

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

Amending Preferred Drug List and Prior Authorization Guide – January 26, 2012 DUR/P&T Action

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

March 19, 2012	10:00	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.

AMEND: The amendment of OAR 410-121-0030 and 410-121-0040

Stat. Auth.: ORS 409.025, 409.040, 409.110, 413.042, 414.065, 414.325, 414.334, 414.355, 414.360, 414.365, 414.370, 414.380, Or Law 2011, chapter 720 (HB 2100)

Other Authority:

Stats. Implemented: ORS 414.065; 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 amended 410-121-0030 and 410-121-0040 per the Drug Use Review (DUR) Pharmacy & Therapeutics (P&T) Committee's recommendations made in the January 26, 2012 meeting.

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.

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.

3/21/12

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

	JEAN S DONOVAN	2/9/12
Signature	Printed name	Date

*Hearing Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday. ARC 920-2005

Secretary of State
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

In the Matter of: The amendment of OAR 410-121-0030 and 410-121-0040

Rule Caption: Amending Preferred Drug List and Prior Authorization Guide – January 26, 2012 DUR/P&T Action

Statutory Authority: ORS 409.025, 409.040, 409.110, 413.042, 414.065, 414.325, 414.334, 414.355, 414.360, 414.365, 414.370, 414.380, Or Law 2011, chapter 720 (HB 2100)

Other Authority: None.

Stats. Implemented: ORS 414.065; 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 amended 410-121-0030 and 410-121-0040 per the Drug Use Review (DUR) Pharmacy & Therapeutics (P&T) Committee's recommendations made in the January 26, 2012 meeting.

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: Updates to the Preferred Drug List (PDL):

- Add Cardiovascular, Anticoagulants, Oral drug class to the PDL and make Warfarin the preferred agent.
- Remove Januvia® and Janumet® from the Endocrine DM-DPP4 Inhibitors drug class.

410-121-0040:

Hepatitis C Oral Protease Inhibitors/Triple Therapy: New criteria.

Methadone – New starts (@ doses >20 mg): New criteria.

Opioids – Long-Acting: Update criteria.

Opioids, Long-Acting – High Dose Limit: New criteria.

Opioids – Long-Acting PDL: Delete criteria (now included in Opioids – Long-Acting).

Oral Direct Factor Xa Inhibitors: New criteria.

Oral Direct Thrombin Inhibitors: New criteria.

Platelet Inhibitors: New 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>

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)):**
N/A

2. **Cost of compliance effect on small business (ORS 183.336):** N/A

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

b. **Projected reporting, record keeping and other administrative activities required for compliance, including costs of professional services:** N/A

c. **Equipment, supplies, labor and increased administration required for compliance:** N/A

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?: The Drug Use Review/Pharmacy & Therapeutics Committee was consulted on January 26, 2012.

If not, why?:


Signature

SEAN S. DONOVAN
Printed name

2/9/12
Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310. ARC 925-2007

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 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 drug 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

1-1-12

The following updates were made to 410-121-0030 Table 121-0030-1:

Added:

- Cardiovascular, Anticoagulants, Oral drug class
- Warfarin to Cardiovascular, Anticoagulants, Oral drug class

Removed:

- Januvia® from the Endocrine DM-DPP4 Inhibitors drug class
- Janumet® from the Endocrine DM-DPP4 Inhibitors drug class

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective April 1, 2012

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 (METHADONE INTENSOL®) **	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 April 1, 2012

System	Class	Preferred	
Analgesics	Short-Acting Opioids	CODEINE SULF	TABLET
		HYDROCODONE BIT/ACETAMINOPHEN **	TABLET ***
		HYDROMORPHONE HCL	TABLET
		MORPHINE SULFATE	SOLUTION
		MORPHINE SULFATE	TABLET
		OXYCODONE HCL	CAPSULE
		OXYCODONE HCL	ORAL CONC
		OXYCODONE HCL	SOLUTION
		OXYCODONE HCL	TABLET
		OXYCODONE HCL/ACETAMINOPHEN **	CAPSULE
		OXYCODONE HCL/ACETAMINOPHEN **	TABLET ***
		TRAMADOL HCL	TABLET
Analgesics	Skeletal Muscle Relaxants	BACLOFEN	TABLET
		CARISOPRODOL **	TABLET
		CARISOPRODOL/ASPIRIN (CARISOPRODOL COMPOUND®) **	TABLET
		CYCLOBENZAPRINE HCL	TABLET ***
		METHOCARBAMOL	TABLET
		ORPHENADRINE CITRATE	TABLET ER
		ORPHENADRINE/ASPIRIN/CAFFEINE (ORPHENADRINE COMPOUND FORTE®)	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 (ZOMIG®) **	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

