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

Goal(s):

- Ensure that non-preferred drugs are used appropriately for OHP-funded conditions in adults.
- Allow case-by-case review for members covered under the EPSDT program.

Initiative:

- PDL: Preferred Drug List

Length of Authorization:

- Up to 12 months

Requires PA:

- Non-preferred drugs

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 a request for continuation of a drug and dose previously approved by the FFS program?	**Yes:** Go to **Renewal Criteria**	**No:** Go to #3
3. Is this an FDA approved indication?	**Yes**: Go to #4	**No:** Pass to RPh. Deny; medical appropriateness
4. Is the dosing consistent with FDA-approved labeling?	**Yes:** Go to #5	**No:** Pass to RPh. Deny; medical appropriateness
5. Is this an OHP-funded diagnosis?	**Yes**: Go to #6	**No**: For current age ≥ 21: Pass to RPh. Deny; not funded by the OHP For current age <21 years: Go to #7.
6. 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.	**Yes**: Inform prescriber of covered alternatives in class.	**No**: Approve until anticipated formal review by the P&T committee, for 6 months, or for length of the prescription, whichever is less.

Approval Criteria		
7. 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 #8	**No:** Pass to RPh. Deny; medical necessity.
8. Has the patient failed to have benefit with, or have contraindications or intolerance to, at least 2 preferred products? Message: Preferred products are evidence-based reviewed for comparative effectiveness and safety by the Oregon Pharmacy & Therapeutics Committee.	**Yes:** Approve for 12 months.	**No:** Pass to RPh. Deny; medical appropriateness. Inform prescriber of covered alternatives in class and process appropriate PA.

Renewal Criteria		
1. Has the patient failed to have benefit with, or have contraindications or intolerance to, at least 2 available preferred products?	**Yes:** Approve for 12 months.	**No:** Go to #2
2. 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.	**Yes**: Inform prescriber of covered alternatives in class.	**No:** Approve until anticipated formal review by the P&T committee, for 6 months, or for length of the prescription, whichever is less.

P&T / DUR Review: *4/23; 12/22; 4/22; 7/15, 9/10; 9/09; 5/09*
Implementation: *5/1/23; 1/1/23; 5/1/22; 10/13/16; 8/25/15; 8/15; 1/1/11, 9/16/10*