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 do not require a co-pay. 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.	**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: Deny; not funded by the OHP

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