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

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Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
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System	Class	Preferred
Antibiotics	Cephalosporin, 2nd Gen	CEFPROZIL SUSP RECON CEFPROZIL TABLET CEFUROXIME AXETIL TABLET
Antibiotics	Cephalosporin, 3rd Gen	CEFDINIR CAPSULE CEFDINIR SUSP RECON CEFPODOXIME PROXETIL TABLET
Antibiotics	Fluoroquinolones, Oral	CIPROFLOXACIN (CIPRO®) 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 (ERY-TAB®) TABLET DR ERYTHROMYCIN ETHYLSUCCINATE ORAL SUSP ERYTHROMYCIN ETHYLSUCCINATE TABLET ERYTHROMYCIN ETHYLSUCCINATE (E.E.S. 200®) ORAL SUSP ERYTHROMYCIN ETHYLSUCCINATE (E.E.S. 400®) TABLET ERYTHROMYCIN ETHYLSUCCINATE (ERYPED 200®) SUSP RECON ERYTHROMYCIN ETHYLSUCCINATE (ERYPED 400®) SUSP RECON ERYTHROMYCIN STEARATE TABLET
Antibiotics	Tetracyclines, Oral	DOXYCYCLINE HYCLATE CAPSULE DOXYCYCLINE HYCLATE TABLET DOXYCYCLINE MONOHYDRATE CAPSULE *** DOXYCYCLINE MONOHYDRATE (VIBRAMYCIN®) SUSP RECON TETRACYCLINE HCL CAPSULE
Antifungal	Antifungal, Oral	CLOTRIMAZOLE TROCHE FLUCONAZOLE SUSP RECON FLUCONAZOLE TABLET KETOCONAZOLE TABLET NYSTATIN ORAL SUSP NYSTATIN TABLET

* Drug coverage subject to meeting clinical prior authorization criteria.

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** Drug coverage subject to quantity limits.

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Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective April 1, 2012

System	Class	Preferred
Antiviral	Hepatitis B	ENTECAVIR (BARACLUDE®) ENTECAVIR (BARACLUDE®) LAMIVUDINE (EPIVIR HBV®) LAMIVUDINE (EPIVIR HBV®) TENOFIVIR DISOPROXIL FUMARATE (VIREAD®)
Antiviral	Hepatitis C	PEGINTERFERON ALFA-2A (PEGASYS®) * PEGINTERFERON ALFA-2B (PEGINTRON REDIPEN®) * PEGINTERFERON ALFA-2B (PEGINTRON®) *
Antiviral	HSV, Oral	ACYCLOVIR ACYCLOVIR ACYCLOVIR
Antiviral	Influenza	AMANTADINE HCL AMANTADINE HCL AMANTADINE HCL OSELTAMIVIR PHOSPHATE (TAMIFLU®) ** OSELTAMIVIR PHOSPHATE (TAMIFLU®) ** RIMANTADINE HCL
Cardiovascular	Anticoagulants, Oral	WARFARIN SODIUM
Cardiovascular	Anticoagulants, Subcutaneous	DALTEPARIN SODIUM, PORCINE (FRAGMIN®) LOVENOX® - BRAND ONLY
Cardiovascular	Anti-Platelet Drugs	ASPIRIN ASPIRIN/DIPYRIDAMOLE (AGGRENOX®) CLOPIDOGREL BISULFATE (PLAVIX®) DIPYRIDAMOLE
Cardiovascular	Beta-Blockers	ACEBUTOLOL HCL ATENOLOL CARVEDILOL LABETALOL HCL METOPROLOL TARTRATE NADOLOL PROPRANOLOL HCL

* 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 April 1, 2012

System	Class	Preferred
Cardiovascular	Calcium Channel Blockers - DH	AMLODIPINE BESYLATE TABLET NICARDIPINE HCL CAPSULE NIFEDIPINE TAB ER 24 NIFEDIPINE TABLET ER
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 (BENICAR HCT®) TABLET QUINAPRIL/HYDROCHLOROTHIAZIDE TABLET TELMISARTAN/HYDROCHLOROTHIAZID (MICARDIS HCT®) TABLET

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** Drug coverage subject to quantity limits.

