Transmucosal Immediate Release Fentanyl (TIRF) Prior Authorization with Quantity Limit Program Summary

This program applies to Medicaid.

The BCBS MN Step Therapy Supplement also applies to this program for Medicaid.

POLICY REVIEW CYCLE

Effective Date	Date of Origin
03-01-2024	01-01-2017

FDA APPROVED INDICATIONS AND DOSAGE

Agent(s)	FDA Indication(s)	Notes	Ref#
Actiq® (fentanyl) Transmucosal lozenge*	Management of breakthrough pain in cancer patients 16 years of age and older who are already receiving, and who are tolerant to, around-the-clock opioid therapy for their underlying persistent cancer pain	*Generic available	2
Fentora®, Fentanyl Buccal tablet	Management of breakthrough pain in cancer patients 18 years of age and older who are already receiving, and who are tolerant to, around-the-clock opioid therapy for their underlying persistent cancer pain		3
Lazanda® (fentanyl) Nasal spray	Management of breakthrough pain in cancer patients 18 years of age and older who are already receiving, and who are tolerant to, around-the-clock opioid therapy for their underlying persistent cancer pain		4
Subsys® (fentanyl) Sublingual spray	Management of breakthrough pain in cancer patients 18 years of age and older who are already receiving, and who are tolerant to, around-the-clock opioid therapy for their underlying persistent cancer pain		5

See package insert for FDA prescribing information: https://dailymed.nlm.nih.gov/dailymed/index.cfm

CLINICAL RATIONALE

CLINICAL RATIONALE	Transmucosal immediate release fentanyl (TIRF) products are indicated only in patients who are already receiving opioid therapy and who are tolerant to opioid therapy. Life-threatening respiratory depression and death could occur at any dose in opioid non-tolerant patients. Patients considered opioid tolerant are those who are taking, for one week or longer, around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg oral oxymorphone per day, at least 60 mg oral hydrocodone per day, or an equianalgesic dose of another opioid daily. Patients must remain on around-the-clock opioids while taking TIRF products. TIRF products are not bioequivalent with other TIRF products. Patients should not be converted on a mcg per mcg basis from one TIRF product to another.(2-5)

Safety	TIRF products carry a boxed warning for the following:(2-5) • Life-threatening respiratory depression • Accidental ingestion, especially by children • Concomitant use with CYP3A4 inhibitors • Concomitant use with benzodiazepines and/or other CNS depressants • Risk of medication errors (e.g. conversion or substitution with other fentanyl products) • Addiction, abuse, and misuse • Risk Evaluation and Mitigation Strategy • Neonatal opioid withdrawal syndrome (i.e., prolonged use during pregnancy) TIRF products have the following contraindications:(2-5) • Opioid non-tolerant patients • Significant respiratory depression • Management of acute or postoperative pain including headache, migraines, dental pain, or use in the emergency department • Acute or severe bronchial asthma in an unmonitored setting or in absence of resuscitative equipment • Known or suspected gastrointestinal obstruction • Known hypersensitivity to fentanyl or any other components of the agent Actiq, Fentora, Lazanda, and Subsys are available only through a restricted program called the TIRF REMS Access program. Outpatients, healthcare professionals who prescribe to outpatients, pharmacies, and distributors are required to enroll in the program.(2-5)

REFERENCES

Number	Reference
1	Reference no longer used.
2	Actiq prescribing information. Cephalon, Inc. November 2022.
3	Fentora prescribing information. Cephalon, Inc. November 2022.
4	Lazanda prescribing information. West Therapeutic Development, LLC. March 2021.
5	Subsys prescribing information. Insys Therapeutics, Inc. April 2021.

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Fentora	fentanyl citrate buccal tab	100 MCG ; 200 MCG ; 400 MCG ; 600 MCG ; 800 MCG	M ; N ; O ; Y	M		
Actiq	fentanyl citrate lozenge on a handle	1200 MCG ; 1600 MCG ; 200 MCG ; 400 MCG ; 600	M ; N ; O ; Y	O ; Y		

