

Secretary of State

**NOTICE OF PROPOSED RULEMAKING HEARING\***

A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division)	410	
Agency and Division	Administrative Rules Chapter Number	
Cheryl Peters,	500 Summer St Ne, Salem, OR 97301	503-945-6527
Rules Coordinator	Address	Telephone

**RULE CAPTION**

Permanent Adoption of the Pharmacy & Therapeutics Committee, Prior Authorization and Preferred Drug List Rules

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

12/18/2012	10:30	500 Summer St NE, Salem, OR 97301, Room 137C	Cheryl Peters
Hearing Date	Time	Location	Hearings Officer

*Auxiliary aids for persons with disabilities are available upon advance request.*

**RULEMAKING ACTION**

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

**ADOPT:** OAR 410-121-0111

**AMEND:** OAR 410-121-0030, 410-121-0033, 410-121-0040, & 410-121-0100

**REPEAL:** OAR 410-121-0030(T), 410-121-0033(T), 410-121-0040(T), 410-121-0100(T), & 410-121-0111(T).

Stat. Auth. : ORS 409.025, 409.040, 409.110, 413.032, 413.042, 414.065, 414.325, 414.330, 414.355, 414.360, 414.365, 414.370, 414.380, 414.414, Or Law 2011, chapter 720 (HB 2100)

Other Auth.:

Stats. Implemented: ORS 414.065; 414.325, 414.334, 414.361, 414.369, 414.371, Or Law 2011, chapter 720 (HB 2100)

**RULE SUMMARY**

The Pharmaceutical Services Program administrative rules (division 121) govern Division payments for services provided to certain clients. The Division permanently adopted 410-121-0111 retroactive to September 5, 2011, pursuant to Oregon Laws 2011, chapter 720 (HB 2100) and amended 410-121-0033 & 410-121-0100 to comply with State and Federal mandates regarding the combined Drug Use Review (DUR)/Pharmacy & Therapeutics Committee. The Division permanently amended 410-121-0030 & 410-121-0040 based on recommendations by the Oregon Pharmacy & Therapeutics Committee to ensure the safety of Oregon Health Plan recipients. The Division will also permanently repeal 410-121-0030(T), 410-121-0033(T), 410-121-0040(T), 410-121-0100(T), & 410-121-0111(T). Having temporarily adopted and amended rules listed below the Division will permanently adopt, amend and repeal with this Notice of Proposed Rulemaking:

410-121-0030 – Permanently adopt temporary changes filed on September 24, 2012 based on recommendations made by the Pharmacy & Therapeutics Committee during the July 28, 2012 meeting. Update the preferred drug list based on recommendations made by the Pharmacy & Therapeutics Committee during the September 27, 2012 meeting.

410-121-0033 – Permanently adopt temporary changes filed on September 19, 2012 based on recommendations made by a Rules Advisory Committee meeting held on November 11, 2011.

410-121-0040 – Permanently adopt temporary changes filed on September 24, 2012 based on recommendations made by the Pharmacy & Therapeutics Committee during the July 28, 2012 meeting. Update the prior authorization guide based on recommendations made by the Pharmacy & Therapeutics Committee during the September 27, 2012 meeting.

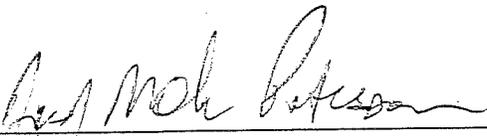
410-121-0100 - Permanently adopt temporary changes filed on September 19, 2012 based on recommendations made by a Rules Advisory Committee meeting held on November 11, 2011.

410-121-0111 - Permanently adopt temporary changes filed on September 19, 2012 based on recommendations made by a Rules Advisory Committee meeting held on November 11, 2011.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

12/20/2012, by 5:00 p.m.

