Pharmacy Management Drug Policy

SUBJECT: Opioid Management Health and Safety Program
POLICY NUMBER: PHARMACY-34
EFFECTIVE DATE: 6/2007
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If the member's subscriber contract excludes coverage for a specific service or prescription drug, it is not covered under that contract. In such cases, medical or drug policy criteria are not applied. Medical or drug policies apply to commercial, SafetyNet, and Health Care Reform products only when a contract benefit for the specific service exists.

General Background

• Center for Disease Control and Prevention (CDC)

In 2016 the Centers for Disease Control and Prevention (CDC) published clinical guidelines titled Prescribing Opioids for Chronic Pain. The guideline recommendations are largely addressed to primary care clinicians who prescribe opioids in an outpatient setting for conditions unrelated to active cancer treatment, palliative care, and end-of-life care. The scope of this coverage policy similarly excludes these diagnoses, as well as sickle cell disease, due to the complex nature of pain management in these conditions. For more information pertaining to pain management in these conditions please refer to the following resources: for cancer related pain management refer to the National Comprehensive Cancer Network Clinical Practice Guidelines, for palliative and end-of-life care please refer to the American Family Physician or National Institutes of Health, for pain management related to sickle cell disease refer to the National Heart, Lung, and Blood Institute division of the National Institutes of Health.

The guidelines provide statistical information related to the utilization of opioid medications for the treatment of pain in the United States. In 2012, a total of 259 million prescriptions for opioid analgesics were written, a 7 % increase per person since 2007. As the numbers of opioid prescriptions have increased, so have the individual and societal consequences. In 2013, approximately 1.9 million individuals met diagnostic criteria for having abused or being dependent on prescription opioid medications. More than 165,000 individuals died from an overdose involving a prescription opioid in the United States from 1999 to 2014. Opioids are increasingly relied upon for pain management however many other treatment modalities exist. (Dowell, 2016)

For the treatment of chronic pain (defined by the guideline as pain that typically lasts greater than 3 months or past the time of normal tissue healing), a preference is given to nonpharmacologic and nonopioid pharmacologic therapy. Several nonpharmacologic therapies (including physical therapy, multidisciplinary biopsychosocial rehabilitation, and weight loss) are identified as being beneficial for a number of pain sources including osteoarthritis, low back pain, and fibromyalgia. For individuals whose pain persists despite the use of nonpharmacologic therapies, several specific nonopioid pharmacologic medications are available. Based on individual characteristics and diagnoses, the guidelines recognize non-steroidal anti-inflammatory drugs, acetaminophen, and select antidepressants and anticonvulsants as first line agents for many common sources of pain. Nonopioid therapies have proven efficacy and are associated with less severe risks than opioid therapies. (Dowell, 2016)

Opioids are associated with significant risks necessitating their judicious use. In addition to common adverse events, opioids are associated with severe risks including dependence, addiction, respiratory depression, overdose, and death. The CDC guidelines offer multiple

strategies intended to mitigate the risks associated with opioid therapy. They recommend treating pain at the lowest possible dose and only for the expected duration of the pain. The guidelines state most cases of acute pain requiring opioids will rarely require treatment longer than seven days and should be treated with immediate-release opioids. (Dowell, 2016)

The risk of overdose and death can be reduced by avoiding dose escalations. Doses greater than fifty morphine milligram equivalents (50 MME) per day have been associated with at least a two time increase in the risk of overdose and have not shown to be more efficacious in reducing pain or restoring function. A tool to assist with calculating morphine milligram equivalent dosages can be found in Appendix A. When doses exceed 50 MME the guidelines recommend implementing additional precautions including providing educational resources for individuals and household members intended to reduce the risk of overdose, prescribing naloxone, and increasing the frequency of appointments. (Dowell, 2016)

The guidelines advocate for frequent appointments for all individuals on opioid therapy. Benefits and risks of therapy should be discussed at least every three months. Shorter intervals, or more frequent appointments, should occur in the presence of dose adjustments or when doses exceed 50 MME per day. Clinicians are recommended to communicate all expectations of therapy, including responsibilities of both the prescriber and patient, to the individual. (Dowell, 2016) A commonly used tool to aid in this communication is a medication use agreement.

In addition to overall guidance regarding opioid therapy, the CDC guidelines also make recommendations for opioid selection. It is recommended to initiate opioid therapy with an immediate-release opioid for a minimum one week trial. Initiating opioid therapy with an extended-release opioid is associated with greater risks of overdose. Additionally, specific concerns regarding methadone and fentanyl are acknowledged by the guidelines. It is stated that methadone should not be the first choice for an extended-release opioid in pain management due to risks of overdose and QT prolongation. Fentanyl is also specifically recognized as a complex extended-release opioid due to dosing, absorption, and pharmacodynamics factors. (Dowell, 2016)

Medication Use Agreements
A medication use agreement is a tool used by clinicians to clearly communicate roles and responsibilities of the individual patient and prescribing clinician in relation to controlled substance prescriptions. The agreement outlines clinician expectations of the patient including circumstances of treatment discontinuation. Several national organizations, including National Institutes of Health and American Academy of Family Physicians, have published such agreements and allow for their use by prescribing clinicians.

- The National Institute on Drug Abuse division of the National Institutes of Health provides two sample medication use agreement forms for public use. One form provided by the National Institute on Drug Abuse is adapted from the American Academy of Pain Medicine. Both medication use agreements can be found online at the following URL or by following the provided web navigation.
    - https://www.drugabuse.gov/sites/default/files/files/SamplePatientAgreementForms.pdf www.nih.gov > Institutes at NIH > NIDA > Medical & Health Professionals > Other Opioid Prescribing Resources > Sample Patient Agreement Forms

- The American Academy of Family Physicians has also published a medication use agreement for public use. The medication use agreement can be found online at the following URL or by following the provided web navigation.
    - http://www.aafp.org/fpm/2001/1100/fpm20011100p47-rt1.pdf
      www.aafp.org > Family Practice Management > Toolbox > Patient Handouts > Medication Use Agreement

Coverage Policy

Opioid Therapy Management includes criteria for ALL of the following:

- Immediate-Release/Extended-Release opioids exceeding a cumulative daily dose of 200 Morphine-Milligram Equivalents (MME)
- New Immediate-Release opioid analgesics exceeding a 7 day supply without prior history of opioid use
- New starts of Extended-Release Opioids
- Transmucosal immediate-release fentanyl (TIRF) medications and their quantity limits
- More than 4 fills of any immediate-release/extended release opioids in a 30 day time period (Managed Medicaid line of business only)
- Cough & cold medications containing opioid ingredients, such as codeine and hydrocodone, for children less than 18 years of age.
- The concurrent use of buprenorphine and opioid medications
- Prior authorization of short-acting opioid levorphanol

Morphine Milligram Equivalents (MME)
Members will be limited to a cumulative daily dose of 200 MME for all active opioids, (short- and long-acting) in their treatment regimen. A coverage review is required if the patient exceeds a combined total of 200mg MME. *See **Appendix A** (on page 7) for conversion chart and dosing calculation formula. Approval will be granted for 1 year if for any of the following criteria: A) Patient has been diagnosed with cancer and appropriate pain management requires dosing that exceeds the restricted amount. B) Patient has a terminal illness and appropriate pain management requires dosing that exceeds the restricted amount. C) The prescriber states based on the patient's clinical circumstances that the amount of opioid and dose prescribed is warranted in order to adequately manage the patient's pain.

Opioid-naïve 7-day supply first fill limit

Opioid-naïve: First fills of short acting opioid medications will be limited to a 7- day supply for members who are opioid naïve.

Coverage of a first fill immediate-release opioid analgesic exceeding a 7-day supply in an opioid-naïve individual will be allowed if:

A. there is documentation that the patient is not opioid-naïve (has been taking an opioid within the past 90 days)
   Examples include but not limited to: individuals who are new to plan, had previous claims paid for under workers compensation or received as inpatient or rehabilitation facility.
B. If approvable, the authorization is for 30 days.

Extended-release (long-acting) opioids

Prior authorization is required on all long-acting opioids that are on formulary. Please refer to the formulary list specific to the patient to see which are covered.

* See **Appendix B** (on page 8) for covered drug list

Coverage of extended-release (long-acting) opioids is recommended in those who meet the following criteria:

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 criteria (A, B or C):
   - **A)** The patient has a cancer diagnosis or request is from hematologist, oncologist or palliative care provider; OR
   - **B)** The patient is in a hospice program, end-of-life care, or palliative care; OR
   - **C)** The patient has chronic pain, defined as pain greater than 3 months, but does not have a cancer diagnosis. Approve for 1 year if the patient meets ALL of the following criteria (i, ii, iii, iv, v, and vi):
     - **i.** Patient is not opioid-naïve; AND
     - **ii.** Non-opioid therapies (e.g., non-opioid medications [e.g., nonsteroidal anti-inflammatory drugs {NSAIDs}, tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitors {SNRIs}, anticonvulsants], and non-pharmacological therapies {such as exercise therapy, weight loss, cognitive behavioral therapy}) have been optimized and are being used in conjunction with opioid therapy according to the prescribing physician; AND
     - **iii.** The patient's history of controlled substance prescriptions has been checked using the state prescription drug monitoring program (PDMP), according to the prescribing physician; AND
     - **iv.** Risks (e.g., addiction, overdose) and realistic benefits of opioid therapy have been discussed with the patient according to the prescribing physician; AND
     - **v.** Medication Agreement/Pain Contract and Treatment plan (including goals for pain and function) is in place and reassessments (including pain levels and function) are scheduled at regular intervals according to the prescribing physician.

vi. Only one long acting agent will be authorized at a time

2. Authorization will NOT be granted (on initial or recertification) for the following:

A) Individual has a known current substance abuse issue (does not apply to buprenorphine products such as patch/film)
B) Individual is currently taking a buprenorphine product (i.e. Suboxone, Subutex)
C) Acute pain conditions (such as tonsillectomy, orthopedic surgery or general post-op pain)

3. Recertification after 1 year will require:

A) Recent progress notes documenting effective pain control, no aberrant behavior and no signs of abuse or misuse
B) If treatment is no longer deemed medically necessary, further therapy will not be authorized

Transmucosal Immediate-Release Fentanyl (TIRF) medications

Prior authorization is required for **Abstral, Actiq, Fentora, Lazanda, Subsys** and equivalent generics.

A. Patients must have a diagnosis of cancer related pain **AND**
B. Must be prescribed by an oncologist, hematologist or palliative care.
C. Severe intolerance or therapeutic failure of at least two other opioid medications.
D. If approvable, an authorization is granted for 1 year.
E. Quantity limit of TIRF agents is as follows:
120 units per 30-day supply for Fentora, Actiq, Abstral and Subsys
30 units per 30-day supply for Lazanda.

Recertification after 1 year will require:

A. Recent progress notes documenting effective pain control, no aberrant behavior and no signs of abuse or misuse
B. If treatment is no longer deemed medically necessary, further therapy will not be authorized.

Four-fill limit (MMC contracts only)

Medicaid members (including HARP) are subject to an **additional quantity limit requirement** for opioid prescriptions. Effective October 1, 2016, Medicaid Managed Care plans must require prior authorization for opioid prescriptions in excess of 4 prescriptions in a 30 day period (Social Services Law section 365-j(26-a)). Drug classes affected include long acting opioids, short acting opioids, methadone, and skeletal muscle relaxers containing an opioid. Opioid dependence agents are *not affected* by this regulation.

Prior authorization will be granted if ONE of the following 3 criteria is met:

A. Approvable if the opioid is prescribed by a hematologist, oncologist or palliative care provider OR
B. Approvable if the opioid is prescribed for newly diagnosed cancer or sickle cell

disease
OR

C. Approvable if ALL of the following conditions are met:
   i. The provider certifies that they have reviewed the NY State Prescription Drug Monitoring System and are aware of all previous prescriptions AND
   ii. The provider certifies that a treatment plan has been reviewed with the patient and other appropriate treatment options (both pharmacologic and non-pharmacologic) have been attempted and failed AND
   iii. The provider certifies that an addiction risk assessment has been performed and a pain management contract has been reviewed and signed by the patient.

If approvable, authorization for the number of fills needed per 30 days will be granted for 30 days with the expectation that individuals will be stabilized on an appropriate regimen that does not require an excess of prescriptions per month.

- If provider is only giving short courses of medications for a particular clinical reason, the authorization date may be extended longer than 30 days based on a case-by-case basis of clinical picture.

Future requests will be reviewed based off the initial criteria above.

Opioid cough and cold medicines

Opioid cough and cold medicines containing codeine or hydrocodone require prior authorization in children younger than 18 years of age. Due to the risk of adverse effects (slowed or difficult breathing, misuse, abuse, addiction, overdose, and death), the FDA in January 2018 recommended against routine use of codeine/hydrocodone containing cough/cold products for patients < 18 years of age and that future manufacturer labeling for these products include a contraindication in this population.

A. Based on FDA labeling changes due to serious risks of these medicines outweighing their potential benefits, the following medications are considered not medically necessary and will not be covered for children less than 18 years of age.
   i. If the provider requests an exception to the policy for a child less than 18 years of age, they will need to attest that the benefit of the drug outweighs the risk for their patient.

B. The opioid cough & cold medications included in this edit are in the following drug categories:
   Narcotic antitussive - anticholinergic combination
   Narcotic antitussive - 1st generation antihistamine combination
   Narcotic antitussive - 1st generation antihistamine - decongestant combination
   Narcotic antitussive - decongestant combination
   Narcotic antitussive - decongestant - expectorant combination
   Narcotic antitussive - expectorant combination

Concurrent use of opioid/buprenorphine products

Concurrent use of **buprenorphine** products (i.e. single agent, buprenorphine/naloxone, Suboxone or Zubsolv) and opioid analgesics will not be authorized. For individuals who have a claim for any one of the above listed substance abuse medications in the past 30 days, opioid analgesics will deny for prior authorization.

A. If an individual is in need of short term pain medication (post-op surgery, acute pain condition, etc.) a provider may request an override if there is a treatment plan in place. The expectation is that the opioid prescriber is in contact with the Substance Abuse provider for coordination of care.
B. The override can be requested prospectively (for known scheduled procedures) or at the time of dispensing for situations that are urgent and require immediate treatment.
C. The request can be made verbally or via a standard prior authorization form. The request may come from the substance abuse provider, the opioid prescriber or the dispensing pharmacist. Authorizations will not be given based on information obtained from the member.
D. Opioid therapy will not be authorized if an individual fails to disclose that they are receiving buprenorphine therapy or if the substance abuse provider does not support the use of an opioid agent.
E. If the request is approvable based on a short term need, the authorization can be placed for a 2-day window to allow current claim to pay.

Levorphanol

Prior authorization is required for **Levorphanol.**

A. Prior authorization is bypassed for oncologists, hematologists and palliative care providers only
B. Patient must have had an adequate trial of at least one non-opioid {such as NSAIDs, neuropathic pain} AND one opioid combination product at appropriate dosing.
C. Authorization will NOT be granted for the following:
    i. Patient has known current substance abuse issues
    ii. Patient is currently taking a buprenorphine product
D. Approval will be granted for one year.
    i. Recertification will require documentation of effective pain control, no aberrant behavior and no signs of abuse or misuse
    ii. Recent progress notes will be required
    iii. If treatment is no longer deemed medically necessary, further therapy will not be authorized

Opioid drugs that require step therapy	
Step therapy requires members try certain first-line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brand and generics. Typically, first-line medications are classified as generics, but there are instances where brand-name medications may be preferred. The following list of drugs requires step therapy. Based upon our review and assessment of the peer-reviewed literature, these medications have been medically proven to be effective and, therefore, medically necessary if the request meets the following criteria:	
Oxycontin	Coverage requires documentation of severe intolerance or therapeutic failure with generic oxycodone ER or Xtampza.

Appendix A

Method for calculation of the cumulative daily Morphine Milligram Equivalents (MME)
The cumulative daily MME correlates with the risk of dose-related morbidity and mortality. The general algorithm used to calculate the daily MME is as follows:

- # Opioid dosage units per day = (Opioid claim quantity) / (opioid claims days' supply)
- Oral MME daily dose per claim = (#opioid dosage units per day) x (#mg opioid per dosage unit) x (MME conversion factor)
- Cumulative MME: Σ Oral MME daily dose per claim for all opiates received

Table A: Opioid Morphine Equivalent Conversion Factors[1]

Type of Opioid	MME Conversion Factor
Buprenorphine patch[2]	12.6
Buprenorphine tab or film	10
Codeine	0.15
Fentanyl buccal or SL tablets, or lozenge/troche[3]	0.13
Fentanyl film or oral spray[4]	0.18
Fentanyl nasal spray[5]	0.16
Fentanyl patch[6]	7.2
Hydrocodone	1
Hydromorphone	4
Levorphanol tartrate	11
Meperidine hydrochloride	0.1
Methadone	
1 – 20 mg/day	4
21 – 40 mg/day	8
41 – 60 mg/day	10
> 60 mg/day	12
Oxycodone	1.5
Oxymorphone	3

Tapentadol	0.4
Tramadol	0.1

1 Centers for Disease Control and Prevention, Atlanta, GA, May 2014. For more information, send an email to Mbohm@cdc.gov.

2. The MME conversion factor for buprenorphine patches is based on the assumption that one milligram of parenteral buprenorphine is equivalent to 75 milligrams of oral morphine and that one patch delivers the dispensed micrograms per hour over a 24 hour day. Example: 5 ug/hr buprenorphine patch * 24 hrs = 120 ug/day buprenorphine = 0.12 mg/day buprenorphine = 9 mg/day oral morphine milligram equivalent. In other words, the conversion factor not accounting for days of use would be 9/5 or 1.8. However, since the buprenorphine patch remains in place for 7 days, we have multiplied the conversion factor by 7 (1.8 X 7 = 12.6). In this example, MME/day for four 5 µg/hr buprenorphine patches dispensed for use over 28 days would work out as follows: Example: 5 ug/hr buprenorphine patch * (4 patches/28 days)* 12.6 = 9 MME/day. **Changed from 42 to 12.6 in call letter dated 7/11/14**

3. MME conversion factor for Fentanyl buccal tablets, sublingual tablets, and lozenges/troche is 0.13. It is intended to be multiplied by the number of micrograms in a given lozenge/troche
4. The MME conversion factor for fentanyl film and oral spray is 0.18. This reflects a 40% greater bioavailability for films compared to lozenges/tablets and 38% greater bioavailability for oral sprays compared to lozenges/tablets.
5. The MME conversion factor for fentanyl nasal spray is 0.16, which reflects a 20% greater bioavailability for sprays compared to lozenges/tablets.
6. The MME conversion factor for fentanyl patches is based on the assumption that one milligram of parenteral fentanyl is equivalent to 100 milligrams of oral morphine and that one patch delivers the dispensed micrograms per hour over a 24 hour day. Example: 25 ug/hr fentanyl patch * 24 hrs = 600 ug/day fentanyl = 60 mg/day oral morphine milligram equivalent. In other words, the conversion factor not accounting for days of use would be 60/25 or 2.4. However, since the fentanyl patch remains in place for 3 days, we have multiplied the conversion factor by 3 (2.4 X 3 = 7.2). In this example, MME/day for ten 25 µg/hr fentanyl patches dispensed for use over 30 days would work out as follows: Example: 25 ug/hr fentanyl patch * (10 patches/30 days)* 7.2 = 60 MME/day.

Appendix B

Extended Release opioid analgesics include the following:

Generic Name/Product	Brand name/Product
buprenorphine patch	Butrans®
buprenorphine SL film	Belbuca™
fentanyl patch 72hr	Duragesic®
hydrocodone ER 12hr capsule	Zohydro® ER

hydrocodone ER 24hr tablet	Hysingla™ ER
hydromorphone ER 24hr tablet	Exalgo®
methadone Hcl	Diskets®, Dolophine®, Methadone Intensol
morphine sulfate ER 12hr tablet	Morphabond™ ER
morphine sulfate ER 24hr capsule	Kadian®
morphine sulfate ER tablet	Arymo™ ER, MSContin®
morphine/naltrexone ER 12-24h	Embeda®
oxycodone ER 12hr capsule	Xtampza® ER
oxycodone ER 12hr tablet	OxyContin®
oxymorphone ER 12hr tablet	
tapentadol ER 12hr tablet	Nucynta® ER
tramadol ER 24hr capsule	Conzip®
tramadol ER 24hr tablet	Ultram® ER

**Please refer to the respective formulary list to see which brand-name products are covered.*

POLICY GUIDELINES:

1. Safety Edits are inclusive of all contracts regardless of whether Step Therapy or Prior Authorization is part of the member's benefit.
2. This policy is applicable to drugs that are included on a specific drug formulary. If a drug referenced in this policy is non-formulary, please reference the Coverage Exception Evaluation Policy for All Lines of Business Formularies policy for review guidelines.
3. Comprehensive assessment and documentation is recommended before initiating opioid therapy, including documentation of comprehensive history, general medical condition, psychosocial history, psychiatric status, and substance use history.
4. Prior to initiating opioid therapy, the prescriber and patient should enter into a treatment agreement which defines expectations for medication use, pharmacy use, receipt of narcotic/controlled substances from other prescribers, urine drug screen, and prescription drug monitoring.
5. If aberrant behaviors are demonstrated, counseling should be done to address them and if the behavior is unchanged, opioid use should be seriously reconsidered.
6. Prescriber should monitor adherence through a proven means such as urine drug testing, pill counts, behavioral assessment during visits

7. Generally, it is believed that patients who do not respond to a low or medium-dose of opioids will not respond to larger doses although individual circumstances also exist.
    a. Low dose therapy is defined as ≤40 mg/day morphine equivalent.
    b. Moderate dose therapy will be defined as 41 – 90 mg/day morphine equivalent
    c. High dose therapy will be defined as >91 mg morphine/day
8. The rate of overdose has been shown to be directly proportional to the prescribed opioid dose.
9. Opioid medications must be started at low doses and titrated gradually to higher amounts if necessary. All attempts must be made to maintain patients on lower doses, including use of other drugs. Combinations of short- and long-acting and high doses of long-acting opioids must be prescribed with extreme caution.
    a. See **table 1** below for recommended starting and maintenance dosing
10. Oral transmucosal, nasal spray and buccal formulation of fentanyl are intended only to be used in the care of opioid-tolerant cancer patients and only by health care providers who are knowledgeable of and skilled in the use of Schedule II opioids to treat cancer pain. Once a successful dose has been found (i.e., an average episode is treated with a single unit), consumption should be limited to 4 units/day or less. If consumption increases to more than 4 units/day, reevaluate the dose of the long-acting opioid for persistent cancer pain.
11. Methadone may be an appropriate alternative for patients using high dose opioids and/or those with musculoskeletal or neuropathic pain. Methadone should only be prescribed by physicians who are expertly trained to handle dosing of the medication.

Table 1.

Opioid	**Recommend Starting Dose for Opioid-Naïve Patients**	**Recommended Starting Dose for Opioid-Exposed Patient's with High Doses leading to High Risks**	**Recommended Maintenance Dose**
Hydrocodone	5 to 10mg, 2 to 3 times daily	5 to 10mg, 3 to 4 times daily	30 to 40mg for 24 hours
Morphine			
- Immediate Release	Not recommended	10mg, 2 to 3 times daily	30 to 60mg per day
- Sustained Release	Not recommended	15 to 30mg twice daily	60 to 90mg daily
Oxycodone			
- immediate release	5 to 10mg, 2 to 3 times daily	5 to 10mg, 3 to 4 times daily	30 to 40mg per day

- sustained release	Not recommended	10mg for 12 hours	30 to 60mg for 24 hours
Methadone	Not recommended	2 to 5mg, 2 to 3 times daily	10 to 30mg per day
Transdermal Fentanyl	Not recommended	12.5 to 25mcg q 72 h	25 to 50mcg per 72 hours
Hydromorphone			
- immediate release	2mg, 2 or 3 times daily	2 to 4mg, 2 to 3 times daily	8 to 16mg per day
- sustained release	Not recommended	5 to 10mg, 2 times daily	20 to 40mg daily
Codeine	15mg, 2 or 3 times daily	30mg, 2 to 4 times daily	120 to 160mg daily
Oxymorphone			
- immediate release	5mg 2 or 3 times daily	5 to 10mg, 2 to 3 times daily	30 to 40mg per day
- sustained release	Not recommended	10mg q 12 h	40 to 60mg per day
Tramadol			
- immediate release	50mg, 2 or 3 times daily	50mg, 3 to 4 times daily	150 to 300mg per day
- sustained release	Not recommended	200mg daily	200 to 350mg per day

UPDATES:

Date:	**Revision:**
5/19	Revision
7/18	Revision
5/18	P & T approval
5/18	Revision
2/18	P & T approval (antitussive section)
8/17	Revision
7/17	Revision
6/17	Revision

4/17	Revision
11/16	Revision
9/16	Revision
6/16	Revision
12/15	Revision
8/15	Revision
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1/15	Revision
6/14	Revision
5/14	Revision
4/14	Revision
2/14	Revision
4/13	Revision
11/12	Revision
7/12	Created

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