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Applying the opioid policy to various prescribing situations

1. Prescription within the limits

Example 1

You are seeing a 17-year-old patient for extraction of an impacted wisdom tooth. You write a prescription for hydrocodone/APAP 5/500, ½-i PO Q4H PRN pain, #15. The patient has not received any opioids in the previous 90 days. At the pharmacy, the prescription is processed and accepted.

- Prescription is under the #18 max for a patient under 21, so this is within limits.
- Patient receives #15.

Example 2

You are seeing a 55-year-old patient recently discharged with a severe skin wound. You write a prescription for acetaminophen with codeine (Tylenol #3) i PO Q4H PRN pain, #40. The patient has not received any opioids in the previous 90 days. At the pharmacy, the prescription is processed and accepted.

- Prescription is under the #42 max for a patient 21 and older, so this is within limits.
- Patient receives #40.

2. Prescription beyond the limits

Example 3

You are seeing a 12-year-old patient with a severe ankle sprain. You write a prescription for hydrocodone/APAP 5/325 mg, i PO Q4H PRN pain for #40 without an exemption. The patient has not received any opioids in the previous 90 days. At the pharmacy, the prescription is processed and notifies pharmacist that prescription is above quantity supply limit.

- Prescription is over the #18 max for a patient under 21, so this is over the limit.
- Pharmacist can process claim and dispense #18 to the patient. The pharmacist calls your office to notify you that only a partial fill of a CII was dispensed to patient.
 - If you feel #18 is adequate, no further action is needed.
 - If you are available at the time of call and feel the higher total is medically justified, you can give a verbal “exempt” order to the pharmacist. The pharmacist will document that on the prescription and be able to process it for #40.
 - If you’re not available to provide a verbal exemption, you would need to write a second prescription (within 30 days of the first) for the additional pills. On the second prescription, write “exempt” if the total of the two prescriptions is above the limit.

3. Expedited authorization

Example 4

You are seeing a 15-year-old who was hit by a car while riding his bicycle and fractured his leg, casted in the ER. He also has extensive soft tissue injuries and a lot of pain. You write a prescription for oxycodone 5mg i PO Q4H PRN pain, #40, and type “Exempt” in the notes section of the prescription to indicate you believe this is a necessary amount to treat the patient’s medical condition.

Continued

The patient has not received any opioids in the previous 90 days. At the pharmacy, the prescription is processed and the pharmacy enters in the code for the exemption via expedited authorization.

- Prescription is over the #18 max for a patient under 21, but is authorized under the “exempt” process.
- Patient receives #40.

Example 5

You’re treating an elderly woman who has fallen and has a non-surgical pelvic fracture with severe pain. The orthopedist indicates no intervention is appropriate, but pain is expected to last 3-4 months. You prescribe hydrocodone/APAP 5/325, ½-i q 4-6 hours PRN, #90, and type EXEMPT in the notes section of the prescription. The patient has not received any opioids in the previous 90 days. At the pharmacy, the prescription is processed and the pharmacy enters in the code for the exemption via expedited authorization.

- Prescription is over the #42 max for a patient over 21, but is authorized under the “exempt” process.
- Patient receives #90.

One week later, your elderly patient with the nonsurgical pelvic fracture returns. She reports the hydrocodone/APAP works great for a few hours. However, she is waking up in the middle of the night with severe pain, and requests something that will last longer overnight. You prescribe slow-release oxycodone 5mg #30, i po QHS. You typically don’t use long-acting preparations early in a treatment course but in this case you feel it is appropriate, so you write EXEMPT in the notes section of the prescription. At the pharmacy, the prescription is processed and the pharmacy enters in the code for the exemption via expedited authorization.

- Long-acting opioids are not typically approved for acute use, but this prescription is authorized under the “exempt” process.
- Patient receives slow-release oxycodone 5 mg #30.

Example 6

A 62-year-old woman presents to you with a 3-month history of progressive weight loss and right upper quadrant pain. A CT reveals widely metastatic pancreatic cancer. She is debating attempting aggressive treatment vs. hospice care. You prescribe OxyContin 10mg QHS and oxycodone 5 mg, #180, i-ii po q 2-4 hours as needed for cancer pain.