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Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
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System	Class	Preferred
Cardiovascular	HP Statins & Combos	LIPITOR® - BRAND ONLY SIMVASTATIN
Cardiovascular	LMP Statins & Combos	LOVASTATIN PRAVASTATIN SODIUM
Dermatologic	Antifungal, Topical	MICONAZOLE NITRATE NYSTATIN NYSTATIN
Dermatologic	Anti-Parasite	PERMETHRIN PERMETHRIN PIP BUTOX/PYRETHRINS/PERMETH PIPERONYL BUTOXIDE/PYRETHRINS PIPERONYL BUTOXIDE/PYRETHRINS PIPERONYL BUTOXIDE/PYRETHRINS PIPERONYL BUTOXIDE/PYRETHRINS
Dermatologic	Impetigo Agents	BACITRACIN BACITRACIN ZINC BACITRACIN/POLYMYXIN B SULFATE GENTAMICIN SULFATE MUPIROCIN NEOMY SULF/BACITRAC ZN/POLY
Dermatologic	Psoriasis, Topical	CALCIPOTRIENE (DOVONEX®) * CALCIPOTRIENE * CALCIPOTRIENE/BETAMETHASONE (TACLONEX®) * TAZAROTENE (TAZORAC®) * TAZAROTENE (TAZORAC®) *

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

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Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
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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 (ANDRODERM®) *	PATCH TD24
		TESTOSTERONE (TESTIM®) *	GEL (GRAM)
		TESTOSTERONE CYPIONATE	VIAL
		TESTOSTERONE ENANTHATE	VIAL
Endocrine	Bone Metabolism Drugs	ALENDRONATE SODIUM	TABLET
		ALENDRONATE SODIUM/VITAMIN D3 (FOSAMAX PLUS D®)	TABLET
		IBANDRONATE SODIUM (BONIVA®)	TABLET
Endocrine	DM-GLP-1 agonists and analogs	PRAMLINTIDE ACETATE (SYMLINPEN 120®) *	PEN INJCTR
		PRAMLINTIDE ACETATE (SYMLINPEN 60®) *	PEN INJCTR

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Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective April 1, 2012

System	Class	Preferred	
Endocrine	DM-Insulin	HUM INSULIN NPH/REG INSULIN HM (HUMULIN 50-50 [®])	VIAL
		HUM INSULIN NPH/REG INSULIN HM (HUMULIN 70-30 [®])	VIAL
		HUM INSULIN NPH/REG INSULIN HM (HUMULIN 70-30 [®]) *	INSULN PEN
		HUM INSULIN NPH/REG INSULIN HM (NOVOLIN 70/30 [®])	VIAL
		HUM INSULIN NPH/REG INSULIN HM (NOVOLIN 70-30 INNOLET [®]) *	INSULN PEN
		INSULIN ASPART (NOVOLOG [®])	VIAL
		INSULIN ASPART (NOVOLOG [®]) *	CARTRIDGE
		INSULIN ASPART (NOVOLOG [®]) *	INSULN PEN
		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 (HUMALOG [®])	VIAL
		INSULIN LISPRO (HUMALOG [®]) *	CARTRIDGE
		INSULIN LISPRO (HUMALOG [®]) *	INSULN PEN
		INSULIN NPL/INSULIN LISPRO (HUMALOG MIX 50/50 [®]) *	INSULN PEN
		INSULIN NPL/INSULIN LISPRO (HUMALOG MIX 50-50 [®])	VIAL
		INSULIN NPL/INSULIN LISPRO (HUMALOG MIX 75-25 [®])	VIAL
		INSULIN NPL/INSULIN LISPRO (HUMALOG MIX 75-25 [®]) *	INSULN PEN
		INSULIN REGULAR, HUMAN (HUMULIN R [®])	VIAL
		INSULIN REGULAR, HUMAN (NOVOLIN R [®])	VIAL
		INSULIN ZINC HUMAN REC (NOVOLIN L [®])	VIAL
		INSULN ASP PRT/INSULIN ASPART (NOVOLOG MIX 70-30 [®])	VIAL
		INSULN ASP PRT/INSULIN ASPART (NOVOLOG MIX 70-30 [®]) *	INSULN PEN
		NPH, HUMAN INSULIN ISOPHANE (HUMULIN N [®])	VIAL
		NPH, HUMAN INSULIN ISOPHANE (HUMULIN N [®]) *	INSULN PEN
		NPH, HUMAN INSULIN ISOPHANE (NOVOLIN N INNOLET [®]) *	INSULN PEN
		NPH, HUMAN INSULIN ISOPHANE (NOVOLIN N [®])	VIAL
		Endocrine	DM-Oral Hypoglycemics
GLIPIZIDE	TABLET		
GLYBURIDE	TABLET		
METFORMIN HCL	TAB ER 24		
METFORMIN HCL	TAB ER 24H		
METFORMIN HCL	TABLET		
Endocrine	DM-Thiazolidinediones	PIOGLITAZONE HCL (ACTOS [®])	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 April 1, 2012

