Pharmacy Pre-Authorization Criteria

Drug (s)	**Morphines** **Arymo ER (morphine extended release tablets)** **Morphabond (morphine extended release tablets)**
Policy #	**12122**
Indications	**Arymo ER and Morphabond** 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.
Criteria	**Arymo ER and Morphabond** are covered only if the following prior authorization criteria are met: • An intolerance to, or treatment failure of, a trial of **two** of the following medications o Exalgo o fentanyl patch (Duragesic) o morphine sulfate ER tabs (MS Contin) o Nucynta ER o oxymorphone ER (Opana ER—MD must write for original formulation on prescription)
Limitations	**This Document DOES NOT APPLY to Freedom Drug List Members** **(Connecticut Exchange members and most ConnectiCare SOLO Plan members)**
References	1. Arymo ER, Egaletus Inc., Wayne, PA 2. Morphabond, Inspirion Delivery Technologies LLC, Valley Cottage, NY
P&T Review History	5/17, 8/17, 5/18
Revision Record	8/17, 5/18