Clinical Policy: Butorphanol Nasal Spray
Reference Number: HIM.PA.46
Effective Date: 12.01.14
Last Review Date: 05.19
Line of Business: HIM

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

Description
Butorphanol tartrate is a synthetically derived opioid agonist-antagonist analgesic of the phenanthrene series.

FDA Approved Indication(s)
Butorphanol tartrate nasal solution is indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

Limitation(s) of use: Because of the risks of addiction, abuse, and misuse, with opioids, even at recommended doses, reserve butorphanol tartrate nasal spray for use in patients for whom alternative treatment options (e.g., non-opioid analgesics)
  • Have not been tolerated, or are not expected to be tolerated,
  • Have not provided adequate analgesia, or are not expected to provide adequate analgesia.

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 butorphanol nasal spray is medically necessary when the following criteria are met:

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 Management (must meet all):
      1. Prescribed for the management of pain;
      2. Age ≥ 18 years;
      3. Failure of at least 2 non-opioid ancillary treatments (such as non-steroidal anti-inflammatory drugs (NSAIDs) or acetaminophen-containing products (see Appendix B for examples), unless contraindicated or clinically significant adverse effect are experienced;
      4. For pain related to migraine headache, failure of at least 2 anti-migraine agents (see Appendix B for examples), unless contraindicated or clinically significant adverse effect are experienced;
5. For chronic pain, failure of an antidepressant or anticonvulsant agent (see Appendix B for examples), unless contraindicated or clinically significant adverse effect are experienced;
6. Member is unable to use oral medications for pain relief.

**Approval duration: 12 months**

**B. Other diagnoses/indications:**
1. Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

**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. Pain Management (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.

**Approval duration: 12 months**

**B. Other diagnoses/indications (must meet 1 or 2):**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

**Approval duration: Duration of request or 12 months (whichever is less);** or
2. Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

**III. Diagnoses/Indications for which coverage is NOT authorized:**
A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – HIM.PHAR.21 or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation Key*
FDA: Food and Drug Administration
NSAID: non-steroidal anti-inflammatory disease

*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 formulary agents and may require prior authorization.
### CLINICAL POLICY

**Butorphanol Nasal Spray**

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Commonly Used Examples</th>
<th>Dose Limit/ Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-steroidal anti-inflammatory agents (NSAIDs)</td>
<td>Motrin® (ibuprofen), Naprosyn® (naproxen), Relafen® (nabumetone), Voltaren® (diclofenac), Orudis® (ketoprofen), Clinoril® (sulindac), Toradol® (ketorolac)</td>
<td>Varies according to the agent used</td>
</tr>
<tr>
<td>Non-opioid analgesics</td>
<td>aspirin, acetaminophen opioid combinations (APAP/codeine, APAP hydrocodone)</td>
<td>Varies according to the agent used</td>
</tr>
<tr>
<td>Anti-migraine agents (non-triptans)</td>
<td>Cafergot® (ergotamine/caffeine), D.H.E.-45® (dihydroergotamine), Midrin® (isometheptene/APAP), Fiorinal® (butalbital/aspirin), Fioricet® (butalbital/APAP)</td>
<td>Varies according to the agent used</td>
</tr>
<tr>
<td>Anti-migraine agents (triptans)</td>
<td>almotriptan (Axert®), eletriptan (Relpax®), frovatriptan (Frova®), naratriptan (Amerge®), rizatriptan (Maxalt®), sumatriptan (Imitrex®), zolmitriptan (Zomig®)</td>
<td>Varies according to the agent used</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>Carbamazepine (Tegretol®), gabapentin (Neurontin®), divalproex (Depakote®), topiramate (Topamax®)</td>
<td>Varies according to the agent used</td>
</tr>
<tr>
<td>Antidepressants/ Tricyclic antidepressants</td>
<td>amitriptyline (Elavil®), desipramine (Norpramin®), imipramine (Tofranil®), nortriptyline (Pamelor®), duloxetine (Cymbalta®), venlafaxine (Effexor®)</td>
<td>Varies according to the agent used</td>
</tr>
</tbody>
</table>

*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.*

### Appendix C: Contraindications/Boxed Warnings

- **Contraindication(s):** significant respiratory depression; acute or severe bronchial asthma in an unmonitored setting or in absence of resuscitative equipment; known or suspected gastrointestinal obstruction, including paralytic ileus; hypersensitivity to butorphanol tartrate, the preservative benzethonium chloride, or any of the formulation excipients (e.g., anaphylaxis).
- **Boxed warning(s):** risks of addiction, abuse, and misuse; life-threatening respiratory depression; accidental ingestion; neonatal opioid withdrawal syndrome; cytochrome P450 3A4 inducers, 3A4 interactions; concomitant use with benzodiazepines or other central nervous system depressants.

### V. References


<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changed guidelines to new format</td>
<td>05.16</td>
<td>05.16</td>
</tr>
<tr>
<td>Clinical changes made to criteria: Added requirement that butorphanol is prescribed for the management of pain. Non-clinical changes: Converted to new template; Updated references.</td>
<td>01.17</td>
<td>05.17</td>
</tr>
<tr>
<td>2Q18 annual review: due to the current concerns around utilization of opioid agents, replaced requirement for prior trials of 2 immediate-release opioids with the requirement for prior trials of at least 2 non-opioid ancillary treatments plus 2 anti-migraine agents (if migraine pain) plus two anticonvulsants or antidepressants (if chronic pain) plus documentation of an inability to take oral medications; added age limit; references reviewed and updated.</td>
<td>02.26.1 8</td>
<td>05.18</td>
</tr>
<tr>
<td>2Q 2019 annual review: no significant changes; references reviewed and updated.</td>
<td>02.27.1 9</td>
<td>05.19</td>
</tr>
<tr>
<td>Added HIM-Arkansas disclaimer re: coverage when the member has a terminal illness.</td>
<td>12.09.1 9</td>
<td></td>
</tr>
</tbody>
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**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.

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