Clinical Policy: Butorphanol Nasal Spray

Reference Number: HIM.PA.46
Effective Date: 12.01.14
Last Review Date: 05.25
Line of Business: HIM

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Butorphanol tartrate is a synthetically derived opioid agonist-antagonist analgesic of the phenanthrene series.

FDA Approved Indication(s)

Butorphanol tartrate nasal spray is indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

Limitation(s) of use: Because of the risks of addiction, abuse, and misuse, with opioids, even at recommended doses, reserve butorphanol tartrate nasal spray for use in patients for whom alternative treatment options (e.g., non-opioid analgesics)

- Have not been tolerated, or are not expected to be tolerated,
- Have not provided adequate analgesia, or are not expected to provide adequate analgesia.

Butorphanol tartrate nasal spray should not be used for an extended period of time unless the pain remains severe enough to require an opioid analgesic and for which alternative treatment options continue to be inadequate.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that butorphanol nasal spray is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

Please note: for HIM-Arkansas – if a member's covered prescription pain medication requires a prior authorization, then the prior authorization shall not be denied if the member has a terminal illness.

A. Pain Management (must meet all)**:**

1. Prescribed for the management of pain;
2. Age ≥ 18 years;
3. Member meets one of the following (a, b or c):
   a. Request is for treatment associated with cancer for a State with regulations against step therapy in certain oncology settings (see *Appendix D*);

b. Prescribed by or in consultation with a pain management specialist, an oncologist, or for use in palliative or hospice care;
c. Failure of at least 2 non-opioid ancillary treatments (such as non-steroidal anti-inflammatory drugs [NSAIDs] or acetaminophen-containing products) (*see Appendix B for examples*), unless contraindicated or clinically significant adverse effect are experienced;

4. For pain related to migraine headache: failure of at least 2 anti-migraine agents (*see Appendix B for examples*), unless contraindicated or clinically significant adverse effect are experienced;
5. For chronic pain: failure of an antidepressant or anticonvulsant agent (*see Appendix B for examples*), unless contraindicated or clinically significant adverse effect are experienced;
6. Member is unable to use oral medications for pain relief.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace.

II. Continued Therapy

Please note: for HIM-Arkansas – if a member's covered prescription pain medication requires a prior authorization, then the prior authorization shall not be denied if the member has a terminal illness.

A. Pain Management (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – HIM.PA.154 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation Key
FDA: Food and Drug Administration
NSAID: non-steroidal anti-inflammatory disease
REMS: Risk Evaluation and Mitigation Strategy

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be formulary agents and may require prior authorization.

Drug Class	Commonly Used Examples	Dose Limit/ Maximum Dose
NSAIDs	ibuprofen (Motrin®), naproxen (Naprosyn®), Relafen® (nabumetone), Voltaren® (diclofenac), Orudis® (ketoprofen), Clinoril® (sulindac), Toradol® (ketorolac)	Varies according to the agent used
Non-opioid analgesics	aspirin, acetaminophen opioid combinations (APAP/codeine, APAP hydrocodone)	Varies according to the agent used
Anti-migraine agents (non-triptans)	Cafergot® (ergotamine/caffeine), D.H.E.-45® (dihydroergotamine), Midrin® (isometheptene/APAP), Fiorinal® (butalbital/aspirin), Fioricet® (butalbital/APAP)	Varies according to the agent used
Anti-migraine agents (triptans)	almotriptan (Axert®), eletriptan (Relpax®), frovatriptan (Frova®), naratriptan	Varies according to the agent used

Drug Class	Commonly Used Examples	Dose Limit/ Maximum Dose
	(Amerge®), rizatriptan (Maxalt®), sumatriptan (Imitrex®), zolmitriptan (Zomig®)	
Anticonvulsants	Carbamazepine (Tegretol®), gabapentin (Neurontin®), divalproex (Depakote®), topiramate (Topamax®)	Varies according to the agent used
Antidepressants/ tricyclic antidepressants	amitriptyline (Elavil®), desipramine (Norpramin®), imipramine (Tofranil®), nortriptyline (Pamelor®), duloxetine (Cymbalta®), venlafaxine (Effexor®)	Varies according to the agent used

