# PRIOR AUTHORIZATION POLICY

**POLICY:** Opioids – Long-Acting Products Prior Authorization Policy

Note: This is not an inclusive list. As new products become available, they will roll into this policy and the list will be updated periodically.

- Buprenorphine (i.e., Belbuca® buccal film, Butrans® transdermal patch)
- Fentanyl transdermal patch (generic only)
- Hydrocodone extended-release capsules/tablets (e.g., Hysingla® ER, generic)
- Hydromorphone extended-release tablets (generic only)
- Morphine sulfate extended-release capsules/tablets (e.g., MS Contin®, generic)
- Oxycodone extended-release capsules/tablets (e.g., Xtampza® ER, OxyContin®)
- Oxymorphone extended-release tablets (generic only)
- Tapentadol extended-release tablets (e.g., Nucynta® ER)
- Tramadol extended-release capsules/tablets (e.g., Conzip®, generic)

**REVIEW DATE:** 01/28/2026

---

***INSTRUCTIONS FOR USE***

*THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.*

## CIGNA NATIONAL FORMULARY COVERAGE:

## OVERVIEW

All of the long-acting (LA) opioids are indicated for the **management of severe and persistent pain that requires an opioid analgesic** and that cannot be adequately treated with alternative options, including immediate-release opioids.[1-9] OxyContin is the only product specifically indicated in pediatric patients 11 years to 18 years of age.[3] Nucynta ER is the only product also indicated for the management of severe and persistent neuropathic pain associated with diabetic peripheral neuropathy in adults that requires an opioid analgesic and cannot be adequately treated with alternative options, including immediate-release opioids.[1]

The currently available LA opioids are buprenorphine, fentanyl, hydrocodone, hydromorphone, morphine sulfate, oxycodone, oxymorphone, tapentadol, and tramadol.[1-9]

## Guidelines

In 2022, the **Centers for Disease Control and Prevention (CDC)** published an updated guideline for prescribing opioids for pain.[10] Nonopioid therapies are at least as effective as opioids for many common types of acute pain, and nonopioid therapies are preferred for subacute and chronic pain. Clinicians should maximize the use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Multiple noninvasive nonpharmacologic interventions (e.g., aerobic, aquatic, or resistance exercises, weight loss, psychological therapy, spinal manipulation, low-level laser therapy, massage, mindfulness-based stress reduction, yoga, tai chi, qigong, acupuncture, cognitive behavioral therapy, and spinal manipulation) are associated with improvements in pain, function, or both, that are sustained after treatment and are not associated with serious harms. Non-opioid drugs (e.g., tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitor [SNRI] antidepressants, duloxetine, selected antiseizure medications [e.g., pregabalin, gabapentin, oxcarbazepine], capsaicin and lidocaine patches, and nonsteroidal anti-inflammatory drugs [NSAIDs]) are associated with small to moderate improvements in chronic pain and function for certain chronic pain conditions.

Before initiating opioid therapy for patients with pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy.[10] Before starting ongoing opioid therapy for patients with subacute or chronic pain, clinicians should work with patients to establish treatment goals for pain and function and consider how opioid therapy will be discontinued if benefits do not outweigh risks. When opioids are initiated, clinicians should prescribe the lowest effective dosage of immediate-release opioids for no longer than needed for the expected duration of pain severe enough to require opioids. During ongoing opioid therapy, clinicians should collaborate with patients to evaluate and carefully weigh the benefits and risks of continuing opioid therapy and exercise care when increasing, continuing, or reducing opioid dosage. The guideline recommends that clinicians should not initiate opioid treatment with LA opioids for patients who are opioid-naïve and should not prescribe LA opioids for intermittent use. LA opioids should be reserved for severe, continuous pain. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate the risk for opioid-related harms and should work

with patients to incorporate relevant strategies to mitigate risk, including offering naloxone and reviewing potential interactions with any other prescribed medications or substances used. When prescribing initial opioid therapy and periodically during opioid therapy, clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose. When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances.

The 2020 **American Society of Hematology** guideline for the management of acute and chronic pain in patients with sickle cell disease states that pain causes significant morbidity for those living with sickle cell disease and manifests as acute intermittent pain, chronic daily pain, and acute-on-chronic pain.[11] For adults and children with chronic pain who are receiving chronic opioid therapy, are functioning well, and have perceived benefit, the guideline suggests shared decision making for continuation of chronic opioid therapy. For adults and children with chronic pain who are receiving chronic opioid therapy, are functioning poorly, or are at high risk for aberrant opioid use or toxicity, the guideline suggests against continuation of chronic opioid therapy.

## POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of long-acting (LA) opioids. LA opioids are controlled substances (CII with the exception of buprenorphine products which are CIII and tramadol-containing products which are CIV) which can be misused and abused. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients with sickle cell disease as well as the monitoring required for adverse events and long-term efficacy, approval requires LA opioids to be prescribed by or in consultation with a hematologist for patients with this diagnosis.
Note: This policy includes long-acting formulations of the medications listed on page 1; the list is not inclusive. As new products become available, they will roll into this policy and the list will be updated periodically.

**I. All long-acting opioids, except fentanyl transdermal products is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):**

**FDA-Approved Indications**

1. **Pain Severe Enough to Require Daily, Around-the-Clock, Long-Term Opioid Treatment.** Approve for 1 year if the patient meets ONE of the following (A, B, C, or D):
   **A)** Patient has a cancer diagnosis; OR
   **B)** Patient is in a hospice program, end-of-life care, or palliative care; OR

**C)** Patient meets BOTH of the following (i and ii):
- **i.** Patient has diagnosis of sickle cell disease; AND
- **ii.** The medication is prescribed by or in consultation with a hematologist; OR

**D)** Patient meets ALL of the following (i, ii, iii, iv, v, vi, and vii):
- **i.** Patient is not opioid-naïve; AND
- **ii.** According to the prescriber, non-opioid therapies have been optimized and are being used in conjunction with opioid therapy; AND
  Note: Examples of non-opioid therapies include non-opioid medications (e.g., nonsteroidal anti-inflammatory drugs, tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitors, antiseizure medications), physical therapy, exercise therapy, weight loss, and cognitive behavioral therapy.
- **iii.** According to the prescriber, patient's history of controlled substance prescriptions has been checked using the state prescription drug monitoring program (PDMP); AND
- **iv.** According to the prescriber, risks (e.g., addiction, overdose) and realistic benefits of opioid therapy have been discussed with the patient; AND
- **v.** According to the prescriber, treatment plan (including goals for pain and function) is in place and reassessments (including pain levels and function) are scheduled at regular intervals; AND
- **vi.** According to the prescriber, need for a naloxone prescription has been assessed and naloxone has been ordered, if necessary; AND
- **vii.** According to the prescriber, need for periodic toxicology testing has been assessed and ordered, if necessary.

**II. Fentanyl transdermal products**

**is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):**

**FDA-Approved Indication**

1. **Pain Severe Enough to Require Daily, Around-the-Clock, Long-Term Opioid Treatment.** Approve for 1 year if the patient has a cancer diagnosis.

## CONDITIONS NOT COVERED

- **Buprenorphine (i.e., Belbuca® buccal film, Butrans® transdermal patch)**
- **Fentanyl transdermal patch (generic only)**
- **Hydrocodone extended-release capsules/tablets (e.g., Hysingla® ER, generic)**
- **Hydromorphone extended-release tablets (generic only)**
- **Morphine sulfate extended-release capsules/tablets (e.g., MS Contin®, generic)**
- **Oxycodone extended-release capsules/tablets (e.g., Xtampza® ER, OxyContin®)**

- **Oxymorphone extended-release tablets (generic only)**
- **Tapentadol extended-release tablets (e.g., Nucynta® ER)**
- **Tramadol extended-release capsules/tablets (e.g., Conzip®, generic)**

**is(are) considered not medically necessary for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):**

1. **Acute Pain.** According to the CDC guideline for prescribing opioids for chronic pain, clinicians should not prescribe extended-release/long-acting opioids for the treatment of acute pain due to the longer half-lives and longer duration of effects (e.g., respiratory depression) with extended-release/long-acting opioids.[17]

