

Ocular Vascular Endothelial Growth Factors

Goal(s):

- Promote use of preferred drugs and ensure that non-preferred drugs are used appropriately for OHP-funded conditions
- Allow case-by-case review for members covered under the EPSDT program.

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 an OHP-funded diagnosis?	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 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 for 12 months, or for length of the prescription, whichever is less
4. RPh only: All other indications need to be evaluated as to whether they are funded or contribute to a funded diagnosis on the OHP prioritized list. <ul style="list-style-type: none"> • If funded and clinic provides supporting literature: Approve for 12 months, or for length of the prescription, whichever is less. • If not funded: <ul style="list-style-type: none"> ○ Members not eligible for EPSDT review: Deny; not funded by the OHP ○ Members eligible for EPSDT review: If clinic provides supporting literature, and 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) then approve for 12 months, or for length of the prescription, whichever is less. 		

P&T / DUR Review: 4/24 (SS); 8/20; 3/17
 Implementation: TBD