System	Class	Preferred
Endocrine	Growth Hormone	GENOTROPIN® - BRAND ONLY * GENOTROPIN® - BRAND ONLY * NUTROPIN® - BRAND ONLY * SAIZEN® - BRAND ONLY * SAIZEN® - BRAND ONLY *
Endocrine	HRT - Estrogen, Oral	ESTRADIOL ESTROGENS,CONJ.,SYNTHETIC A (CENESTIN®) ESTROPIPATE NORETHIND AC/ETHINYL ESTRADIOL (FEMHRT®)
Endocrine	HRT - Estrogen, Topical	ESTRADIOL ESTRADIOL (ALORA®) ESTRADIOL (CLIMARA®)
Endocrine	HRT - Estrogen, Vaginal	ESTRADIOL (ESTRING®) ESTRADIOL (VAGIFEM®) ESTROGENS,CONJUGATED (PREMARIN®)
Gastrointestinal	Antiemetics, Newer	ONDANSETRON ** ONDANSETRON HCL ** ONDANSETRON HCL **
Gastrointestinal	Digestive Enzymes	CREON® PANCRELIPASE® ZENPEP®
Gastrointestinal	H2-Antagonists	CIMETIDINE CIMETIDINE HCL FAMOTIDINE RANITIDINE HCL RANITIDINE HCL
Gastrointestinal	Inflammatory Bowel	MESALAMINE (APRISO®) MESALAMINE (ASACOL®) MESALAMINE (ROWASA®) MESALAMINE W/CLEANSING WIPES OLSALAZINE SODIUM (DIPENTUM®) SULFASALAZINE (SULFAZINE EC®) SULFASALAZINE (SULFAZINE®)

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Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective April 1, 2012