**Last Day for Public Comment** (Last day to submit written comments to the Rules Coordinator)

  
Signature

Judy Mohr Peterson  
Printed name

11-8-12  
Date

**STATEMENT OF NEED AND FISCAL IMPACT**

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

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

Permanent Adoption of the Pharmacy & Therapeutics Committee, Prior Authorization and Preferred Drug List Rules  
 Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The proposed amendment of administrative rules that govern payment for the Pharmaceutical Services Program. The Division will permanently adopt 410-121-0111, amend 410-121-0030, 410-121-0033, 410-121-0040, & 410-121-0100 and repeal 410-121-0030(T), 410-121-0033(T), 410-121-0040(T), 410-121-0100(T), & 410-121-0111(T).

Statutory Authority: ORS 409.025, 409.040, 409.110, 413.032, 413.042, 414.065, 414.325, 414.330, 414.355, 414.360, 414.365, 414.370, 414.380, 414.414, Or Law 2011, chapter 720 (HB 2100)

Other Authority: None.

Stats. Implemented: ORS 414.065; 414.325, 414.334, 414.361, 414.369, 414.371, Or Law 2011, chapter 720 (HB 2100)

Need for the Rule(s): The Pharmaceutical Services Program administrative rules (division 121) govern Division payments for services provided to certain clients. The Division permanently adopted 410-121-0111 retroactive to September 5, 2011, pursuant to Oregon Laws 2011, chapter 720 (HB 2100) and amended 410-121-0033 & 410-121-0100 to comply with State and Federal mandates regarding the combined Drug Use Review (DUR)/Pharmacy & Therapeutics Committee. The Division permanently amend 410-121-0030 & 410-121-0040 based on recommendations by the Oregon Pharmacy & Therapeutics Committee to ensure the safety of Oregon Health Plan recipients. The Division will also permanently repeal 410-121-0030(T), 410-121-0033(T), 410-121-0040(T), 410-121-0100(T), & 410-121-0111(T). Having temporarily adopted and amended rules listed below the Division will permanently adopt, amend and repeal with this Notice of Proposed Rulemaking:

**410-121-0030** – Permanently adopt temporary changes filed on September 24, 2012 based on recommendations made by the Pharmacy & Therapeutics Committee during the July 28, 2012 meeting. Update the preferred drug list based on recommendations made by the Pharmacy & Therapeutics Committee during the September 27, 2012 meeting.

**410-121-0033** – Permanently adopt temporary changes filed on September 19, 2012 based on recommendations made by a Rules Advisory Committee meeting held on November 11, 1011.

**410-121-0040** – Permanently adopt temporary changes filed on September 24, 2012 based on recommendations made by the Pharmacy & Therapeutics Committee during the July 28, 2012 meeting. Update the prior authorization guide based on recommendations made by the Pharmacy & Therapeutics Committee during the September 27, 2012 meeting.

**410-121-0100** - Permanently adopt temporary changes filed on September 19, 2012 based on recommendations made by a Rules Advisory Committee meeting held on November 11, 1011.

**410-121-0111** - Permanently adopt temporary changes filed on September 19, 2012 based on recommendations made by a Rules Advisory Committee meeting held on November 11, 1011.

Documents Relied Upon, and where they are available: Or Law 2011, chapter 720 (HB 2100):  
<http://www.leg.state.or.us/l1reg/measpdf/hb2100.dir/hb2100.en.pdf> . Pharmacy & Therapeutics Committee meeting minutes:  
[http://pharmacy.oregonstate.edu/drug\\_policy/meetings](http://pharmacy.oregonstate.edu/drug_policy/meetings)

**Fiscal and Economic Impact:**

**Statement of Cost of Compliance:**

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)): This permanent filing is needed in order for the legislatively mandated Pharmacy & Therapeutics Committee to convene and conduct official business under the auspices of the Oregon Health Authority. It is also necessary for the health and safety of Oregon Health Plan recipients receiving drugs and prior authorizations.