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
		MCG ; 800 MCG				
Lazanda	Fentanyl Citrate Nasal Spray 100 MCG/ACT (Base Equiv)	100 MCG/ACT	M ; N ; O ; Y	N		
Lazanda	Fentanyl Citrate Nasal Spray 400 MCG/ACT (Base Equiv)	400 MCG/ACT	M ; N ; O ; Y	N		
Subsys	fentanyl sublingual spray	100 MCG ; 1200 MCG ; 1600 MCG ; 200 MCG ; 400 MCG ; 600 MCG ; 800 MCG	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Actiq	Fentanyl Citrate Lozenge on a Handle 1200 MCG	1200 MCG	120	Lozenges	30	DAYS			
Actiq	Fentanyl Citrate Lozenge on a Handle 1600 MCG	1600 MCG	120	Lozenges	30	DAYS			
Actiq	Fentanyl Citrate Lozenge on a Handle 200 MCG	200 MCG	120	Lozenges	30	DAYS			
Actiq	Fentanyl Citrate Lozenge on a Handle 400 MCG	400 MCG	120	Lozenges	30	DAYS			
Actiq	Fentanyl Citrate Lozenge on a Handle 600 MCG	600 MCG	120	Lozenges	30	DAYS			
Actiq	Fentanyl Citrate Lozenge on a Handle 800 MCG	800 MCG	120	Lozenges	30	DAYS			
Fentora	Fentanyl Citrate Buccal Tab 100 MCG (Base Equiv)	100 MCG	120	Tablets	30	DAYS			
Fentora	Fentanyl Citrate Buccal Tab 200 MCG (Base Equiv)	200 MCG	120	Tablets	30	DAYS			
Fentora	Fentanyl Citrate Buccal Tab 400 MCG (Base Equiv)	400 MCG	120	Tablets	30	DAYS			
Fentora	Fentanyl Citrate Buccal Tab 600 MCG (Base Equiv)	600 MCG	120	Tablets	30	DAYS			
Fentora	Fentanyl Citrate Buccal Tab 800 MCG (Base Equiv)	800 MCG	120	Tablets	30	DAYS			
Lazanda	Fentanyl Citrate Nasal Spray 100 MCG/ACT (Base Equiv)	100 MCG/ACT	30	Bottles	30	DAYS			
Lazanda	Fentanyl Citrate Nasal Spray 400 MCG/ACT (Base Equiv)	400 MCG/ACT	30	Bottles	30	DAYS			

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Subsys	Fentanyl Sublingual Spray 100 MCG	100 MCG	120	Sprays	30	DAYS			
Subsys	Fentanyl Sublingual Spray 1200 MCG (600 MCG X 2)	1200 MCG	240	Sprays	30	DAYS			
Subsys	Fentanyl Sublingual Spray 1600 MCG (800 MCG X 2)	1600 MCG	240	Sprays	30	DAYS			
Subsys	Fentanyl Sublingual Spray 200 MCG	200 MCG	120	Sprays	30	DAYS			
Subsys	Fentanyl Sublingual Spray 400 MCG	400 MCG	120	Sprays	30	DAYS			
Subsys	Fentanyl Sublingual Spray 600 MCG	600 MCG	120	Sprays	30	DAYS			
Subsys	Fentanyl Sublingual Spray 800 MCG	800 MCG	120	Sprays	30	DAYS			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Actiq	fentanyl citrate lozenge on a handle	1200 MCG ; 1600 MCG ; 200 MCG ; 400 MCG ; 600 MCG ; 800 MCG	Medicaid
Fentora	fentanyl citrate buccal tab	100 MCG ; 200 MCG ; 400 MCG ; 600 MCG ; 800 MCG	Medicaid
Lazanda	Fentanyl Citrate Nasal Spray 100 MCG/ACT (Base Equiv)	100 MCG/ACT	Medicaid
Lazanda	Fentanyl Citrate Nasal Spray 400 MCG/ACT (Base Equiv)	400 MCG/ACT	Medicaid
Subsys	fentanyl sublingual spray	100 MCG ; 1200 MCG ; 1600 MCG ; 200 MCG ; 400 MCG ; 600 MCG ; 800 MCG	Medicaid

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Actiq	Fentanyl Citrate Lozenge on a Handle 1200 MCG	1200 MCG	Medicaid
Actiq	Fentanyl Citrate Lozenge on a Handle 1600 MCG	1600 MCG	Medicaid
Actiq	Fentanyl Citrate Lozenge on a Handle 200 MCG	200 MCG	Medicaid
Actiq	Fentanyl Citrate Lozenge on a Handle 400 MCG	400 MCG	Medicaid
Actiq	Fentanyl Citrate Lozenge on a Handle 600 MCG	600 MCG	Medicaid
Actiq	Fentanyl Citrate Lozenge on a Handle 800 MCG	800 MCG	Medicaid
Fentora	Fentanyl Citrate Buccal Tab 100 MCG (Base Equiv)	100 MCG	Medicaid
Fentora	Fentanyl Citrate Buccal Tab 200 MCG (Base Equiv)	200 MCG	Medicaid
Fentora	Fentanyl Citrate Buccal Tab 400 MCG (Base Equiv)	400 MCG	Medicaid
Fentora	Fentanyl Citrate Buccal Tab 600 MCG (Base Equiv)	600 MCG	Medicaid
Fentora	Fentanyl Citrate Buccal Tab 800 MCG (Base Equiv)	800 MCG	Medicaid

