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**DIVISION OF HEALTH CARE FINANCING AND POLICY**  
**NEVADA MEDICAID**  
**DRUG USE REVIEW (DUR) BOARD**  
**PROPOSED PRIOR AUTHORIZATION CRITERIA**

Immediate-release fentanyl products are a covered benefit of Nevada Medicaid for recipients who meet the criteria for coverage.

1. Coverage and Limitations:

Authorization will be given if the following criteria are met and documented:

Requests for Subsys<sup>®</sup> (fentanyl sublingual spray), Onsolis<sup>®</sup> (fentanyl citrate buccal film), Fentora<sup>®</sup> (fentanyl citrate buccal tablet), Lazanda<sup>®</sup> (fentanyl citrate nasal spray), Abstral<sup>®</sup> (fentanyl citrate sublingual tablet) and Actiq<sup>®</sup> (fentanyl citrate transmucosal lozenge):

1. Must have ALL of the following:

- a. The recipient is ≥18 years of age or ≥16 years of age if requesting fentanyl citrate transmucosal lozenge (Actiq<sup>®</sup>).

**AND**

The recipient has pain resulting from a malignancy.

**AND**

The recipient is already receiving and is tolerant to opioid therapy.

**AND**

The recipient is intolerant of at least two of the following immediate-release opioids: hydrocodone, hydromorphone, morphine or oxycodone.

Immediate-release fentanyl products will not be covered for the following:

- a. The recipient has a diagnosis of non-malignant pain including but not limited to fibromyalgia, migraines, headaches, peripheral neuropathy, or chronic pain syndrome.
- b. The recipient is not opioid tolerant.
- c. The recipient is not taking chronic opioids.
- d. The recipient has a diagnosis of acute pain or chronic pain due to surgery or injury.
- e. The requested medication will be used for migraine/headache relief or prevention.

2. PA Guidelines:

Prior Authorization approval will be 6 months.

3. Quantity Limitations:

120 lozenges/tablets per rolling 30 days for all strengths.