2. Cost of compliance effect on small business (ORS 183.336): Small businesses will not be affected by this rule.

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:

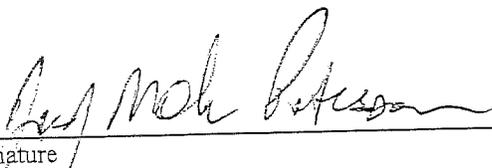
b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: There is no anticipated increase.

c. Equipment, supplies, labor and increased administration required for compliance: There is no anticipated increase.

How were small businesses involved in the development of this rule? Small businesses were not involved in the development of this rule as it will not affect them.

Administrative Rule Advisory Committee consulted?: Yes, a Rules Advisory Committee meeting was held on November 11, 2011 for 410-121-0033, 410-121-0100 & 410-121-0111. The Pharmacy & Therapeutics Committee meeting held on June 28, 2012 acted as a Rules Advisory Committee meeting for 410-121-0030 & 410-121-0040.

If not, why?:

  
Signature

Judy Mohr Peterson  
Printed name

11-8-12  
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

[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

1-1-13

---

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List  
Effective January 1, 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 January 1, 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
		CEFPODOXIME PROXETIL	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 January 1, 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 TENOFVIR DISOPROXIL FUMARATE * TABLET
Antiviral	Hepatitis C	BOCEPREVIR * CAPSULE PEGINTERFERON ALFA-2B * KIT *** PEGINTERFERON ALFA-2B * PEN IJ 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 January 1, 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

\* 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 January 1, 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	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(MICARDIS®)	TABLET
		TRANDOLAPRIL	TABLET
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	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

\* 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 January 1, 2013

System	Class	Preferred	
Cardiovascular	Other Lipid Lowering Agents	CHOLESTYRAMINE (WITH SUGAR)	PACKET
		CHOLESTYRAMINE (WITH SUGAR)	POWDER
		CHOLESTYRAMINE/ASPARTAME	PACKET
		FENOFIBRATE,MICRONIZED(ANTARA®)	CAPSULE
		FENOFIBRATE,MICRONIZED(TRICOR®)	TABLET
		GEMFIBROZIL	TABLET
		NIACIN	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)
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 *	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 January 1, 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
		DENOSUMAB	DISP SYRIN
		DENOSUMAB	VIAL
		IBANDRONATE SODIUM	TABLET
		RISEDRONATE SODIUM	TABLET
Endocrine	DM-Amylin Analogs	PRAMLINTIDE ACETATE(SYMLINPEN®) *	PEN INJCTR

\* 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 January 1, 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®)	INSULN PEN
		INSULIN DETEMIR(LEVEMIR®)	VIAL
		INSULIN GLARGINE,HUM.REC.ANLOG(LANTUS SOLOSTAR®) *	INSULN PEN
		INSULIN GLARGINE,HUM.REC.ANLOG(LANTUS®)	VIAL
		INSULIN GLARGINE,HUM.REC.ANLOG(LANTUS®) *	CARTRIDGE
		INSULIN LISPRO	VIAL
		INSULIN LISPRO *	CARTRIDGE
		INSULIN LISPRO *	INSULN PEN
		INSULIN NPL/INSULIN LISPRO	VIAL
		INSULIN NPL/INSULIN LISPRO *	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 *	CARTRIDGE
		SAIZEN® - BRAND ONLY *	VIAL
		SOMATROPIN(OMNITROPE®) *	CARTRIDGE
Endocrine	HRT - Estrogen, Oral	ESTRADIOL	TABLET
		ESTROGENS,CONJ.,SYNTHETIC A	TABLET
		ESTROPIPATE	TABLET
		NORETHIND AC/ETHINYL ESTRADIOL	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 January 1, 2013

System	Class	Preferred	
Endocrine	HRT - Estrogen, Topical	ESTRADIOL	PATCH TDSW ***
		ESTRADIOL	PATCH TDWK ***
Endocrine	HRT - Estrogen, Vaginal	ESTRADIOL	TABLET
		ESTRADIOL	VAG RING
		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
		ZENPEP	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

