### QUANTITY LIMIT AND POST LIMIT PRIOR AUTHORIZATION CRITERIA

<table>
<thead>
<tr>
<th>DRUG CLASS</th>
<th>EXTENDED-RELEASE OPIOID ANALGESICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRAND NAME*</td>
<td>(generic)</td>
</tr>
<tr>
<td>ARYMO ER</td>
<td>(morphine sulfate extended-release tablets)</td>
</tr>
<tr>
<td>AVINZA</td>
<td>(morphine extended-release capsules)</td>
</tr>
<tr>
<td>BELBUCA</td>
<td>(buprenorphine buccal film)</td>
</tr>
<tr>
<td>BUTRANS</td>
<td>(buprenorphine transdermal system)</td>
</tr>
<tr>
<td>CONZIP</td>
<td>(tramadol hydrochloride extended-release)</td>
</tr>
<tr>
<td>DOLOPHINE 5 MG, 10 MG</td>
<td>(methadone hydrochloride tablets)</td>
</tr>
<tr>
<td>DURAGESIC</td>
<td>(fentanyl transdermal system)</td>
</tr>
<tr>
<td>EMBEDA</td>
<td>(morphine sulfate and naltrexone hydrochloride extended-release caps)</td>
</tr>
<tr>
<td>EXALGO</td>
<td>(hydromorphone hydrochloride extended-release tablets)</td>
</tr>
<tr>
<td>HYSINGLA ER</td>
<td>(hydrocodone bitartrate extended-release tablets)</td>
</tr>
<tr>
<td>KADIAN</td>
<td>(morphine extended-release capsules)</td>
</tr>
</tbody>
</table>
METHADONE 200 MG/20 ML INJ, 5 MG/5 ML & 10 MG/5 ML
(methadone hydrochloride injection, oral solution)

METHADONE INTENSOL 10 MG/ML
(methadone oral concentrate)

METHADOSE 5 MG, 10 MG
(methadone hydrochloride tablets)

MORPHABOND
(morphine extended-release tablets)

MS CONTIN
(morphine extended-release tablets)

NUCYNTA ER
(tapentadol extended-release tablets)

OPANA ER
(oxydornone hydrochloride extended-release tablets)

OXCONTIN
(oxydornone hydrochloride extended-release tablets)

TARGINIQ ER
(oxydornone HCl/naloxone HCl extended-release tablets)

(T tramadol hydrochloride extended-release)

TROXYCA ER
(oxydornone hydrochloride/naltrexone extended-release capsules)

ULTRAM ER
(tramadol hydrochloride extended-release tablets)

VANTRELA ER
(hydrocodone bitartrate extended-release tablets)

XTAMPZA ER
(oxydornone extended-release capsules)

ZOHYDRO ER
FDA-APPROVED INDICATIONS
Arymo ER, Avinza, Kadian, MorphaBond, MS Contin, and Embeda
Arymo ER, Avinza, Kadian, MorphaBond, MS Contin, and Embeda are indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use
Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Arymo ER, Avinza, Kadian, MorphaBond, MS Contin, and Embeda for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.

Arymo ER, Avinza, Kadian, MorphaBond, MS Contin, and Embeda are not indicated as an as-needed (prn) analgesic.

Belbuca and Butrans
Belbuca and Butrans are indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use
• Because of the risks of addiction, abuse and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-acting opioid formulations, reserve Belbuca and Butrans for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.

• Belbuca and Butrans are not indicated as an as-needed (prn) analgesic.

ConZip, Ultram ER, and Tramadol Hydrochloride Extended-Release
ConZip, Ultram ER, and Tramadol Hydrochloride Extended-Release are indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use
• Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release/long-acting opioid formulations, reserve ConZip, Ultram ER, and Tramadol Hydrochloride Extended-Release for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.

• ConZip, Ultram ER, and Tramadol Hydrochloride Extended-Release is not indicated as an as-needed (prn) analgesic.

Dolophine Tablets
Dolophine is indicated for the:
• Management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Use
• Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-acting opioids, reserve Dolophine for use in patients for whom alternative analgesic treatment options (e.g., non-opioid...
analgesics or immediate-release opioid analgesics) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.

- Dolophine is not indicated as an as-needed (prn) analgesic.
- Detoxification treatment of opioid addiction (heroin or other morphine-like drugs).
- Maintenance treatment of opioid addiction (heroin or other morphine-like drugs), in conjunction with appropriate social and medical services.

**Duragesic**

Duragesic is indicated for the management of pain in opioid-tolerant patients, severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Patients considered opioid-tolerant are those who are taking, for one week or longer, at least 60 mg of oral morphine daily, or at least 30 mg of oral oxycodone daily, or at least 8 mg of oral hydromorphone daily, or an equianalgesic dose of another opioid.

**Limitations of Use**

Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Duragesic for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.

**Exalgo**

Exalgo is indicated for the management of pain in opioid-tolerant patients severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Patients considered opioid tolerant are those who are receiving, for one week or longer, at least 60 mg oral morphine per day, 25 mcg transdermal fentanyl per hour, 30 mg oral oxycodone per day, 8 mg oral hydromorphone per day, 25 mg oral oxymorphone per day or an equianalgesic dose of another opioid.

**Limitations of Use**

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Exalgo for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Exalgo is not indicated as an as-needed (prn) analgesic.

**Hysingla ER**

Hysingla ER is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

**Limitations of Use**

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Hysingla ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Hysingla ER is not indicated as an as-needed (prn) analgesic.

**Methadone Injection**

Methadone Injection is indicated:

- For the management of pain severe enough to require an opioid analgesic and for which alternative treatment options are inadequate.

**Limitations of Use**

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses reserve Methadone Hydrochloride Injection for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products):
  - Have not been tolerated, or are not expected to be tolerated,
  - Have not provided adequate analgesia, or are not expected to provide adequate analgesia.
- For use in temporary treatment of opioid dependence in patients unable to take oral medication.
Injectable methadone products are not approved for the outpatient treatment of opioid dependence. In this patient population, parenteral methadone is to be used only for patients unable to take oral medication, such as hospitalized patients.

**Methadone Intensol**
Methadone Hydrochloride Intensol (Oral concentrate) is indicated for the:
- Management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

**Limitations of Use**
- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-acting opioids, reserve methadone for use in patients for whom alternative analgesic treatment options (e.g., non-opioid analgesics or immediate-release opioid analgesics) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Methadone is not indicated as an as-needed (prn) analgesic.
- Detoxification treatment of opioid addiction (heroin or other morphine-like drugs).
- Maintenance treatment of opioid addiction (heroin or other morphine-like drugs), in conjunction with appropriate social and medical services.

**Methadone Oral Solution**
Methadone Hydrochloride Oral Solution USP is indicated for the:
- Management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

**Limitations of Use**
- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-acting opioids, reserve Methadone Hydrochloride Oral Solution USP for use in patients for whom alternative analgesic treatment options (e.g., non-opioid analgesics or immediate-release opioid analgesics) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Methadone Hydrochloride Oral Solution USP is not indicated as an as-needed (prn) analgesic.
- Detoxification treatment of opioid addiction (heroin or other morphine-like drugs).
- Maintenance treatment of opioid addiction (heroin or other morphine-like drugs), in conjunction with appropriate social and medical services.

