Opioid Formulary Treatment Alternatives for Fibromyalgia or Peripheral Neuropathy
   Antidepressants: Amitriptyline, Nortriptyline, Duloxetine, Venlafaxine, Savella
   Anticonvulsants: Gabapentin capsules, Carbamazepine
   Muscle Relaxants: Baclofen, Cyclobenzaprine, Methocarbamol, Tizanidine tablets
   NSAIDs: Aspirin, Celebrex (PA required), Diclofenac, Etodolac, Ibuprofen, Indomethacin, Meloxicam, Nabumetone (PA required), Naproxen, Salsalate, Sulindac
   Non-Opioid Analgesics: Acetaminophen
   If yes, list alternatives tried:_____
   Non-Opioid Formulary Treatment Alternatives for Back Pain or Other Generalized Pain
   Muscle Relaxants: Baclofen, Cyclobenzaprine, Methocarbamol, Tizanidine tablets
   NSAIDs: Aspirin, Celebrex (PA required), Diclofenac, Etodolac, Ibuprofen, Indomethacin, Meloxicam, Nabumetone (PA required), Naproxen, Salsalate, Sulindac
   Non-Opioid Analgesics: Acetaminophen
   If yes, list alternatives tried:_____
   b. Explain medical necessity:
   _____
   _____

3. For requests for **Vicoprofen**:
   a. Diagnosis of acute pain? _____Yes _____No
   b. Documented trial and failure or intolerance to at least three of the following medications: oxycodone/acetaminophen, hydrocodone/acetaminophen, acetaminophen/codeine, morphine and hydromorphone? _____Yes _____No

4. For requests for **long-acting opioids** and/or to exceed the quantity limits for **long-acting opioids**:
   Explain medical necessity:_____
   _____
   _____

5. For requests for **Oxycontin Extended Release**:
   a. Documented trial and failure or intolerance to sustained-release morphine sulfate? _____Yes _____No
   b. Documented trial and failure or intolerance to fentanyl patches? _____Yes _____No

6. For requests to exceed the **Morphine Equivalent Dosing (MED) limits**:
   a. Explain medical necessity:_____
   b. The prescriber attests to titration of dose requested: ***If using for breakthrough pain, dose requested is 10-20% of total daily analgesic dose*** _____Yes _____No

7. Physician address:
   (Street)_____
   (City)_____(State)_____(Zip)_____

For questions, please call 1-800-684-5502.

THIS SECTION APPLIES TO **LA LEGACY FFS MEDICAID** RECIPIENTS ONLY.

FFS

Is the patient currently a resident in a long-term care facility? _____Yes _____No
If yes, provide facility name, phone number, and contact person: _____

For questions, please call 1-866-730-4357.

THIS SECTION APPLIES TO **LA HEALTHCARE CONNECTIONS** RECIPIENTS ONLY.

LA Healthcare Connections

1. If this is a non-formulary request, member must try and fail 2 formulary alternatives before non-formulary request can be considered for approval.
2. Short Term Therapy (up to a total 90 days therapy within 180 days): Member may only have 2 concurrent opioids and total opioid dose may not exceed 120 morphine equivalent dose (MED) per day. **State Mandated quantity/days' supply limits apply. **
3. Long Term Therapy (excess of 90 days therapy within 180 days): A. Member must have failed at least 2 non-opioid ancillary treatments (NSAIDS, APAP, anticonvulsants, antidepressants, etc.) B. Immediate release must be failed before extended release can be approved. C. Member may only have 2 concurrent opioids with therapy consisting of one short acting and one long acting opioid. D. Total opioid dose may not exceed 120 MED per day.
   If criteria are met, chronic pain approval duration=3 months and cancer pain, palliative care approval duration = 12 months
   **State Mandated quantity/days' supply limits apply. **
4. Request for > 2 opioid analgesics concurrently- Cancer pain/Palliative care/Sickle cell crisis - **A.** Opioid therapy must be prescribed by a specialist for sickle cell crisis pain/cancer pain/palliative care; **B.** Prescriber will be requested to discontinue opioid analgesic to meet the two (2) or less opioid limit by the following methods: 1. Addition of an extended release opioid analgesic, if not present; 2. Upward titration of existing opioids within plan allowed quantity limits; **C.** Prescriber must provide documented clinical rationale for the use of > 2 opioid analgesics concurrently instead of adding an extended release opioid or titrating/discontinuing current opioid analgesics.
   ** If criteria are met, approval duration=6 months. **
   **State Mandated quantity/days' supply limits apply. **

For questions, please call 1-888-929-3790.