\* 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 January 1, 2013

System	Class	Preferred	
Genitourinary	BPH	DOXAZOSIN MESYLATE	TABLET
		FINASTERIDE	TABLET
		TAMSULOSIN HCL	CAP ER 24H
		TERAZOSIN HCL	CAPSULE
Genitourinary	Overactive Bladder Drugs	FESOTERODINE FUMARATE	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(ARANESP®)	DISP SYRIN
		DARBEPOETIN ALFA IN POLYSORBAT(ARANESP®) *	VIAL
		EPOGEN® - 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

\* 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 January 1, 2013

System	Class	Preferred	
Immunologics	Targeted Immune Modulators	ADALIMUMAB(HUMIRA®)	KIT
		ADALIMUMAB(HUMIRA®)	PEN IJ KIT
		ETANERCEPT(ENBREL®)	DISP SYRIN
		ETANERCEPT(ENBREL®)	KIT
		ETANERCEPT(ENBREL®)	PEN INJCTR
		INFLIXIMAB	VIAL
Neurologic	Alzheimer's Dx	DONEPEZIL HCL	TABLET ***
		GALANTAMINE HBR	TABLET
		MEMANTINE 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 Enforceable Physical Health Preferred Drug List  
Effective January 1, 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	GLATIRAMER ACETATE(COPAXONE®)	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 January 1, 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
Ophthalmic	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)
Ophthalmic	Antibiotics	BACITRACIN/POLYMYXIN B SULFATE	OINT. (G)
		CIPROFLOXACIN HCL	DROPS
		CIPROFLOXACIN HCL(CIOXAN®)	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)
Ophthalmic	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 ***

\* 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 January 1, 2013

System	Class	Preferred	
Ophthalmic	Glaucoma	APRACLONIDINE HCL	DROPS
		BETAXOLOL HCL	DROPS
		BRIMONIDINE TARTRATE	DROPS ***
		BRINZOLAMIDE	DROPS SUSP
		CARTEOLOL HCL	DROPS
		DORZOLAMIDE HCL/TIMOLOL MALEAT	DROPS
		PILOCARPINE HCL	DROPS
		PILOCARPINE HCL	GEL (GRAM)
		TIMOLOL MALEATE	DROPS
		TRAVOPROST(TRAVATAN Z®)	DROPS
Otic	Antibiotic	CIPROFLOXACIN HCL	DROPERETTE
		NEOMY SULF/COLIST SUL/HC/THONZ	DROPS SUSP
		OFLOXACIN	DROPS
Psychiatric	ADHD	AMPHET ASP/AMPHET/D-AMPHET **	TABLET
		DEXMETHYLPHENIDATE HCL **	TABLET
		DEXMETHYLPHENIDATE HCL(FOCALIN XR®) **	CPMP 50-50
		DEXTROAMPHETAMINE SULFATE **	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 January 1, 2013**

<b>System</b>	<b>Class</b>	<b>Preferred</b>	
Pulmonary	Asthma Controllers	BECLOMETHASONE DIPROPIONATE(QVAR®)	AER W/ADAP
		BUDESONIDE	AMPUL-NEB
		BUDESONIDE/FORMOTEROL FUMARATE(SYMBICORT®) *	HFA AER AD
		CICLESONIDE(ALVESCO®)	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
		MOMETASONE/FORMOTEROL(DULERA®) *	HFA AER AD
		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
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

\* 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 January 1, 2013

System	Class	Preferred	
Renal	Phosphate Binders	CALCIUM ACETATE	CAPSULE
		CALCIUM ACETATE(CALPHRON®)	TABLET
		SEVELAMER HCL(RENAGEL®)	CAPSULE
		SEVELAMER HCL(RENAGEL®)	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 January 1, 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

## 410-121-0033 Polypharmacy profiling

(1) The Division of Medical Assistance Programs may impose prescription drug payment limitations on clients with more than 15 unique fee-for-service drug prescriptions in a six-month period.