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Lazanda	Fentanyl Citrate Nasal Spray 100 MCG/ACT (Base Equiv)	100 MCG/ACT	Medicaid
Lazanda	Fentanyl Citrate Nasal Spray 400 MCG/ACT (Base Equiv)	400 MCG/ACT	Medicaid
Subsys	Fentanyl Sublingual Spray 100 MCG	100 MCG	Medicaid
Subsys	Fentanyl Sublingual Spray 1200 MCG (600 MCG X 2)	1200 MCG	Medicaid
Subsys	Fentanyl Sublingual Spray 1600 MCG (800 MCG X 2)	1600 MCG	Medicaid
Subsys	Fentanyl Sublingual Spray 200 MCG	200 MCG	Medicaid
Subsys	Fentanyl Sublingual Spray 400 MCG	400 MCG	Medicaid
Subsys	Fentanyl Sublingual Spray 600 MCG	600 MCG	Medicaid
Subsys	Fentanyl Sublingual Spray 800 MCG	800 MCG	Medicaid

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	Evaluation **Target Agent(s)** will be approved when ALL of the following are met: 1. The patient has a diagnosis of chronic cancer pain due to active malignancy **AND** 2. If the patient has an FDA approved indication, then ONE of the following: A. The patient's age is within FDA labeling for the requested agent **OR** B. The prescriber has provided information in support of using the requested agent for the patient's age for the requested indication **AND** 3. The patient is currently opioid tolerant (taking, for one week or longer, around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg oral oxymorphone per day, at least 60 mg oral hydrocodone per day, or an equianalgesic dose of another opioid daily) **AND** 4. The patient is taking a long-acting opioid concurrently with the requested TIRF agent **AND** 5. The patient will NOT be using the requested agent with any other TIRF agent in any other strength **AND** 6. ONE of the following: A. The request is for a generic TIRF agent **OR** B. The request is for a brand TIRF agent AND ONE of the following: 1. The patient's medication history includes use of at least ONE generic TIRF agent **OR** 2. Information has been provided that indicates the patient is currently being treated with the requested agent within the past 90 days **OR** 3. The prescriber states the patient is currently being treated with the requested agent within the past 90 days AND is at risk if therapy is changed **OR** 4. The patient is currently being treated with the requested agent as indicated by ALL of the following: A. A statement by the prescriber that the patient is currently taking the requested agent **AND** B. A statement by the prescriber that the patient is currently receiving a positive therapeutic outcome on requested agent **AND** C. The prescriber states that a change in therapy is expected to be ineffective or cause harm **OR** 5. The patient has an intolerance or hypersensitivity to at least ONE generic TIRF agent that is not expected to occur with the requested agent **OR** 6. The patient has an FDA labeled contraindication to ALL generic TIRF agents that is not expected to occur with the requested agent **OR** 7. The prescriber has provided documentation that ALL generic TIRF agents cannot be used due to a documented medical condition or comorbid

Module	Clinical Criteria for Approval
	condition that is likely to cause an adverse reaction, decrease ability of the patient to achieve or maintain reasonable functional ability in performing daily activities or cause physical or mental harm **AND** 7. The patient does NOT have any FDA labeled contraindications to the requested agent **Opioid MME conversion factors:** https://www.cdc.gov/drugoverdose/prescribing/guideline.html **Length of Approval:** 1 month for increased dose requests during a dose titration period Up to 6 months for all other requests

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
Through Generic	**Quantity Limit for the Target Agent(s)** will be approved when ONE of the following is met: 1. The requested quantity (dose) does NOT exceed the program quantity limit **OR** 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: A. ALL of the following: 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose **AND** 2. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit **AND** 3. Episodes of breakthrough pain cannot be controlled by modifying the dose of the maintenance long-acting opioid used for underlying persistent pain **AND** 4. The prescriber has provided information in support of therapy with a higher quantity (dose) **OR** B. ALL of the following: 1. The requested quantity (dose) exceeds the maximum FDA labeled dose **AND** 2. Episodes of breakthrough pain cannot be controlled by modifying the dose of the maintenance long-acting opioid used for underlying persistent pain **AND** 3. The prescriber has provided information in support of therapy with a higher quantity (dose) **Length of Approval:** 1 month for increased dose requests during a dose titration period; Up to 6 months for all other requests