CLINICAL POLICY

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Methadone for Management of Pain
PAGE:	**RETIRED:**
APPROVED DATE: 7/2015	**REPLACES DOCUMENT:**
EFFECTIVE DATE: 7/2015	**REVIEWED/ REVISED:** 10/15; 9/16; 7/17, 7/18
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** IN.CP.PMN.02

IMPORTANT REMINDER

This Clinical Policy has been developed by appropriately experienced and licensed health care professionals based on a thorough 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 the policy; and other indicia of medical necessity. Centene Corporation makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this policy.

The purpose of this Clinical Policy is to provide a guide to medical necessity. Benefit determinations should be based on the applicable contract provisions governing plan benefits ("Benefit Plan Contract") and applicable state and federal requirements, as well as applicable plan-level administrative policies and procedures. To the extent there are any conflicts between this Clinical Policy and the Benefit Plan Contract provisions, the Benefit Plan Contract provisions will control.

Clinical policies are intended to be reflective of current scientific research and clinical thinking. This policy is current at the time of approval, may be updated and therefore is subject to change. This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.

Description:

Methadone is a potent synthetic opiate agonist of the phenylheptylamine class and is structurally unrelated to morphine. Methadone is the most frequently used agent in medically supervised opiate withdrawal and maintenance programs. Methadone is an effective analgesic but is considered a second-line agent in the treatment of severe, chronic pain. Methadone is useful in patients who have developed tolerance to other opiate agonists or have developed intractable side effects due to opiate therapy. Equianalgesic dosing of chronic methadone and other opiate agonists is unclear. Benefits of methadone in the treatment of chronic pain include lack of active metabolites, high bioavailability following oral administration, and low cost.

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Policy/Criteria:
It is the policy of health plans affiliated with Centene Corporation® that buprenorphine/naloxone or buprenorphine is **medically necessary** for members meeting the following criteria:

Initial Approval Criteria:

methadone oral tablet, dispersible tablet, or oral solution

A. Indication of methadone is for the treatment of long term chronic pain requiring long term therapy (must meet all);
   1. Diagnosis of moderate to severe chronic pain;
   2. Failure of at least TWO non-opioid ancillary treatments (such as non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, anticonvulsants, antidepressants, etc.) at maximum tolerated doses, unless contraindicated;
   3. Member must have trialed and failed monotherapy with an immediate release agent;
   4. Member has tried and failed all preferred long acting opioids

AND

B. Total daily dose ≤ 60mg;
OR
C. Total daily dose > 60mg; and
D. Member not opiate naïve; and
E. Member tried methadone with total daily dose ≤ 60mg with suboptimal pain relieving effect and therefore this is a dose increase; or
F. Member has intractable side effects or tolerance to pain relieving effects of other opiate medication and equinanalgesic conversion from other opiate suggests starting dose of methadone > 60mg (Appendix A).

Approval duration: 6 months

Continued Approval (must meet all criteria as applicable)**:**

A. Indication for methadone continues to be pain management
B. Member not experiencing severe adverse reactions to methadone

Approval duration: 6 months

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Appendix A: Equinalgesic Conversion Chart[2]

Equianalgesic Table : Changing Opioid Administration Routes or Agents:

Opioid agonist	Oral/rectal mg	IV/SC mg	IV to PO
Morphine	30	10	3
Oxycodone	20	N/A	
Hydromorphone	7.5	1.5	5
Codeine	200	120 (IM)	
Hydrocodone	30	N/A	N/A
Oxymorphone	10	1	
Fentanyl[1]	N/A	100mcgr single dose	
Methadone [2]	1-20	1-10	1.5
Codeine	200	130	1.5

$$\frac{\text{Equianalgesic dose (route) } \textbf{current} \text{ opioid}}{\text{24hr dose(route) } \textbf{current} \text{ opioid}} = \frac{\text{Equianalgesic dose (route) } \textbf{Desired} \text{ opioid}}{\text{24hr dose (route) } \textbf{Desired} \text{ opioid}}$$

Equianalgesic Dose Conversion Formula

These are NOT suggested starting doses; these are doses of opioids that produce **approximately the same amount of analgesia.**
Titration to clinical response is necessary. Recommended doses do not apply to patients with renal or hepatic insufficiency. Elderly patients generally require lower doses, titrated slowly to the desired effect or intolerable side effects.

CONVERTING TO/FROM FENTANYL PATCH
1mcg/hr fentanyl transdermal ≈ 2mg total oral morphine/day
25mcgr/fentanyl transdermal ≈ 9 tabs per day of:
Oxycodone 5mgAPAP 325mg, *(Percocet™)* Hydrocodone5mg/APAP500 *(Lortab5™)* ,Codeine 30mg/APAP *(Tylenol #3™)*

PREVENTING CROSS TOLERANCE
When converting from one opioid to another decrease the equianalgesic dose by 25-50% to allow for incomplete cross-tolerance between different opioids. (may need to titrate rapidly to an analgesic dose within the first 24 hrs).

OPIOIDS NOT RECOMMENDED FOR USE
Meperidine SHOULD NOT BE USED in older adults or patients with renal failure because of CNS toxic metabolites. Contraindicated with MAOIs.
Mixed agonist/ antagonist (pentazocine, butorphanol, nalbuphine) : compete with agonists leading to withdrawal. analgesic ceiling effect. high risk of psychotomimetic adverse effects
Propoxyphene: no better than placebo. toxic metabolite at high doses.

OPIOIDS SPECIAL PRECAUTIONS
Methadone : Variable pharmacodynamic and pharmacokinetic effects complicate the use of methadone for analgesia. Symptoms of overdose may be delayed 3-7 days after starting or increasing Methadone. Escalate methadone q4-7 days

References:

1. Methadone monograph. Clinical Pharmacology. Accessed June 2015. http://www.clinicalpharmacology-ip.com/Forms/drugoptions.aspx?cpnum=380&n=Methadone&t=0 Accessed 6/09/2015.
2. University of Texas Geriatric Equianalgesic Conversion Table. http://geriatrics.uthscsa.edu/tools/PAIN%20CARD%20SanchezReilly%20&%20Ross%202008.pdf

Revision Log	
Revision	**Date**
New Policy	7/15
Reformatted policy to be consistent with pharmacy medical necessity format Added Appendix A, Equinanalgesic Table	10/15
Added detail to long term chronic therapy for initial therapy criteria A	9/16
Added that methadone has step therapy through all other preferred long acting opioids.	7/2017

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Annual Review – No updates needed	7/2018

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Pharmacy & Therapeutics Committee: Approval on file

Pharmacy Director:

Chief Medical Director: