Secretary of State
Certificate and Order for Filing

TEMPORARY ADMINISTRATIVE RULES

A Statement of Need and Justification accompanies this form..

I certify that the attached copies* are true, full and correct copies of the TEMPORARY Rule(s) adopted on [upon filing] by the
Date prior to or same as filing date

Oregon Health Authority, Division of Medical Assistance Programs 410
Agency and Division Administrative Rules Chapter Number

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Rules Coordinator Address Telephone

to become effective [2/21/13] through [8/16/13].
Date upon filing or later A maximum of 180 days including the effective date.

RULE CAPTION

Amending Preferred Drug List and Prior Authorization Guide – August 30 and November 29, 2012 DUR/P&T Action

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

List each rule number separately, 000-000-0000.
Secure approval of new rule numbers (Adopted rules) with the Administrative Rules Unit prior to filing

ADOPT:
AMEND: 410-121-0030 and 410-121-0040
SUSPEND:

Stat. Auth.: ORS 413.032, 413.042, 414.065, 414.325, and 414.330 to 414.414

Other Auth.: None.

Stats. Implemented: ORS 414.065; 414.325, 414.334, 414.361, 414.369 and 414.371

RULE SUMMARY

The Pharmaceutical Services Program administrative rules (Division 121) govern Division payments for services provided to certain clients. The Division needs to amend rules as follows:

410-121-0030:

- Humira® and Enbrel® preferred and Remicade® and all other drugs in the Targeted Immune Modulators (TIMS) drug class non preferred
- Procrit® preferred and Epogen® and peginesatide non-preferred in the Erythropoiesis Stimulating Agents (ESAs) drug class
- Tobi® preferred with quantity limits and Cayston® non-preferred with quantity limits in the Cystic Fibrosis drug class
- Ranexa® non-preferred in the Anti Anginals drug class
- Add Diuretics drug class and make amiloride HCL tablet, chrorothiazide tablet and oral suspension, chlorthalidone tablet, eplerenone tablet, ethacrynic acide tablet, furosemide 40mg/5ml solution, methyclothiazide tablet, metolazone tablet, polythiazide tablet and triamterene/hydrochlorothiazide tablet non preferred. Make amiloride/hydrochlorothiazide tablet, bendroflumethiazide tablet, bumetanide tablet, furosemide 10mg/ml solution, furosemide tablet, hydrochlorothiazide capsule, solution and tablet, indapamide tablet, spironolact/hydrochlorothiazide tablet, spironolactone tablet, torsemide tablet, triamterene capsule and triamterene/hydrochlorothiazide capsule preferred.
- Latanoprost preferred and Zioptin®, Alphagan P® and apraclonidine HCL non-preferred in the Opthalmic Glaucoma drug class
- Pegaptanib non-preferred and bevacizumab preferred in the Vascular Endothelial Growth Factors (VEGF) drug class
- Renagel® and brand Calphron® preferred in the Phosphate Binders drug class
- Januvia® and Janumet® preferred in the DPP-4 Inhibitors drug class
- Creon® and lipase/protease/amylase preferred in the Pancreatic Enzyme Replacement drug class
- Climara® preferred and Estring® non-preferred in the Estrogens drug class
- Suprax®, cefpodoxime and Cedax® suspensions non-preferred in the Cephalosporin drug class

410-121-0040:

- Antipsoriatics – update criteria
- Benign Prostiatic Hypertrophy – update criteria
- Fingolimod® - update criteria
- Incretin Enhancers – update criteria
- Oral Direct Factor XA Inhibitors – update criteria
- Phosphate Binders – new criteria
- Targeted Immune Modulators (TIMS) – new criteria
- Weight Loss Medications – delete criteria

Authorized Signer	Printed name	Date

*****With this original and Statement of Need, file one photocopy of certificate, one paper copy of rules listed in Rulemaking Actions, and electronic copy of rules.

Secretary of State

STATEMENT OF NEED AND JUSTIFICATION

A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

Oregon Health Authority, Division of Medical Assistance Programs — 410

Agency and Division — Administrative Rules Chapter Number

In the Matter of: OAR 410-121-0030 and 410-121-0040
Rule Caption: Amending Preferred Drug List and Prior Authorization Guide – August 30 and November 29, 2012 DUR/P&T Action
Statutory Authority: ORS 413.032, 413.042, 414.065, 414.325, and 414.330 to 414.414
Other Authority: None.
Stats. Implemented: ORS 414.065; 414.325, 414.334, 414.361, 414.369 and 414.371

Need for the Temporary Rule(s): The Pharmaceutical Services Program administrative rules (division 121) govern Division payments for services provided to certain clients. The Division temporarily amended 410-121-0030 and 410-121-0040 per the Drug Use Review (DUR) Pharmacy & Therapeutics (P&T) Committee's recommendations made during the August 30, 2012 and November 29, 2012 meetings.

The Authority needs to implement changes to the Preferred Drug List and Prior Authorization Guide to ensure the safe and appropriate use of cost effective prescription drugs for the Oregon Health Plan's fee-for-service recipients.

410-121-0030:

- Humira® and Enbrel® preferred and Remicade® and all other drugs in the Targeted Immune Modulators (TIMS) drug class non preferred
- Procrit® preferred and Epogen® and peginesatide non-preferred in the Erythropoiesis Stimulating Agents (ESAs) drug class
- Tobi® preferred with quantity limits and Cayston® non-preferred with quantity limits in the Cystic Fibrosis drug class
- Ranexa® non-preferred in the Anti Anginals drug class
- Add Diuretics drug class and make amiloride HCL tablet, chrorothiazide tablet and oral suspension, chlorthalidone tablet, eplerenone tablet, ethacrynic acide tablet, furosemide 40mg/5ml solution, methyclothiazide tablet, metolazone tablet, polythiazide tablet and triamterene/hydrochlorothiazide tablet non preferred. Make amiloride/hydrochlorothiazide tablet, bendroflumethiazide tablet, bumetanide tablet, furosemide 10mg/ml solution, furosemide tablet, hydrochlorothiazide capsule, solution and tablet, indapamide tablet, spironolact/hydrochlorothiazide tablet, spironolactone tablet, torsemide tablet, triamterene capsule and triamterene/hydrochlorothiazide capsule preferred.
- Latanoprost preferred and Zioptin®, Alphagan P® and apraclonidine HCL non-preferred in the Opthalmic Glaucoma drug class
- Pegaptanib non-preferred and bevacizumab preferred in the Vascular Endothelial Growth Factors (VEGF) drug class
- Renagel® and brand Calphron® preferred in the Phosphate Binders drug class
- Januvia® and Janumet® preferred in the DPP-4 Inhibitors drug class
- Creon® and lipase/protease/amylase preferred in the Pancreatic Enzyme Replacement drug class
- Climara® preferred and Estring® non-preferred in the Estrogens drug class
- Suprax®, cefpodoxime and Cedax® suspensions non-preferred in the Cephalosporin drug class

410-121-0040:

- Antipsoriatics – update criteria
- Benign Prostiatic Hypertrophy – update criteria
- Fingolimod® - update criteria
- Incretin Enhancers – update criteria
- Oral Direct Factor XA Inhibitors – update criteria
- Phosphate Binders – new criteria
- Targeted Immune Modulators (TIMS) – new criteria
- Weight Loss Medications – delete criteria

Documents Relied Upon, and where they are available: Or Law 2011, chapter 720 (HB 2100):
http://www.leg.state.or.us/11reg/measpdf/hb2100.dir/hb2100.en.pdf

Justification of Temporary Rule(s): The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority and clients enrolled in Oregon's Medicaid Program by delaying the reassessment and update of preferred drug lists and prior authorization requirements. These rules need to be adopted promptly so the Authority can ensure the safe and appropriate use of Medicaid covered drugs.

Authorized Signer — Printed name — Date

410-121-0030 Practitioner-Managed Prescription Drug Plan

(1) The Practitioner-Managed Prescription Drug Plan (PMPDP) is a plan that ensures that fee-for-service clients of the Oregon Health Plan shall have access to the most effective prescription drugs appropriate for their clinical conditions at the best possible price:

(a) Licensed health care practitioners (informed by the latest peer reviewed research), make decisions concerning the clinical effectiveness of the prescription drugs;

(b) The licensed health care practitioners also consider the health condition of a client or characteristics of a client, including the client's gender, race or ethnicity.

(2) PMPDP Preferred Drug List (PDL):

(a) The PDL is the primary tool that the Division developed to inform licensed health care practitioners about the results of the latest peer-reviewed research and cost effectiveness of prescription drugs;

(b) The PDL (as defined in 410-121-0000 (cc) consists of prescription drugs that the Division, in consultation with the Drug Use Review (DUR) / Pharmacy & Therapeutics Committee (P&T), has determined represent the most effective drug(s) available at the best possible price;

(c) The PDL shall include drugs that are Medicaid reimbursable and the Food and Drug Administration (FDA) has determined to be safe and effective.

(3) PMPDP PDL Selection Process:

(a) The Division shall utilize the recommendations made by the P&T, that result from an evidence-based evaluation process, as the basis for selecting the most effective drug(s);

(b) The Division shall determine the drugs selected in (3)(a) that are available for the best possible price and shall consider any input from the P&T about other FDA-approved drug(s) in the same class that are available for a lesser relative price. The Division shall determine relative price using the methodology described in subsection (4);

(c) The Division shall evaluate selected drug(s) for the drug classes periodically:

(A) Evaluation shall occur more frequently at the discretion of the Division if new safety information or the release of new drugs in a class or other information which makes an evaluation advisable;

(B) New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T;

(C) The Division shall make all changes or revisions to the PDL, using the rulemaking process and shall publish the changes on the Division's Pharmaceutical Services provider rules Web page.

(4) Relative cost and best possible price determination:

(a) The Division shall determine the relative cost of all drugs in each selected class that are Medicaid reimbursable and that the FDA has determined to be safe and effective;

(b) The Division may also consider dosing issues, patterns of use and compliance issues. The Division shall weigh these factors with any advice provided by the P&T in reaching a final decision;

(5) Pharmacy providers shall dispense prescriptions in the generic form, unless:

(a) The practitioner requests otherwise, subject to the regulations outlined in OAR 410-121-0155;

(b) The brand name medication is listed as preferred on the PDL.

(6) The exception process for obtaining non-preferred physical health drugs that are not on the PDL drugs shall be as follows:

(a) If the prescribing practitioner, in their professional judgment, wishes to prescribe a physical health drug not on the PDL, they may request an exception, subject to the requirements of OAR 410-121-0040;

(b) The prescribing practitioner must request an exception for physical health drugs not listed in the PDL subject to the requirements of OAR 410-121-0060;

(c) Exceptions shall be granted in instances:

(A) Where the prescriber in their professional judgment determines the non-preferred drug is medically appropriate after consulting with the Division or the Oregon Pharmacy Help Desk; or

(B) Where the prescriber requests an exception subject to the requirement of (6)(b) and fails to receive a report of PA status within 24 hours, subject to OAR 410-121-0060.

(7) Table 121-0030-1, PMPDP PDL dated February 21, 2013~~January 1, 2013~~ is incorporated in rule by reference and is found on our Web page at: www.orpdl.org

[ED. NOTE: Tables referenced are not included in rule text. Click here for PDF copy of table(s).]

Stat. Auth.: ORS 409.025, 409.040, 409.110, 414.065, 413.042 and 414.325
Stats. Implemented: ORS 414.065

2-21-13

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Allergy/Cold	Antihistamines - 2nd Generation	CETIRIZINE HCL	SOLUTION
		CETIRIZINE HCL	TABLET
		LORATADINE	SOLUTION
		LORATADINE	TAB RAPDIS ***
		LORATADINE	TABLET
Analgesics	Gout	ALLOPURINOL	TABLET
		COLCHICINE/PROBENECID	TABLET
Analgesics	Long-Acting Opioids	FENTANYL *	PATCH TD72
		METHADONE HCL *	ORAL CONC
		METHADONE HCL *	SOLUTION
		METHADONE HCL *	TABLET
		MORPHINE SULFATE *	TABLET ER
Analgesics	NSAIDs	DICLOFENAC POTASSIUM	TABLET
		DICLOFENAC SODIUM	TABLET DR
		ETODOLAC	TABLET
		FLURBIPROFEN	TABLET
		IBUPROFEN	CAPSULE
		IBUPROFEN	DROPS SUSP
		IBUPROFEN	ORAL SUSP
		IBUPROFEN	TAB CHEW
		IBUPROFEN	TABLET
		INDOMETHACIN	CAPSULE
		KETOPROFEN	CAPSULE
		KETOROLAC TROMETHAMINE *	TABLET
		MELOXICAM	TABLET
		NABUMETONE	TABLET
		NAPROXEN	TABLET
		NAPROXEN	TABLET DR
		NAPROXEN SODIUM	TABLET
		OXAPROZIN	TABLET
		SALSALATE	TABLET
		SULINDAC	TABLET

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Analgesics	Short-Acting Opioids	CODEINE SULFATE * **	TABLET
		HYDROCODONE BIT/ACETAMINOPHEN **	TABLET ***
		HYDROMORPHONE HCL * **	TABLET
		MORPHINE SULFATE * **	SOLUTION
		MORPHINE SULFATE * **	TABLET
		OXYCODONE HCL * **	SOLUTION
		OXYCODONE HCL * **	TABLET
		OXYCODONE HCL/ACETAMINOPHEN **	CAPSULE
		OXYCODONE HCL/ACETAMINOPHEN **	TABLET ***
		TRAMADOL HCL	TABLET
Analgesics	Skeletal Muscle Relaxants	BACLOFEN	TABLET
		CYCLOBENZAPRINE HCL	TABLET ***
		TIZANIDINE HCL	TABLET
Analgesics	Topical	CAPSAICIN	CREAM (G) ***
Analgesics	Triptans, Injection	IMITREX® - BRAND ONLY **	CARTRIDGE
		IMITREX® - BRAND ONLY **	PEN INJCTR
		IMITREX® - BRAND ONLY **	VIAL
Analgesics	Triptans, Nasal	IMITREX® - BRAND ONLY **	SPRAY
		ZOLMITRIPTAN **	SPRAY
Analgesics	Triptans, Oral	NARATRIPTAN HCL **	TABLET
		SUMATRIPTAN SUCCINATE **	TABLET
Antibiotics	Amoxicillin-Clavulanate	AMOXICILLIN/POTASSIUM CLAV	SUSP RECON
		AMOXICILLIN/POTASSIUM CLAV	TAB CHEW
		AMOXICILLIN/POTASSIUM CLAV	TABLET
Antibiotics	Cephalosporin, 1st Gen	CEPHALEXIN	CAPSULE ***
		CEPHALEXIN	SUSP RECON ***
Antibiotics	Cephalosporin, 2nd Gen	CEFPROZIL	SUSP RECON
		CEFPROZIL	TABLET
		CEFUROXIME AXETIL	TABLET
Antibiotics	Cephalosporin, 3rd Gen	CEFDINIR	CAPSULE
		CEFDINIR	SUSP RECON

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Antibiotics	Fluoroquinolones, Oral	CIPROFLOXACIN	SUS MC REC
		CIPROFLOXACIN HCL	TABLET
		LEVOFLOXACIN	SOLUTION
		LEVOFLOXACIN	TABLET
		NORFLOXACIN	TABLET
Antibiotics	Macrolide / Ketolide	AZITHROMYCIN	SUSP RECON
		AZITHROMYCIN	TABLET
		CLARITHROMYCIN	TABLET
		ERYTHROMYCIN BASE	CAPSULE DR
		ERYTHROMYCIN BASE	TABLET DR
		ERYTHROMYCIN ETHYLSUCCINATE	ORAL SUSP
		ERYTHROMYCIN ETHYLSUCCINATE	SUSP RECON
		ERYTHROMYCIN ETHYLSUCCINATE	TABLET
		ERYTHROMYCIN STEARATE	TABLET
Antibiotics	Tetracyclines, Oral	DOXYCYCLINE HYCLATE	CAPSULE
		DOXYCYCLINE HYCLATE	TABLET
		DOXYCYCLINE MONOHYDRATE	CAPSULE ***
		DOXYCYCLINE MONOHYDRATE	SUSP RECON
		TETRACYCLINE HCL	CAPSULE
Antifungal	Antifungal, Oral	CLOTRIMAZOLE	TROCHE
		FLUCONAZOLE	SUSP RECON
		FLUCONAZOLE	TABLET
		KETOCONAZOLE	TABLET
		NYSTATIN	ORAL SUSP
		NYSTATIN	TABLET
Antiviral	Hepatitis B	LAMIVUDINE *	SOLUTION
		LAMIVUDINE *	TABLET
		TENOFOVIR DISOPROXIL FUMARATE *	TABLET
Antiviral	Hepatitis C	BOCEPREVIR *	CAPSULE
		PEGINTERFERON ALFA-2B(PEGINTRON REDIPEN®) *	PEN IJ KIT
		PEGINTERFERON ALFA-2B(PEGINTRON®) *	KIT ***
		RIBAVIRIN *	CAPSULE
		RIBAVIRIN *	TABLET
		TELAPREVIR *	TABLET

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Antiviral	HSV, Oral	ACYCLOVIR	CAPSULE
		ACYCLOVIR	ORAL SUSP
		ACYCLOVIR	TABLET
Antiviral	Influenza	AMANTADINE HCL	CAPSULE
		AMANTADINE HCL	SYRUP
		AMANTADINE HCL	TABLET
		OSELTAMIVIR PHOSPHATE **	CAPSULE
		OSELTAMIVIR PHOSPHATE **	SUSP RECON
		RIMANTADINE HCL	TABLET
Cardiovascular	Anti-Anginals	ISOSORBIDE DINITRATE	CAPSULE ER
		ISOSORBIDE DINITRATE	TABLET
		ISOSORBIDE MONONITRATE	TABLET
		NITROGLYCERIN	CAPSULE ER
		NITROGLYCERIN	PATCH TD24
		NITROGLYCERIN	TAB SUBL
Cardiovascular	Anticoagulants, Oral	WARFARIN SODIUM	TABLET
Cardiovascular	Anticoagulants, Subcutaneous	DALTEPARIN SODIUM,PORCINE(FRAGMIN®)	DISP SYRIN
		LOVENOX® - BRAND ONLY	DISP SYRIN
Cardiovascular	Beta-Blockers	ACEBUTOLOL HCL	CAPSULE
		ATENOLOL	TABLET
		CARVEDILOL	TABLET
		LABETALOL HCL	TABLET
		METOPROLOL TARTRATE	TABLET
		NADOLOL	TABLET
		PROPRANOLOL HCL	TABLET
Cardiovascular	Calcium Channel Blockers - DH	AMLODIPINE BESYLATE	TABLET
		NICARDIPINE HCL	CAPSULE
		NIFEDIPINE	TAB ER 24
		NIFEDIPINE	TABLET ER

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Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Cardiovascular	Calcium Channel Blockers - NDH	DILTIAZEM HCL	CAP ER 12H
		DILTIAZEM HCL	CAP ER 24H
		DILTIAZEM HCL	CAP ER DEG
		DILTIAZEM HCL	CAPSULE ER
		DILTIAZEM HCL	TABLET
		VERAPAMIL HCL	CAP24H PEL
		VERAPAMIL HCL	TABLET
		VERAPAMIL HCL	TABLET ER
Cardiovascular	Diuretics	AMILORIDE/HYDROCHLOROTHIAZIDE	TABLET
		BENDROFLUMETHIAZIDE	TABLET
		BUMETANIDE	TABLET
		FUROSEMIDE	SOLUTION ***
		FUROSEMIDE	TABLET
		HYDROCHLOROTHIAZIDE	CAPSULE
		HYDROCHLOROTHIAZIDE	SOLUTION
		HYDROCHLOROTHIAZIDE	TABLET
		INDAPAMIDE	TABLET
		SPIRONOLACT/HYDROCHLOROTHIAZID	TABLET
		SPIRONOLACTONE	TABLET
		TORSEMIDE	TABLET
		TRIAMTERENE	CAPSULE
		TRIAMTERENE/HYDROCHLOROTHIAZID	CAPSULE
Cardiovascular	DRIs, ACE-Is and ARBs	BENAZEPRIL HCL	TABLET
		CAPTOPRIL	TABLET
		ENALAPRIL MALEATE	TABLET
		FOSINOPRIL SODIUM	TABLET
		LISINOPRIL	TABLET
		LOSARTAN POTASSIUM	TABLET
		MOEXIPRIL HCL	TABLET
		OLMESARTAN MEDOXOMIL(BENICAR®)	TABLET
		QUINAPRIL HCL	TABLET
		RAMIPRIL	CAPSULE
		RAMIPRIL	TABLET
		TELMISARTAN	TABLET
		TRANDOLAPRIL	TABLET

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Cardiovascular	DRIs, ACE-Is and ARBs + HCT	BENAZEPRIL/HYDROCHLOROTHIAZIDE	TABLET
		CAPTOPRIL/HYDROCHLOROTHIAZIDE	TABLET
		ENALAPRIL/HYDROCHLOROTHIAZIDE	TABLET
		FOSINOPRIL/HYDROCHLOROTHIAZIDE	TABLET
		LISINOPRIL/HYDROCHLOROTHIAZIDE	TABLET
		LOSARTAN/HYDROCHLOROTHIAZIDE	TABLET
		MOEXIPRIL/HYDROCHLOROTHIAZIDE	TABLET
		OLMESARTAN/HYDROCHLOROTHIAZIDE(BENICAR HCT®)	TABLET
		QUINAPRIL/HYDROCHLOROTHIAZIDE	TABLET
		TELMISARTAN/HYDROCHLOROTHIAZID	TABLET
Cardiovascular	HP Statins & Combos	ATORVASTATIN CALCIUM	TABLET
		SIMVASTATIN	TABLET
Cardiovascular	LMP Statins & Combos	LOVASTATIN	TABLET
		PRAVASTATIN SODIUM	TABLET
Cardiovascular	Other Lipid Lowering Agents	CHOLESTYRAMINE (WITH SUGAR)	PACKET
		CHOLESTYRAMINE (WITH SUGAR)	POWDER
		CHOLESTYRAMINE/ASPARTAME	PACKET
		CHOLESTYRAMINE/ASPARTAME	POWDER
		FENOFIBRATE,MICRONIZED	TABLET
		FENOFIBRATE,MICRONIZED(ANTARA®)	CAPSULE
		GEMFIBROZIL	TABLET
		NIACIN	TABLET
		NIACIN(NIASPAN®)	TAB ER 24H
Cardiovascular	Platelet Inhibitors	ASPIRIN	TABLET
		ASPIRIN/DIPYRIDAMOLE(AGGRENOX®)	CPMP 12HR
		CLOPIDOGREL BISULFATE	TABLET
		DIPYRIDAMOLE	TABLET
Dermatologic	Antifungal, Topical	MICONAZOLE NITRATE	CREAM (G)
		NYSTATIN	CREAM (G)
		NYSTATIN	OINT. (G)

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Dermatologic	Anti-Parasite	PERMETHRIN	CREAM (G)
		PERMETHRIN	LIQUID
		PIP BUTOX/PYRETHRINS/PERMETH	KIT
		PIPERONYL BUTOXIDE/PYRETHRINS	GEL (GRAM)
		PIPERONYL BUTOXIDE/PYRETHRINS	KIT
		PIPERONYL BUTOXIDE/PYRETHRINS	LIQUID
		PIPERONYL BUTOXIDE/PYRETHRINS	SHAMPOO
		SPINOSAD(NATROBA®) *	SUSPENSION
Dermatologic	Impetigo Agents	BACITRACIN	OINT. (G)
		BACITRACIN ZINC	OINT. (G)
		BACITRACIN/POLYMYXIN B SULFATE	OINT. (G)
		GENTAMICIN SULFATE	CREAM (G)
		MUPIROCIN	OINT. (G)
		NEOMY SULF/BACITRAC ZN/POLY	OINT. (G)
Dermatologic	Psoriasis, Topical	CALCIPOTRIENE *	CREAM (G)
		CALCIPOTRIENE *	SOLUTION
		CALCIPOTRIENE/BETAMETHASONE *	OINT. (G)
		TAZAROTENE(TAZORAC®) *	CREAM (G)
		TAZAROTENE(TAZORAC®) *	GEL (GRAM)

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Dermatologic	Steroids, Topical	ALCLOMETASONE DIPROPIONATE	CREAM (G)
		ALCLOMETASONE DIPROPIONATE	OINT. (G)
		BETAMETHASONE DIPROPIONATE	CREAM (G)
		BETAMETHASONE DIPROPIONATE	LOTION
		BETAMETHASONE DIPROPIONATE	OINT. (G)
		BETAMETHASONE VALERATE	CREAM (G)
		BETAMETHASONE VALERATE	OINT. (G)
		CLOBETASOL PROPIONATE	CREAM (G)
		CLOBETASOL PROPIONATE	OINT. (G)
		DESONIDE	CREAM (G)
		DESONIDE	OINT. (G)
		FLUOCINOLONE ACETONIDE	CREAM (G)
		FLUOCINOLONE ACETONIDE	SOLUTION
		FLUOCINONIDE	CREAM (G)
		FLUOCINONIDE	SOLUTION
		FLUOCINONIDE/EMOLLIENT	CREAM (G)
		HYDROCORTISONE	CREAM (G)
		HYDROCORTISONE	OINT. (G)
		HYDROCORTISONE ACETATE	CREAM (G)
		HYDROCORTISONE BUTYRATE	SOLUTION
		TRIAMCINOLONE ACETONIDE	CREAM (G)
		TRIAMCINOLONE ACETONIDE	OINT. (G)
Endocrine	Androgens	TESTOSTERONE *	GEL (GRAM)
		TESTOSTERONE *	GEL PACKET
		TESTOSTERONE *	PATCH TD24
		TESTOSTERONE CYPIONATE	VIAL
		TESTOSTERONE ENANTHATE	VIAL
Endocrine	Bone Metabolism Drugs	ALENDRONATE SODIUM	TABLET
		IBANDRONATE SODIUM	TABLET
		RISEDRONATE SODIUM	TABLET
Endocrine	DM-Incretin Enhancers	SITAGLIPTIN PHOS/METFORMIN HCL *	TABLET
		SITAGLIPTIN PHOSPHATE *	TABLET

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Endocrine	DM-Insulin	HUM INSULIN NPH/REG INSULIN HM	VIAL
		HUM INSULIN NPH/REG INSULIN HM *	INSULN PEN
		INSULIN ASPART	VIAL
		INSULIN ASPART *	CARTRIDGE
		INSULIN ASPART *	INSULN PEN
		INSULIN DETEMIR(LEVEMIR®)	VIAL
		INSULIN DETEMIR(LEVEMIR®) *	INSULN PEN
		INSULIN LISPRO	VIAL
		INSULIN LISPRO *	CARTRIDGE
		INSULIN LISPRO(HUMALOG®) *	INSULN PEN
		INSULIN NPL/INSULIN LISPRO	VIAL
		INSULIN NPL/INSULIN LISPRO(HUMALOG MIX 50/50®) *	INSULN PEN
		INSULIN NPL/INSULIN LISPRO(HUMALOG MIX 75-25®) *	INSULN PEN
		INSULIN REGULAR, HUMAN	VIAL
		INSULIN ZINC HUMAN REC	VIAL
		INSULN ASP PRT/INSULIN ASPART	VIAL
		INSULN ASP PRT/INSULIN ASPART *	INSULN PEN
		NPH, HUMAN INSULIN ISOPHANE	VIAL
		NPH, HUMAN INSULIN ISOPHANE *	INSULN PEN
Endocrine	DM-Oral Hypoglycemics	GLIMEPIRIDE	TABLET
		GLIPIZIDE	TABLET
		GLYBURIDE	TABLET
		METFORMIN HCL	TAB ER 24
		METFORMIN HCL	TAB ER 24H
		METFORMIN HCL	TABLET
Endocrine	DM-Thiazolidinediones	PIOGLITAZONE HCL	TABLET
Endocrine	Growth Hormone	SAIZEN® - BRAND ONLY *	VIAL
		SOMATROPIN(OMNITROPE®) *	CARTRIDGE ***
		SOMATROPIN(SAIZEN®) *	CARTRIDGE ***
Endocrine	HRT - Estrogen, Oral	ESTRADIOL	TABLET
		ESTROGENS,CONJ.,SYNTHETIC A	TABLET
		ESTROPIPATE	TABLET
		NORETHIND AC/ETHINYL ESTRADIOL	TABLET
Endocrine	HRT - Estrogen, Topical	ESTRADIOL	PATCH TDWK ***

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Endocrine	HRT - Estrogen, Vaginal	ESTRADIOL	TABLET
		ESTROGENS, CONJUGATED	CREAM (G)
		ESTROGENS, CONJUGATED	CREAM/APPL
Gastrointestinal	Antiemetics, Newer	ONDANSETRON	TAB RAPDIS
		ONDANSETRON HCL	SOLUTION
		ONDANSETRON HCL	TABLET
Gastrointestinal	Clostridium difficile	METRONIDAZOLE	TABLET
		VANCOMYCIN HCL	CAPSULE
		VANCOMYCIN HCL	VIAL
Gastrointestinal	Digestive Enzymes	CREON	CAPSULE DR
		LIPASE/PROTEASE/AMYLASE	CAPSULE DR
Gastrointestinal	H2-Antagonists	CIMETIDINE	TABLET
		CIMETIDINE HCL	SOLUTION
		FAMOTIDINE	TABLET
		RANITIDINE HCL	SYRUP
		RANITIDINE HCL	TABLET
Gastrointestinal	Inflammatory Bowel	BALSALAZIDE DISODIUM	CAPSULE
		CANASA® - BRAND ONLY	SUPP.RECT
		MESALAMINE	TABLET DR ***
		MESALAMINE(APRISO®)	CAP ER 24H
		OLSALAZINE SODIUM	CAPSULE
		SULFASALAZINE	TABLET
		SULFASALAZINE	TABLET DR
Gastrointestinal	PPIs	OMEPRAZOLE	CAPSULE DR
		OMEPRAZOLE	TABLET DR
		PANTOPRAZOLE SODIUM	TABLET DR
Genitourinary	BPH	DOXAZOSIN MESYLATE	TABLET
		FINASTERIDE	TABLET
		TAMSULOSIN HCL	CAP ER 24H
		TERAZOSIN HCL	CAPSULE

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Genitourinary	Overactive Bladder Drugs	FESOTERODINE FUMARATE(TOVIAZ®)	TAB ER 24H
		HYOSCYAMINE SULFATE	DROPS
		HYOSCYAMINE SULFATE	ELIXIR
		HYOSCYAMINE SULFATE	TAB ER 12H
		OXYBUTYNIN	PATCH TDSW
		OXYBUTYNIN CHLORIDE	SYRUP
		OXYBUTYNIN CHLORIDE	TAB ER 24
		OXYBUTYNIN CHLORIDE	TABLET
		TOLTERODINE TARTRATE	TABLET
Hematology	Colony Stimulating Factors	FILGRASTIM	DISP SYRIN
		FILGRASTIM	VIAL
		PEGFILGRASTIM	DISP SYRIN
		SARGRAMOSTIM	VIAL
Hematology	Hematopoietic Agents	DARBEPOETIN ALFA IN POLYSORBAT *	DISP SYRIN
		DARBEPOETIN ALFA IN POLYSORBAT *	VIAL
		PROCRIT® - BRAND ONLY *	VIAL
Hematology	Iron Chelators	DEFEROXAMINE MESYLATE	VIAL
Immunologics	Immunosuppressants	AZATHIOPRINE	TABLET ***
		CYCLOSPORINE	CAPSULE
		CYCLOSPORINE, MODIFIED	CAPSULE
		CYCLOSPORINE, MODIFIED	SOLUTION
		EVEROLIMUS	TABLET
		MYCOPHENOLATE MOFETIL	CAPSULE
		MYCOPHENOLATE MOFETIL	SUSP RECON
		MYCOPHENOLATE MOFETIL	TABLET
		SIROLIMUS	SOLUTION
		SIROLIMUS	TABLET
		TACROLIMUS	CAPSULE
Immunologics	Targeted Immune Modulators	ADALIMUMAB(HUMIRA®)	KIT
		ADALIMUMAB(HUMIRA®)	PEN IJ KIT
		ETANERCEPT(ENBREL®)	DISP SYRIN
		ETANERCEPT(ENBREL®)	PEN INJCTR
Neurologic	Alzheimer's Dx	DONEPEZIL HCL	TABLET ***
		GALANTAMINE HBR	TABLET
		MEMANTINE HCL(NAMENDA®)	TABLET

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Neurologic	Anticonvulsants	CARBAMAZEPINE	ORAL SUSP
		CARBAMAZEPINE	TAB CHEW
		CARBAMAZEPINE	TAB ER 12H
		CARBAMAZEPINE	TABLET
		CLONAZEPAM	TABLET
		DIASTAT ACUDIAL® - BRAND ONLY	KIT
		DIASTAT® - BRAND ONLY	KIT
		DIVALPROEX SODIUM	CAP SPRINK
		DIVALPROEX SODIUM	TAB ER 24H
		DIVALPROEX SODIUM	TABLET DR
		ETHOSUXIMIDE	CAPSULE
		ETHOTOIN	TABLET
		GABAPENTIN	CAPSULE
		LACOSAMIDE	TABLET
		LAMOTRIGINE	TABLET
		LEVETIRACETAM	SOLUTION
		LEVETIRACETAM	TABLET
		MEPHOBARBITAL	TABLET
		METHSUXIMIDE	CAPSULE
		OXCARBAZEPINE	ORAL SUSP
		OXCARBAZEPINE	TABLET
		PHENOBARBITAL	ELIXIR
		PHENOBARBITAL	TABLET
		PHENYTOIN	ORAL SUSP
		PHENYTOIN	TAB CHEW
		PHENYTOIN SODIUM EXTENDED	CAPSULE
		PRIMIDONE	TABLET
		RUFINAMIDE	TABLET
		TIAGABINE HCL	TABLET
		TOPIRAMATE *	TABLET
		VALPROIC ACID	CAPSULE
		ZONISAMIDE	CAPSULE
Neurologic	MS Drugs	INTERFERON BETA-1A(AVONEX PEN®)	PEN IJ KIT
		INTERFERON BETA-1A(AVONEX®)	KIT
		INTERFERON BETA-1A/ALBUMIN(AVONEX ADMINISTRATION PACK®)	KIT

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Neurologic	Parkinson's Drugs	AMANTADINE HCL	CAPSULE
		AMANTADINE HCL	SYRUP
		AMANTADINE HCL	TABLET
		BENZTROPINE MESYLATE	TABLET
		CARBIDOPA/LEVODOPA	TABLET
		ENTACAPONE	TABLET
		PRAMIPEXOLE DI-HCL *	TABLET
		SELEGILINE HCL	CAPSULE
		TRIHEXYPHENIDYL HCL	ELIXIR
		TRIHEXYPHENIDYL HCL	TABLET
Opthalmic	Antibiotic/Steroid	NEO/POLYMYX B SULF/DEXAMETH	DROPS SUSP
		NEOMY SULF/BACITRAC ZN/POLY/HC	OINT. (G)
		SULFACETM NA/PREDNISOL AC	DROPS SUSP
		SULFACETM NA/PREDNISOL AC	OINT. (G)
		TOBRAMYCIN/DEXAMETHASONE	DROPS SUSP
		TOBRAMYCIN/DEXAMETHASONE	OINT. (G)
Opthalmic	Antibiotics	BACITRACIN/POLYMYXIN B SULFATE	OINT. (G)
		CIPROFLOXACIN HCL	DROPS
		CIPROFLOXACIN HCL	OINT. (G)
		ERYTHROMYCIN BASE	OINT. (G)
		GENTAMICIN SULFATE	DROPS
		GENTAMICIN SULFATE	OINT. (G)
		MOXIFLOXACIN HCL(VIGAMOX®)	DROPS
		NATAMYCIN	DROPS SUSP
		NEOMYCIN/POLYMYXN B/GRAMICIDIN	DROPS
		OFLOXACIN	DROPS
		POLYMYXIN B SULFATE/TMP	DROPS
		SULFACETAMIDE SODIUM	DROPS
		TOBRAMYCIN SULFATE	DROPS
		TOBRAMYCIN SULFATE	OINT. (G)

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Opthalmic	Anti-Inflammatory Drugs	DEXAMETHASONE	DROPS SUSP
		DEXAMETHASONE SOD PHOSPHATE	DROPS
		DICLOFENAC SODIUM	DROPS
		FLUOROMETHOLONE	DROPS SUSP ***
		FLUOROMETHOLONE	OINT. (G)
		FLURBIPROFEN SODIUM	DROPS
		KETOROLAC TROMETHAMINE	DROPS
		LOTEPREDNOL ETABONATE	DROPS SUSP ***
		PREDNISOLONE ACETATE	DROPS SUSP ***
Opthalmic	Glaucoma	BETAXOLOL HCL	DROPS
		BRIMONIDINE TARTRATE	DROPS ***
		BRINZOLAMIDE	DROPS SUSP
		CARTEOLOL HCL	DROPS
		DORZOLAMIDE HCL/TIMOLOL MALEAT	DROPS
		LATANOPROST	DROPS
		PILOCARPINE HCL	DROPS
		PILOCARPINE HCL	GEL (GRAM)
		TIMOLOL MALEATE	DROPS
		TRAVOPROST(TRAVATAN Z®)	DROPS
Opthalmic	Vascular Endothelial Growth Factors	BEVACIZUMAB	VIAL
Otic	Antibiotic	NEOMY SULF/COLIST SUL/HC/THONZ	DROPS SUSP
		OFLOXACIN	DROPS
Psychiatric	ADHD	AMPHET ASP/AMPHET/D-AMPHET **	TABLET
		DEXMETHYLPHENIDATE HCL(FOCALIN XR®) **	CPMP 50-50
		DEXTROAMPHETAMINE SULFATE **	TABLET
		FOCALIN® - BRAND ONLY	TABLET
		LISDEXAMFETAMINE DIMESYLATE(VYVANSE®) **	CAPSULE
		METHYLPHENIDATE HCL **	TABLET
Psychiatric	Sedatives	ZOLPIDEM TARTRATE *	TABLET
Pulmonary	Anticholinergic Inhalers	IPRATROPIUM BROMIDE	HFA AER AD
		IPRATROPIUM BROMIDE	SOLUTION
		IPRATROPIUM/ALBUTEROL SULFATE	AER W/ADAP
		IPRATROPIUM/ALBUTEROL SULFATE	AMPUL-NEB
		TIOTROPIUM BROMIDE(SPIRIVA®)	CAP W/DEV

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Pulmonary	Asthma Controllers	BECLOMETHASONE DIPROPIONATE(QVAR®)	AER W/ADAP
		CICLESONIDE	HFA AER AD
		FLUTICASONE PROPIONATE(FLOVENT DISKUS®)	DISK W/DEV
		FLUTICASONE PROPIONATE(FLOVENT HFA®)	AER W/ADAP
		FLUTICASONE/SALMETEROL(ADVAIR DISKUS®) *	DISK W/DEV
		FLUTICASONE/SALMETEROL(ADVAIR HFA®) *	HFA AER AD
		FORMOTEROL FUMARATE	CAP W/DEV
		MONTELUKAST SODIUM *	GRAN PACK
		MONTELUKAST SODIUM *	TAB CHEW
		MONTELUKAST SODIUM *	TABLET
		SALMETEROL XINAFOATE	DISK W/DEV
		ZAFIRLUKAST	TABLET
Pulmonary	Asthma Rescue	ALBUTEROL SULFATE	SOLUTION
		ALBUTEROL SULFATE	VIAL-NEB
		PIRBUTEROL ACETATE	AER BR.ACT
		PROAIR HFA® - BRAND ONLY	HFA AER AD
		PROVENTIL HFA® - BRAND ONLY	HFA AER AD
Pulmonary	Cystic Fibrosis	DORNASE ALFA **	SOLUTION
		SODIUM CHLORIDE FOR INHALATION	AEROSOL
		SODIUM CHLORIDE FOR INHALATION	VIAL-NEB
		TOBRAMYCIN IN 0.225% NACL **	AMPUL-NEB
Pulmonary	PAH	BOSENTAN(TRACLEER®) *	TABLET
		SILDENAFIL CITRATE *	TABLET ***
Pulmonary	Smoking Cessation	BUPROPION HCL	TABLET ER
		NICOTINE	PATCH DYSQ
		NICOTINE	PATCH TD24 ***
		NICOTINE POLACRILEX	GUM
		NICOTINE POLACRILEX	LOZENGE
		VARENICLINE TARTRATE **	TAB DS PK
		VARENICLINE TARTRATE **	TABLET
Renal	Phosphate Binders	CALPHRON® - BRAND ONLY	TABLET
		SEVELAMER HCL *	TABLET

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization

Table 121-0030-1 Oregon Fee-for-Service Voluntary Mental Health Preferred Drug List
Effective February 21, 2013

System	Class	Preferred	
Psychiatric	Antidepressants	AMITRIPTYLINE HCL	TABLET
		BUPROPION HCL	TABLET
		BUPROPION HCL	TABLET ER
		CITALOPRAM HYDROBROMIDE **	SOLUTION
		CITALOPRAM HYDROBROMIDE **	TABLET
		CLOMIPRAMINE HCL	CAPSULE
		DOXEPIN HCL	CAPSULE
		FLUOXETINE HCL	CAPSULE
		FLUOXETINE HCL	SOLUTION
		FLUOXETINE HCL	TABLET
		FLUVOXAMINE MALEATE	TABLET
		MIRTAZAPINE	TAB RAPDIS
		MIRTAZAPINE	TABLET
		NORTRIPTYLINE HCL	CAPSULE
		NORTRIPTYLINE HCL	SOLUTION
		PAROXETINE HCL	TABLET
		SERTRALINE HCL	ORAL CONC
		SERTRALINE HCL	TABLET
		VENLAFAXINE HCL	CAP ER 24H
		VENLAFAXINE HCL	TABLET
Psychiatric	Antipsychotics - 2nd Generation	CLOZAPINE	TABLET
		OLANZAPINE	TABLET
		QUETIAPINE FUMARATE *	TABLET
		RISPERIDONE	SOLUTION
		RISPERIDONE	TABLET
		ZIPRASIDONE HCL	CAPSULE

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization

410-121-0040 Prior Authorization Required for Drugs and Products

(1) Prescribing practitioners are responsible for obtaining prior authorization (PA) for the drugs and categories of drugs requiring PA in this rule, using the procedures required in OAR 410-121-0060.

(2) All drugs and categories of drugs, including but not limited to those drugs and categories of drugs that require PA as described in this rule, are subject to the following requirements for coverage:

(a) Each drug must be prescribed for conditions funded by Oregon Health Plan (OHP) in a manner consistent with the Oregon Health Services Commission's Prioritized List of Health Services (OAR 410-141-0480 through 410-141-0520). If the medication is for a non-covered diagnosis, the medication shall not be covered unless there is a co-morbid condition for which coverage would be extended. The use of the medication must meet corresponding treatment guidelines, be included within the client's benefit package of covered services, and not otherwise excluded or limited;

(b) Each drug must also meet other criteria applicable to the drug or category of drug in these pharmacy provider rules, including PA requirements imposed in this rule.

(3) The Oregon Health Authority (Authority) may require PA for individual drugs and categories of drugs to ensure that the drugs prescribed are indicated for conditions funded by OHP and consistent with the Prioritized List of Health Services and its corresponding treatment guidelines (*see* OAR 410-141-0480). The drugs and categories of drugs that the Authority requires PA for this purpose are found in the OHP Fee-For-Service Pharmacy PA Criteria Guide (PA Criteria Guide) dated ~~January 1, 2013~~February 21, 2013, incorporated in rule by reference and found on our Web page at: http://www.dhs.state.or.us/policy/healthplan/guides/pharmacy/clinical.html

(4) The Authority may require PA for individual drugs and categories of drugs to ensure medically appropriate use or to address potential client safety risk associated with the particular drug or category of drug, as recommended by the Pharmacy & Therapeutics Committee

(P&T) and adopted by the Authority in this rule (*see* OAR 410-121-0100 for a description of the DUR program). The drugs and categories of drugs for which the Authority requires PA for this purpose are found in the Pharmacy PA Criteria Guide.

(5) New drugs shall be evaluated when added to the weekly upload of
the First DataBank drug file:

(a) If the new drug is in a class where current PA criteria apply, all associated PA criteria shall be required at the time of the drug file load;

(b) If the new drug is indicated for a condition below the funding line on the Prioritized List of Health Services, PA shall be required to ensure that the drug is prescribed for a condition funded by OHP;

(c) PA criteria for all new drugs shall be reviewed by the DUR/P&T Committee.

(6) PA is required for brand name drugs that have two or more generically equivalent products available and that are NOT determined Narrow Therapeutic Index drugs by the Oregon DUR/P&T Committee:

(a) Immunosuppressant drugs used in connection with an organ transplant must be evaluated for narrow therapeutic index within 180 days after United States patent expiration;

(b) Manufacturers of immunosuppressant drugs used in connection with an organ transplant must notify the department of patent expiration within 30 days of patent expiration for (5)(a) to apply;

(c) Criteria for approval are:

(A) If criteria established in subsection (3) or (4) of this rule applies, follow that criteria;

(B) If (6)(A) does not apply, the prescribing practitioner must document that the use of the generically equivalent drug is medically

contraindicated, and provide evidence that either the drug has been used and has failed or that its use is contraindicated based on evidence-based peer reviewed literature that is appropriate to the client's medical condition.

(7) PA is required for non-preferred Preferred Drug List (PDL) products in a class evaluated for the PDL except in the following cases:

(a) The drug is a mental health drug as defined in OAR 410-121-0000;

(b) The original prescription is written prior to 1/1/10;

(c) The prescription is a refill for the treatment of seizures, cancer, HIV or AIDS; or

(d) The prescription is a refill of an immunosuppressant.

(8) PA may not be required:

(a) When the prescription ingredient cost plus the dispensing fee is less than the PA processing fees as determined by the Authority;

(b) For over-the-counter (OTC) covered drugs when prescribed for conditions covered under OHP or;

(c) If a drug is in a class not evaluated from the Practitioner-Managed Prescription Drug Plan under ORS 414.334.

Stat. Auth.: ORS Chap. 409.110, 413.042, 414.325, 414.065, and 414.334

Stats. Implemented: 414.065

2-21-13

Antipsoriatics

Goal(s): Cover topical antipsoriatics only for covered OHP diagnoses. Moderate/Severe psoriasis treatments are covered on the OHP. Treatments for mild psoriasis (696.1-696.2, 696.8), seborrheic dermatitis (690.XX), keroderma (701.1-701.3) and other hypertrophic and atrophic conditions of skin (701.8, 701.9) are not covered.

Length of Authorization: 1 year

Alternatives with no PA:
Topical corticosteroids, methotrexate, cyclosporine See: http://www.oregon.gov/DHS/healthplan/tools_prov/pdl.shtml

Requires PA for OHP coverage: TC = 92 and HIC = L1A, L5F, L9D, T0A

After OHP coverage verified these products are preferred:

ANTHRALIN	CREAM(GM)
CALCIPOTRIENE	SOLUTION
DOVONEX	CREAM(GM)
TACLONEX	OINT.(GM)
TAZORAC	CREAM(GM)

Approval Criteria		
1. What is the diagnosis being treated?	Record ICD9 code	
2. Is the diagnosis for seborrheic dermatitis (690.XX), keroderma (701.1-701.3) or other hypertrophic and atrophic conditions of skin (701.8, 701.9)?	**Yes:** PASS TO RPH - Deny (Not Covered by the OHP).	**No:** Go to #**3.**
3. Is the diagnosis Psoriasis? (ICD-9: 696.1-696.2, 696.8)	**Yes:** Go to #**4.**	**No:** Go to #6.
4. Is the Psoriasis Moderate/Severe? *Defined as:* At least 10% body surface area involved or with functional impairment?	**Yes:** Go to 5.	**No:** PASS TO RPH Deny (Not Covered by the OHP).
5. Is the product requested a non-preferred biologic agent approved for plaque psoriasis?	**Yes:** Go to #6	**No:** Got to 7
6. Has the patient tried and not had an adequate response to standard systemic therapies, including cyclosporine or methotrexate or acitretin, or the person is intolerant of or has a contraindication to these treatments?	**Yes:** Approve for length of treatment; maximum 1 year.	No: Pass to RPH; Deny (medical appropriateness)
7~~5~~. Is the product requested preferred?	**Yes**: Approve for length of treatment ; maximum 1 year	**No:** Go to #8~~6~~
8~~6~~. Will the prescriber consider a change to a preferred product? Message: • Preferred products are evidence-based reviewed for comparative effectiveness & safety by the Pharmacy and Therapeutics (P&T) Committee. ~~Health Resources Commission (HRC).~~ Reports are available at: http://pharmacy.oregonstate.edu/drug_policy/index.php ~~http://www.oregon.gov/OHPPR/HRC/Evidence_Based_~~	**Yes**: Inform provider of covered alternatives in class. http://www.oregon.gov/DHS/healthplan/tools_prov/pdl.shtml. .Approve for length of treatment or 1year.	**No:** Approve for length of treatment; maximum 1 year.

~~Reports.shtml.~~		
9~~6~~. RPH only All other indications need to be evaluated as to whether they are above the line or below the line diagnosis.	**If above the line or clinic provides supporting literature:** approve for length of treatment.	**If below the line:** Deny, (Not Covered by the OHP).

DUR Board/P&T Action: *09/16/2010 (DO),9/24/09 (klk), 3/19/09(klk), 2/26/06, 5/24/07*
Revision(s): *09/16/2010 (DO),1/1/10, 7/1/09, 6/1/07, 6/28/12 (MH),*
Initiated: *9/1/06*

Benign Prostatic Hypertrophy (BPH) Medications

Goal(s):

- BPH with urinary obstruction treatment is covered by OHP only when post-void residuals are at least 150ml.
- Cosmetic use for baldness is NOT covered.
- Erectile dysfunction is NOT covered.

* Note: Finasteride is also available as Propecia®, which is FDA-approved for alopecia/male pattern baldness. Alopecia and male pattern baldness are not approvable diagnoses for 5-Alpha Reductase (5AR) Inhibitors.

Length of Authorization: 1 year

Preferred Alternatives: All preferred alternatives on PDL list: http://www.dhs.state.or.us/policy/healthplan/guides/pharmacy/pdl.pdf~~http://www.oregon.gov/DHS/healthplan/tools_prov/pdl.shtml~~

Requires PA: Non-preferred drugs

Approval Criteria		
1. What is the diagnosis?	Record ICD9 code.	
2. ~~Is the~~ Is the request for a phosphodiesterase type 5 inhibitor (e.g. tadalafil or sildenafil)?	**Yes: Go to #3**	**No: Go to #5**
3. Is the diagnosis pulmonary arterial hypertension (PAH)?	**Yes: Go to Pulmonary arterial hypertension PA criteria**	**No: Go to #5**
4. Is the diagnosis erectile dysfunction?	**Yes: Pass to RPh; Deny (not covered by OHP).**	**No: Go to #5**
~~2.~~5. Will the prescriber consider a change to a preferred product? Message: • Preferred products do not require a PA. • Preferred products are evidence-based reviewed for comparative effectiveness and safety by the Health Resource Commission (HRC). Reports are available at: http://pharmacy.oregonstate.edu/drug_policy/index.php	**Yes:** Inform Provider of covered alternatives in class. http://www.dhs.state.or.us/policy/healthplan/guides/pharmacy/pdl.pdf ~~http://www.oregon.gov/DHS/healthplan/tools_prov/dl.shtml.~~	**No**: Go to #6~~3~~
~~3.~~6. Is the request for renewal of current therapy?~~http://www.oregon.gov/OHPPR/HRC/Evidence_Based_Reports.shtml.~~	**Yes: Go to "Renewal Therapy"**	**No: Go to #7**
7~~3~~. Is the request for an alpha blocker, and does client have a diagnosis related to	**Yes:** Go to #8~~4~~	**No:** Go to #9~~5~~

