



DRUG QUANTITY MANAGEMENT POLICY – MORPHINE MILLIGRAM EQUIVALENT

POLICY: Opioids – Morphine Milligram Equivalent (90) Drug Quantity Management Policy

Note: This is not an inclusive list. As new products become available, they will roll into this policy and the list will be updated periodically.

- Benzhydrocodone combination oral tablets
- Butorphanol injectable, nasal solution
- Codeine oral tablets, combination product oral tablets/capsules, combination product oral solution
- Dihydrocodeine combination oral tablets/capsules
- Fentanyl transmucosal lozenges, buccal tablets, nasal solution, sublingual spray, injectable, transdermal patches
- Hydrocodone oral tablets/capsules, combination product oral tablets, combination product oral solution
- Hydromorphone injectable, oral tablets, oral solution, rectal suppositories
- Levorphanol oral tablets
- Meperidine oral tablets, oral solution, injectable
- Methadone oral tablets, tablets for oral suspension, oral solution, injectable
- Morphine oral capsules/tablets, oral solution, injectable, rectal suppositories
- Nalbuphine injectable
- Oliceridine injectable
- Opium/belladonna rectal suppositories
- Oxycodone oral tablets/capsules, oral solution, combination product oral tablets, combination product oral solution
- Oxymorphone oral tablets
- Pentazocine/naloxone oral tablets
- Tapentadol oral tablets
- Tramadol oral capsules/tablets, oral solution, combination product oral tablets

REVIEW DATE: 03/05/2024

INSTRUCTIONS FOR USE

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EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Use of morphine milligram equivalents (MME) as a method to assess opioid-associated risk based on overall daily opioid dose has been cited in the professional literature and pain guidelines.¹ There is not one universally accepted MME per day that has been found to represent the dose at which a patient is at the greatest risk for adverse events (AEs). However, there is general consensus that as opioid doses are increased, the risk of AEs also increases. Additional guideline information is summarized below. Of note, the Centers for Medicare and Medicaid Services (CMS) require plan sponsors to implement a point-of-service safety edit at 90 MME and recommend a hard safety edit at a threshold of 200 MME.²

Guidelines

In 2022, the **Centers for Disease Control and Prevention (CDC)** published an updated guideline for prescribing opioids for pain.¹ Nonopioid therapies are at least as effective as opioids for many common types of acute pain, and nonopioid therapies are preferred for subacute and chronic pain. Clinicians should maximize the use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Multiple noninvasive nonpharmacologic interventions (e.g., aerobic, aquatic, or resistance exercises, weight loss, psychological therapy, spinal manipulation, low-level laser therapy, massage, mindfulness-based stress reduction, yoga, tai chi, qigong, acupuncture, cognitive behavioral therapy, and spinal manipulation) are associated with improvements in pain, function, or both, that are sustained after treatment and are not associated with serious harms. Non-opioid drugs (e.g., tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitor [SNRI] antidepressants, duloxetine, selected antiseizure medications (e.g., pregabalin, gabapentin, oxcarbazepine), capsaicin and lidocaine patches, and nonsteroidal anti-inflammatory drugs [NSAIDs]) are associated with small to moderate improvements in chronic pain and function for certain chronic pain conditions.

Before initiating opioid therapy for patients with pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy.¹ Before starting ongoing opioid therapy for patients with subacute or chronic pain, clinicians should work with patients to establish treatment goals for pain and function and consider

how opioid therapy will be discontinued if benefits do not outweigh risks. When opioids are initiated, clinicians should prescribe the lowest effective dosage of immediate-release opioids for no longer than needed for the expected duration of pain severe enough to require opioids. During ongoing opioid therapy, clinicians should collaborate with patients to evaluate and carefully weigh the benefits and risks of continuing opioid therapy and exercise care when increasing, continuing, or reducing opioid dosage. While they do not make specific dosing recommendations, it is noted that many patients do not experience additional pain reduction or improved function from increasing their opioid dose to ≥ 50 MME per day, but they are exposed to progressive increased risks. Therefore, before increasing a patient's dose to ≥ 50 MME per day, clinicians should pause and reassess the individual patient's benefits and risks. Guidelines also note that few trials have evaluated doses ≥ 90 MME per day.

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate the risk for opioid-related harms and should work with patients to incorporate relevant strategies to mitigate risk, including offering naloxone and reviewing potential interactions with any other prescribed medications or substances used.¹ When prescribing initial opioid therapy and periodically during opioid therapy, clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose. When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances.

