Mass General Brigham
Health Plan

Methadone Oral Solution
Effective 08/01/2025

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

Overview
Methadone oral solution is indicated for the management of severe and persistent pain that requires an extended treatment period with a daily opioid analgesic and for which alternative treatment options are inadequate.

Coverage Guidelines
Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted for members when all the following criteria are met:

1. Member has ONE of the following diagnoses:
    a. Diagnosis of cancer
    b. Member is receiving opioids as part of end-of-life care
    c. For all other diagnoses:
        i. ONE of the following
            1) Member has moderate to severe chronic pain that is non-neuropathic.
            2) Member has moderate to severe neuropathic pain or fibromyalgia AND all of the following:
                a. Inadequate response to 8 weeks of treatment with or contraindication to gabapentin titrated to a therapeutic dose (Document drug(s), dose, duration, and date of trial).
                b. Inadequate response to at least 6-8 weeks of treatment with or contraindication to a tricyclic antidepressant (e.g., amitriptyline, nortriptyline, imipramine) titrated to a therapeutic dose (Document drug(s), dose, duration, and date of trial).

ii. The requested drug will NOT be used for any of the following:
    1) For use as an as-needed PRN analgesic
    2) For pain that is mild or not expected to persist for an extended period of time
    3) For acute pain
    4) For postoperative pain, unless the member is already receiving chronic opioid therapy prior to surgery, or if postoperative pain is expected to be moderate to severe and persist for an extended period of time
iii. ONE of the following:
    1) For members that are filling the prescribed medication for the first time, prior to the start of therapy with the prescribed medication, the member has failed an adequate (minimum 4 week) trial of a short-acting opioid (Document drug(s), dose, duration, and date of trial).
    2) Member is established on the prescribed medication and this prescription is for continuation of therapy.

Continuation of Therapy

Reauthorizations may be granted for members requesting continued treatment with methadone oral solution when ONE of the following criteria is met:

1. Member is requesting medication for cancer or end-of-life care.
2. For all other diagnoses, documentation has been provided addressing ALL of the following:
    a. Treatment goals are defined, including estimated duration of treatment
    b. Treatment plan includes the use of a nonopioid analgesic and/or nonpharmacologic intervention
    c. Member demonstrates meaningful improvement in pain and function using a validated instrument (e.g., Brief Pain Inventory)
    d. Member has been screened for substance abuse/opioid dependence using a validated instrument (e.g., DAST-10)
    e. Rationale for not tapering and discontinuing
    f. Member has been screened for comorbid mental health conditions
    g. If a state prescription drug monitoring program (PDMP) is available, the prescriber has identified there are no concurrently prescribed controlled substances from PDMP
    h. If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression
    i. Total daily morphine equivalent dose

Limitations

1. Initial approvals may be granted for the following:
    a. For diagnosis of cancer/end-of-life care: 12 months
    b. For all other diagnoses: 6 months
2. Reauthorizations may be granted for the following:
    a. For diagnosis of cancer/end-of-life care: 12 months
    b. All other diagnoses: 6 months

References

1. Methadone oral solution [prescribing information]. Berkeley Heights, NJ: Hikma Pharmaceutical US Inc.; December 2023.

Review History

05/14/2025 – Reviewed at May P&T. Effective 08/01/2025.
07/09/2025 – Reviewed and Updated at July P&T. For diagnosis of moderate to severe neuropathic pain or fibromyalgia, clarified trial requirements with gabapentin and TCA to indicate inadequate response is required. Removed approval length for post-operative pain. Effective 08/01/2025.