## REFERENCES


1. Nucynta® ER extended-release oral tablets [prescribing information]. Stoughton, MA: Collegium; December 2025.
2. MS Contin® tablets [prescribing information]. Stamford, CT: Purdue; December 2025.
3. OxyContin® tablets [prescribing information]. Stamford, CT: Purdue; December 2025.
4. Oxymorphone ER tablets [prescribing information]. Bridgewater, NJ: Amneal; December 2025.
5. Hysingla® ER extended-release tablets [prescribing information]. Stamford, CT: Purdue; December 2025.
6. Xtampza ER® extended-release capsules [prescribing information]. Cincinnati, OH: Patheon; December 2025.
7. Conzip® extended-release capsules [prescribing information]. Alpharetta, GA: Vertical; December 2025.
8. Belbuca® buccal film [prescribing information]. Raleigh, NC: BioDelivery Sciences; December 2025.
9. Fentanyl transdermal system [prescribing information]. Morgantown, WV: Mylan; December 2025.
10. Dowell D, Ragan KR, Jones CM, et al. CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. *MMWR Recomm Rep*. 2022;71(3):1-95.
11. Brandow AM, Carroll CP, Creary S, et al. American Society of Hematology 2020 guidelines for sickle cell disease: management of acute and chronic pain. *Blood Adv*. 2020;4(12):2656-2701.


## HISTORY

| Type of Revision | Summary of Changes | Review Date |
|---|---|---|
| Early Annual Revision | **Methadone:** Methadone products were removed from the policy. Methadone will be moved to a separate Methadone PA policy.<br>**Opioid Addiction (Dependence)** [methadone products only]: Criteria removed from the Opioids – Long-Acting Products PA policy and moved to Opioids -– Methadone PA policy. | 01/17/2024 |
| Annual Revision | **Duragesic (brand product):** Removed from the policy; obsolete for ≥ 3 years.<br>**Arymo ER (brand product):** Removed from the policy; obsolete for ≥ 3 years.<br>**Kadian (brand product):** Removed from the policy; obsolete for ≥ 3 years.<br>**Zohydro ER (brand product):** Removed from the policy; obsolete for ≥ 3 years.<br>**Ultram ER (brand product):** Removed from the policy; obsolete for ≥ 3 years. | 01/29/2025 |

| | | |
|---|---|---|
| Annual Revision | **Hydromorphone extended-release tablets:** Removed reference to discontinued Exalgo from the product list as this brand has been obsolete for ≥ 3 years.<br>**Appendix A:** The list of targeted STCs to identify cancer medications was updated to add the following codes: I738, I746, I832, I938, I996, J253, J521, J733, K108, K186. Of note, the intent of the policy is that new STCs roll into the coding as they become available; Appendix A is updated periodically for visibility.<br>**Appendix B:** The list of targeted ICD-10 codes to identify cancer-related diagnoses was updated to include D49 (neoplasms of unspecified behavior). | 01/28/2026 |

## APPENDIX A

Note: This list is not inclusive. As new STCs become available, they will roll into this policy and the list will be updated periodically.

| STC* | STC Description |
|---|---|
| 0470 | ANTINEOPLASTIC - ALKYLATING AGENTS |
| 0471 | ANTINEOPLASTIC – ANTIMETABOLITES |
| 0472 | ANTINEOPLASTIC - VINCA ALKALOIDS |
| 0473 | ANTIBIOTIC ANTINEOPLASTICS |
| 0475 | ANTINEOPLASTICS, MISCELLANEOUS |
| 6323 | ANTINEOPLASTIC - ANTIANDROGENIC AGENTS |
| 7235 | ANTINEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES |
| 7977 | ANTINEOPLASTIC IMMUNOMODULATOR AGENTS |
| 8254 | ANTINEOPLASTIC LHRH(GNRH) AGONIST, PITUITARY SUPPR. |
| 8460 | ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS |
| 8569 | ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY |
| 8585 | ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY |
| 9150 | ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS |
| B759 | ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS |
| C232 | ANTINEOPLASTIC - MTOR KINASE INHIBITORS |
| C370 | ANTINEOPLASTIC - EPOTHILONES AND ANALOGS |
| C532 | ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS |
| C593 | ANTINEOPLASTIC - AROMATASE INHIBITORS |
| D426 | ANTINEOPLASTIC - IMMUNOTHERAPY, THERAPEUTIC VAC |
| D560 | ANTINEOPLASTIC - HALICHONDRIN B ANALOGS |
| D687 | CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY |
| E039 | ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS |
| E150 | ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR |
| E600 | ANTINEOPLASTIC - VEGF-A,B AND PLGF INHIBITORS |
| F495 | ANTINEOPLASTIC - INTERLEUKIN-6(IL-6)INHIB,ANTIBODY |
| F501 | ANTINEOPLASTIC - VEGFR ANTAGONIST |
| F665 | ANTINEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB |
| G545 | ANTINEOPLASTIC - IMMUNOTHERAPY, VIRUS-BASED AGENTS |
| G575 | ANTINEOPLASTIC - MEK1 AND MEK2 KINASE INHIBITORS |
| G590 | ANTINEOPLASTIC - ANTI-CD38 MONOCLONAL ANTIBODY |
| G607 | ANTINEOPLASTIC - ANTI-SLAMF7 MONOCLONAL ANTIBODY |
| G802 | ANTINEOPLASTIC- B CELL LYMPHOMA-2(BCL-2) INHIBITORS |
| G857 | ANTI-PROGRAMMED CELL DEATH-LIGAND 1 (PD-L1) MAB |
| H018 | ANTINEOPLASTIC, PDGFR-ALPHA BLOCKER MC ANTIBODY |
| H214 | ANTINEOPLASTIC COMB-KINASE AND AROMATASE INHIBIT |
| H289 | ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS |
| H309 | ANTINEOPLASTIC – ANTIBIOTIC AND ANTIMETABOLITE |
| H317 | ANTINEOPLASTIC – CD22 ANTIBODY-CYTOTOXIC ANTIBIOTIC |
| H324 | ANTINEOPLASTIC- CD19 DIR. CAR-T CELL IMMUNOTHERAPY |
| H329 | ANTINEOPLASTIC – CD33 ANTIBODY-CYTOTOXIC ANTIBIOTIC |
| H617 | ANTINEOPLASTIC – BRAF KINASE INHIBITORS |
| H768 | ANTINEOPLASTIC-CD22 DIRECT ANTIBODY/CYTOTOXIN CONJ |
| H868 | ANTINEOPLASTIC-CD123-DIRECTED CYTOTOXIN CONJUGATE |
| I054 | ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE) |
| I264 | ANTINEOPLASTIC – PROTEIN METHYLTRANSFERASE INHIBITORS |
| I482 | ANTINEOPLASTIC – CD19 (B LYMPHOCYTE) MC ANTIBODY |
| I738 | ANTINEOPLASTIC - EGFR AND MET RECEPTOR INHIB, MAB |
| I746 | ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR |
| I832 | ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH |
| I938 | ANTINEOPLASTIC - IMMUNOTHERAPY, T-CELL ENGAGER |
| I996 | ANTINEOPLASTIC-IMMUNOTHERAPY CHECKPOINT INHIB COMB |

## APPENDIX A (CONTINUED)

Note: This list is not inclusive. As new STCs become available, they will roll into this policy and the list will be updated periodically.

| STC* | STC Description |
|---|---|
| J253 | ANTINEOPLASTIC - GENE THERAPY AGENTS |
| J521 | ANTINEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB. |
| J733 | ANTINEOPLASTIC - INTERLEUKIN-15 RECEPTOR AGONISTS |
| K108 | ANTINEOPLASTIC - SYSTEMIC ENZYME INHIBITORS COMBS |
| K186 | ANTINEOPLASTIC SYSTEMIC ENZYME ACTIVATORS |

* Excluding topical products.

## APPENDIX B

| ICD-10 Codes |
|---|
| Cancer-related codes |
| C00.* to D09.* |
| D3A.* to D49.* |
| E34.0* |
| Q85.0* |

*Indicates the inclusion of subheadings.