**Methadone Tablets**
Methadone hydrochloride tablets are indicated for the:
- Management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

**Limitations of Use**
- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-acting opioids, reserve methadone for use in patients for whom alternative analgesic treatment options (e.g., non-opioid analgesics or immediate-release opioid analgesics) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Methadone hydrochloride is not indicated as an as-needed (prn) analgesic.
- Detoxification treatment of opioid addiction (heroin or other morphine-like drugs).
- Maintenance treatment of opioid addiction (heroin or other morphine-like drugs), in conjunction with appropriate social and medical services.

**Conditions For Distribution And Use Of Methadone Products For The Treatment Of Opioid Addiction**

**Code of Federal Regulations, Title 42, Sec 8**
Methadone products when used for the treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed only by opioid treatment programs (and agencies, practitioners or institutions by formal agreement with the program sponsor) certified by the Substance Abuse and Mental Health Services Administration and approved by the designated state authority. Certified treatment programs shall dispense and use methadone in oral form only and according to the treatment requirements stipulated in the Federal Opioid Treatment Standards (42 CFR 8.12). See below for
important regulatory exceptions to the general requirement for certification to provide opioid agonist treatment.

Failure to abide by the requirements in these regulations may result in criminal prosecution, seizure of the drug supply, revocation of the program approval, and injunction precluding operation of the program.

**Regulatory Exceptions To The General Requirement For Certification To Provide Opioid Agonist Treatment:**

During inpatient care, when the patient was admitted for any condition other than concurrent opioid addiction [pursuant to 21CFR 1306.07(c)], to facilitate the treatment of the primary admitting diagnosis.

During an emergency period of no longer than 3 days while definitive care for the addiction is being sought in an appropriately licensed facility [pursuant to 21CFR 1306.07(b)].

**Nucynta ER**

Nucynta ER is indicated for the management of:

- Pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.
- Neuropathic pain associated with diabetic peripheral neuropathy (DPN) in adults severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

**Limitations of Usage**

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Nucynta ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Nucynta ER is not indicated as an as-needed (prn) analgesic.

**Opana ER**

Opana ER is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

**Limitations of Use**

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Opana ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Opana ER is not indicated as an as-needed (prn) analgesic.

**OxyContin**

OxyContin is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate in:

- Adults; and
- Opioid-tolerant pediatric patients 11 years of age and older who are already receiving and tolerate a minimum daily opioid dose of at least 20 mg oxycodone orally or its equivalent.

**Limitations of Usage**

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve OxyContin for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- OxyContin is not indicated as an as-needed (prn) analgesic.

**Targiniq ER**

Targiniq ER is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

**Limitations of Use**

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Targiniq ER for use in patients for whom alternative treatment options (e.g., non-opioid
analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.

- **Targiniq ER** is not indicated as an as-needed (prn) analgesic.
- The maximum total daily dose of Targiniq ER should not exceed 80 mg/40 mg (40 mg/20 mg q12h) because higher doses may be associated with symptoms of opioid withdrawal or decreased analgesia.

**Troxyca ER**

Troxyca ER is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

**Limitations of Use**

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Troxyca ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Troxyca ER is not indicated as an as-needed (prn) analgesic.

**Vantrela ER**

Vantrela ER is an opioid agonist indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

**Limitation of Use**

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Vantrela ER for use in patients for whom alternative treatment options (e.g., non-opoid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Vantrela ER is not indicated as an as-needed (prn) analgesic.

**Xtampza ER**

Xtampza ER is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

**Limitations of Use**

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Xtampza ER for use in patients for whom alternative treatment options (e.g., non-opoid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Xtampza ER is not indicated as an as-needed (prn) analgesic.

**Zohydro ER**

Zohydro ER is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

**Limitations of Use**

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Zohydro ER for use in patients for whom alternative treatment options (e.g., non-opoid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Zohydro ER is not indicated as an as-needed (prn) analgesic.

**COVERAGE CRITERIA**

The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for pain associated with cancer, a terminal condition, or pain being managed through hospice or palliative care

**OR**
The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND

The patient can safely take the requested dose based on their history of opioid use AND

The patient has been evaluated and will be monitored regularly for the development of opioid use disorder AND

The patient's pain will be reassessed in the first month after the initial prescription or any dose increase AND every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety AND

If the request is for a methadone product, then it is NOT being prescribed for detoxification treatment or as part of a maintenance treatment plan for opioid/substance abuse or addiction

[Note: These drugs should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.]

Quantity limits may apply.

RATIONALITY

The intent of the criteria is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines. Extended-release opioids are indicated for the management of pain in opioid-tolerant patients severe enough to require daily, around-the-clock, long-term opioid treatment in a patient who has been taking an opioid. Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve extended-release opioids for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. Extended-release opioids are not indicated as as-needed (prn) analgesics. These drugs should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.1-30

If the patient has filled a prescription for at least a 1-day supply of a drug indicating the patient is being treated for cancer within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.

The Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care.31 National Comprehensive Cancer Network (NCCN) guidelines for Adult Cancer Pain recommend for continuous pain to give pain medication on a regular schedule with supplemental doses for breakthrough pain. Add an extended-release or long-acting formulation to provide background analgesia for control of chronic persistent pain controlled on stable doses of short-acting opioids. When possible, use the same opioid for short-acting and extended-release forms. Allow rescue doses of short-acting opioids every 1 hour as needed.33 The NCCN Palliative Care pain management recommendation is to treat according to NCCN guidelines for adult cancer pain.32 For patients with no prescription claims of a cancer drug in the past 365 days who are identified through the prior authorization criteria as having cancer, a terminal condition or pain being managed through hospice or palliative care, post limit quantities will not apply.

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid

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therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.  

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should consider history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use.  

The CDC Guideline for Prescribing Opioids for Chronic Pain recommends that when opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day. The extended-release opioid drug initial quantity limits are set to encompass the usual starting dosage and frequency range recommendations in labeling without exceeding a monthly quantity that corresponds to 90 MME per day. If the patient is requesting more than the initial quantity limit, then the system will reject with a message indicating that a prior authorization is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

The American Pain Society Opioid Treatment Guidelines state that a reasonable definition for high dose opioid therapy is >200 mg daily of oral morphine (or equivalent). The extended-release opioid drug post quantity limits are set to encompass the usual dosage range recommendations in labeling, or up to one additional dose per day above the initial quantity limit without exceeding a monthly quantity that corresponds to 200 MME per day (unless minimum FDA-labeled strength/dose/frequency exceeds a monthly quantity that corresponds to 200 MME/day) to promote optimization of pain management, safe and effective use, and to reduce misuse, abuse, and overdose.

Methadone products, when used for the treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed only by opioid treatment programs (and agencies, practitioners or institutions by formal agreement with the program sponsor) certified by the Substance Abuse and Mental Health Services Administration and approved by the designated state authority. Certified treatment programs shall dispense and use methadone in oral form only and according to the treatment requirements stipulated in the Federal Opioid Treatment Standards (42 CFR 8.12). The limit is set to reflect the use of methadone for the relief of pain. The limit is not intended for patients in detoxification and methadone maintenance programs. A separate initial quantity limit prior authorization criteria exists for methadone concentrate and dispersible tablets since they are indicated for opioid dependence only.

**PROGRAM DESCRIPTION**

Quantity limits do not apply if the patient has a drug in claims history in the past year that indicates the patient is being treated for cancer.

Plans implementing morphine milligram equivalent (MME) based quantity limits on extended-release opioids are providing coverage for an initial amount of a monthly quantity that corresponds to 90 MME or less per day. Coverage is provided for up to the initial quantity limit per Column A and Column B in the Opioid Analgesics ER Quantity Limits Chart below.

Prior authorization review is required to determine coverage for additional quantities above the initial limit.

Post limit quantities are set not to exceed a monthly quantity that corresponds to 200 MME per day (unless minimum FDA-labeled strength/dose/frequency exceeds a monthly quantity that corresponds to 200 MME/day). For patients with no prescription claims of a cancer drug in the past 365 days who
are identified through the prior authorization criteria as having cancer, a terminal condition or pain being managed through hospice or palliative care, post limit quantities will not apply.

REFERENCES

INITIAL STEP THERAPY

If the patient has filled a prescription for at least a 1-day supply of a drug indicating the patient is being treated for cancer within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then initial quantity limits will apply. If initial quantities are exceeded, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

<table>
<thead>
<tr>
<th>CRITERIA FOR APPROVAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Is the requested drug being prescribed for pain associated with cancer, a terminal condition, or pain being managed through hospice or palliative care? [If yes, then no further questions.] Yes No</td>
</tr>
<tr>
<td>2 Is the requested drug being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid? Yes No</td>
</tr>
<tr>
<td>3 Can the patient safely take the requested dose based on their history of opioid use? Yes No</td>
</tr>
<tr>
<td>4 Has the patient been evaluated and will the patient be monitored regularly for the development of opioid use disorder? Yes No</td>
</tr>
<tr>
<td>5 Will the patient’s pain be reassessed in the first month after the initial prescription or any dose increase AND every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety? Yes No</td>
</tr>
<tr>
<td>6 Which drug is being requested? Please check drug being requested. [Note: These drugs should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.]</td>
</tr>
<tr>
<td>□ Arymo ER (morphine extended-release tablets) (if checked, go to 18)</td>
</tr>
<tr>
<td>□ Avinza (morphine extended-release capsules) (if checked, go to 10)</td>
</tr>
<tr>
<td>□ Belbuca (buprenorphine buccal film) (if checked, go to 11)</td>
</tr>
<tr>
<td>□ Butrans (buprenorphine transdermal system) (if checked, go to 12)</td>
</tr>
<tr>
<td>□ Conzip (tramadol hydrochloride extended-release) (if checked, go to 13)</td>
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<tr>
<td>□ Dolophine 5 mg, 10 mg (methadone hydrochloride tablets) (if checked, go to 8)</td>
</tr>
<tr>
<td>□ Duragesic (fentanyl transdermal system) (if checked, go to question 14)</td>
</tr>
</tbody>
</table>
7 Does the patient require use of MORE than any of the following:  
A) 60 units/month of Hysingla ER 20 mg, 30 mg, 40 mg, 60 mg, 80 mg, 100 mg OR Zohydro ER 50 mg OR Vantrela ER 60 mg, 90 mg, 
B) 30 units/month of Hysingla ER 120 mg, C) 90 units/month of Zohydro ER 10 mg, 15 mg, 20 mg, 30 mg, 40 mg OR Vantrela ER 15 mg, 30 mg, 45 mg?  
[No further questions.]  

[RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 60 units/month of Hysingla ER 20 mg, 30 mg, 40 mg, 60 mg, 80 mg, 100 mg OR Zohydro ER 50 mg OR Vantrela ER 60 mg, 90 mg, B) 30 units/month of Hysingla ER 120 mg, C) 90 units/month of Zohydro ER 10 mg, 15 mg, 20 mg, 30 mg, 40 mg OR Vantrela ER 15 mg, 30 mg, 45 mg.]  

8 Is the requested methadone product being prescribed for detoxification treatment or as part of a maintenance treatment plan for opioid/substance abuse or addiction?  

9 Does the patient require use of MORE than any of the following:  
A) 120 tablets/month of Dolophine 5 mg or Methadose 5 mg, B) 90 tablets/month of Dolophine 10 mg or Methadose 10 mg, C) 600 mL/month of Methadone oral solution 5 mg/5 mL, D) 450 mL/month of Methadone oral solution 10 mg/5 mL, E) 40 mL (2 multidose vials) of Methadone 200 mg/20 mL injection, F) 90 mL/month of Methadone Intensol (10 mg/mL) solution?
1. Does the patient require use of MORE than 60 capsules/month of Avinza 30 mg, 45 mg, 60 mg, 75 mg, 90 mg OR MORE than 30 capsules/month of Avinza 120 mg?  
[No further questions.]

2. Does the patient require use of MORE than 90 films/month of Belbuca 75 mcg, 150 mcg, 300 mcg, 450 mcg OR MORE than 60 films/month of Belbuca 600 mcg, 750 mcg, 900 mcg?  
[No further questions.]

3. Does the patient require use of MORE than 8 patches/month of Butrans 5 mcg/hr, 7.5 mcg/hr, 10 mcg/hr OR MORE than 4 patches/month of Butrans 15 mcg/hr, 20 mcg/hr?  
[No further questions.]

4. Does the patient require use of MORE than 60 units/month of Conzip 100 mg, tramadol ER 100 mg, 150 mg, or Ultram ER 100 mg, OR MORE than 30 units/month of Conzip 200 mg, 300 mg, or tramadol ER 200 mg, 300 mg, or Ultram ER 200 mg, 300 mg?  
[No further questions.]

5. Does the patient require use of MORE than 20 patches/month of Duragesic 12 mcg, 25 mcg, 37.5 mcg OR MORE than 10 patches/month of Duragesic 50 mcg, 62.5 mcg, 75 mcg, 87.5 mcg, 100 mcg?  
[No further questions.]
1. Does the patient require use of MORE than 90 capsules/month of Embeda 20/0.8 mg, 30/1.2 mg OR MORE than 60 capsules/month of Embeda 50/2 mg, 60/2.4 mg, 80/3.2 mg, 100/4 mg?

[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for 90 capsules/month of Embeda 20/0.8 mg, 30/1.2 mg OR 60 capsules/month of Embeda 50/2 mg, 60/2.4 mg, 80/3.2 mg, 100/4 mg.]

Yes  No

1. Does the patient require use of MORE than 60 tablets/month of Exalgo 8 mg, 12 mg, 16 mg OR MORE than 30 tablets/month of Exalgo 32 mg?

[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for 60 tablets/month of Exalgo 8 mg, 12 mg, 16 mg OR 30 tablets/month of Exalgo 32 mg.]

Yes  No

1. Does the patient require use of MORE than any of the following: A) 90 capsules/month of Kadian 10 mg, 20 mg, 30 mg, 40 mg, B) 60 capsules/month of Kadian 50 mg, 60 mg, 70 mg, 80 mg, 100 mg, C) 30 capsules/month of Kadian 130 mg, 150 mg, 200 mg?

[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 90 capsules/month of Kadian 10 mg, 20 mg, 30 mg, 40 mg, B) 60 capsules/month of Kadian 50 mg, 60 mg, 70 mg, 80 mg, 100 mg, C) 30 capsules/month of Kadian 130 mg, 150 mg, 200 mg.]

Yes  No

1. Does the patient require use of MORE than any of the following: A) 90 tablets/month of Arymo ER 60 mg or MorphaBond 15 mg, 30 mg or MS Contin 60 mg, B) 120 tablets/month of Arymo ER 15 mg, 30 mg or MS Contin 15 mg, 30 mg, C) 60 tablets/month of MorphaBond 60 mg, 100 mg or MS Contin 100 mg, 200 mg?

[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for ONE of the following: A) 90 tablets/month of Arymo ER 60 mg or MorphaBond 15 mg, 30 mg or MS Contin 60 mg, B) 120 tablets/month of Arymo ER 15 mg, 30 mg or MS Contin 15 mg, 30 mg, C) 60 tablets/month of MorphaBond 60 mg, 100 mg or MS Contin 100 mg, 200 mg.]

Yes  No

1. Does the patient require use of MORE than 90 tablets/month of Nucynta ER 50 mg, 100 mg, 150 mg OR MORE than 60 tablets/month of Nucynta ER 200 mg, 250 mg?

[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for 90 tablets/month of Nucynta ER 50 mg, 100 mg, 150 mg OR 60 tablets/month of Nucynta ER 200 mg, 250 mg.]

Yes  No

2. Does the patient require use of MORE than 90 tablets/month of Opana ER 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, OR MORE than 60 tablets/month of Opana ER, 30 mg, 40 mg?

[No further questions.]

Yes  No
2. Does the patient require use of MORE than 90 tablets/month of Opana ER 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, OR 60 tablets/month of Opana ER, 30 mg, 40 mg?
   [No further questions.]

   [RPh Note: If yes, then deny and enter a partial approval for 90 tablets/month of Opana ER 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, OR 60 tablets/month of Opana ER, 30 mg, 40 mg.]

2. Does the patient require use of MORE than 90 tablets/month of OxyContin 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, OR MORE than 60 tablets/month of OxyContin 60 mg, 80 mg?
   [No further questions.]

   [RPh Note: If yes, then deny and enter a partial approval for 90 tablets/month of OxyContin 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, OR 60 tablets/month of OxyContin 60 mg, 80 mg.]

2. Does the patient require use of MORE than 90 tablets/month of Targiniq ER 10 mg/5 mg, 20 mg/10 mg OR MORE than 60 tablets/month of Targiniq ER 40 mg/20 mg?
   [No further questions.]

   [RPh Note: If yes, then deny and enter a partial approval for 90 tablets/month of Targiniq ER 10 mg/5 mg, 20 mg/10 mg OR 60 tablets/month of Targiniq ER 40 mg/20 mg.]

2. Does the patient require use of MORE than 90 capsules/month of Xtampza ER?
   [No further questions.]

   [RPh Note: If yes, then deny and enter a partial approval for 90 capsules/month of Xtampza ER.]

2. Does the patient require use of MORE than 90 capsules/month of Troxyca ER 10 mg/1.2 mg, 20 mg/2.4 mg, 30 mg/3.6 mg, 40 mg/4.8 mg OR MORE than 60 capsules/month of Troxyca ER 60 mg/7.2 mg, 80 mg/9.6 mg?

   [RPh Note: If yes, then deny and enter a partial approval for 90 capsules/month of Troxyca ER 10 mg/1.2 mg, 20 mg/2.4 mg, 30 mg/3.6 mg, 40 mg/4.8 mg OR 60 capsules/month of Troxyca ER 60 mg/7.2 mg, 80 mg/9.6 mg.]

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### Mapping Instructions

<table>
<thead>
<tr>
<th>1. #</th>
<th>YES</th>
<th>NO</th>
<th>DENIAL REASONS – DO NOT USE FOR MEDICARE PART D</th>
</tr>
</thead>
</table>
| 1.   | Approve, 12 months, No set post limit quantity | Go to 2 | Your plan covers this drug when you meet one of the following conditions:  
- You have been taking an opioid and you are using the drug for pain that is severe enough that you need daily, around-the-clock, long-term treatment  
- You have pain due to cancer or a terminal condition |
| 2.   | Go to 3 | Deny | |

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<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
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<td>4.</td>
<td>#</td>
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<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td>Go to 6</td>
</tr>
</tbody>
</table>
|   |   |   | **Your plan covers this drug when you meet all of these conditions:**  
- Your pain is checked the first month after your initial prescription or after a dose increase and every 3 months after that  
- Your pain is improving with the medication  
- You are able to function better with the medication  
- The benefits outweigh the risks of taking the medication  
Your use of this drug does not meet the requirements. This is based on the information we have. |
|   |   |   | Short Description: Patient’s pain is not being reassessed.] |
| 6. | 1=18; 2=10; 3=11; 4=12; 5=13; 6=8; 7=14; 8=15; 9=16; 10=7; 11=17; 12=8; 13=8; 14=8; 15=18; 16=18; 17=19; 18=20; 19=21; 20=22; 21=13; 22=13; 23=7; 24=23; 25=7; 26=24 | N/A |
| 7. | Deny | Approve, 12 months | You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to:  
- 60 units/month of Hysingla ER 20 mg, 30 mg, 40 mg, 60 mg, 80 mg, 100 mg OR Zohydro ER 50 mg OR Vantrela ER 60 mg, 90 mg or |
|   | RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage. | See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply) |   |

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| 8. | Deny | Go to 9 | Your plan covers this drug when you meet all of these conditions:
- You are using the drug for pain that is severe enough that you need daily, around-the-clock, long-term treatment
- You are not using the drug for detoxification treatment
- You are not using the drug as part of a treatment plan for opioid/substance abuse or addiction
Your use of this drug does not meet the requirement. This is based on the information we have.

[Short Description: Should not be used for opioid/substance abuse or addiction.]

| 9. | Deny | Approve, 12 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply) | You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to:
- 120 tablets/month of Dolophine 5 mg or Methadose 5 mg or
- 90 tablets/month of Dolophine 10 mg or Methadose 10 mg or
- 600 mL/month of Methadone oral solution 5 mg/5 mL or
- 450 mL/month of Methadone oral solution 10 mg/5 mL or
- 40 mL (2 multidose vials) of Methadone 200 mg/20 mL injection or
- 90 mL/month of Methadone Intensol (10 mg/mL) solution
You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied.

[Short Description: Over max quantity.]

| 10. | Deny | Approve, 12 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply) | You have requested more than the maximum quantity allowed by your plan. Current plan approved criteria cover up to:
- 60 capsules/month of Avinza 30 mg, 45 mg, 60 mg, 75 mg, 90 mg or
- 30 units/month of Hysingla ER 120 mg or
- 90 units/month of Zohydro ER 10 mg, 15 mg, 20 mg, 30 mg, 40 mg OR Vantrela ER 15 mg, 30 mg, 45 mg
You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied.

[Short Description: Over max quantity.]
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>other drugs from the verbiage.</td>
<td>for 1 month supply or Column D for a 3 month supply</td>
<td>- 30 capsules/month of Avinza 120 mg&lt;br&gt;You have been approved for the maximum quantity that your plan covers for a duration of 12 months. Your request for additional quantities of the requested drug and strength has been denied. [Short Description: Over max quantity.]</td>
</tr>
<tr>
<td>11.</td>
<td>Deny&lt;br&gt;RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.</td>
<td>Approve, 12 months&lt;br&gt;See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)</td>
</tr>
<tr>
<td>12.</td>
<td>Deny</td>
<td>Approve, 12 months&lt;br&gt;See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)</td>
</tr>
<tr>
<td>13.</td>
<td>Deny&lt;br&gt;RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.</td>
<td>Approve, 12 months&lt;br&gt;See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)</td>
</tr>
<tr>
<td></td>
<td>Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.</td>
<td>Approve, 12 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
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</tr>
<tr>
<td>14.</td>
<td>Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.</td>
<td>Approve, 12 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)</td>
</tr>
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<td>15.</td>
<td>Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.</td>
<td>Approve, 12 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)</td>
</tr>
<tr>
<td>16.</td>
<td>Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.</td>
<td>Approve, 12 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)</td>
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<tr>
<td>17.</td>
<td>Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.</td>
<td>Approve, 12 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)</td>
</tr>
<tr>
<td></td>
<td>Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.</td>
<td>Approve, 12 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)</td>
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<td>---</td>
<td>---</td>
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</tr>
<tr>
<td>18.</td>
<td>Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.</td>
<td>Approve, 12 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)</td>
</tr>
<tr>
<td>19.</td>
<td>Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.</td>
<td>Approve, 12 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)</td>
</tr>
<tr>
<td>20.</td>
<td>Deny RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.</td>
<td>Approve, 12 months See Opioid Analgesics ER Quantity Limits Chart (Column C for 1 month supply or Column D for a 3 month supply)</td>
</tr>
<tr>
<td>21.</td>
<td>Deny RPh Note: For the denial verbiage, only</td>
<td>Approve, 12 months</td>
</tr>
<tr>
<td></td>
<td>Deny</td>
<td>Approve, 12 months</td>
</tr>
<tr>
<td>---</td>
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<td>--------------------</td>
</tr>
<tr>
<td>22.</td>
<td>RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.</td>
<td>Current plan approved criteria cover up to: - 90 tablets/month of OxyContin 10 mg, 15 mg, 20 mg, 30 mg, 40 mg or - 60 tablets/month of OxyContin 60 mg, 80 mg</td>
</tr>
<tr>
<td>23.</td>
<td>RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.</td>
<td>Current plan approved criteria cover up to: - 90 tablets/month of Targiniq ER 10 mg/5 mg, 20 mg/10 mg or - 60 tablets/month of Targiniq ER 40 mg/20 mg</td>
</tr>
<tr>
<td>24.</td>
<td>RPh Note: For the denial verbiage, only include the requested drug. Remove all the other drugs from the verbiage.</td>
<td>Current plan approved criteria cover up to: - 90 capsules/month of Troxyca ER 10 mg/1.2 mg, 20 mg/2.4 mg, 30 mg/3.6 mg, 40 mg/4.8 mg or - 60 capsules/month of Troxyca ER 60 mg/7.2 mg, 80 mg/9.6 mg</td>
</tr>
</tbody>
</table>
Coverage is provided without prior authorization for 30-day or 90-day ER opioid prescriptions for a quantity that corresponds to ≤ 90 MME/day. Coverage for quantities that correspond to ≤ 200 MME/day (unless minimum FDA-labeled strength/dose/frequency exceeds 200 MME/day) for a 30-day or 90-day supply is provided through prior authorization when coverage conditions are met.

These quantity limits should accumulate across all drugs of the same unit limit (i.e., drugs with 30 units accumulate together, drugs with 60 units accumulate together, etc.).

<table>
<thead>
<tr>
<th>Drug/Strength</th>
<th>Initial 1 Month Limit* ≤ 90 MME/day (per 25 days)</th>
<th>Initial 3 Month Limit* ≤ 90 MME/day (per 75 days)</th>
<th>Post 1 Month Limit* ≤ 200 MME/day** (per 25 days)</th>
<th>Post 3 Month Limit* ≤ 200 MME/day** (per 75 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arymo ER 15 mg</td>
<td>q8-12h</td>
<td>90 tabs (45 MME/day)</td>
<td>270 tabs (45 MME/day)</td>
<td>120 tabs (60 MME/day)</td>
</tr>
<tr>
<td>Arymo ER 30 mg</td>
<td>q8-12h</td>
<td>90 tabs (90 MME/day)</td>
<td>270 tabs (90 MME/day)</td>
<td>120 tabs (120 MME/day)</td>
</tr>
<tr>
<td>Arymo ER 60 mg</td>
<td>q8-12h</td>
<td>0***</td>
<td>0***</td>
<td>90 tabs (180 MME/day)</td>
</tr>
<tr>
<td>Avinza 30 mg</td>
<td>q24h, MAX 1600 mg/day</td>
<td>30 caps (30 MME/day)</td>
<td>90 caps (30 MME/day)</td>
<td>60 caps (60 MME/day)</td>
</tr>
<tr>
<td>Avinza 45 mg</td>
<td>q24h, MAX 1600 mg/day</td>
<td>30 caps (45 MME/day)</td>
<td>90 caps (45 MME/day)</td>
<td>60 caps (90 MME/day)</td>
</tr>
<tr>
<td>Avinza 60 mg</td>
<td>q24h, MAX 1600 mg/day</td>
<td>30 caps (60 MME/day)</td>
<td>90 caps (60 MME/day)</td>
<td>60 caps (120 MME/day)</td>
</tr>
<tr>
<td>Avinza 75 mg</td>
<td>q24h, MAX 1600 mg/day</td>
<td>30 caps (75 MME/day)</td>
<td>90 caps (75 MME/day)</td>
<td>60 caps (150 MME/day)</td>
</tr>
<tr>
<td>Avinza 90 mg</td>
<td>q24h, MAX 1600 mg/day</td>
<td>30 caps (90 MME/day)</td>
<td>90 caps (90 MME/day)</td>
<td>60 caps (180 MME/day)</td>
</tr>
<tr>
<td>Avinza 120 mg</td>
<td>q24h, MAX 1600 mg/day</td>
<td>0***</td>
<td>0***</td>
<td>30 caps (120 MME/day)</td>
</tr>
<tr>
<td>Belbuca 75 mcg</td>
<td>1 film q12h, MAX 900 mcg/12 hrs</td>
<td>60 films (4.5 MME/day)</td>
<td>180 films (4.5 MME/day)</td>
<td>90 films (6.75 MME/day)</td>
</tr>
<tr>
<td>Belbuca 150 mcg</td>
<td>1 film q12h, MAX 900 mcg/12 hrs</td>
<td>60 films (9 MME/day)</td>
<td>180 films (9 MME/day)</td>
<td>90 films (13.5 MME/day)</td>
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<tr>
<td>Belbuca 300 mcg</td>
<td>1 film q12h, MAX 900 mcg/12 hrs</td>
<td>60 films (18 MME/day)</td>
<td>180 films (18 MME/day)</td>
<td>90 films (27 MME/day)</td>
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<tr>
<td>Belbuca 450 mcg</td>
<td>1 film q12h, MAX 900 mcg/12 hrs</td>
<td>60 films (27 MME/day)</td>
<td>180 films (27 MME/day)</td>
<td>90 films (27 MME/day)</td>
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<td>Dose</td>
<td>Schedule</td>
<td>Maximum Dose</td>
<td>Conversions</td>
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<tr>
<td>Belbuca 600 mcg</td>
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<td>60 films</td>
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<td>Belbuca 750 mcg</td>
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<td>60 films</td>
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<tr>
<td>Belbuca 900 mcg</td>
<td>1 film q12h, MAX 900 mcg/12 hrs</td>
<td>0***</td>
<td>60 films</td>
<td>(54 MME/day)</td>
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<tr>
<td>Butrans 5 mcg/hr</td>
<td>1 patch q7d, MAX 20 mcg/hr</td>
<td>4 patches</td>
<td>8 patches</td>
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<td>Butrans 7.5 mcg/hr</td>
<td>1 patch q7d, MAX 20 mcg/hr</td>
<td>4 patches</td>
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<td>(27 MME/day)</td>
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<tr>
<td>Butrans 10 mcg/hr</td>
<td>1 patch q7d, MAX 20 mcg/hr</td>
<td>4 patches</td>
<td>8 patches</td>
<td>(36 MME/day)</td>
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<tr>
<td>Butrans 15 mcg/hr</td>
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<td>0***</td>
<td>4 patches</td>
<td>(27 MME/day)</td>
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<tr>
<td>Butrans 20 mcg/hr</td>
<td>1 patch q7d, MAX 20 mcg/hr</td>
<td>0***</td>
<td>4 patches</td>
<td>(36 MME/day)</td>
</tr>
<tr>
<td>Conzip 100 mg</td>
<td>1 tab qd, MAX 300 mg/day</td>
<td>30 caps</td>
<td>60 caps</td>
<td>(20 MME/day)</td>
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<tr>
<td>Conzip 200 mg</td>
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<td>0***</td>
<td>30 caps</td>
<td>(20 MME/day)</td>
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<tr>
<td>Conzip 300 mg</td>
<td>1 tab qd, MAX 300 mg/day</td>
<td>0***</td>
<td>30 caps</td>
<td>(30 MME/day)</td>
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<tr>
<td>Dolophine 5 mg</td>
<td>q8-12h</td>
<td>90 tabs</td>
<td>120 tabs</td>
<td>(80 MME/day)</td>
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<tr>
<td>Dolophine 10 mg</td>
<td>q8-12h</td>
<td>60 tabs</td>
<td>90 tabs</td>
<td>(80 MME/day)</td>
</tr>
<tr>
<td>Duragesic 12 mcg</td>
<td>1 patch q72h</td>
<td>10 patches</td>
<td>20 patches</td>
<td>(57.6 MME/day)</td>
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<tr>
<td>Duragesic 25 mcg</td>
<td>1 patch q72h</td>
<td>10 patches</td>
<td>20 patches</td>
<td>(120 MME/day)</td>
</tr>
<tr>
<td>Duragesic 37.5 mcg</td>
<td>1 patch q72h</td>
<td>10 patches</td>
<td>20 patches</td>
<td>(180 MME/day)</td>
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<tr>
<td>Duragesic 50 mcg</td>
<td>1 patch q72h</td>
<td>0***</td>
<td>10 patches</td>
<td>(120 MME/day)</td>
</tr>
<tr>
<td>Duragesic 62.5 mcg</td>
<td>1 patch q72h</td>
<td>0***</td>
<td>10 patches</td>
<td>(150 MME/day)</td>
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<tr>
<td>Duragesic 75 mcg</td>
<td>1 patch q72h</td>
<td>0***</td>
<td>10 patches</td>
<td>(180 MME/day)</td>
</tr>
<tr>
<td>Duragesic 87.5 mcg</td>
<td>1 patch q72h</td>
<td>0***</td>
<td>10 patches</td>
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<tr>
<td>Brand</td>
<td>Frequency</td>
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<td>Dose 2</td>
<td>Dose 3</td>
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<td>-------------------</td>
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<tr>
<td>Duragesic 100 mcg</td>
<td>1 patch q72h</td>
<td>0***</td>
<td>0***</td>
<td>10 patches (240 MME/day)</td>
</tr>
<tr>
<td>Embeda 20/0.8 mg</td>
<td>q12-24h</td>
<td>60 caps (40 MME/day)</td>
<td>180 caps (40 MME/day)</td>
<td>90 caps (60 MME/day)</td>
</tr>
<tr>
<td>Embeda 30/1.2 mg</td>
<td>q12-24h</td>
<td>60 caps (60 MME/day)</td>
<td>180 caps (60 MME/day)</td>
<td>90 caps (90 MME/day)</td>
</tr>
<tr>
<td>Embeda 50/2 mg</td>
<td>q12-24h</td>
<td>30 caps (50 MME/day)</td>
<td>90 caps (50 MME/day)</td>
<td>60 caps (100 MME/day)</td>
</tr>
<tr>
<td>Embeda 60/2.4 mg</td>
<td>q12-24h</td>
<td>30 caps (60 MME/day)</td>
<td>90 caps (60 MME/day)</td>
<td>60 caps (120 MME/day)</td>
</tr>
<tr>
<td>Embeda 80/3.2 mg</td>
<td>q12-24h</td>
<td>30 caps (80 MME/day)</td>
<td>90 caps (80 MME/day)</td>
<td>60 caps (160 MME/day)</td>
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<tr>
<td>Embeda 100/4 mg</td>
<td>q12-24h</td>
<td>0***</td>
<td>0***</td>
<td>60 caps (200 MME/day)</td>
</tr>
<tr>
<td>Exalgo 8 mg</td>
<td>1 tab qd</td>
<td>30 tabs (32 MME/day)</td>
<td>90 tabs (32 MME/day)</td>
<td>60 tabs (64 MME/day)</td>
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<tr>
<td>Exalgo 12 mg</td>
<td>1 tab qd</td>
<td>30 tabs (48 MME/day)</td>
<td>90 tabs (48 MME/day)</td>
<td>60 tabs (96 MME/day)</td>
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<td>Exalgo 16 mg</td>
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<td>90 tabs (64 MME/day)</td>
<td>60 tabs (128 MME/day)</td>
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<tr>
<td>Exalgo 32 mg</td>
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<td>0***</td>
<td>30 tabs (128 MME/day)</td>
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<tr>
<td>Hysingla ER 20 mg</td>
<td>q24h</td>
<td>30 tabs (20 MME/day)</td>
<td>90 tabs (20 MME/day)</td>
<td>60 tabs (40 MME/day)</td>
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<tr>
<td>Hysingla ER 30 mg</td>
<td>q24h</td>
<td>30 tabs (30 MME/day)</td>
<td>90 tabs (30 MME/day)</td>
<td>60 tabs (60 MME/day)</td>
</tr>
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<td>Hysingla ER 40 mg</td>
<td>q24h</td>
<td>30 tabs (40 MME/day)</td>
<td>90 tabs (40 MME/day)</td>
<td>60 tabs (80 MME/day)</td>
</tr>
<tr>
<td>Hysingla ER 60 mg</td>
<td>q24h</td>
<td>30 tabs (60 MME/day)</td>
<td>90 tabs (60 MME/day)</td>
<td>60 tabs (120 MME/day)</td>
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<tr>
<td>Hysingla ER 80 mg</td>
<td>q24h</td>
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<td>90 tabs (80 MME/day)</td>
<td>60 tabs (160 MME/day)</td>
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<tr>
<td>Hysingla ER 100 mg</td>
<td>q24h</td>
<td>0***</td>
<td>0***</td>
<td>60 tabs (200 MME/day)</td>
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<tr>
<td>Hysingla ER 120 mg</td>
<td>q24h</td>
<td>0***</td>
<td>0***</td>
<td>30 tabs (120 MME/day)</td>
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<td>Kadian 10 mg</td>
<td>q12-24h</td>
<td>60 caps (20 MME/day)</td>
<td>180 caps (20 MME/day)</td>
<td>90 caps (30 MME/day)</td>
</tr>
<tr>
<td>Kadian 20 mg</td>
<td>q12-24h</td>
<td>60 caps (40 MME/day)</td>
<td>180 caps (40 MME/day)</td>
<td>90 caps (60 MME/day)</td>
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<td>Product</td>
<td>Administration</td>
<td>Dose 1</td>
<td>Dose 2</td>
<td>Dose 3</td>
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<tr>
<td>Kadian 30 mg</td>
<td>q12-24h</td>
<td>60 caps (60 MME/day)</td>
<td>180 caps (60 MME/day)</td>
<td>90 caps (90 MME/day)</td>
</tr>
<tr>
<td>Kadian 40 mg</td>
<td>q12-24h</td>
<td>60 caps (80 MME/day)</td>
<td>180 caps (80 MME/day)</td>
<td>90 caps (120 MME/day)</td>
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<tr>
<td>Kadian 50 mg</td>
<td>q12-24h</td>
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<td>90 caps (50 MME/day)</td>
<td>60 caps (100 MME/day)</td>
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<tr>
<td>Kadian 60 mg</td>
<td>q12-24h</td>
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<td>90 caps (60 MME/day)</td>
<td>60 caps (120 MME/day)</td>
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<td>Kadian 70 mg</td>
<td>q12-24h</td>
<td>30 caps (70 MME/day)</td>
<td>90 caps (70 MME/day)</td>
<td>60 caps (140 MME/day)</td>
</tr>
<tr>
<td>Kadian 80 mg</td>
<td>q12-24h</td>
<td>30 caps (80 MME/day)</td>
<td>90 caps (80 MME/day)</td>
<td>60 caps (160 MME/day)</td>
</tr>
<tr>
<td>Kadian 100 mg</td>
<td>q12-24h</td>
<td>0***</td>
<td>0***</td>
<td>60 caps (200 MME/day)</td>
</tr>
<tr>
<td>Kadian 130 mg</td>
<td>q12-24h</td>
<td>0***</td>
<td>0***</td>
<td>30 caps (130 MME/day)</td>
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<tr>
<td>Kadian 150 mg</td>
<td>q12-24h</td>
<td>0***</td>
<td>0***</td>
<td>30 caps (150 MME/day)</td>
</tr>
<tr>
<td>Kadian 200 mg</td>
<td>q12-24h</td>
<td>0***</td>
<td>0***</td>
<td>30 caps (200 MME/day)</td>
</tr>
<tr>
<td>Methadone 10 mg/mL Intensol soln</td>
<td>q8-12h</td>
<td>60 mL (80 MME/day)</td>
<td>180 mL (80 MME/day)</td>
<td>90 mL (120 MME/day)</td>
</tr>
<tr>
<td>Methadone 5 mg/5 mL Oral soln</td>
<td>q8-12h</td>
<td>450 mL (60 MME/day)</td>
<td>1350 mL (60 MME/day)</td>
<td>600 mL (80 MME/day)</td>
</tr>
<tr>
<td>Methadone 10 mg/5 mL Oral soln</td>
<td>q8-12h</td>
<td>300 mL (80 MME/day)</td>
<td>900 mL (80 MME/day)</td>
<td>450 mL (120 MME/day)</td>
</tr>
<tr>
<td>Methadone 200 mg/20 mL inj</td>
<td>q8-12h</td>
<td>20 mL (1 multidose vial) (26.7 MME/day)</td>
<td>60 mL (3 multidose vials) (26.7 MME/day)</td>
<td>40 mL (2 multidose vials) (53.3 MME/day)</td>
</tr>
<tr>
<td>Methadose 5 mg</td>
<td>q8-12h</td>
<td>90 tabs (60 MME/day)</td>
<td>270 tabs (60 MME/day)</td>
<td>120 tabs (80 MME/day)</td>
</tr>
<tr>
<td>Methadose 10 mg</td>
<td>q8-12h</td>
<td>60 tabs (80 MME/day)</td>
<td>180 tabs (80 MME/day)</td>
<td>90 tabs (120 MME/day)</td>
</tr>
<tr>
<td>MorphaBond 15 mg</td>
<td>q12h</td>
<td>60 tabs (30 MME/day)</td>
<td>180 tabs (30 MME/day)</td>
<td>90 tabs (45 MME/day)</td>
</tr>
<tr>
<td>MorphaBond 30 mg</td>
<td>q12h</td>
<td>60 tabs (60 MME/day)</td>
<td>180 tabs (60 MME/day)</td>
<td>90 tabs (90 MME/day)</td>
</tr>
<tr>
<td>MorphaBond 60 mg</td>
<td>q12h</td>
<td>0***</td>
<td>0***</td>
<td>60 tabs (120 MME/day)</td>
</tr>
<tr>
<td>Controlled Substance</td>
<td>Frequency</td>
<td>Dose</td>
<td>MME/day</td>
<td>Number of Tablets</td>
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<tr>
<td>MorphaBond 100 mg</td>
<td>q12h</td>
<td>0***</td>
<td>200 MME/day</td>
<td>60 tabs</td>
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<tr>
<td></td>
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<td>0***</td>
<td>200 MME/day</td>
<td>180 tabs</td>
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<tr>
<td>MS Contin 15 mg</td>
<td>q8-12h</td>
<td>90 tabs (45 MME/day)</td>
<td>120 tabs (60 MME/day)</td>
<td>360 tabs (120 MME/day)</td>
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<td>MS Contin 30 mg</td>
<td>q8-12h</td>
<td>90 tabs (90 MME/day)</td>
<td>120 tabs (120 MME/day)</td>
<td>360 tabs (120 MME/day)</td>
</tr>
<tr>
<td>MS Contin 60 mg</td>
<td>q8-12h</td>
<td>0***</td>
<td>180 MME/day</td>
<td>90 tabs</td>
</tr>
<tr>
<td>MS Contin 100 mg</td>
<td>q8-12h</td>
<td>0***</td>
<td>200 MME/day</td>
<td>60 tabs</td>
</tr>
<tr>
<td>MS Contin 200 mg</td>
<td>q8-12h</td>
<td>0***</td>
<td>200 MME/day</td>
<td>180 tabs</td>
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<tr>
<td>Nucynta ER 50 mg</td>
<td>q12h, MAX 500 mg/day</td>
<td>60 tabs (40 MME/day)</td>
<td>180 tabs (60 MME/day)</td>
<td>90 tabs (60 MME/day)</td>
</tr>
<tr>
<td>Nucynta ER 100 mg</td>
<td>q12h, MAX 500 mg/day</td>
<td>60 tabs (80 MME/day)</td>
<td>180 tabs (120 MME/day)</td>
<td>270 tabs (120 MME/day)</td>
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<tr>
<td>Nucynta ER 150 mg</td>
<td>q12h, MAX 500 mg/day</td>
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<td>180 MME/day</td>
<td>90 tabs</td>
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<tr>
<td>Nucynta ER 200 mg</td>
<td>q12h, MAX 500 mg/day</td>
<td>0***</td>
<td>180 MME/day</td>
<td>60 tabs</td>
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<td>Nucynta ER 250 mg</td>
<td>q12h, MAX 500 mg/day</td>
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<td>180 MME/day</td>
<td>60 tabs</td>
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<tr>
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<td>Opana ER 7.5 mg</td>
<td>q12h</td>
<td>60 tabs (45 MME/day)</td>
<td>180 tabs (67.5 MME/day)</td>
<td>90 tabs (67.5 MME/day)</td>
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<tr>
<td>Opana ER 10 mg</td>
<td>q12h</td>
<td>60 tabs (60 MME/day)</td>
<td>180 tabs (90 MME/day)</td>
<td>90 tabs (90 MME/day)</td>
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<tr>
<td>Opana ER 15 mg</td>
<td>q12h</td>
<td>60 tabs (90 MME/day)</td>
<td>180 tabs (135 MME/day)</td>
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<td>180 MME/day</td>
<td>90 tabs</td>
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<td>270 tabs</td>
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<td>240 MME/day</td>
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<td>0***</td>
<td>240 MME/day</td>
<td>180 tabs</td>
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<td>OxyContin 10 mg</td>
<td>q12h</td>
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<td>90 tabs (45 MME/day)</td>
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<td>q12h</td>
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<td>90 tabs (67.5 MME/day)</td>
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<td>OxyContin 60 mg</td>
<td>q12h</td>
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<td>Targiniq ER 10 mg/5 mg</td>
<td>q12h, MAX 80 mg/40 mg (40 mg/20 mg q12h)</td>
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<td>180 tabs</td>
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<td>(120 MME/day)</td>
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<tr>
<td>Tramadol ER 100 mg</td>
<td>1 tab qd, MAX 300 mg/day</td>
<td>30 tabs</td>
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<td>60 tabs</td>
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<td>Tramadol ER 150 mg</td>
<td>1 cap qd, MAX 300 mg/day</td>
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<td>Tramadol ER 200 mg</td>
<td>1 tab qd, MAX 300 mg/day</td>
<td>0***</td>
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<tr>
<td>Tramadol ER 300 mg</td>
<td>1 tab qd, MAX 300 mg/day</td>
<td>0***</td>
<td>0***</td>
<td>30 tabs</td>
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<td>Troxyca ER 10 mg/1.2 mg</td>
<td>q12h</td>
<td>60 caps</td>
<td>180 caps</td>
<td>90 caps</td>
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<tr>
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<td>30 MME/day</td>
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<td>Troxyca ER 20 mg/2.4 mg</td>
<td>q12h</td>
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<td>180 caps</td>
<td>90 caps</td>
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<td>60 MME/day</td>
<td>60 MME/day</td>
<td>(90 MME/day)</td>
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<td>Troxyca ER 30 mg/3.6 mg</td>
<td>q12h</td>
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<td>180 caps</td>
<td>90 caps</td>
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<tr>
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<td>90 MME/day</td>
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<td>(135 MME/day)</td>
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<tr>
<td>Troxyca ER 40 mg/4.8 mg</td>
<td>q12h</td>
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<td>0***</td>
<td>90 caps</td>
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<td>(180 MME/day)</td>
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<tr>
<td>Troxyca ER 60 mg/7.2 mg</td>
<td>q12h</td>
<td>0***</td>
<td>0***</td>
<td>60 caps</td>
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<tr>
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<td>(180 MME/day)</td>
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<tr>
<td>Troxyca ER 80 mg/9.6 mg</td>
<td>q12h</td>
<td>0***</td>
<td>0***</td>
<td>60 caps</td>
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<td>Ultram ER 100 mg</td>
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<td>10 MME/day</td>
<td>10 MME/day</td>
<td>(20 MME/day)</td>
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<tr>
<td>Ultram ER 200 mg</td>
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<td>0***</td>
<td>0***</td>
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<tr>
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<td>0***</td>
<td>0***</td>
<td>30 tabs</td>
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<td>Dosage Form</td>
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<td>Dose/Frequency</td>
<td>Quantity (MME/day)</td>
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<td>60 MME/day</td>
<td>60 tabs</td>
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<tr>
<td>Vantrela ER 45 mg</td>
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<tr>
<td>Xtampza ER 9 mg</td>
<td>q12h, MAX</td>
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<td>27 MME/day</td>
<td>60 caps</td>
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<td>288 mg/day</td>
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<tr>
<td>Xtampza ER 13.5 mg</td>
<td>q12h, MAX</td>
<td>13.5 mg</td>
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<td></td>
<td>288 mg/day</td>
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<td>q12h, MAX</td>
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<td>288 mg/day</td>
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<tr>
<td>Xtampza ER 27 mg</td>
<td>q12h, MAX</td>
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<td>60 caps</td>
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<td>(0*** MME/day)</td>
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<td>Zohydro ER 10 mg</td>
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<td>60 caps</td>
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<td>Zohydro ER 50 mg</td>
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<tr>
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*The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing. Limits are set up as quantity versus time edits.

**Unless minimum FDA-labeled strength/dose/frequency exceeds 200 MME/day.

***The initial limit is zero. All requests for this drug and strength will be considered through post limit prior authorization.