**Missouri Pharmacy Program – Preferred Drug List**

## Long-Acting Narcotics

***Effective 02/16/2005***
***Revised 04/07/2016***

**Preferred Agents**

*(Existing clinical edits may apply)*

- Butrans® Transdermal
- **Embeda®**
- **Fentanyl Patches**
- **Hysingla ER**
- Morphine Sulfate ER Tabs
- Oxycontin®

**Non-Preferred Agents**

*(Existing clinical edits may apply)*

- Avinza®
- **Duragesic®**
- Exalgo ER®
- **Fentanyl 37.5, 62.5, 87.5mg Patches**
- Hydromorphone ER
- **Kadian®**
- Morphine ER Caps (gen Kadian)
- Morphine ER Caps (gen Avinza)
- MS Contin®
- Opana ER
- Oramorph SR®
- Oxycodone ER
- Oxymorphone ER
- Targiniq ER
- Zohydro® ER

| Approval Criteria | Denial Criteria |
|---|---|
| Therapy for pediatric patients under 19 years of age subject to Clinical Consultant review. | Lack of appropriate diagnoses. |
| Documented appropriate diagnosis – see approval diagnosis box | Dosing outside of inferred opioid tolerance requirements |
| Failure to achieve desired therapeutic outcomes with trial on 3 or more preferred agents<br>• Documented trial period for preferred agents<br>• Documented ADE/ADR to preferred agents | Doses exceeding dose optimization limitations |
| Documented compliance on current therapy regimen | 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 |

<table>
<tr><th colspan="3">Approval Diagnoses</th></tr>
<tr><th>Condition</th><th>Inferred Drugs</th><th>Date Range</th></tr>
<tr><td>Cancer</td><td>NA</td><td>2 years</td></tr>
<tr><td>Opioid Tolerance*</td><td>Antineoplastics</td><td>12 months</td></tr>
<tr><td rowspan="2">Chronic nonmalignant pain (CNMP):</td><td>NA</td><td>1 year</td></tr>
<tr><td>Non-opioid analgesics</td><td>90 days</td></tr>
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*Inferred diagnosis of opioid tolerance required only for Oxycontin 80mg and 160mg tablets and Duragesic doses greater than 25mcg/hr.