Clinical Policy: Age Limit Override (Codeine, Tramadol, Hydrocodone)

Reference Number: CP.PMN.138
Effective Date: 03.13.18
Last Review Date: 05.19
Line of Business: Commercial, HIM, Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Prior authorization is required for the following medications in the respective age groups due to FDA labeling of these medications:

- Codeine-containing medications indicated for pain are contraindicated in pediatric patients younger than age 12 years;
- Tramadol-containing medications are not indicated for pain in patients younger than age 18 years (use is contraindicated in patients less than 18 years to treat post-tonsillectomy and post-adenoidectomy pain);
- Codeine- and hydrocodone-containing medications indicated for cough and cold are not indicated for use in pediatric patients younger than age 18 years.

FDA Approved Indication(s)
Codeine- and tramadol-containing medications are indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate, including discomfort associated with acute painful musculoskeletal conditions and management of the symptom complex of tension (or muscle contraction) headache.

Codeine- and hydrocodone-containing medications are indicated for relief of cough, nasal congestion, and other upper respiratory symptoms associated with allergies or cold.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that codeine-, tramadol-, and hydrocodone-containing opioids are medically necessary for the following reasons:

I. Initial Approval Criteria
   Please note: for HIM-Arkansas – if a member's covered prescription pain medication requires a prior authorization, then the prior authorization shall not be denied if the member has a terminal illness.

   A. Pain (must meet all):
      *In addition to meeting these criteria, requests for all opioids are subject to the criteria outlined in the opioid analgesic policy for the relevant line of business.
      1. Prescribed for pain management;
      2. Prescribed agent is FDA-approved for pain management;
      3. Member meets one of the following (a or b):
a. Failure of at least two non-opioid ancillary treatments (e.g., non-steroidal anti-inflammatory drugs [NSAIDs], acetaminophen, anticonvulsants, antidepressants) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
b. Prescribed by or in consultation with an oncologist, hematologist, hospice provider, or pain specialist for cancer, palliative care, or sickle cell disease;
4. Failure of at least two age-appropriate opioid analgesics (e.g., morphine, oxycodone), unless contraindicated or clinically significant adverse effects are experienced;
5. Use is not for pain post-tonsillectomy or post-adenoidectomy;
6. Dose does not exceed health plan’s approved quantity limit.

Approval duration:
Non-cancer pain – 7 days
Cancer, sickle cell, or palliative care – 12 months

B. Cough (must meet all):
1. Diagnosis of cough due to viral or bacterial infection;
2. Prescribed agent is FDA-approved for the treatment of cough;
3. Failure of at least two of the following agents at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced: dextromethorphan, benzonatate, guaifenesin;
4. Member is concurrently receiving appropriate therapy for the underlying cause of the cough (e.g., antihistamines, decongestants, bronchodilators, oral and/or inhaled corticosteroids, antibiotics);
5. Dose does not exceed the FDA-approved maximum recommended dose.

Approval duration: health plan-specific duration of approval, not to exceed 7 days

C. Other diagnoses/indications: Not applicable.

II. Continued Therapy

Please note: for HIM-Arkansas – if a member's covered prescription pain medication requires a prior authorization, then the prior authorization shall not be denied if the member has a terminal illness.

A. Cancer, Sickle Cell, or Palliative Care Pain (must meet all):
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed health plan’s approved quantity limit.

Approval duration: 12 months

B. All Other Indications in Section I (must meet all):
Continued therapy for cough, or non-cancer, non-sickle cell or non-palliative care pain will not be authorized as the underlying causes of cough and pain must be treated with appropriate therapy.
C. Other diagnoses/indications: Not applicable.

III. Diagnoses/Indications for which coverage is NOT authorized: Not applicable

IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*
FDA: Food and Drug Administration
NSAIDs: non-steroidal anti-inflammatory drugs

*Appendix B: Therapeutic Alternatives*
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
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</thead>
<tbody>
<tr>
<td><strong>Analgesic agents</strong></td>
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<tr>
<td>acetaminophen (Tylenol®)</td>
<td><strong>Analgesia</strong>&lt;br&gt;Weight-based pediatric dosing&lt;br&gt;10 – 15 mg/kg/dose PO Q4 – 6 hr PRN&lt;br&gt;Age 6 to 11 years&lt;br&gt;325 mg PO Q4 – 6 hr PRN&lt;br&gt;Age 12 years or older&lt;br&gt;Immediate-release: 650 mg PO Q4 – 6 hr PRN or 1000 mg PO Q6 hr PRN&lt;br&gt;Extended-release: 1300 mg PO Q8 hr PRN</td>
<td>75 mg/kg/day not to exceed 4 g/day</td>
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<td>carbamazepine (Tegretol®)</td>
<td><strong>Neuropathic pain</strong>&lt;br&gt;Initial: 50 – 100 mg PO BID&lt;br&gt;Maintenance: 100 – 200 mg PO Q4 – 6 hr</td>
<td>1,200 mg/day</td>
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<td>cyclobenzaprine (Fexmid®)</td>
<td><strong>Muscle spasm</strong>&lt;br&gt;Age 15 years or older&lt;br&gt;5 – 10 mg PO TID</td>
<td>30 mg/day</td>
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<tr>
<td>duloxetine (Cymbalta®)</td>
<td><strong>Chronic musculoskeletal pain</strong>&lt;br&gt;30 mg PO QD for 1 week, then 60 mg PO QD</td>
<td>60 mg/day</td>
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<tr>
<td>gabapentin (Neurontin®)</td>
<td><strong>Neuropathic pain</strong>&lt;br&gt;1,200 – 3,600 mg/day PO in 3 divided doses</td>
<td>3,600 mg/day</td>
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<tr>
<td>ibuprofen (Advil®, Motrin®)</td>
<td><strong>Analgesia</strong>&lt;br&gt;Age 6 months to less than 12 years&lt;br&gt;4 – 10 mg/kg/dose PO Q6 – 8 hr PRN&lt;br&gt;Age 12 to 17 years&lt;br&gt;400 mg PO Q4 – 6 hr PRN</td>
<td>40 mg/kg/day not to exceed 2,400 mg/day</td>
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<tr>
<td>oxycodone (Roxicodone®, OxyContin®)</td>
<td><strong>Moderate-to-severe pain</strong> (immediate-release tablets)</td>
<td>N/A</td>
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<tr>
<td>Drug Name</td>
<td>Dosing Regimen</td>
<td>Dose Limit/Maximum Dose</td>
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<tr>
<td>codeine</td>
<td>0.1 – 0.2 mg/kg/dose (moderate pain) or 0.2 mg/kg/dose (severe pain) PO</td>
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<td><strong>Severe pain</strong> (extended-release tablets)</td>
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<td></td>
<td>Age 11 months or older</td>
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<td>Initial dose PO based on conversion from current opioid regimen dose</td>
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<tr>
<td>dextromethorphan (Delsym®, Robitussin®)</td>
<td><strong>Acute pain</strong></td>
<td>N/A</td>
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<td></td>
<td>Age 6 months or younger</td>
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<td>0.08 – 0.1 mg/kg/dose PO Q3 – 4 hr</td>
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<td>Age greater than 6 months</td>
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<td>Weight &lt; 50 kg: 0.2 – 0.5 mg/kg/dose PO Q3 – 4 hr PRN</td>
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<td>Weight ≥ 50 kg: 15 – 20 mg/kg PO Q3 – 4 hr PRN</td>
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<tr>
<td>guaifenesin (Mucinex®)</td>
<td><strong>Cough (suppressant)</strong></td>
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<td>Age 4 to 6 years (syrup)</td>
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<td>Immediate-release: 2.5 – 7.5 mg PO Q4 – 8 hr PRN</td>
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<td></td>
<td>Extended-release: 15 mg PO BID PRN</td>
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<td></td>
<td>Age 6 to less than 12 years</td>
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<td></td>
<td>Immediate-release: 5 – 10 mg PO Q4 hr PRN or 15 mg PO Q6 – 8 hr PRN</td>
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<td></td>
<td>Extended-release: 30 mg PO BID PRN</td>
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<td></td>
<td>Age 12 years or older</td>
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<tr>
<td></td>
<td>Immediate-release: 10 – 20 mg PO Q4 hr PRN or 20 – 30 mg PO Q6 – 8 hr PRN</td>
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<tr>
<td>benzonatate (Tessalon Perles®)</td>
<td><strong>Cough</strong></td>
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<td>Age greater than 10 years</td>
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<td></td>
<td>600 mg/day</td>
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<tr>
<td>Drug Name</td>
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<td>Dose Limit/Maximum Dose</td>
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| albuterol nebulizer                             | **Bronchospasm**  
Age 2 to less than 12 years  
Weight 10 – 15 kg: 0.63 – 1.25 mg PO TID or QID PRN  
Weight > 15 kg: 0.63 – 2.5 mg PO TID or QID PRN  
Age 12 years or older  
2.5 mg PO TID or QID PRN | Varies                                   |
| albuterol metered dose inhaler (ProAir®, Proventil®, Ventolin®) | **Bronchospasm**  
2 inhalations Q4 – 6 hr PRN | Varies                                   |
| diphenhydramine (Benadryl®)                    | **Cough**  
Age 12 years or older  
25 mg PO Q4 hr PRN | 150 mg/day                               |
| oxymetazoline (Afrin® Nasal Spray)             | **Nasal congestion**  
Age 6 years or older  
2 – 3 sprays in each nostril BID for ≤ 3 days | Max 3 days use                           |
| phenylephrine (Afrin® Childrens)               | **Nasal congestion**  
Age 2 to less than 6 years  
0.125% solution: 2 – 3 sprays in each nostril for no more than Q4 hrs for ≤ 3 days  
Age 6 to less than 12 years  
0.25% solution: 2 – 3 sprays in each nostril for no more than Q4 hrs for ≤ 3 days  
Age 12 years or greater  
0.25% to 1% solution: 2 – 3 sprays in each nostril for no more than Q4 hrs for ≤ 3 days | Max 3 days use                           |
| phenylephrine (Sudafed PE® Childrens)          | **Nasal congestion**  
Age 4 to less than 6 years  
2.5 mg PO Q4 hr PRN for ≤ 7 days  
Age 6 to less than 12 years  
5 mg PO Q4 hr PRN for ≤ 7 days  
Age 12 years or greater  
10 mg PO Q4 hr PRN for ≤ 7 days | Age 4 to < 6 years: 15 mg/day  
Age 6 to < 12 years: 30 mg/day  
Age ≥ 12 years: 60 mg/day |
| Qvar® (beclomethasone)                         | **Asthma**  
Age 5 to 11 years | Age 5 to 11 years: 80 mcg BID/day       |
**Drug Name** | **Dosing Regimen** | **Dose Limit/Maximum Dose**
--- | --- | ---
 | 40 – 80 mcg inhaled BID | Age ≥ 12 years: 320 mcg BID/day
Age 12 years or greater | 40 – 320 mcg inhaled BID |

*Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.*

*Off-label

**Appendix C: Contraindications/Boxed Warnings**

- Contraindication(s): use in children younger than 12 years of age; postoperative management in children younger than 18 years of age following tonsillectomy and/or adenoidectomy; significant respiratory depression; acute or severe bronchial asthma in an unmonitored setting or in absence of resuscitative equipment; concurrent use of monoamine oxidase inhibitors (MAOIs) or use of MAOIs within the last 14 days; known or suspected gastrointestinal obstruction, including paralytic ileus; hypersensitivity to the active ingredient.
- Boxed warning(s): risks of misuse, abuse, addiction, overdose, death; serious or life-threatening respiratory depression; accidental ingestion; neonatal opioid withdrawal syndrome; concomitant use or discontinuation of cytochrome P450 3A4 inducers, 3A4 inhibitors, or 2D6 inhibitors; concomitant use with benzodiazepines or other central nervous system depressants.

**V. Dosage and Administration**

There are various codeine-, tramadol-, and hydrocodone-containing medications commercially available. Please refer to the respective package inserts for dosing and administration.

**VI. Product Availability**

Please refer to the respective package inserts for product availability.

**VII. References**


<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
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<tbody>
<tr>
<td>Policy created</td>
<td>03.13.18</td>
<td>05.18</td>
</tr>
<tr>
<td>2Q 2019 annual review: Updated the initial approval duration for cough to 7 days (or health plan-specific limit) to align with the treatment duration for pain. References reviewed and updated.</td>
<td>02.27.19</td>
<td>05.19</td>
</tr>
<tr>
<td>Added HIM-Arkansas disclaimer re: coverage when the member has a terminal illness.</td>
<td>12.09.19</td>
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</table>

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a 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 this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. 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. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note:**

**For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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