The 2020 **American Society of Hematology** guideline for the management of acute and chronic pain in patients with sickle cell disease states that pain causes significant morbidity for those living with sickle cell disease and manifests as acute intermittent pain, chronic daily pain, and acute-on-chronic pain.³ For adults and children with chronic pain who are receiving chronic opioid therapy, are functioning well, and have perceived benefit, the guideline suggests shared decision making for continuation of chronic opioid therapy. For adults and children with chronic pain who are receiving chronic opioid therapy, are functioning poorly, or are at high risk for aberrant opioid use or toxicity, the guideline suggests against continuation of chronic opioid therapy.

POLICY STATEMENT

This Drug Quantity Management program has been developed to prevent stockpiling, misuse and/or overuse of opioids.

The MME (90) DQM policy works in combination with the MME (200) DQM policy. A quantity of each opioid medication referenced in this policy is limited to 30 days and will be covered without prior authorization if there are no other opioid claims for the same chemical. A total quantity of opioid up to a morphine milligram equivalent of 90 per day is allowed with a quantity limit.

A MME is calculated for each patient's opioid prescription claim using the appropriate conversion factor associated with the opioid product for the claim. After converting the patient's opioid medications to their MME, the patient's cumulative prescription opioid daily dose (the MME per day) is calculated to determine if the member exceeded the 90 MME threshold. If a prescription will cause the patient to exceed the cumulative daily MME threshold of 90, then it will be rejected and additional coverage will be determined by the Criteria below. All approvals are provided for 1 year in duration, unless otherwise noted.

Note: This policy includes multiple formulations of the medications listed on page 1; the list is not inclusive. As new products become available, they will roll into this policy and the list will be updated periodically. Opioid cough and cold products are excluded from the calculations of the daily MME. Only new users of opioids are targeted by this policy. Point of sale alerts also manage the quantity of opioid product distribution. Those point of sale alerts occur prior to any Utilization Management edits.

Opioids – Morphine Milligram Equivalent (90) Drug Quantity Management Policy product(s) is(are) covered as medically necessary when the following criteria is(are) met. Any other exception is considered not medically necessary.

CRITERIA

- 1.** Approve the quantity requested, not to exceed 200 morphine milligram equivalents (MME) daily for up to 1 year, if the patient meets ONE of the following (A, B, C, or D):
 - A)** Patient has a cancer diagnosis; OR
 - B)** Patient is in a hospice program, end-of-life care, or palliative care; OR
 - C)** Patient meets BOTH of the following criteria (i and ii):
 - i.** Patient has a diagnosis of sickle cell disease; AND
 - ii.** Medication is prescribed by or in consultation with a hematologist; OR
 - D)** Patient meets ALL of the following (i, ii, iii, iv, and v):
 - i.** Non-opioid therapies have been optimized and are being used in conjunction with opioid therapy, according to the prescriber; AND
Note: Examples of non-opioid therapies include non-opioid medications (e.g., nonsteroidal anti-inflammatory drugs, tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitors, antiseizure medications), exercise therapy, physical therapy, weight loss, and cognitive behavioral therapy.
 - ii.** Patient's history of controlled substance prescriptions has been checked using the state prescription drug monitoring program (PDMP), according to the prescriber; AND
 - iii.** Risks (e.g., addiction, overdose) and realistic benefits of opioid therapy have been discussed with the patient, according to the prescriber; AND
 - iv.** Need for a naloxone prescription has been assessed and naloxone has been ordered, if necessary, according to the prescriber; AND

- v. Need for periodic toxicology testing has been assessed and ordered, if necessary, according to the prescriber.

Note: A morphine milligram equivalent calculator can be found at: <https://www.mdcalc.com/calc/10170/morphine-milligram-equivalents-mme-calculator>.

REFERENCES

1. Dowell D, Ragan KR, Jones CM, et al. CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022. *MMWR Recomm Rep.* 2022;71(3):1-95.
2. Announcement of calendar year (CY) 2019 Medicare Advantage capitation rates and Medicare Advantage and Part D payment policies and final call letter. The Centers for Medicare and Medicaid Services. Available at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf>. Accessed January 29, 2024.
3. Brandow AM, Carroll CP, Creary S, et al. American Society of Hematology 2020 guidelines for sickle cell disease: management of acute and chronic pain. *Blood Adv.* 2020;4(12):2656-2701.

HISTORY

| Type of Revision | Summary of Changes | Review Date |
|-----------------------|--|-------------|
| Early Annual Revision | <p>A note was added to state “Point of sale alerts also manage the quantity of opioid product distribution. Those point of sale alerts occur prior to any Utilization Management edits.”</p> <p>New override criteria were added to approve the quantity requested if the patient has a diagnosis of sickle cell disease and the medication is prescribed by or in consultation with a hematologist. Added criterion that the need for a naloxone prescription has been assessed and naloxone has been ordered, if necessary, according to the prescriber. Added criterion that the need for periodic toxicology testing has been assessed and ordered, if necessary, according to the prescriber.</p> | 02/01/2023 |
| Annual Revision | <p>Fentanyl sublingual tablets were removed from the policy (obsolete).</p> <p>Methadone tablets for oral suspension, oliceridine injectable, opium/belladonna rectal suppositories were added to the policy document (as they rolled into the policy since the last update).</p> | 03/05/2024 |

