



AETNA BETTER HEALTH®  
Coverage Policy/Guideline

Name: Immediate-Release Opioid Analgesic Duration of Therapy and Quantity Limits Page: 1 of 4

Effective Date: 5/28/2025 Last Review Date: 5/2025

Applies to:  Illinois  Florida  Florida Kids  
 New Jersey  Maryland  Michigan  
 Pennsylvania Kids  Virginia  KY PRMD

### Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for immediate-release opioid analgesics under the patient's prescription drug benefit.

### Description:

The intent of the criteria is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines for immediate-release opioid analgesics. All immediate-release opioid analgesics are limited to a maximum 5-day supply and other quantity limits. The American Pain Society Opioid Treatment Guidelines state that a reasonable definition for high dose opioid therapy is greater than 200 mg daily of oral morphine (or equivalent). Requests to exceed these limits and those for any non-preferred product are subject to the criteria in this policy. Medications requested for more than 200 Morphine Milligram Equivalents (MME) per day will require a Medical Director Review.

### Applicable Drug List:

#### **Immediate-Release Opioid Analgesics**

Codeine sulfate tablets  
Hydromorphone hydrochloride oral solution, suppositories, tablets  
Levorphanol tartrate tablets  
Meperidine hydrochloride oral solution, tablets  
Morphine sulfate oral solution, oral solution concentrate, suppositories, tablets  
Oxycodone hydrochloride capsules, oral solution, oral solution concentrate, tablets  
Oxymorphone hydrochloride tablets  
Pentazocine/naloxone tablets  
Tapentadol tablets  
Tramadol hydrochloride oral solution, tablets

#### **Acetaminophen/Aspirin/Ibuprofen Containing Opioid Analgesics**

Acetaminophen and benzhydrocodone  
Acetaminophen and codeine  
Acetaminophen and hydrocodone  
Acetaminophen and oxycodone  
Acetaminophen and tramadol  
Acetaminophen, caffeine, and dihydrocodeine  
Aspirin and oxycodone  
Celecoxib and tramadol  
Ibuprofen and hydrocodone



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	<input type="checkbox"/> New Jersey	<input type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input type="checkbox"/> KY PRMD

**Policy/Guideline:**

**The requested drug will be covered with prior authorization when the following criteria are met:**

- The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through hospice or palliative care  
**AND**
- If the request is for a non-preferred product, the patient is unable to take 2 formulary alternatives for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

**OR**

- The patient can safely take the requested dose based on their history of opioid use. [Note: The lowest effective dosage should be prescribed for opioid naïve patients.]  
**AND**
- The patient has been evaluated and the patient will be monitored regularly for the development of opioid use disorder

**AND**

- The requested drug is being prescribed for CHRONIC pain severe enough to require an opioid analgesic. [Note: Chronic pain is generally defined as pain that typically lasts greater than 3 months.]

**AND**

- The patient’s pain will be reassessed in the first month after the initial prescription or any dose increase **AND** every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety

**OR**

- The patient requires extended treatment beyond 5 days for ACUTE pain severe enough to require an opioid analgesic. [NOTE: Many acute pain conditions (e.g., the pain that occurs with a number of surgical procedures or acute musculoskeletal injuries) require no more than a few days of an opioid analgesic.]

**AND**

- If the request is for a non-preferred product, the patient is unable to take 2 formulary alternatives for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

Quantity Limits may apply.



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### Approval Duration and Quantity Restrictions:

For pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through hospice or palliative care: Approve 12 months

Chronic Pain: Approve 6 months

Acute pain: Approve 1 month

**Quantity Level Limit:** Reference Formulary for drug specific quantity level limits

### References:

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7. Morphine Sulfate 10 mg/5 mL, 20 mg/5 mL, 100 mg/5 mL (20 mg/mL) oral solution [package insert]. Berkeley Heights, NJ: Hikma Pharmaceuticals USA Inc.; December 2023.
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