Estrogen Derivatives

Goal(s):
- Restrict use to medically appropriate conditions funded under the OHP

Length of Authorization:
- Up to 12 months

Requires PA:
- Non-preferred estrogen derivatives

Covered Alternatives:
- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code.	
2. Will the prescriber consider a change to a preferred product? Message: • Preferred products do not require prior authorization • Preferred products are evidence-based reviewed for comparative effectiveness and safety by the Oregon Pharmacy & Therapeutics (P&T) Committee.	**Yes:** Inform prescriber of covered alternatives in class	**No:** Go to #3
3. Is the request for a funded diagnosis?	**Yes**: Approve for up to 6 months	**No:** If non-funded and current age ≥21 years: Deny; not funded by the OHP If non-funded and current age < 21 years: Go to #4
4. Is there documentation that the condition is of sufficient severity that it impacts the patient's health (e.g., quality of life, function, growth, development, ability to participate in school, perform activities of daily living, etc)?	**Yes:** Go to #5	**No:** Pass to RPh. Deny; medical necessity.

Approval Criteria

5. Is the request for: a) an FDA approved indication AND b) for a preferred product or has the patient failed to have benefit with, or have contraindications or intolerance to the preferred products?	**Yes:** Approve for up to 12 months	**No:** Pass to RPh. Deny; medical appropriateness