New Hampshire Medicaid Fee-for-Service Program

Methadone (Pain Management Only) Criteria

Approval Date: January 22, 2024

Indication

Management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Medications

Brand Name	Generic Name	Dosage Strengths
Methadone®, Diskets®	methadone	Solution, oral: 10 mg/5 mL; 5 mg/5 mL; Tablet, oral: 5 mg, 10 mg

Criteria for Authorization

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. Patient has documented failure on two other opioids with same Food and Drug Administration (FDA) indication for pain management; **AND**
4. Attestation that the New Hampshire Prescription Drug Monitoring Program (PDMP) has been reviewed within the last 60 days; **AND**

5. Attestation that the prescriber has reviewed with the patient the risks associated with continuing high-dose opioids; **AND**
6. Confirmation that patient has a written pain agreement; **AND**
7. Attestation that the prescriber has discussed with the patient to attempt to taper the dose slowly at an individualized pace; **AND**
8. Attestation that the prescriber is monitoring the patient to mitigate overdose risk; **AND**
9. Confirmation that the patient will be prescribed concurrent naloxone.

Criteria for Denial

1. Failure to meet criteria for authorization; **OR**
2. History of severe asthma or other lung disease; **OR**
3. Concurrent long-acting opioid; **OR**
4. Concurrent benzodiazepine, sedative hypnotics, or barbiturates.

Initial approval period: Six months

Continued approval: Six months, provided there is documentation that patient continues to be assessed for pain control

Dispensing Limits: 150 mg/day

References

Available upon request.

Revision History

Reviewed by	Reason for Review	Date Approved
DUR Board	New	05/31/2016
Commissioner	Approval	06/18/2016
DUR Board	Update	09/27/2018
Commissioner Designee	Approval	11/27/2018
DUR Board	Update	10/28/2019
Commissioner Designee	Approval	12/03/2019
DUR Board	Update	12/15/2020
Commissioner Designee	Approval	02/24/2021
DUR Board	Revision	06/02/2022
Commissioner Designee	Approval	07/12/2022
DUR Board	Revision	12/08/2023
Commissioner Designee	Approval	01/22/2024