(2) The Division will review the client's drug therapy in coordination with the client's prescribing practitioner to evaluate for appropriate drug therapy.

(3) Appropriate drug therapy criteria will include, but is not limited to, the following:

(a) Overuse of selected drug classes;

(b) Under-use of generic drugs;

(c) Therapeutic drug duplication;

(d) Drug to disease interactions;

(e) Drug to drug interactions;

(f) Inappropriate drug dosage;

(g) Drug selection for age;

(h) Duration of treatment;

(i) Clinical abuse or misuse.

(4) The Division Medical Director in conjunction with the ~~Drug Utilization Review (DUR) Board~~ [Drug Use Review/Pharmacy & Therapeutics](#) Committee will make final determinations on imposed drug prescription payment limitations relating to this policy.

Stat. Auth.: ORS 409.120, 413.042 & 414.380

Stats. Implemented: ORS 414.065

## 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 ~~September 24, 2012~~ January 1, 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

## 410-121-0100 Drug Use Review

(1) Drug Use Review (DUR) in Division of Medical Assistance Programs (Division) is a program designed to measure and assess the proper utilization, quality, therapy, medical appropriateness, appropriate selection and cost of prescribed medication through evaluation of claims data. This is done on both a retrospective and prospective basis. This program shall include, but is not limited to, education in relation to over-utilization, under-utilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage, duration of treatment and clinical abuse or misuse:

(a) Information collected in a DUR program that identifies an individual is confidential;

(b) Staff of the [Drug Use Review \(DUR\)](#)/Pharmacy & Therapeutics (P&T) Committee and contractors may have access to identifying information to carry out intervention activities approved by the Division. The Division, [DUR](#)/P&T Committee or contractors shall adhere to all requirements of the Health Insurance Portability and Accountability Act (HIPAA) and all Division policies relating to confidential client information.

(2) Prospective DUR is the screening for potential drug therapy problems before each prescription is dispensed. It is performed at the point of sale by the dispensing pharmacist:

(a) Dispensing pharmacists must offer to counsel each Division client receiving benefits who presents a new prescription, unless the client refuses such counsel. Pharmacists must document these refusals;

(A) Dispensing pharmacists may offer to counsel the client's caregiver rather than the client presenting the new prescription if the dispensing pharmacist determines that it is appropriate in the particular instance;

(B) Counseling must be done in person whenever practicable;

(C) If it is not practicable to counsel in person, providers whose primary patient population does not have access to a local measured telephone service must provide access to toll-free services (for example, some mail order pharmacy services) and must provide access to toll-free service for long-distance client calls in relation to prescription counseling;

(b) Prospective DUR is not required for drugs dispensed by Fully Capitated Health Plans (FCHPs);

(c) Oregon Board of Pharmacy rules defining specific requirements relating to patient counseling, record keeping and screening must be followed.

(3) Retrospective DUR is the screening for potential drug therapy problems based on paid claims data. The Division provides a professional drug therapy review for Medicaid clients through this program:

(a) The criteria used in retrospective DUR are compatible with those used in prospective DUR. Retrospective DUR criteria may include Pharmacy Management (Lock-In), Polypharmacy, and Psychotropic Use in Children. Drug therapy review is carried out by pharmacists with the Oregon State University College of Pharmacy, Drug Use Research and Management Program.

(b) If therapy problems are identified, an educational letter is sent to the prescribing provider, the dispensing provider, or both. Other forms of education are carried out under this program with Division approval.

(4) The DUR/P&T Committee is designed to develop policy recommendations in the following areas in relation to Drug Use Review:

(a) Appropriateness of criteria and standards for prospective DUR and needs for modification of these areas. DUR criteria are predetermined elements of health care based upon professional expertise, prior experience, and the professional literature with which

the quality, medical appropriateness, and appropriateness of health care service may be compared.

