

Clinical Policy: Narcotic Quantity Limits

Reference Number: CP.HNMC.123

Effective Date: 11.16.16

Last Review Date: 01.18.17

Line of Business: Medicaid – Medi-Cal

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Narcotic Quantity Limits are applied to requests for quantities that exceed the limits set by the health plan.

FDA approved indication

- Varies by drug product

Policy/Criteria

Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of health plans affiliated with Centene Corporation® that Narcotics exceeding the quantity limits are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Requests for quantities of narcotics which exceed the limits set by the health plan (must meet all):

1. Diagnosis of one of the following:
 - a. Cancer pain;
 - b. End-stage medical conditions accompanied by significant pain;
 - c. Pain for which there is a documented, objective etiology;
2. For pain with a documented, objective etiology (a or b):
 - a. Documentation that the patient is being managed under a pain medication contract signed by both the provider and the patient individually and dated within the year;
 - b. Patient resides in a Skilled Nursing Facility (SNF) or Long Term Care (LTC) facility;
3. For a non-formulary drug, failure or clinically significant adverse effect to two or more formulary alternatives (or one if only one is available) that are FDA approved or standard pharmacopeias (e.g., DrugDex) support efficacy and safety for the requested indication.

Approval duration:

- **Cancer Pain:** Length of Benefit
- **End-stage medical conditions accompanied by significant pain:** Length of Benefit
- **LTC Facility Resident:** Length of Benefit
- **All other diagnoses:** Up to 1 year

B. Other diagnoses/indications

1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized)

II. Continued Therapy

A. Requests for quantities of narcotics which exceed the limits set by the health plan (must meet all):

1. Currently receiving medication via health plan benefit or member has previously met initial approval criteria;
2. For all other diagnoses excluding cancer pain, end-stage medical conditions accompanied by significant pain, and LTC facility residents: Documentation of a new pain medication contract is required every year.

Approval duration: Up to one year

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via health plan benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 12 months (whichever is less); or

2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized)

III. Diagnoses/Indications for which coverage is NOT authorized:

- A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

N/A

Appendix B: General Information

N/A

Appendix C: Therapeutic Alternatives

N/A

V. Dosage and Administration

Various Narcotics		
Indication	Dosing Regimen	Maximum Dose
Varies	Varies	Varies

VI. Product Availability

Drug	Availability
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VII. References

1. Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain 6th Edition; American Pain Society 2008.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Converted to new template; minor changes to verbiage and grammar. References updated.	01.18.17	11.17
Clarify requirement for pain contract or SNF/LTC applies only to pain with a documented, objective etiology.	05.10.18	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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