Clinical Policy: OH.PHAR.PPA.21
Clinical Policy: Analgesic Agents – NSAIDs

Effective Date: 01.2020
Last Review Date: mm.yy
Line of Business: Medicaid

Coding Implications
remove if no codes added
Revision Log

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

Description

ANALGESIC AGENTS: NON-GASTROPROTECTIVE NSAIDS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DICLOFENAC SODIUM (generic of Voltaren®) DICLOFENAC POTASSIUM (generic of Cataflam®) ETODOLAC (generic of Lodine, Lodine XL) IBUPROFEN Tablets and Susp (generic of Motrin®) INDOMETHACIN (generic of Indocin®) KETOROLAC MECLOFENAMATE SODIUM MEFENAMIC ACID (generic of Ponstel®) MELOXICAM (generic of Mobic®) NABUMETONE NAPROXEN NAPROXEN SUSP (no PA age <12) OXAPROZIN (generic of Daypro®) PIROXICAM (generic of Feldene®) SULINDAC	FENOPROFEN KETOPROFEN NAPRELAN (naproxen) NAPROXEN CR, DR NAPROXEN SUSP (PA required age ≥12) QMIIZ ODTTM (meloxicam) TIVORBEX® (indomethacin) TOLMETIN VIVLODEX TM (meloxicam) ZORVOLEX® (diclofenac)

ANALGESIC AGENTS: GASTROPROTECTIVE NSAIDS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CELECOXIB (generic for Celebrex®) (no PA required for age 60 or older)	CELECOXIB (generic for Celebrex®) (PA required for under age 60) DICLOFENAC/MISOPROSTOL (generic of Arthrotec®) DUEXIS® (ibuprofen/famotidine) VIMOVO® (naproxen/esomeprazole)

ANALGESIC AGENTS: NSAIDS TRANSDERMAL/TOPICAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DICLOFENAC 1% (generic of VOLTAREN® gel)	DICLOFENAC 1.5% topical solution (generic of Pennsaid®) FLECTOR® patch (diclofenac epolamine) PENNSAID® 2% solution (diclofenac sodium)

FDA Approved Indication(s)
The list below may not be all inclusive. Varies by drug product. If needed, please see package insert; clinical pharmacology or other appropriate clinical reference.
Ankylosing spondylitis
Arthralgia
Bone pain
Bursitis
Dental pain
Dysmenorrhea
Fever
Gouty arthritis
Headache
Mild pain
Moderate pain
Myalgia
Osteoarthritis
Patent ductus arteriosus (PDA)
Rheumatoid arthritis
Severe pain
Tendinitis
Juvenile rheumatoid arthritis (JRA)/juvenile idiopathic arthritis (JIA)

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 Buckeye Health Plan, an affiliate of Centene Corporation® that a Non-preferred NSAID is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. NON-GASTROPROTECTIVE NSAIDS All Indications (must meet all)**:**

1. Failure of no less than a 30 day trial of at least two non-gastroprotective NSAID medications UNLESS there is a reason the patient cannot be changed to a PDL Medication

Acceptable reasons include:

- Allergy to all medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
- History of unacceptable/toxic side effects to medications not requiring prior approval

Approval duration: Medicaid: 12 months

B. GASTROPROTECTIVE NSAIDS All Indications
****Please note for Celecoxib(Celebrex) PA required for age under 60)****
(Must meet at least one of the following 1, 2 or 3

1. Failure of no less than a 30 day trial of at least two non-gastroprotective NSAID medications; OR
2. Member is undergoing surgical or other medical procedures that may predispose them to potential bleeding complications; OR
3. Member is being treated for H. pylori. UNLESS there is a reason the patient cannot be changed to a PDL Medication

Acceptable reasons include:

- Allergy to all medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Concurrent or history of a GI event (perforation, ulcer, bleed)
- Other risks for treatment with NON-GASTROPROTECTIVE NSAIDs:
  - Coagulation disorders (i.e. hemophilia, chronic liver disease), erosive esophagitis
  - Documented NSAID-induced ulcer
  - Peptic ulcer disease (PUD)
  - Patient on warfarin or heparin
  - Patient on oral corticosteroids
  - Patient on methotrexate

Approval duration: **12 months (please note the following exceptions)**
Member undergoing surgical or other medical procedure = 60 days
Member treated for H.pylori = 30 days

C. **TRANSDERMAL/TOPICAL NSAIDS All Indications (must meet all):**

1. Failure of no less than a 30 day trial of at least one preferred topical NSAID medications within the past 180 days UNLESS there is A reason the patient cannot be changed to a PDL Medication;

Acceptable reasons include:

- Allergy to all medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
- History of unacceptable/toxic side effects to medications not requiring prior approval

Approval duration: 90 days

D. Other diagnoses/indications
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

II. **Diagnoses/Indications for which coverage is NOT authorized:**

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 policies – CP.PMN.53 for Medicaid or evidence of coverage documents.

III. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
PA: Prior Authorization
ER: Extended Release

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.***

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Diclofenac sodium (Voltaren®)	50 mg PO TID	150 mg/day
Etodolac (Lodine®)	400 - 500 mg PO BID	1200 mg/day
Ibuprofen (Motrin®)	400 - 800 mg PO Q6-8hr	3200 mg/day
Indomethacin (Indocin®)	25 - 50 mg PO BID -TID	200 mg/day
Indomethacin SR (Indocin® SR)	75 mg PO QD - BID	150 mg/day
Meclofenamate (Meclomen®)	50 - 100 mg PO Q4-6hr	400 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Meloxicam (Mobic®)	7.5 – 15 mg PO QD	15 mg/day
Nabumetone (Relafen®)	1000 mg PO QD or 500 mg PO BID	2000 mg/day
Naproxen (Naprosyn®)	250 – 500 mg PO BID	1500 mg/day
Oxaprozin (Daypro®)	600 - 1200 mg PO BID	1800 mg/day
Piroxicam (Feldene®)	10 - 20 mg PO QD	20 mg/day
Sulindac (Clinoril®)	150 mg - 200 mg PO BID	400 mg/day

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

- *See package insert; clinical pharmacology or other appropriate clinical reference.*

IV. Dosage and Administration - varies by drug product. See package insert; clinical pharmacology or other appropriate clinical reference for FDA approved dosing and administration

V. Product Availability – See package insert; clinical pharmacology or other appropriate clinical reference for product availability

VI. References. Refer to see package insert.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created	10-2019	

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.