Missouri Pharmacy Program – Preferred Drug List

Long-Acting Opioids

Effective 02/16/2005
Revised 04/05/2018

Preferred Agents

Clinical Edits May Apply

- Butrans® Transdermal Patch
- Embeda® ER Capsules
- Fentanyl Transdermal Patch
- Hysingla® ER Tablets
- Morphine Sulfate ER Tablets
- Oxycontin® ER Tablets

Non-Preferred Agents

Clinical Edits May Apply

- Avinza® ER Capsules
- Belbuca® Buccal Film
- Duragesic® Transdermal Patch
- Exalgo ER® Tablets
- Fentanyl 37.5mg, 62.5mg, 87.5mg Patches
- Hydromorphone ER Tablets
- Kadian® ER Capsules
- Morphine ER Caps (gen Kadian)
- Morphine ER Caps (gen Avinza)
- MS Contin® ER Tablets
- Opana® ER Tablets (discontinued)
- Oxycodone ER Tablets
- Oxymorphone ER Tablets
- Targiniq® ER Tablets (discontinued)
- Xtampza® ER Capsules
- Zohydro® ER Capsules

Approval Criteria

Approval Diagnoses

Condition	Inferred Drugs	Date Range
Cancer	NA	2 years
	Antineoplastics	12 months
Opioid Tolerance*	Opioids	> 7 days supply in the last 30 days
Chronic nonmalignant pain (CNMP):	NA	1 year
	Non-opioid analgesics	90 days

*Inferred diagnosis of opioid tolerance required only for Oxycontin 80mg and 160mg tablets and Fentanyl doses greater than 25mcg/hr.

- Therapy for pediatric patients under 19 years of age subject to Clinical Consultant review.
- Documented appropriate diagnosis – see approval diagnoses box **and Appendix E**
- Failure to achieve desired therapeutic outcomes with trial on 3 or more preferred agents
    - Documented trial period for preferred agents
    - Documented ADE/ADR to preferred agents

  Documented compliance on current therapy regimen

Denial Criteria

- Lack of appropriate diagnoses.
- **Dosing exceeding established daily Morphine-Milligram-Equivalents (MMEs), including MME Accumulation Edit**
- Doses exceeding dose optimization limitations
- Lack of adequate trial on required preferred agents
- Therapy will be denied if no approval criteria are met
- Drug Prior Authorization Hotline: (800) 392-8030