System	Class	Preferred
Gastrointestinal	PPIs	OMEPRAZOLE OMEPRAZOLE PANTOPRAZOLE SODIUM CAPSULE DR TABLET DR TABLET DR
Genitourinary	BPH	DOXAZOSIN MESYLATE FINASTERIDE TAMSULOSIN HCL TERAZOSIN HCL TABLET TABLET CAP ER 24H CAPSULE
Genitourinary	Overactive Bladder Drugs	FESOTERODINE FUMARATE (TOVIAZ®) HYOSCYAMINE SULFATE HYOSCYAMINE SULFATE (HYOMAX-SR®) HYOSCYAMINE SULFATE (HYOSYNE®) OXYBUTYNIN (OXYTROL®) OXYBUTYNIN CHLORIDE OXYBUTYNIN CHLORIDE OXYBUTYNIN CHLORIDE TOLTERODINE TARTRATE (DETROL®) TAB ER 24H DROPS TAB ER 12H ELIXIR PATCH TDSW SYRUP TAB ER 24 TABLET TABLET
Hematology	Colony Stimulating Factors	FILGRASTIM (NEUPOGEN®) FILGRASTIM (NEUPOGEN®) PEGFILGRASTIM (NEULASTA®) SARGRAMOSTIM (LEUKINE®) DISP SYRIN VIAL DISP SYRIN VIAL
Hematology	Hematopoietic Agents	DARBEPOETIN ALFA IN POLYSORBATE (ARANESP®) * EPOGEN® - BRAND ONLY * VIAL VIAL
Immunologics	Immunosuppressants	AZATHIOPRINE CYCLOSPORINE CYCLOSPORINE (SANDIMMUNE®) CYCLOSPORINE, MODIFIED (GENGRAF®) CYCLOSPORINE, MODIFIED (GENGRAF®) CYCLOSPORINE, MODIFIED (NEORAL®) EVEROLIMUS (ZORTRESS®) MYCOPHENOLATE MOFETIL MYCOPHENOLATE MOFETIL MYCOPHENOLATE MOFETIL (CELLCEPT®) SIROLIMUS (RAPAMUNE®) SIROLIMUS (RAPAMUNE®) TACROLIMUS (PROGRAF®) TABLET *** CAPSULE CAPSULE CAPSULE SOLUTION CAPSULE TABLET CAPSULE TABLET TABLET SUSP RECON SOLUTION TABLET 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 April 1, 2012

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 (REMICADE®)	VIAL
Neurologic	Alzheimer's Dx	DONEPEZIL HCL (ARICEPT®)	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 April 1, 2012

System	Class	Preferred	
Neurologic	Anticonvulsants	CARBAMAZEPINE	ORAL SUSP
		CARBAMAZEPINE	TAB CHEW
		CARBAMAZEPINE	TABLET
		CARBAMAZEPINE (TEGRETOL XR®)	TAB ER 12H
		CLONAZEPAM	TABLET
		DIASTAT ACUDIAL® - BRAND ONLY	KIT
		DIASTAT® - BRAND ONLY	KIT
		DIVALPROEX SODIUM	TAB ER 24H
		DIVALPROEX SODIUM	TABLET DR
		DIVALPROEX SODIUM (DEPAKOTE SPRINKLE®)	CAP SPRINK
		ETHOSUXIMIDE	CAPSULE
		ETHOSUXIMIDE	SYRUP
		ETHOTOIN (PEGANONE®)	TABLET
		GABAPENTIN	CAPSULE
		LACOSAMIDE (VIMPAT®)	TABLET
		LAMOTRIGINE	TABLET
		LEVETIRACETAM	TABLET
		LEVETIRACETAM (KEPPRA®)	SOLUTION
		MEPHOBARBITAL (MEBARAL®)	TABLET
		METHSUXIMIDE (CELONTIN®)	CAPSULE
		OXCARBAZEPINE	TABLET
		OXCARBAZEPINE (TRILEPTAL®)	ORAL SUSP
		PHENOBARBITAL	ELIXIR
		PHENOBARBITAL	TABLET
		PHENYTOIN	ORAL SUSP
		PHENYTOIN (DILANTIN®)	TAB CHEW
		PHENYTOIN SODIUM EXTENDED	CAPSULE
		PHENYTOIN SODIUM EXTENDED (DILANTIN®)	CAPSULE
		PHENYTOIN SODIUM EXTENDED (PHENYTEK®)	CAPSULE
		PRIMIDONE	TABLET
		RUFINAMIDE (BANZEL®)	TABLET
		TIAGABINE HCL (GABITRIL®)	TABLET
		TOPIRAMATE *	TABLET
		VALPROIC ACID	CAPSULE
		ZONISAMIDE	CAPSULE
		Neurologic	MS Drugs
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 April 1, 2012