APPENDIX A

Note: This list is not inclusive. As new STCs become available, they will roll into this policy and the list will be updated periodically.

| STC* | STC Description |
|------|--|
| 0470 | ANTINEOPLASTIC - ALKYLATING AGENTS |
| 0471 | ANTINEOPLASTIC - ANTIMETABOLITES |
| 0472 | ANTINEOPLASTIC - VINCA ALKALOIDS |
| 0473 | ANTIBIOTIC ANTINEOPLASTICS |
| 0475 | ANTINEOPLASTICS,MISCELLANEOUS |
| 6323 | ANTINEOPLASTIC - ANTIANDROGENIC AGENTS |
| 7235 | ANTINEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES |
| 7977 | ANTINEOPLASTIC IMMUNOMODULATOR AGENTS |
| 8254 | ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPR. |
| 8460 | ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS |
| 8569 | ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY |
| 8585 | ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY |
| 9150 | ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS |
| B759 | ANTINEOPLAST,HISTONE DEACETYLASE (HDAC) INHIBITORS |
| C232 | ANTINEOPLASTIC - MTOR KINASE INHIBITORS |
| C370 | ANTINEOPLASTIC - EPOTHILONES AND ANALOGS |
| C532 | ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS |
| C593 | ANTINEOPLASTIC - AROMATASE INHIBITORS |
| D426 | ANTINEOPLASTIC - IMMUNOTHERAPY, THERAPEUTIC VAC |
| D560 | ANTINEOPLASTIC - MICROTUBULE INHIBITORS |
| D687 | CYTOTOXIC T-LYMPHOCYTE ANTIGEN(CTLA-4)RMC ANTIBODY |
| E039 | ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS |
| E150 | ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR |
| E600 | ANTINEOPLASTIC - VEGF-A,B AND PLGF INHIBITORS |
| F495 | ANTINEOPLASTIC-INTERLEUKIN-6(IL-6)INHIB,ANTIBODY |
| F501 | ANTINEOPLASTIC - VEGFR ANTAGONIST |
| F665 | ANTINEOPLASTIC,ANTI-PROGRAMMED DEATH-1 (PD-1) MAB |
| G545 | ANTINEOPLASTIC - IMMUNOTHERAPY, VIRUS-BASED AGENTS |
| G575 | ANTINEOPLASTIC - MEK1 AND MEK2 KINASE INHIBITORS |
| G590 | ANTINEOPLASTIC - ANTI-CD38 MONOCLONAL ANTIBODY |
| G607 | ANTINEOPLASTIC - ANTI-SLAMF7 MONOCLONAL ANTIBODY |
| G802 | ANTINEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS |
| G857 | ANTI-PROGRAMMED CELL DEATH-LIGAND 1 (PD-L1) MAB |
| H214 | ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT |
| H289 | ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS |
| H309 | ANTINEOPLASTIC - ANTIBIOTIC AND ANTIMETABOLITE |
| H317 | ANTINEOPLASTIC- CD22 ANTIBODY-CYTOTOXIC ANTIBIOTIC |
| H324 | ANTINEOPLASTIC - CAR-T CELL IMMUNOTHERAPY |
| H329 | ANTINEOPLASTIC- CD33 ANTIBODY-CYTOTOXIC ANTIBIOTIC |
| H617 | ANTINEOPLASTIC - BRAF KINASE INHIBITORS |
| H768 | ANTINEOPLASTIC-CD22 DIRECT ANTIBODY/CYTOTOXIN CONJ |
| H868 | ANTINEOPLASTIC-CD123-DIRECTED CYTOTOXIN CONJUGATE |
| I054 | ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE) |
| I264 | ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT |
| I482 | ANTINEOPLASTIC - CD19 (B LYMPHOCYTE) MC ANTIBODY |
| I738 | ANTINEOPLASTIC - EGFR AND MET RECEPTOR INHIB, MAB |
| I746 | ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR |
| I832 | ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH |
| I938 | ANTINEOPLASTIC - IMMUNOTHERAPY, T-CELL ENGAGER |
| I996 | ANTINEOPLASTIC-IMMUNOTHERAPY CHECKPOINT INHIB COMB |
| J253 | ANTINEOPLASTIC - GENE THERAPY AGENTS |

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| J521 | ANTINEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB |
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* Excluding topical products

APPENDIX B

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| ICD-10 Codes |
| Cancer-related codes |
| C00.* to D09.* |
| D3A.* to D48.* |
| E34.0* |
| Q85.0* |

* Indicates the inclusion of subheadings.

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