Premier Health Plan

# POLICY AND PROCEDURE



**POLICY TITLE:** ***Butrans (burprenophine transdermal)***
**DEPARTMENT:** **Clinical Pharmacy Services- Utilization Management**
**ORIGINAL DATE:** ***October 2017***

**Last P & T Committee Approval Date:** *February 2018*

**Product Applicability:** *mark all applicable products below:*

| | |
|---|---|
| **COMMERCIAL** | [ ] HMO [ ] PPO *Products*: [ ] Small [ ] Indiv. [ ] Large *Exchange*: [ ] Shop [ ] Indiv. [x ] All |
| **OTHER** | [ x ] Self-funded/ASO |

## PURPOSE

The purpose of this policy is to define the prior authorization process for Butrans (buprenorphine transdermal).

Butrans (buprenorphine transdermal) is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

## DEFINITIONS

N/A

## POLICY

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.002 Pharmacy and Therapeutics Committee and RX.003-Prior Authorization Process.

evolent HEALTH

The drug, Butrans (buprenorphine transdermal), is subject to the prior authorization process.

## PROCEDURE

**Initial Authorization Criteria:**

*Must meet all of the criteria listed under the respective diagnosis:*

- Must have a diagnosis of pain severe enough to require daily, around-the-clock, long-opioid treatment and clinical rationale for the use of long acting narcotic
- Must submit chart documentation showing the member has tried TWO generic prescription-strength NSAIDs for at least one month each with an inadequate response or significant side effects/toxicities unless there is a contraindication to this type of medication
- Must submit chart documentation showing the member has tried TWO of the following medications for at least one month with an inadequate response or significant side effect/toxicity unless there is a contraindication to these medications:
    - Hydrocodone/acetaminophen
    - Morphine sulfate immediate release
    - Oxycodone
    - Oxycodone/acetaminophen
    - Tramadol

**Reauthorization Criteria:**

All prior authorization renewals are reviewed on an annual basis to determine the Medical Necessity for continuation of treatment. Authorization may be extended at one-year intervals based upon documentation from the prescriber indicating the member's condition has improved as a result of treatment.

## Limitations:

| Length of Authorization (if above criteria met) | |
|---|---|
| Initial Authorization | Up to 1 year |
| Reauthorization | Same as initial |

If the established criteria are not met, the request is referred to a Medical Director for review.

## REFERENCES

1. Butrans [prescribing information]. Purdue Pharma.: Stamford, CT; June 2010

## RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

## REVIEW HISTORY

| DESCRIPTION OF REVIEW / REVISION | DATE APPROVED |
|---|---|
| *New Policy* | *10/17* |
| *Annual Review* | *02/18* |