

## Preferred Drug List (PDL) – Non-Preferred Drugs in Select PDL Classes

**Goal(s):**

- The purpose of this prior authorization policy is to ensure that non-preferred drugs are used appropriately for an OHP-funded condition.

**Initiative:**

- PDL: Preferred Drug List

**Length of Authorization:**

Up to 6 months

**Requires PA:**

- Non-preferred drugs

**Covered Alternatives:**

Preferred alternatives listed at <http://www.orpdl.org/drugs/>

**Note:**

A complete list of PDL classes is available at <http://www.orpdl.org/drugs/>

Approval Criteria		
1. What diagnosis is being treated?	Record ICD9 code.	
2. Is this an FDA approved indication?	<b>Yes:</b> Go to #3	<b>No:</b> Pass to RPh. Deny for medical appropriateness
3. Is this an OHP-funded diagnosis?	<b>Yes:</b> Go to #4.	<b>No:</b> Go to #5.
4. Will the prescriber consider a change to a preferred product?  Message: Preferred products do not generally require a PA. Preferred products are evidence-based and reviewed for comparative effectiveness and safety by the P&T Committee.	<b>Yes:</b> Inform provider of covered alternatives in class.	<b>No:</b> Approve until anticipated formal review by the P&T committee, for 6 months, or for length of the prescription, whichever is less.
5. RPH only: All other indications need to be evaluated as to whether they are a funded diagnosis on the OHP prioritized list.  <ul style="list-style-type: none"> <li>• If funded and clinic provides supporting literature: Approve until anticipated formal review by the P&amp;T committee, for 6 months, or for length of the prescription, whichever is less.</li> <li>• If not funded: Deny; not funded by the OHP.</li> </ul>		

P&T / DUR Review: 7/15 (RC), 9/10; 9/09; 5/09  
 Implementation: 8/15; 1/1/11, 9/16/10