(b) The use of different types of education and interventions to be carried out or delegated by the [DUR/P&T](#) Committee and the evaluation of the results of this portion of the program; and

(c) The preparation of an annual report on Oregon Medicaid DUR Program which describes:

(A) [DUR/P&T](#) Committee Activities;

(i) A description of how pharmacies comply with prospective DUR;

(ii) Detailed information on new criteria and standards in use; and

(iii) Changes in state policy in relation to DUR requirements for residents in nursing homes;

(B) A summary of the education/intervention strategies developed; and

(C) An estimate of the cost savings in the pharmacy budget and indirect savings due to changes in levels of [medicalphysician](#) visits and hospitalizations.

Stat. Auth.: ORS 413.042, 414.355, 414.360, 414.365, 414.370 & 414.380 )

Stats. Implemented: ORS 414.065

1-1-13

Appendix 2 : New Authorization Criteria

IV/SQ Pulmonary Arterial Hypertension Agents

**Goal(s):**

- To ensure appropriate drug use and limit to patient populations in which agents for pulmonary arterial hypertension (PAH) has been shown to be effective and safe.

**Length of Authorization: 12 months**

**Requires PA:**

- Epoprostenol (Flolan®, Veletri®)
- Treprostinil (Remodulin®)

Approval Criteria		
1. What is the diagnosis?	Record ICD-9 code	
2. Does the client have a diagnosis of pulmonary arterial hypertension (PAH) classified as World Health Organization (WHO) Group 1 (see table 1 below)?	<b>Yes:</b> Go to #3.	<b>No:</b> Pass to RPH; Deny (medical appropriateness)
3. Does the client have WHO or New York Heart Association (NYHA) Functional Class III-IV symptoms (see table 2 below)?	<b>Yes:</b> Go to #4	<b>No:</b> Pass to RPH; Deny (medical appropriateness)
4. Is the drug being prescribed by a PAH specialist (pulmonologist or cardiologist)?	<b>Yes:</b> Approve for 12 months	<b>No:</b> Pass to RPH; Deny (medical appropriateness)

**Table 1. Updated Clinical Classification of Pulmonary Hypertension (Dana Point, 2008)**

<b>WHO Group I: Pulmonary Arterial Hypertension</b>	
1. Pulmonary arterial Hypertension	1.5 Associated with
1.2 Idiopathic PAH (IPAH)	1.4.1 Connective tissue diseases
1.2 Heritable	1.4.2 HIV infection
1.2.1 Bone morphogenetic protein receptor (BMPR) type 2	1.4.3 Portal hypertension
1.2.2 Activin receptor-like kinase 1 (ALK1) endoglin (with or without hereditary hemorrhagic telangiectasia)	1.4.4 Congenital heart disease
	1.4.5 Schistosomiasis
1.2.3 Unknown	1.4.6 Chronic hemolytic anemia
1.3 Drug induced	1.5 Persistent pulmonary hypertension of the newborn
	1'. Pulmonary veno-occlusive disease (PVOD) and/or pulmonary capillary hemangiomatosis (PCH)

\* Simonneau, G, et al. Updated Clinical Classification of Pulmonary Hypertension. *J AM Coll Cardiol* 2009; 54:S43-S54.

**Table 2. World Health Organization (WHO) Functional Classification of Pulmonary Hypertension**

<b>Class</b>	<b>Description</b>
I	Patients with pulmonary hypertension (PH) with no limitation in physical ability
II	Patients with PH with slight limitations in physical activity; ordinary physical activity produces dyspnea, fatigue, chest pain or near-syncope
III	Patients with PH with marked limitation of physical activity; less than ordinary physical activity produces dyspnea, fatigue, chest pain or near-syncope
IV	Patients with PH unable to perform any physical activity without symptoms; dyspnea and/or fatigue present at rest

\* Rubin, Lewis. Diagnosis and Management of Pulmonary Arterial Hypertension: ACCP Evidence-Based Clinical Practice Guidelines. *CHEST* 2004; 126:7S-10S)

