

Exclusion List

- Deny payment for drugs that are only FDA-approved for indications that are not covered by the Oregon Health Plan (OHP).
- Allow case-by-case review for members covered under the EPSDT program.
- Other exclusionary criteria are in rules at:
<https://www.oregon.gov/oha/HSD/OHP/Pages/Policy-Pharmacy.aspx>

A full list of exclusions and limitations is listed in OAR 410-121-0147 Exclusions and Limitations (DMAP Pharmaceutical Services Program):

<https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87>

Examples of drugs which are not covered include (but may not be limited to):

- Expired drug products;
- Drug products from non-rebatable manufacturers, with the exception of selected oral nutritionals, vitamins, and vaccines;
- Active Pharmaceutical Ingredients (APIs) and Excipients as described by Centers for Medicare and Medicaid (CMS);
- Drug products that are not assigned a National Drug Code (NDC) number;
- Drug products that are not approved by the Food and Drug Administration (FDA);
- Non-emergency drug products dispensed for Citizenship Waived Medical client benefit type;
- Drug Efficacy Study Implementation (DESI) drugs;
- Medicare Part D covered drugs or classes of drugs for fully dual eligible clients

NOTE: Returns as “70 – NDC NOT COVERED”

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code.	
2. For what reason is it being rejected?		
3. “70” NDC Not Covered (Transaction line states “Bill Medicare”)	Yes: Go to the Medicare B initiative in these criteria.	No: Go to #4
4. “70” NDC Not Covered (Transaction line states “Bill Medicare or Bill Medicare D”)	Yes: Informational PA to bill specific agency	No: Go to #5
5. “70” NDC Not Covered (due to expired or invalid NDC number)	Yes: Informational PA with message “The drug requested does not have a valid National Drug Code number and is not covered by Medicaid. Please bill with correct NDC number.”	No: Go to #6
6. “70” NDC Not Covered (due to DME items, excluding diabetic supplies) (Error code M5 –requires manual claim)	Yes: Informational PA (Need to billed via DME billing rules) 1-800-336-6016	No: Go to #7

Approval Criteria

7. "70" NDC Not Covered (Transaction line states "DESI Drug")	Yes: Pass to RPh. Deny (DESI Drug) with message, "The drug requested is listed as a "Less-Than-Effective Drug" by the FDA and not covered by Medicaid."	No: Go to #8
8. Is the request for a patient ≥ 21 years of age?	Yes: Go to #9	No: Go to EPSDT assessment Message: Requests for non-covered services can be considered with individual review under EPSDT.
9. "70" NDC Not Covered (Transaction line states "Non-Rebatable Drugs")	Yes: Go to #10	No: Go to #12
10. Is the request for an over-the-counter (OTC) product? See types of OTC products currently covered by OHP here: www.orpdl.org	Yes: Go to #11	No: Pass to RPh. Deny (Non-Rebatable Drug) with message "The drug requested is made by company that does not participate in Medicaid Drug Rebate Program and is therefore not covered"
11. Is there documentation that covered alternatives are not medically appropriate or are unavailable? Note: many OTC products have rebatable or legend alternatives that are covered.	Yes: Pass to RPh; Deny and refer non-rebatable products to DMAP for consideration of a rebate-exception. Document reason (e.g., drug shortage, lack of covered alternatives, intolerance/contraindication to alternatives, etc)	No: Pass to RPh. Deny (Non-Rebatable Drug) with message "The drug requested is made by company that does not participate in Medicaid Drug Rebate Program and is therefore not covered. Consider switching treatment to a covered alternative."

Approval Criteria

12. RPh only: "70" NDC Not Covered (Drugs on the Exclusion List) All indications need to be evaluated to see if they are covered and whether they are above the line or below the line.

Above: Deny with yesterday's date (Medically Appropriateness) and use clinical judgment to APPROVE for 1 month starting today to allow time for appeal.

Message: "Although the request has been denied for long term use because it is considered medically inappropriate, it has also been APPROVED for one month to allow time for appeal."

Below: Pass to RPh; Deny. Not covered

Message: "The treatment for your condition is not a covered service on the Oregon Health Plan."

EPSDT Assessment

1. Is the request for a member ≥ 21 years of age?

Yes: Go to Approval Criteria

No: Go to #2

2. Is the request for a cosmetic indication, impotency, erectile dysfunction or infertility?

These conditions are not covered under the OHP.
See state plan full coverage list.

Yes: Pass to RPh. Deny; not covered

Message: "The treatment for your condition is not a covered service on OHP."

No: Go to #3

3. Is the request for an unfunded condition?

Yes: Go to #4

No: Go to #5

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.

5. Is the request for an FDA approved indication?

Yes: Go to #7

No: Go to #6

6. Is there documentation that the requested treatment is supported by guidelines and compendia?

Yes: Go to #7

Document guideline, compendia, and/or literature referenced by the provider.

No: Pass to RPh. Deny; medical appropriateness.

Off-label requests must include supporting literature.

EPSDT Assessment

7. Is there documentation that alternative therapies (including covered pharmacologic and non-pharmacologic therapies) provide inadequate treatment, are not medically appropriate, are unavailable, or are inaccessible?

