

Phosphate Binders

Goal(s):

- Promote use of preferred drugs for OHP-funded diagnoses.
- Allow case-by-case review for members covered under the EPSDT program.

Length of Authorization:

- Up to 12 months

Requires PA:

- Non-preferred phosphate binders

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 this an OHP-funded diagnosis?	Yes: Go to #3	No: Go to #5
3. Has the patient tried or contraindicated to calcium acetate?	Yes: Document trial dates and/or intolerance. Go to #4	No: Pass to RPh. Deny; medical appropriateness. Recommend trial of preferred calcium acetate product.
4. Will the prescriber consider a change to a preferred non-calcium-based phosphate binder?	Yes: Approve for 1 year and inform prescriber of preferred alternatives in class.	No: Approve for 1 year or length of prescription, whichever is less.
<p>5.</p> <ul style="list-style-type: none"> • RPh only: All other indications need to be evaluated as to whether use is for an OHP-funded diagnosis. • If funded and clinic provides supporting literature, approve for up to 12 months. • If not funded: <ul style="list-style-type: none"> ○ If current age < 21 years; 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)? AND ○ Is the request for a preferred product OR has the patient failed to have benefit with, or have contraindications or intolerance to, at least 2 preferred products? <ul style="list-style-type: none"> ▪ Is yes, may approve for up to 12 months. ▪ If No, Deny (medical appropriateness) • If current age ≥ 21 years, Deny; not funded by the OHP. 		