MEDICATION POLICY

Generic Name: Buprenorphine

Therapeutic Class or Brand Name: Butrans®

Applicable Drugs (if Therapeutic Class)**:**

Buprenorphine Transdermal Patch, Butrans®

Date of Origin: 2/1/13 **Date Last Reviewed/Revised:** 1/4/18

GPI Code: 6520001000

Prior Authorization Criteria (may be considered medically necessary when criteria I through V are met):

I. Patient has been approved for chronic opioid therapy as outlined in the Chronic Opioid Medication Policy.

II. Documented trial and failure of, or contraindication to, at least one preferred oral non-opioid agent(s) at therapeutic doses.

III. Documented trial and failure of, or contraindication to, at least two preferred extended-release opioid analgesics (not including fentanyl patch). Must include the names of the preferred products tried or contraindicated, length of therapy, and reason for discontinuation.

IV. Documented trial and failure of, or contraindication to, fentanyl patch at maximum tolerated dose.

V. Minimum age requirement: 18 years old.

Exclusion Criteria:

- Significant respiratory depression.
- Acute or severe bronchial asthma.
- Known or suspected paralytic ileus.
- Long QT Syndrome, family history of Long QT Syndrome, or patients taking Class IA or Class III antiarrhythmic medications.
- Circulatory shock.
- Impaired consciousness or coma.

Other Criteria:

- N/A

MEDICATION POLICY

Quantity/Days Supply Restrictions:

- 4 patches per 28 days. Additional quantities may be granted as long as the maximum dose of 20 mcg/hour is not exceeded and with satisfactory prescriber explanation during the first and last months of therapy to allow for dose titration.

Approval Length:

- **Authorization:** 3 months.
- **Re-Authorization:** Up to 6 months. Reauthorization periods of up to 6 months require an updated letter of medical necessity or progress notes showing current medical necessity criteria are met and documentation of satisfactory pain control.

Appendix:

N/A

References:

1. https://medicaid.utah.gov/pharmacy/priorauthorization/pdf/Butrans.pdf.
2. http://dhs.iowa.gov/sites/default/files/470-5017.pdf.
3. Medi-Span.
4. http://app.purduepharma.com/xmlpublishing/pi.aspx?id=b.

MEDICATION POLICY

Historical Tracking Of Changes Made To Policy	
1/4/2018	1. **Changed** "N/A" **to** "Buprenorphine Transdermal Patch, Butrans®" **under Applicable Drugs**. 2. **Added** "Long QT Syndrome, family history of Long QT Syndrome, or patients taking Class IA or Class III antiarrhythmic medications; Circulatory shock; Impaired consciousness or coma" **under Exclusion Criteria**.
10/9/2016	1. Policy reviewed: no changes made.
7/28/2015	1. **Changed** "I. Documented diagnosis of Moderate to Severe Chronic Pain requiring continuous, around-the-clock opioid analgesic for an extended period of time" **to** "I. Patient has been approved for chronic opioid therapy as outlined in the Chronic Opioid Medication Policy" **under Prior Authorization Criteria**. 2. **Changed** "N/A" **to** "Significant respiratory depression; Acute or severe bronchial asthma; Known or suspected paralytic ileus" **under Exclusion Criteria**. 3. **Changed** "Prior Authorization will be granted for up to 4 patches per 28 days. Additional quantities may be granted with satisfactory prescriber explanation during the first and last months of therapy to allow for dose titration" **to** "4 patches per 28 days. Additional quantities may be granted as long as the maximum dose of 20 mcg/hour is not exceeded and with satisfactory prescriber explanation during the first and last months of therapy to allow for dose titration" **under Quantity/Days Supply Restrictions**. 4. **Changed Re-Authorization under Approval Length from** "Up to 1 year. Reauthorization periods of up to one year require an updated letter of medical necessity or progress notes showing current medical necessity criteria are met, documentation that the patient is using the medication appropriately, and documentation of satisfactory pain control" **to** "Up to 6 months. Reauthorization periods of up to 6 months require an updated letter of medical necessity or progress notes showing current medical necessity criteria are met and documentation of satisfactory pain control". 5. **Updated** "http://www.health.utah.gov/medicaid/pharmacy/priorauthorization/pdf/Butrans.pdf" **to** "https://medicaid.utah.gov/pharmacy/priorauthorization/pdf/Butrans.pdf" **and** "http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Forms/470-5017.pdf" **to** "http://dhs.iowa.gov/sites/default/files/470-5017.pdf" **under References**.
2/12/2014	1. **Adapted policy to new format.** 2. **Added GPI Code**. 3. **Changed criterion III under Prior Authorization Criteria from**: "Documented trial and failure of, or contraindication to, a preferred long acting morphine sulfate product and methadone at therapeutic doses. The preferred trials must allow for adequate dose titration and show use of a preferred short acting narcotic for breakthrough pain" **to:** "Documented trial and failure of, or contraindication to, at least two preferred extended-release opioid analgesics (not including fentanyl patch). Must include the names of the preferred products tried or contraindicated, length of therapy, and reason for discontinuation". 4. **Reworded criterion IV under Prior Authorization Criteria from** "A trial and therapy failure with, or contraindication to, fentanyl patch at maximum tolerated dose" **to** "Documented trial and failure of, or contraindication to, fentanyl patch at maximum tolerated dose". 5. **Changed Re-Authorization under Approval Length from** "Up to 1 year. Reauthorization periods of up to one year require documentation that the patient is using the drug appropriately and documentation of satisfactory pain control" **to** "Up to 1 year. Reauthorization periods of up to one year require an updated letter of medical necessity or progress notes showing current medical necessity criteria are met, documentation that the patient is using the medication appropriately, and documentation of satisfactory pain control". 6. **Updated references** to include Medi-Span and package insert.