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): significant respiratory depression; acute or severe bronchial asthma in an unmonitored setting or in absence of resuscitative equipment; known or suspected gastrointestinal obstruction, including paralytic ileus; hypersensitivity to butorphanol tartrate, the preservative benzethonium chloride, or any of the formulation excipients (e.g., anaphylaxis).
- Boxed warning(s): risks of addiction, abuse, and misuse; opioid analgesic Risk Evaluation and Mitigation Strategy (REMS); life-threatening respiratory depression; accidental exposure; neonatal opioid withdrawal syndrome; cytochrome P450 3A4 interactions; concomitant use with benzodiazepines or other central nervous system depressants.

Appendix D: States with Regulations against Redirections in Cancer

State	Step Therapy Prohibited?	Notes
FL	Yes	For stage 4 metastatic cancer and associated conditions
GA	Yes	For stage 4 metastatic cancer. Redirection does not refer to review of medical necessity or clinical appropriateness
IA	Yes	For standard of care stage 4 cancer drug use, supported by peer-reviewed, evidence-based literature, and approved by FDA
LA	Yes	For stage 4 advanced, metastatic cancer or associated conditions. Exception if "clinically equivalent therapy, contains identical active ingredient(s), and proven to have same efficacy
MS	Yes	**Applies to HIM requests only** For advanced metastatic cancer and associated conditions
NV	Yes	Stage 3 and stage 4 cancer patients for a prescription drug to treat the cancer or any symptom thereof of the covered person
OH	Yes	**Applies to Commercial and HIM requests only** For stage 4 metastatic cancer and associated conditions
OK	Yes	**Applies to HIM requests only** For advanced metastatic cancer and associated conditions

State	Step Therapy Prohibited?	Notes
PA	Yes	For stage 4 advanced, metastatic cancer
TN	Yes	For advanced metastatic cancer and associated conditions
TX	Yes	For stage 4 advanced, metastatic cancer and associated conditions

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Pain	1 mg (1 spray in one nostril) If adequate pain relief is not achieved within 60 to 90 minutes, an additional 1 mg dose may be given. This initial dose sequence may be repeated in 3 to 4 hours as required after the second dose of the sequence. Depending on the severity of the pain, an initial dose of 2 mg (1 spray in each nostril) may be used in patients who will be able to remain recumbent in the event drowsiness or dizziness occurs. In such patients single additional 2 mg doses should not be given for 3 to 4 hours.	Not applicable

VI. Product Availability

Nasal spray solution bottle: 2.5 mL (10 mg/mL)

VII. References

1. Butorphanol Tartrate Nasal Solution Prescribing Information. Weston, FL: Apotex Corp.; January 2024. Available at: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b8e48063-0b40-ee43-85c1-4ef2de80c404. Accessed January 15, 2025.
2. Butorphanol Nasal Spray Drug Monograph. Clinical Pharmacology [database online]. Philadelphia, PA: Elsevier. Updated periodically. Available at: http://www.clinicalkey.com/pharmacology. Accessed January 24, 2025.
3. Micromedex® Healthcare Series [Internet database]. Ann Arbor, Michigan: Merative™. Updated periodically. Accessed January 24, 2025.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
S0012	Butorphanol tartrate, nasal spray, 25 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2021 annual review: no significant changes; HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	02.24.21	05.21
2Q 2022 annual review: no significant changes; references reviewed and updated.	02.27.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.11.22	
2Q 2023 annual review: no significant changes; references reviewed and updated.	02.03.23	05.23
2Q 2024 annual review: no significant changes; references reviewed and updated.	01.18.24	05.24
2Q 2025 annual review: added option to bypass redirection if prescribed by or in consultation with a pain management specialist, an oncologist, or for use in palliative care or hospice care; added by-passing of redirection if state regulations do not allow step therapy in certain oncology settings along with Appendix D; added HCPCS code [S0012]; references reviewed and updated.	01.15.25	05.25

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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