Cascade Health Alliance, LLC

This document represents the efforts of the Cascade Health Alliance Pharmacy and Therapeutics (P & T) Committee to provide physicians and pharmacists with a method to begin to evaluate the various drug products available. The medical treatment of patients is frequently relative to the practical application of drug therap y.
Due to the vast availability of medication therapy and treatment modalities, a reasonable program of drug product selection and drug usage must be developed. The goal of the Cascade Health Alliance Drug Formulary is to enhance the physician and pharmacist's abilities to provide optimal cost-effective drug therapy for patients.

The Cascade Health Alliance P & T and Formulary Committees use the following criteria in the evaluation of product selection for the Cascade Health Alliance Drug Formulary:

- Product safety profile
- Product efficacy
- Product effectiveness
- Comparison of relevant product benefits to current formulary agents of similar use, while minimizing duplications
- Equitable cost and outcomes of the total cost of product and medical care

Benefit Coverage and Limitations

The Formulary does not provide information regarding the specific coverage and limitations an individual member may have. Many members have specific benefit inclusions, exclusions, copays, or a lack of coverage, which are not reflected in the Drug Formulary.

The Drug Formulary applies only to outpatient drugs provided to members and does not apply to medications used in inpatient settings. If a member has any specific questions regarding their coverage, they should contact Cascade Health Alliance at 541-883-2947 or MedImpact at (800) 788-2949.

1. Generic Substitution

When available, FDA approved generic drugs are to be used in all situations, regardless of the brand name indicated. Greater economy is realized through the use of generic equivalents. This policy is not meant to preclude or supplant any state statutes that may exist. All drugs that are or become available generically are subject to review by CCC's Pharmacy and Therapeutics Committee. MedImpact approves such multi-source drugs for addition to the MAC list based on the following criteria:

- A multi-source product manufactured by at least one (1) nationally marketed company.
- There must be a significant price spread between the brand and the generic product.
- At least one (1) of the generic manufacturer's products must have an "A" rating.
- Product will be approved for generic substitution by the CCC's P & T Committee.

- Certain drug products with complex pharmacokinetics, dosage forms, narrow therapeutic efficacy or where blood level maintenance is crucial will not be subject to substitution. These products are:
  - Neoral Oral Solution
  - Premarin

This list is reviewed and updated periodically based on the clinical literature and available pharmacokinetic principles of the drug products.

If a member or physician requests a brand name product in lieu of an approved generic, the member, based upon their coverage, will typically be required to pay the difference in cost between the br and and the generic. If a physician determines that there is a documented medical need for the brand equivalent, a request for coverage may be made using the medication request process.

2. Preferred Branded Interchange

Certain cross-licensed or multi-source branded drug products may be excluded from coverage. For example, the Proventil HFA™ brand of albuterol sulfate

may not be covered while the Ventolin HFA™ brand is. If a member requests the non-covered brand, the member must pay the full price.

3. Medication Request Process

A. Formulary Agents

Drug products that are listed in the Formulary as Prior Authorization (PA) require evaluation, per Cascade Health Alliance P & T Committee guidelines, when the member presents a prescription to a network phar macy. Each request will be reviewed on individual patient need. If the request does not meet the guidelines established by the P & T Committee, the request will not be approved and an alternative therapy may be recommended.

B. Non-Formulary Agents

Any product not found in the Formulary listing, or any Formulary updates published by Cascade Health Alliance, shall be considered a Non-Formulary drug. Coverage for non-formulary agents may be applied for in advance. When a member gives a prescription order for a non-formulary drug to a pharmacist, the pharmacist will evaluate the patient's drug history and contact the physician to determine if there is a legitimate medical need for a non-formulary drug. Each request will be reviewed on individual patient need. Approval will be given if a documented medical need exists. The following basic guidelines are used:

- The use of Formulary Drug Products is contraindicated in the patient.
- The patient has failed an appropriate trial of Formulary or related agents.
- The choices available in the Drug Formulary are not suited for the present patient care need, and the drug selected is required for patient safety.
- The use of a Formulary drug may provoke an underlying condition, which would be detrimental to patient care.