functional and mechanical disorders of the genitourinary system including bladder outlet obstruction? (592.1, 595.1, 596.0, 596.3-596.5, 596.54, 596.7-596.9, 598, 599.82-599.89)		
8~~4~~. Has the client tried and failed a 2-month trial of a covered alternative alpha blocker (terazosin, doxazosin, prazosin, tamsulosin)?	**Yes:** Approve an alpha blocker only for 1 year	**No:** Deny until client has tried and failed a covered alternative
9~~5~~. Does client have a diagnosis of BPH (Benign Prostatic Hypertrophy) or enlarged prostate with obstruction? (600.01, 600.11, 600.21, and 600.91; 788.2 + 600.xx see RPH notes)	**Yes:** Approve for the shorter of 1 year or length of the prescription	**No:** Go to #10~~6~~
10~~6~~. Does client have a diagnosis of unspecified urinary obstruction or benign prostatic hyperplasia without obstruction? **(599.6, 600.00, 600.10, 600.20, and 600.90**)	**Yes:** Pass to RPH; Deny, (Not Covered by the OHP)	**No:** Pass to RPH; Go to #11~~7~~
11~~7~~. RPH Notes only - All other indications need to be evaluated to see if they are above or below the line: **Above the line** covered diagnoses related to prostate may be approved for 1 year **Below the line** diagnoses (e.g. Hair growth, erectile dysfunction) should be denied (Not Covered by the OHP). Alpha Blockers and 5-alpha reductase inhibitors (ARI) may be used concurrently for BPH up to 1 year. Alpha-blockers may be discontinued once prostate is reduced to normal size. • 788.2 (retention of urine, obstructive); Ask for more specific diagnosis. If along with 600.01, 600.11, 600.21 or 600.91, then may approve. Refer questions of coverage to DMAP.		

Renewal Therapy		
1. Is the request for an alpha blocker, and does client have a diagnosis related to functional and mechanical disorders of the genitourinary system including bladder outlet obstruction? (592.1, 595.1, 596.0, 596.3-596.5, 596.54, 596.7-596.9, 598, 599.82-599.89)	**Yes:** Go to #2	**No:** Go to #3

2. Has the patient also been taking a 5-alpha reductase inhibitor for the last year?	**Yes:** Recommend against combination therapy exceeding 1 year	**No:** Approve for the shorter of 1 year or length of the prescription
3. Does client have a diagnosis of BPH (Benign Prostatic Hypertrophy) or enlarged prostate with obstruction? (600.01, 600.11, 600.21, and 600.91; 788.2 + 600.xx see RPH notes)	**Yes:** Approve for 1 year	**No:** Go to #4
4. Does client have a diagnosis of unspecified urinary obstruction or benign prostatic hyperplasia without obstruction? **(599.6, 600.00, 600.10, 600.20, and 600.90**)	**Yes:** Pass to RPH; Deny, (Not Covered by the OHP)	**No:** Pass to RPH; Go to #5
5. RPH only All other indications need to be evaluated as to whether they are above the line or below the line diagnosis. • Alpha Blockers and 5-alpha reductase inhibitors (ARI) may be used concurrently for BPH up to 1 year. Alpha-blockers may be discontinued once prostate is reduced to normal size. • 788.2 (retention of urine, obstructive); Ask for more specific diagnosis. If along with 600.01, 600.11, 600.21 or 600.91, then may approve.	**If above the line or clinic provides supporting literature:** approve for one year.	**If below the line:** Deny, (Not Covered by the OHP).

DUR Board Action: 9/16/10 (KS), 3/18/10(KK), 5-22-08, 2-23-06
Revision(s): 11/29/12 (MH), 1/1/11, 4/20/10, 5-22-08 (Aebi), 7-1-06, 9-30-05
Effective: 10-14-04 (previously excluded)

fingolimod (Gilenya)

Goal(s):

- To ensure appropriate and safe drug use of fingolimod
- Promote preferred drugs

Length of Authorization: One year

Approval Criteria		
1. What is the diagnosis?	Record ICD-9 code	
2. Does the patient have a diagnosis of relapsing Multiple Sclerosis (ICD-9 340)?	**Yes:** Go to #3.	**No:** Pass to RPH; Deny (medical appropriateness)
3. Will the prescriber consider a change to a Preferred MS product? Message: • Preferred products are evidence-based reviewed for comparative effectiveness and safety by the Pharmacy and Therapeutics Committee.	**Yes:** Inform Provider of covered alternatives in class. http://www.oregon.gov/DHS/healthplan/tools_prov/dl.shtml	**No:** Go to #4
4. Has the patient failed or cannot tolerate a full course of interferon beta 1a or interferon beta 1b, and glatiramer?	**Yes:** Go to #5.	**No:** Pass to RPH; Deny (medical appropriateness)
5. Is the medication being prescribed by or in consultation with a neurologist?	**Yes:** Go to #6.	**No:** Pass to RPH; Deny (medical appropriateness)
6. Is the patient on concurrent treatment with a disease modifying drug (i.e. interferon beta-1B, glatiramer acetate, interferon beta 1A, natalizumab, mitoxantrone)?	**Yes:** Pass to RPH; Deny (medical appropriateness)	**No:** Go to #7
7. Does the patient have evidence of macular edema (ICD-9 362.07)?	**Yes:** Pass to RPH; Deny (medical appropriateness)	**No:** Go to #8
8. Does the patient have a~~s~~ preexisting or recent (within last 6 months) MI, unstable angina, TIA, stroke, decompensated heart failure requiring hospitalization or Class III/IV heart failure, or taking Class Ia or Class III anti-arrhythmic drugs (see list below)? ~~cardiac disease, risk factors for bradycardia, or is on antiarrhythmics, beta-blockers, or calcium channel blockers?~~	**Yes:** Pass to RPH; Deny (medical appropriateness~~Go to #9.~~	**No:** Go to #9~~Approve up to one year~~
9. Is the patient on beta-blockers, digoxin or calcium channel blockers?	**Yes:** Go to #10	**No:** Approve up to one year
10~~9~~. Has the patient had a cardiology consultation before initiation?	**Yes:** Approve up to one year	**No:** Pass to RPH; Deny (medical appropriateness)

Clinical Notes:

- Class Ia anti-arrhythmics: quinidine, procainamide, disopyramide.
- Class III anti-arrhythmics: amiodarone, dofetilide, sotalol, dronedarone, ibutilide.

- Because of bradycardia and atrioventricular conduction, patients must be observed for six hours after initial dose in a clinically appropriate area. The time of cardiovascular monitoring should be extended past 6 hours if patients are at higher risk (prolonged QTc interval, severe bradycardia post-administration, HR lowering medications) or may not tolerate bradycardia, which includes continuous ECG monitoring.
- Patients on antiarrhythmics, beta-blockers or calcium channel blockers or with bradycardia risk factors (h/o MI, age >70 yrs, electrolyte disorder, hypothyroidism) may be more prone to development of symptomatic bradycardia and should be initiated on fingolimod with caution and cardiology evaluation should be done before considering treatment in addition to extended monitoring. Posibility of switching to drugs that do not slow heart rate is an option.
- Additional contraindications include baseline QTc interval >500 ms or a history or presence of Mobitz Type II second-degree or third-degree AV block or sick sinus syndrome unless patient has a functioning pacemaker.
- Injectable disease modifying treatments remain first line agents in MS therapy.
- Injectable disease modifying treatments remain first line agents in MS therapy.
- An ophthalmology evaluation should be repeated 3- 4 months after fingolimod initiation with subsequent evaluations based on clinical symptoms.

DUR Board Action: 3-29-2012 (MH)
Revision(s): 8-30-12 (MH)
Initiated:

Incretin Enhancers

Initiative:

- Optimize correct use of incretin enhancers that corresponds to National Guidelines.

Length of Authorization:

Up to 12 months

Requires PA:

- Non-preferred drugs
- Sitagliptin (Januvia®)
- Sitagliptin/metformin (Janumet®)
- Sitagliptin/metformin ER (Janumet XR ®)
- Saxagliptin (Onglyza®)
- Saxagliptin/metformin (Kombiglyze XR®)
- Linagliptin (Tradjenta®)
- Linagliptin/metformin (Jentadueto®)

Covered Alternatives:

Preferred alternatives listed at http://www.oregon.gov/DHS/healthplan/tools_prov/pdl.shtml

Approval Criteria		
1. Does the patient have a diagnosis of Type 2 diabetes?	Yes: Go to #2	No: Deny based on appropriateness of therapy.
2. Will the prescriber consider a change to a preferred product? Message: Preferred products do not require PA. Preferred products are evidence-based reviewed for comparative effectiveness & safety by the Health Resources Commission (HRC).	Yes: Inform provider of covered alternatives in class.	No: Go to #3.

Approval Criteria		
3. Has the patient tried and failed metformin and sulfonylurea therapy or have contraindications to these treatments? Contraindications include: • Renal disease or renal dysfunction • Known hypersensitivity to therapies • Acute or chronic metabolic acidosis • Patients at increased risk of lactic acidosis (CHF, advanced age, impaired hepatic function)	Yes: ~~Approve for up to 12 months.~~ Go to #4	No: Recommend trial of metformin or sulfonylurea. See below for metformin titration schedule.
4. Is the request for sitagliptin (Januvia®) or sitagliptin/metformin (Janumet®)?	Yes: Approve for up to 12 months.	No: Recommend a trial of preferred incretin enhancers (sitagliptin or sitagliptin/metformin).