System	Class	Preferred	
Neurologic	Parkinson's Drugs	BENZTROPINE MESYLATE	TABLET
		CARBIDOPA/LEVODOPA	TABLET
		CARBIDOPA/LEVODOPA/ENTACAPONE	TABLET
		PRAMIPEXOLE DI-HCL *	TABLET
		SELEGILINE HCL	CAPSULE
		TOLCAPONE (TASMAR®)	TABLET
		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 (BLEPHAMIDE S.O.P.®)	OINT. (G)
		SULFACETM NA/PREDNISOL AC (BLEPHAMIDE®)	DROPS SUSP
		TOBRAMYCIN SULF/DEXAMETHASONE	DROPS SUSP
		TOBRAMYCIN SULF/DEXAMETHASONE (TOBRADEX®)	OINT. (G)
Ophthalmic	Antibiotics	BACITRACIN/POLYMYXIN B SULFATE	OINT. (G)
		CIPROFLOXACIN HCL	DROPS
		ERYTHROMYCIN BASE	OINT. (G)
		GATIFLOXACIN (ZYMAR®)	DROPS ***
		GENTAMICIN SULFATE	DROPS
		GENTAMICIN SULFATE (GENTAK®)	OINT. (G)
		LEVOFLOXACIN (QUIXIN®)	DROPS ***
		MOXIFLOXACIN HCL (VIGAMOX®)	DROPS
		NATAMYCIN (NATACYN®)	DROPS SUSP
		NEOMYCIN/POLYMYXN B/GRAMICIDIN	DROPS
		OFLOXACIN	DROPS
		POLYMYXIN B SULFATE/TMP	DROPS
		SULFACETAMIDE SODIUM	DROPS ***
		TOBRAMYCIN SULFATE	DROPS
		TOBRAMYCIN SULFATE (TOBREX®)	OINT. (G)

* 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 ~~Jan. 1~~April 1, 2011, incorporated in rule by reference and found on our Web page at: 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) PA is required for all new drugs added to the National Drug Data File (NDDF):

(a) The new drug will be prioritized to be presented to the P & T Committee after the drug's NDDF add date. The P & T Committee will make additional drug specific recommendations to the Authority regarding PA criteria, if any, that should be adopted for the new drug:

(i) If the new drug is in a class where current PA criteria apply, all PA criteria associated with that class shall be required at the time the new drug is added to the NDDF;

(ii) 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;

(b) PA for the new drug under section (5) of this rule remains in effect until such time as the Authority makes a determination regarding the applicability of PA criteria for the new drug or six months elapse from the drug's NDDF add date without a decision regarding PA criteria for that drug, whichever occurs first;

(c) Oral oncology medications, anti-retrovirals, and family planning drugs are excluded from the PA requirements in section (5) of this rule.

(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 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, 414.065, and 414.334

Stats. Implemented: 414.065

1-1-12

Table 121-0030-1 Oregon Fee-for-Service Enforceable Physical Health Preferred Drug List
Effective April 1, 2012

System	Class	Preferred
Ophthalmic	Anti-Inflammatory Drugs	DEXAMETHASONE (MAXIDEX®) DEXAMETHASONE SOD PHOSPHATE DICLOFENAC SODIUM FLUOROMETHOLONE FLUOROMETHOLONE (FML S.O.P®) FLURBIPROFEN SODIUM KETOROLAC TROMETHAMINE LOTEPREDNOL ETABONATE (LOTEMAX®) PREDNISOLONE ACETATE DROPS SUSP DROPS DROPS DROPS SUSP *** OINT. (G) DROPS DROPS DROPS SUSP *** DROPS SUSP ***
Ophthalmic	Glaucoma	APRACLOPIDINE HCL (IOPIDINE®) BETAXOLOL HCL BRIMONIDINE TARTRATE BRINZOLAMIDE (AZOPT®) CARTEOLOL HCL DORZOLAMIDE HCL/TIMOLOL MALEAT PILOCARPINE HCL (ISOPTO CARPINE®) PILOCARPINE HCL (PILOPINE HS®) TIMOLOL MALEATE TRAVOPROST (TRAVATAN Z®) DROPS DROPS DROPS *** DROPS SUSP DROPS DROPS DROPS GEL (GRAM) DROPS DROPS
Otic	Antibiotic	CIPROFLOXACIN HCL/DEXAMETH (CIPRODEX®) NEOMY SULF/COLIST SUL/HC/THONZ (CORTISPORIN-TC®) NEOMY SULF/POLYMYX B SULF/HC OFLOXACIN DROPS SUSP DROPS SUSP DROPS SUSP DROPS
Psychiatric	ADHD	AMPHET ASP/AMPHET/D-AMPHET ** DEXMETHYLPHENIDATE HCL ** DEXTROAMPHETAMINE SULFATE ** LISDEXAMFETAMINE DIMESYLATE (VYVANSE®) ** METHYLPHENIDATE HCL (CONCERTA®) ** METHYLPHENIDATE HCL (RITALIN LA®) ** METHYLPHENIDATE HCL ** METHYLPHENIDATE HCL ** TABLET TABLET TABLET CAPSULE TAB ER 24 CPMP 50-50 TABLET TABLET ER
Psychiatric	Sedatives	ZOLPIDEM 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 April 1, 2012

