AdvancedHealth
Bridging the Future of Healthcare

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General Drug Use Criteria for Prior Authorizations

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Reviewed:

Includes: Multiple medications. To be used for non-formulary and formulary medications that require pre-approval, but do not have specified drug use criteria.

GUIDELINE FOR USE:

Prior authorization requests received for non-formulary and formulary medications that require pre-approval must meet basic principles established by Oregon Administrative Rule (OAR) to be considered for coverage by Advanced Health. The medication must be used for treatment of a condition that has been determined funded for coverage consistent with the Health Evidence Review Commission Prioritized List of Health Services for Oregon Health Plan (OHP) members; the medication must be used for an FDA-approved indication and prescribed consistent with FDA approved package insert (dosing, duration, etc.). Experimental, investigational, or off-label use of medication is excluded for coverage by Oregon Health Plan, including clinical trials and demonstration projects, and medications for which there is insufficient outcome data to indicate efficacy. Medications not expected to significantly improve the basic health status of the client are excluded from coverage. It is required the least costly medication be utilized when it is anticipated the outcome for the member will essentially be the same. Services must be medically appropriate to be considered for coverage by OHP.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck) mean the Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary and medically appropriate health care services and items and to help Authority clients and their parents or guardians effectively use them.

Initial Request:

1. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services?
    a. If yes, go to #4
    b. If no, go to #2

2. Is there a comorbid condition for which coverage would be allowed?
    a. If yes, go to #4
    b. If no, go to #3

3. Is the request for a member that is less than 21 years of age?
    a. If yes, go to #4
    b. If no, deny as below the Oregon Health Plan funded line.

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4. Are the chart notes less than 12 months old?
   a. If yes, go to #5
   b. If no, request current chart notes. OAR 410-120-1320(7) limits coverage up to 12 months. If the medication was previously approved, may approve for 1 month to allow time for a visit. If the medication was not previously approved, deny as not meeting criteria. Chart notes within the past 12 months are required.
5. Is the medication listed in the treatment plan?
   a. If yes, go to #6
   b. If no, deny as not meeting criteria. Medication must be listed in the treatment plan.

6. Is the medication listed on the DESI Less-Than-Effective drug list?
   a. If yes, deny as not meeting criteria. Per OAR 410-121-0420, medications listed on the DESI Less-Than-Effective drug list are not covered under the Oregon Health Plan.
   b. If no, go to #7

7. Is the medication requested used for impotency, erectile dysfunction, weight loss, cosmetic purposes, or is it an herbal supplement?
   a. If yes, deny as not meeting criteria. Per OAR 410-121-0147, medications used for these conditions are not covered under the Oregon Health Plan.
   b. If no, go to #8

8. Is the medication prescribed used for an FDA-approved indication and at the appropriate FDA-approved dose and/or a substantial body of proof to treat the covered condition?
   a. If yes, go to #9
   b. If no, deny as not meeting criteria. Off-label use of a medication is not a covered benefit on OHP.

9. Is the medication prescribed by or in consultation with an appropriate health care provider with expertise in treating the condition?
   a. If yes, go to #10
   b. If no, forward to MD for review to determine medical appropriateness.

10. Does the member have any contraindications to therapy according to the FDA-approved labeling?
    a. If yes, deny as not meeting criteria. Medications must be prescribed consistent with FDA-approved package insert.
    b. If no, go to #11

11. If FDA-approved labeling or national clinical guidelines categorize the medications as a second line therapy, has there been trial and failure of or contraindication to the first-line therapy?
    a. If yes (or N/A), go to #12
    b. If no, forward to MD for review to determine medical appropriateness.

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12. Has the member trialed and failed all less-costly alternative therapies that are similar or identical to the requested therapy (within the same drug class or therapeutic class)?
    a. If yes, go to #13
    b. If no, deny as not meeting criteria. Request does not meet less costly rule or step therapy.

13. Has member been adherent to first-line therapies used to treat the condition? (Adherence is defined as Medication Possession Ratio (MPR) greater than or equal to 80% or no gaps between fills that exceed 5 days).
    a. If yes, go to #14
    b. If no, deny as not meeting criteria. Review of claims does not support consistent fill history. Please optimize use of first-line therapy.

14. Is the request for a medication that has a fill limit and/or quantity limit?
    a. If yes, go to #15
    b. If no, go to #16

15. Has the prescriber provided documentation that medication is beneficial and clinical rationale to why other formulary alternatives cannot be used?
    a. If yes, go to #16
    b. If no, deny as not meeting criteria. Please utilize formulary alternatives that do not have fill limits and/or quantity limits.

16. Is the drug requested for patient convenience and not medically necessary?
    a. If yes, deny as not meeting criteria. Medications of convenience are not a covered benefit on OHP.
    b. If no, approve for requested duration of therapy OR approve as modified approval with number of fills and request follow-up evaluation with next prior authorization request.

Renewal Request:

1. Is the requested medication being prescribed outside of the FDA-approved treatment duration?
    a. If yes, go to #2
    b. If no, go to #3

2. Is the request for a member that is less than 21 years of age?
    a. If yes, go to #3
    b. If no, deny as not meeting criteria. Off-label use of a medication is not a covered benefit on OHP.

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3. Is there documentation that supports medical necessity and ongoing use of requested medication?
    a. If yes, go to #3
    b. If no, deny as not meeting criteria. Please submit current evaluation that supports ongoing medical necessity.

4. Does review of claims support adherence to prescribed medication therapy? (Adherence is defined as MPR greater than or equal to 80% or no gaps between fills that exceed 5 days).
    a. If yes, approve for requested duration of therapy OR approve as modified approval with number of fills and request follow-up evaluation with next prior authorization request.
    b. If no, deny as not meeting criteria.

Rationale:
To ensure non-formulary medications and formulary medication that require pre-approval are prescribed in a manner consistent with Oregon Administration Rule.

References:

1. OAR 410-120-0000 (51) (62) (85) (93) (146) (147) (157) (202)
2. OAR 410-120-1200 (2) (a) (b) (c)
3. OAR 410-120-1320 (7)
4. OAR 410-121-0040 (2) (3) (4)
5. OAR 410-121-0147 (1) (a) (e) (f) (g) (h) (j) (k)
6. OAR 410-121-0420 (2)
7. OAR 410-141-3820 (1) (2) (10) (a) (A) (B) (C)
8. OAR 410-141-3825 (1) (c) (2) (a)
9. Health Evidence Review Commission (HERC) Prioritized List of Health Services