Initiating Metformin

1. Begin with low-dose metformin (500 mg) taken once or twice per day with meals (breakfast and/or dinner) or 850 mg once per day.
2. After 5-7 days, if gastrointestinal side effects have not occurred, advance dose to 850 mg, or two 500 mg tablets, twice per day (medication to be taken before breakfast and/or dinner).
3. If gastrointestinal side effects appear as doses advanced, decrease to previous lower dose and try to advance the dose at a later time.
4. The maximum effective dose can be up to 1,000 mg twice per day but is often 850 mg twice per day. Modestly greater effectiveness has been observed with doses up to about 2,500 mg/day. Gastrointestinal side effects may limit the dose that can be used.

Nathan, et al. Medical Management of Hyperglycemia in Type 2 Diabetes; A Consensus Algorithm for the Initiation and Adjustment of Therapy. Diabetes Care 31;1-11, 2008.

Oral Direct Factor Xa Inhibitors (Rivaroxaban)

Goal(s):

- Promote safe and effective therapies for oral direct factor Xa inhibitors.

Length of Authorization: 1 year

Covered Alternatives: Listed at; http://www.oregon.gov/DHS/healthplan/tools_prov/pdl.shtml

Approval Criteria		
What is the diagnosis that rivaroxaban is being prescribed for?	Record the ICD9 code:	
1. Does the patient have a diagnosis requiring short-term (<45 days) anticoagulation (i.e. total knee replacement: ICD9 - 81.54 or 81.55) or total hip replacement: ICD9 – 81.51 or 81.52)?	**Yes:** Approve for 12 days for TKR. Approve for 35 days for THR.	**No:** Go to #2
2. Does the patient have a diagnosis of nonvalvular atrial fibrillation (ICD9 – 427.3x)?	**Yes:** Go to #3	**No:** Deny (Medical Appropriateness)
3. Will the prescriber consider a change to the preferred oral anticoagulant, warfarin?	**Yes:** Approve. Additional information can be found at: http://www.dhs.state.or.us/policy/healthplan/guides/pharmacy/clinical.html	**No:** Go to #4
4. Is the patient unable to tolerate the preferred oral anticoagulant due to one of the following: - unstable INR - allergy - contraindications to therapy - drug-drug interactions - intolerable side effects	**Yes:** Go to #5	**No:** Deny with the allowance of a 14 days of rivaroxaban (or until patient is deemed adequately anticoagulated)*. Recommend warfarin trial.
5. Is patient unable to tolerate the second line agent, dabigatran (Pradaxa)?	**Yes:** Approve for up to 1 year.	**No:** Deny with the allowance of a 14 days of rivaroxaban (or until patient is deemed adequately anticoagulated)*. Recommend dabigatran trial.
* Patients switching from rivaroxaban to other anticoagulants have been shown to have an increased risk of thrombotic events. Adequate anticoagulation is recommended during the switch from rivaroxaban to another anticoagulant. Rivaroxaban effects INR measurements, therefore, the appropriate dose of warfarin based on INR can not be used. Adding a parenteral anticoagulant in addition to warfarin at the time the next dose of rivaroxaban is due is recommended.		

~~DUR Board~~P&T Action: 8/30/12 (KS), 1/26/12(KS)
Revision(s):
Initiated: ~~1/26/12 (KS)~~

Phosphate Binders

Goal(s):

- Promote preferred drugs.
- Reserve non-calcium acetate binders for second-line therapy

Length of Authorization:

Up to 12 months

Requires PA:

- Non-preferred phosphate binders and all non-calcium acetate phosphate binders

Covered Alternatives:

Preferred alternatives listed at www.orpdl.org

Approval Criteria		
1. What diagnosis is being treated?	Record ICD9 code.	
2. Is this an OHP-covered diagnosis?	Yes: Go to #3.	No: Go to #5.
3. Has the patient tried or contraindicated to calcium acetate?	Yes: Go to #4. Document trial dates and/or intolerance	No: Pass to RPH, Deny, (Medical Appropriateness) Recommend trial of preferred calcium acetate.
4. Will the prescriber consider a change to a preferred non-calcium acetate product?	Yes: Approve for 1 year and inform provider of preferred alternatives in class.	No: Approve for 1 year or length of prescription, whichever is less.
5. RPH only; All other indications need to be evaluated as to whether they are above the line or below the line diagnosis. • If above the line and clinic provides supporting literature: Approve for length of treatment. • If below the line: Deny, (Not Covered by the OHP).		

Targeted Immune Modulators (TIMS)

Goal(s):

- *Cover TIMs according to OHP list guidelines.*
- *Promote use that is consistent with National Guidelines and medical evidence.*
- *Promote use of high value products.*

Requires PA: Non-preferred products
~~Preferred products for non-approved indications~~

Preferred Products: Adalimumab (Humira®), Etanercept (Enbrel®)

Length of Authorization: 12 months

Generic Name	Trade Name	Indication
Abatacept	Orencia	RA, Juvenile RA, Juvenile idiopathic arthritis
Adalimumab	Humira	RA, Psoriatic arthritis, ankylosing spondylitis, Juvenile idiopathic arthritis, Crohn's disease, Plaque psoriasis, ulcerative colitis
Anakinra	Kineret	RA
Certolizumab	Cimzia	RA, Crohn's disease
Etanercept	Enbrel	RA, psoriatic arthritis, ankylosing spondylitis, juvenile idiopathic arthritis, plaque psoriasis
Golimumab	Simponi	RA, psoriatic arthritis, ankylosing spondylitis
Infliximab*	Remicade	RA, Crohn's disease, psoriatic arthritis, ankylosing spondylitis, ulcerative colitis, plaque psoriasis
Natalizumab*	Tysabri	Crohn's disease
Rituximab*	Rituxan	RA
Tocilizumab*	Actemra	RA, juvenile idiopathic arthritis
Ustekinumab	Stelara	Plaque psoriasis

Abbreviations: RA, rheumatoid arthritis
* Must be billed via J-code and payment requires trial of preferred self-administered drug first.

Approval Criteria : Nicotine Replacement Therapy (NRT)		
1. What is the diagnosis?	Record ICD-9 code	
2. Is the diagnosis covered by OHP?	**Yes:** Go to #3	**No:** Pass to RPH; Deny (medical appropriateness)
~~**3.** Is the product requested preferred?~~	~~**Yes:** Go to #5~~	~~**No:** Go to #4~~
~~4.~~**3.** Will the provider change to a preferred product?	**Yes:** Inform provider of covered alternatives in class.~~Go to #5~~.	**No:** Go to #4~~6~~
~~5. Is the diagnosis a FDA-approved indication for the product requested (see table above)?~~	~~**Yes:** Approve treatment for up to 1 year~~	~~**No:** Pass to RPH; Deny (medical appropriateness)~~
~~6.~~**4.** Is the diagnosis psoriasis (ICD-9: 696.1-696.2, 696.8) and the product requested FDA approved for psoriasis (see table above)? * Moderate/Severe psoriasis treatments are covered on	**Yes:** Refer to anti-psoriatics PA criteria at http://www.dhs.state.or.us/policy/healthplan/guides/pharmacy/OR%20Med	**No:** Go to #5~~7~~

the OHP.	icaid%20PA%20Criteria/PA%200711.pdf	
~~7.~~**5.** Is the diagnosis ankylosing spondylitis (ICD-9 720) and the product requested is FDA approved for ankylosing spondylitis?	**Yes:** Approve treatment for up to 1 year	**No:** Go to #6~~8~~
~~8.~~**6.** Is the diagnosis rheumatoid arthritis (ICD-9 714.xx) or psoriatic arthropathy (ICD-9 696.0) and the product requested FDA approved for rheumatoid arthritis (see table above)?	**Yes:** Go to #7~~9~~	**No:** Go to #8~~10~~
~~9.~~**7.** Has the patient had a trial and inadequate response to methotrexate or other first line DMARDs (leflunomide, sulfasalazine, hydroxychloroquine, penicillamine) and a disease duration of ≥6 months? Or, An intolerance or contraindication to oral DMARDs?	**Yes:** Approve treatment for up to 1 year	**No:** Pass to RPH; Deny (medical appropriateness)
~~10.~~**8.** Is the diagnosis Crohn's disease (ICD-9 555) and the product requested FDA approved for Crohn's (see table above)?	**Yes:** Go to #9~~11~~	**No:** Pass to RPH; Deny (medical appropriateness)
~~11.~~**9.** Has the patient had a trial and inadequate response to conventional therapy including immunosuppressive therapy (mercaptopurine, azathioprine) and/or corticosteroid treatments? Or, Has an intolerance or contraindications to conventional therapy?	**Yes:** Approve treatment for up to 1 year	**No:** Pass to RPH; Deny (medical appropriateness)