System	Class	Preferred
Pulmonary	Anticholinergic Inhalers	IPRATROPIUM BROMIDE SOLUTION IPRATROPIUM BROMIDE (ATROVENT HFA®) HFA AER AD IPRATROPIUM/ALBUTEROL SULFATE AMPUL-NEB IPRATROPIUM/ALBUTEROL SULFATE (COMBIVENT®) AER W/ADAP TIOTROPIUM BROMIDE (SPIRIVA®) CAP W/DEV
Pulmonary	Asthma Controllers	BECLOMETHASONE DIPROPIONATE (QVAR®) AER W/ADAP BUDESONIDE (PULMICORT FLEXHALER®) AER POW BA FLUNISOLIDE (AEROBID®) AER W/ADAP FLUTICASONE PROPIONATE (FLOVENT DISKUS®) DISK W/DEV FLUTICASONE PROPIONATE (FLOVENT HFA®) AER W/ADAP FORMOTEROL FUMARATE (FORADIL®) CAP W/DEV MOMETASONE FUROATE (ASMANEX®) AER POW BA MONTELUKAST SODIUM (SINGULAIR®) * GRAN PACK MONTELUKAST SODIUM (SINGULAIR®) * TAB CHEW MONTELUKAST SODIUM (SINGULAIR®) * TABLET SALMETEROL XINAFOATE (SEREVENT DISKUS®) DISK W/DEV ZAFIRLUKAST (ACCOLATE®) TABLET
Pulmonary	Asthma Rescue	ALBUTEROL SULFATE SOLUTION ALBUTEROL SULFATE VIAL-NEB PIRBUTEROL ACETATE (MAXAIR AUTOHALER®) AER BR.ACT PROAIR HFA® - BRAND ONLY HFA AER AD PROVENTIL HFA® - BRAND ONLY HFA AER AD
Pulmonary	PAH	BOSENTAN (TRACLEER®) TABLET SILDENAFIL CITRATE (REVATIO®) TABLET *** TADALAFIL (ADCIRCA®) TABLET ***
Renal	Phosphate Binders	CALCIUM ACETATE 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 Voluntary Mental Health Preferred Drug List
Effective April 1, 2012

System	Class	Preferred	
Psychiatric	Antidepressants - 2nd Generation	BUPROPION HCL	TABLET
		BUPROPION HCL	TABLET ER
		CITALOPRAM HYDROBROMIDE	SOLUTION
		CITALOPRAM HYDROBROMIDE	TABLET
		FLUOXETINE HCL	CAPSULE
		FLUOXETINE HCL	SOLUTION
		FLUOXETINE HCL	TABLET
		FLUVOXAMINE MALEATE	TABLET
		MIRTAZAPINE	TAB RAPDIS
		MIRTAZAPINE	TABLET
		PAROXETINE HCL	TABLET
		SERTRALINE HCL	ORAL CONC
		SERTRALINE HCL	TABLET
		VENLAFAXINE HCL	TABLET
Psychiatric	Antipsychotics - 2nd Generation	CLOZAPINE	TABLET
		QUETIAPINE FUMARATE (SEROQUEL®) **	TABLET
		RISPERIDONE	SOLUTION
		RISPERIDONE	TAB RAPDIS
		RISPERIDONE	TABLET
		ZIPRASIDONE HCL (GEODON®)	CAPSULE

* Drug coverage subject to meeting clinical prior authorization criteria.

** Drug coverage subject to quantity limits.

***Certain strengths may require Prior Authorization