- Patient has a diagnosis of malignancy; limits including pill numbers and acute use of long-acting opiates do not apply. This would also be true for a patient in hospice for any diagnosis. You do not need to write “exempt” on the prescription, but you should write that this is being prescribed for cancer pain or hospice.
- Patient receives meds as written.

4. Prior authorization following 6 weeks of opioid therapy

Example 7

You have a 55-year-old patient with chronic pelvic pain. She’s had extensive workup without revealing a cause. She has an upcoming two-week family reunion, so you reluctantly prescribe #40 of hydrocodone/APAP 5/325 to “get her through” the event. She sees your partner three weeks later for follow up when you are out, reports that it worked great and she feels terrific, and gets a refill. She requests a third refill.

- When a refill is requested beyond 6 weeks of therapy, prior authorization is required. The PA consists of an attestation form, attesting that best practices are being followed for the transition from acute to chronic opioid use.

- If you feel that chronic opioid use is the best option for this patient, you will need to document in the chart that best practices are being followed. These include appropriate use of non-narcotic medications and therapies; checking the PDMP; using a pain contract; educating the patient about the risks of chronic narcotic use; periodic urine drug screens; etc. You do not need to send documentation of these elements for the PA, but they should be documented in the chart in case of an audit. You sign the attestation and send it in, and the prescription is approved.
- Alternatively, you may feel that chronic opioid therapy is not the best option for this patient's care. In this case, the policy creates a structural opportunity to discuss with the patient that chronic opioid therapy for this condition may not be supported by data and guidelines, and what alternatives might be more appropriate.

Example 8

Your elderly patient with the pelvic fracture is improving slowly, but she continues to have pain at night that is unresponsive to APAP. Her first prescription goes through under the "EXEMPT" process, but the with the second prescription for slow-release oxycodone 5 mg #30, i PO QHS, you receive a call that she is going beyond 42 days of treatment, and a prior authorization is required for her to receive the full supply. You review the attestation form. You check the PDMP, and discover that her psychiatrist is prescribing 2 mg clonazepam QHS; you call them to discuss reducing the dose. You feel certain elements of the "best practices" are not applicable to her case (i.e., you do not feel urine drug testing is appropriate since she's very low risk), and you document why in her chart. You sign the attestation.

- After 6 weeks/42 days of narcotic use, attestation is required that you are applying best practices for chronic narcotic use as appropriate.
- You submit the signed attestation and patient receives slow-release oxycodone 5 mg #30 as prescribed.

Example 9

You have a 60-year-old patient with recurrent back pain. You write a prescription for oxycodone 5mg i PO Q4H PRN pain, #40. The patient has previously received 40 days' supply of opioids in the previous 90 days. At the pharmacy, the prescription is processed and denies as needing prior authorization. The current prescription pushes the patient beyond the 6 weeks in 90 days point, which defines chronic use.

- Attestation/PA is required to document that you are applying best practices for chronic narcotic use.
- The pharmacist calls your office and informs you that an attestation must be completed prior to dispensing the full amount. If you are unavailable, the pharmacist can process the prescription for 2 days and dispense #12 to patient. Pharmacist notifies you that only a partial fill of a CII was dispensed to patient.

5. Expedited authorization beyond the limits

Example 10

You see a 38-year-old patient with recurrent severe low back pain. You write a prescription for oxycodone 5mg i PO Q4H PRN pain for #180 (30 day supply), and type "Exempt" in the notes section of the prescription. The patient received a 30-day supply of opioids in the previous 90 days, for a prior episode. At the pharmacy, the prescription is processed and the pharmacy enters in the code for the expedited authorization, but it is denied.

The following can occur:

- Pharmacist calls and notifies you that an attestation must be completed prior to dispensing the full amount.
- The pharmacist can process claim for 12 days and dispense #72 to patient. Pharmacist calls your office to notify you that only a partial fill of a CII was dispensed to patient.

6. Grandfathered population

Example 11

You have inherited a 42-year-old patient with an unspecified connective tissue disorder from a colleague who retired. The patient has been taking slow-release oxycodone 80 mg BID plus hydromorphone 4 mg QID for 15 years, filling 115 days' supply in the last 120 days. You hope to taper the patient down gradually, but you feel that this will take time and you will need to build trust. You write to continue the current meds for now.

- The patient is in the "chronic use" category, but is grandfathered under the policy and limits do not apply.
- Patient receives meds as written; no PA/attestation is required.