THIS SECTION APPLIES TO **UNITED HEALTHCARE** NON-CANCER PAIN RECIPIENTS ONLY.

United Healthcare

Please provide defined **treatment goals**, including estimated duration of treatment:

- Treatment goals: _____
- Estimated duration of treatment: _____
- Does the treatment plan include concurrent use of a **non-opioid analgesic and/or non-pharmacologic intervention**? __Yes __No
- List other treatment interventions:

_____
_____

Does the total dose of opioid therapy **exceed the Louisiana plan quantity limit of 120 MED**? _____Yes _____No

- If "Yes", did you consult a pain specialist, defined as a prescriber with a pain management specialty designated by the American Board of Anesthesiology, or one of the following specialties: hematology, oncology, anesthesiology, neurology, or psychiatry? _____Yes ____ No
- Document prescriber specialty and total daily dose: _____

Has the patient demonstrated meaningful improvement in pain and function using a validated instrument (e.g. Brief Pain Inventory)?
_____Yes _____No

- Score: _____
- Instrument used: _____

Rationale for not tapering and discontinuing opioid treatment:

_____
_____
_____

If the request **exceeds the quantity limit**, document rationale for the requested quantity and/or for exceeding the Louisiana Health Plan approved limit: _____

If the request is for **Oxymorphone ER-non crush resistant (generic) or Zohydro ER**, is there a clinical reason why a preferred agent cannot be used (preferred long-acting agents: morphine sulfate controlled release tablets (generic of MS Contin), fentanyl transdermal)?
_____Yes _____No

- If yes, explain: _____

If the request is for a **non-preferred agent**, is there a clinical reason why a preferred agent cannot be used (Preferred agents: morphine sulfate controlled release tablets (generic of MS Contin) and fentanyl transdermal. Preferred agents with Step Therapy: oxymorphone ER non-crush resistant (generic) and Zohydro ER)? _____Yes _____No

- If yes, explain: _____
  _____

If the request is for **tramadol ER capsules or tablets**, is there a clinical reason why preferred alternatives cannot be used (preferred alternatives include opioid and non-opioid analgesics):

- _____If yes, explain: _____
- _____If no, list preferred alternatives previously tried (document dose, dates of therapy and rationale for discontinuation): _____

If the medication is being prescribed for **moderate to severe neuropathic pain or fibromyalgia**, complete the two questions below:

- Has the patient not exhibited an adequate response to eight weeks of treatment with gabapentin titrated to a therapeutic dose? _____Yes ____No If "Yes", document duration and date of trial: _____
- Has the patient not exhibited an adequate response to at least six weeks of treatment with a tricyclic antidepressant titrated to a therapeutic dose?
  _____Yes _____No If "Yes", document duration and date of trial: _____

If the medication is being prescribed for **post-operative pain**, complete the two questions below:

- Is the patient already receiving chronic opioid therapy prior to surgery? _____Yes _____No
- Is the post-operative pain expected to be moderate to severe and persist for an extended period of time?
  _____Yes _____No

For questions, please call 1-800-310-6826.

Opioid overdose reversal medications are a covered benefit. Prior authorization is not required for some products. CDC guidelines recommend offering naloxone to patients at increased risk of overdose, defined as: history of overdose or substance use disorder, doses ≥ 50 MED /day, or concurrent use with benzodiazepines. Please refer to the appropriate FFS/MCO Preferred Drug List for preferred products.

I certify that the benefits of opioid treatment for this patient outweigh the risks of treatment and that the information provided herein is true and accurate to the best of my knowledge and may be subject to a routine audit requesting the medical information necessary to verify the accuracy of the information provided.

Prescriber's Signature: _____Date:_____