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
- All estrogen derivatives for patients <18 years of age

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. Is the estrogen requested for a patient ≥18 years old?	**Yes:** Go to #3	**No**: Go to #4
3. Will the prescriber consider a change to a preferred product? Message: • 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 and approve for up to 12 months.	**No:** Approve for up to 12 months.
4. Is the medication requested for gender dysphoria (ICD10 F642, F641)?	**Yes:** Go to #5	**No:** Go to #6
5. Have **all** of the following criteria been met? • Patient has the capacity to make fully informed decisions and to give consent for treatment; and • If patient <18 years of age, the prescriber is a pediatric endocrinologist; and • The prescriber agrees criteria in Guideline Notes on the OHP List of Prioritized Services have been met. See: https://www.oregon.gov/oha/HPA/DSI-HERC/SearchablePLdocuments//Prioritized-List-GN-127.docx	**Yes:** Approve for up to 6 months	**No**: Pass to RPh. Deny; medical appropriateness
6. Is the medication requested for hypogonadism?	**Yes:** Approve for up to 6 months	**No**: Go to #7

Approval Criteria		
7. RPh only: All other indications need to be evaluated to see if funded under the OHP.	If funded and prescriber provides supporting literature: Approve for up to 12 months.	If non-funded and current age ≥21 years: Deny; not funded by the OHP If non-funded and current age < 21 years: Go to #8
8. 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 #9	**No:** Pass to RPh. Deny; medical necessity.
9. Is the request for: 1) an FDA approved indication AND 2) 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

P&T / DUR Review: *8/22 (KS), 1/17 (SS); 11/15 (KS)*
Implementation: *4/1/17; 1/1/16*