Yes: Pass to RPh; Deny; non-covered service and refer to DMAP for secondary evaluation.

Message: The requested treatment cannot be approved without secondary evaluation by DMAP. The request has been referred for evaluation under EPSDT.

No: Pass to RPh. Deny; medical appropriateness.

Document therapies that have been previously tried. Consider switching to a covered alternative if appropriate.

If the DMAP call center notes a drug is often requested for a covered indication, notify Lead Pharmacist so that policy changes can be considered for valid covered diagnoses.

Table 1. Drug categories commonly used for non-covered conditions

Exclusion List		
Drug Code	Description	DMAP Policy
DCC = 1	Drugs To Treat Impotency/ Erectile Dysfunction	Impotency Not Covered on OHP List, BPH is covered
DCC = B	Fertility Agents	Fertility Treatment Not Covered on OHP List
DCC= F	Weight Loss Drugs	Obesity is a covered condition, but weight loss drugs are not a covered drug class. Case-by-case review for members covered under the EPSDT program allowed.
HIC3= L1C	Hypertrichotic Agents, Systemic/Including Combinations	Cosmetic Indications Not Covered
HIC3= Q6F	Contact Lens Preparations	Cosmetic Indications Not Covered
HIC3=L5B	Sunscreens	Cosmetic Indications Not Covered
HIC3=L5C	Abrasives	Cosmetic Indications Not Covered
HIC3=L7A	Shampoos	Cosmetic Indications Not Covered
HIC3=L8A	Deodorants	Cosmetic Indications Not Covered
HIC3=L8B	Antiperspirants	Cosmetic Indications Not Covered
HIC3=L9A	Topical Agents, Misc	Cosmetic Indications Not Covered
HIC3=L9C	Antimelanin Agents	Cosmetic Indications Not Covered
HIC3=L9D	Topical Hyperpigmentation Agent	Cosmetic Indications Not Covered
HIC3=L9F	Topical Skin Coloring Dye Agent	Cosmetic Indications Not Covered
HIC3=L9I	Topical Cosmetic Agent; Vit A	Cosmetic Indications Not Covered
HIC3=L9J	Hair Growth Reduction Agents	Cosmetic Indications Not Covered
HIC3=Q5C	Topical Hypertrichotic Agents	Cosmetic Indications Not Covered

Table 2. Drugs requiring alternative billing

Exclusion List		
Drug Code	Description	DMAP Policy

DCC = D	Diagnostics	DME Billing Required
DCC= Y	Ostomy Supplies	DME Billing Required
HIC3= B0P	Inert Gases	DME Billing Required

Table 3. Drugs commonly used for unfunded conditions or OTC drugs that have not been reviewed for coverage under the Oregon Health Plan

Exclusion List		
Drug Code	Description	DMAP Policy
HIC3=D6C	Alosetron Hcl	IBS Not Funded on OHP List
HIC3=D6E	Tegaserod	IBS Not Funded on OHP List
HIC3=L3P	Topical Antipruritic Agents	Not Covered OTC
HIC3=L4A	Astringents	Not Covered OTC
HIC3=L5A; Except HSN= 002466 (Podophyllin Resin), 006081 (podofilox), 002470 (benzoyl peroxide)	Keratolytics	Not Covered OTC; Warts, Corns/Calluses; Seborrhea Are Not Funded on OHP List
HIC3=L5B	Sunscreens	Not Covered OTC
HIC3=L5C	Abrasives	Not Covered OTC; Acne, Warts, Corns/Callouses; Diaper Rash, Seborrhea Are Not Funded on OHP List
HIC3=L5E	Anti Seborrheic Agents	Seborrhea Not Funded on OHP List
HIC3=L5G	Rosacea Agents, Topical	Rosacea Not Funded on OHP list, some acne severities are Funded
HIC3=L6A; Except HSN = 002577 (coal tar) 002576 002574 036916 002572 (Capsaicin)	Irritants	Not Covered OTC; Seborrhea, Sprains Not Funded on OHP List
HIC3=L7A	Shampoos	Not Covered OTC; Seborrhea, Not Funded on OHP List
HIC3=L9A	Topical Agents, Misc	Not Covered OTC; Warts, Corns/Callouses; Diaper Rash, Seborrhea, are Not Funded on OHP List
HIC3=Q6R, Q6U, Q6D	Antihistamine-Decongestant, Vasoconstrictor and Mast Cell Eye Drops	Allergic Conjunctivitis Not Funded on OHP List
HIC3= U5A, U5B, U5F & S2H plus HSN= 014173	Herbal Supplements “ Natural Anti-Inflammatory Supplements” - Not Including Nutritional Supplements such as: Ensure, Boost, Etc.	Not Covered OTC

HSN=003344	Sulfacetamide Sodium/Sulfur Topical	Seborrhea Not Funded on OHP list
HSN=025510	Rosacea	Rosacea Not Funded on OHP List, some acne severities are funded
TC=93; Except lotions, creams, and ointments	Emollients/Protectants	Not Covered OTC

P&T Review: 12/23; 3/18; 2/23/06
Implementation: 1/1/24; 4/16/18; 5/1/16; 9/1/06; 1/1/12