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

Approval Date: November 21, 2024

Medications

Brand Names	Generic Names	Available Dosages	Abuse-Deterrent Formulation
Belbuca®	buprenorphine buccal	75, 150, 300, 450, 600, 750, 900 mcg buccal film	No
Butrans®	buprenorphine transdermal	5, 7.5, 10, 15, 20 mcg/hr patches	No
Duragesic® (brand no longer available)	fentanyl transdermal	12, 25, 37.5, 50, 62.5, 75, 87.5, 100 mcg/hour patches	No
Hysingla® ER	hydrocodone ER	20, 30, 40, 60, 80, 100, 120 mg tablets	Yes
Zohydro® ER (brand no longer available)	hydrocodone ER	10, 15, 20, 30, 40, 50 mg capsules	No
Exalgo® (brand no longer available)	hydromorphone ER	8, 12, 16, 32 mg tablets	No
MS Contin®	morphine sulfate CR	15, 30, 60, 100, 200 mg tablets	No
Kadian® (brand no longer available)	morphine sulfate ER	10, 20, 30, 50, 60, 80, 100 mg capsules	No
Avinza® (brand no longer available)	morphine sulfate extended-release	30, 45, 60, 75, 90, 120 mg capsule	No
OxyContin®	oxycodone CR	10, 15, 20, 30, 40, 60, 80 mg tablets	Yes
Xtampza ER®	oxycodone extended-release	9, 13.5, 18, 27, 36 mg capsules	Yes

Brand Names	Generic Names	Available Dosages	Abuse-Deterrent Formulation
Opana® ER (brand no longer available)	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® (brand no longer available)	tramadol ER	100, 200, 300 mg tablets	No

Criteria for Approval

Hospice patients and end-of-life patients are exempt from prior authorization. Patients with pain associated with cancer or sickle cell disease are exempt from prior authorization.

1. Patient is ≥ 18 years of age who requires management of severe, persistent pain with a continuous around-the-clock analgesic for at least 10 days; **AND**
2. Patient has tried and failed or is not a candidate for at least 3 of the following:
   a. Topical nonsteroidal anti-inflammatory drugs (NSAIDs)
   b. Oral NSAIDS
   c. Oral acetaminophen
   d. Transcutaneous electrical nerve stimulation; **AND**
3. Failure on two other opioids for pain treatment for which the requested long-acting opioid is indicated; **AND**
4. Attestation that the New Hampshire Prescription Drug Monitoring Program (PDMP) has been reviewed within the last 60 days; **AND**
5. Confirmation that patient has a written pain agreement; **AND**
6. 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 and 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

Reviewed by	Reason for Review	Date Approved
DUR Board	Revision	12/15/2020
Commissioner Designee	Approval	02/24/2021
DUR Board	Revision	06/02/2022
Commissioner Designee	Approval	07/12/2022
DUR Board	Revision	06/19/2023
Commissioner Designee	Approval	06/29/2023
DUR Board	Revision	10/15/2024
Commissioner Designee	Approval	11/21/2024