## NEW RULE

### **410-121-0111 Drug Use Review/Pharmacy & Therapeutics Committee**

(1) Pursuant to Oregon Laws 2011, chapter 720 (HB 2100), the Drug Use Review Board (DUR Board) is abolished and the tenure of office for the members of the DUR Board expires. The legislature transferred the duties, functions and powers previously vested in the DUR Board to the Drug Use Review (DUR)/Pharmacy and Therapeutics (P&T) Committee. This rule is retroactively effective on September 5, 2011, the date the DUR/P&T Committee was created and the DUR Board was abolished by HB 2100, and expires on March 10, 2013 or whenever the Oregon Health Authority (Authority) suspends the rule, whichever comes first.

(2) Unless otherwise inconsistent with these administrative rules or other laws, any administrative rule or agency policy with reference to the DUR Board or a DUR Board volunteer, staff or contractor shall be considered to be a reference to the DUR/P&T Committee or a DUR/P&T Committee volunteer, staff or contractor. The current preferred drug list (PDL), prior authorization process and utilization review process developed by the DUR Board remains in effect until such time as the Authority, after recommendations and advice from the DUR/P&T Committee, modifies them through the adoption of new administrative rules or policies and procedures.

(3) The DUR/P&T Committee shall advise the Oregon Health Authority (Authority) on the:

(a) Implementation of the medical assistance program retrospective and prospective programs, including the type of software programs to be used by the pharmacist for prospective drug use review and the provisions of the contractual agreement between the state and any entity involved in the retrospective program;

(b) Implementation of the Practitioner Managed Prescription Drug Plan (PMPDP);

(c) Adoption of administrative rules pertaining to the DUR/P&T Committee;

(d) Development of and application of the criteria and standards to be used in retrospective and prospective drug use review programs in a manner that ensures that such criteria and standards are based on compendia, relevant guidelines obtained from professional groups through consensus-driven processes, the experience of practitioners with expertise in drug therapy, data and experience obtained from drug utilization review program operations. The DUR/P&T Committee must have an open professional consensus process, establish an explicit ongoing process for soliciting and considering input from interested parties, and make timely revisions to the criteria and standards based on this input and scheduled reviews;

(e) Development, selection and application of and assessment for interventions being educational and not punitive in nature for medical assistance program prescribers, dispensers and patients.

(4) The DUR/P&T Committee shall make recommendations to the Authority, subject to approval by the Director or the Director's designee, for drugs to be included on any PDL adopted by the Authority and on the PMPDP. The DUR/P&T Committee shall also recommend all utilization controls, prior authorization requirements or other conditions for the inclusion of a drug on the PDL.

(5) The DUR/P&T Committee shall, with the approval of the Director or designee, do the following:

(a) Publish an annual report;

(b) Publish and disseminate educational information to prescribers and pharmacists regarding the DUR/P&T Committee and the drug use review programs, including information on the following:

(A) Identifying and reducing the frequency of patterns of fraud, abuse or inappropriate or medically unnecessary care among prescribers, pharmacists and recipients;

(B) Potential or actual severe or adverse reactions to drugs;

(C) Therapeutic appropriateness;

- (D) Overutilization or underutilization;
- (E) Appropriate use of generic products;
- (F) Therapeutic duplication;
- (G) Drug-disease contraindications;
- (H) Drug-drug interactions;
- (I) Drug allergy interactions;
- (J) Clinical abuse and misuse.

(6) Adopt and implement procedures designed to ensure the confidentiality of any information that identifies individual prescribers, pharmacists or recipients and that is collected, stored, retrieved, assessed or analyzed by the DUR/P&T Committee, staff of the DUR/P&T Committee, contractors to the DUR/P&T Committee or the Authority.

Stat. Auth.: ORS 413.042, 414.065, 414.355, 414.360, 414.365, 414.370, 414.380, Or Law 2011, chap. 720 (HB 2100)

Stats. Implemented: ORS 414.065, Or Law 2011, chap. 720 (HB 2100)

1-1-13