- If the request does not meet the guidelines established by the P & T Committee, the request will not be approved and alternative therapy may be recommended.

C. Obtaining Coverage

Coverage may be obtained by:

1. Faxing a completed Medication Request Form to CHA at 541-883-6104
2. Contacting CHA at 541-883-2947 and providing all necessary information requested.
   Non-approved requests may be appealed. The prescriber must provide information to support the appeal on the basis of medical necessity.
3. If an emergency situation justifies the immediate medical need for the drug during this review process, an emergency supply of 72 hours shall be made available until the MCE makes a coverage decision.

General Exclusions

A. Over the Counter (OTC) medications or their equivalents are not covered, unless otherwise specified in the Formulary listing.
B. Some Nicotine Smoking Cessation products (i.e. nicotine inhaler) require a Prior Authorization.
C. Drug Products not listed in the Drug Formulary, or specifically listed as not covered are not covered.
D. Any drug products used for cosmetic purposes are not covered.
E. Experimental drug products, or any drug product used in an experimental manner, are not covered.
F. Replacement of lost or stolen medication is not covered.
G. Non self-administered injectable drug products, unless otherwise noted, are not covered.
H. Foreign drugs or drugs not approved by the United States Food & Drug Administration are not covered.
I. Mental Health medications are not included in CHA's formulary. These medications are covered directly by OHP.

The P & T Committee recognizes that not all medical needs can be met with this document and encourages inquiries about alternative therapies.

Pharmacist and Physician Communication

The Drug Formulary is a tool to promote cost-effective prescription drug use. The P & T and Formulary Committees have made every attempt to create a document that meets all therapeutic needs; however, the art of medicine makes this a formidable task. CHA welcomes the participation of physicians, pharmacists, and ancillary medical providers, in this dynamic process. Physicians and pharmacists are highly encouraged to direct any suggestions, comments or formulary additions to CHA at the following address:

Cascade Health Alliance Pharmacy Services
2909 Daggett Ave Suite 200
Klamath Falls, OR 97601
541-883-2947

Cascade Health Alliance

GUIDELINE 8-01
22 April 2019
Pharmacy
Prior Authorization Criteria for Captopril Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Captopril Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Captopril Tablet (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. All prescriptions for Captopril Tablet will be reviewed for a possible change to another formulary ACE Inhibitor that does not require a PA.

3.4. Once the criteria for the *Prior Authorization* is met (trial/failure of another formulary ACE inhibitor) the coverage for the Captopril Tablet will remain in effect for up to 12 months.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or medical necessity.

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5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Revised: *April 22, 2019*

Cascade Health Alliance

GUIDELINE 8-02
23 April 2019
Pharmacy
Prior Authorization Criteria for Enoxaparin Syringe

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Enoxaparin Syringe coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing age ncy may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Enoxaparin Syringe (all strengths) will reject at the POS with a claim greater than a 7 day supply of treatment. All claims 7 day supply or less will adjudicate with a paid claim at the POS to provide a member medication for initial treatment, bridge therapy or complete therapy.

3.2. Oral anti-coagulation medication is the preferred treatment when medically appropriate . Warfarin tablet is the first-line agent for when long-term or chronic anti-coagulation is necessary and desired.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for greater than 7 day supply will be reviewed and maybe granted a *Prior Authorization* based on medical necessity.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-03
23 April 2019
Pharmacy
Prior Authorization Criteria for Fondaparinux Syringe

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Fondaparinux Syringe coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Fondaparinux Syringe (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Enoxaparin Syringe (all strengths) is the first-line agent for injectable anti-coagulation.

3.3. Oral anti-coagulation medication is the preferred treatment when medically appropriate . Warfarin tablet is the first-line agent for when long-term or chronic anti-coagulation is necessary and desired.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Fondaparinux Syringe will be reviewed and evaluated with provider for possible change to Enoxaparin Syringe.

4.3. All changes to Enoxaparin Syringe will have to meet criteria in Guideline 8 -04.

4.4. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-04
23 April 2019
Pharmacy
Prior Authorization Criteria for Rivaroxaban (Xarelto) tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Rivaroxaban (Xarelto) tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Rivaroxaban (Xarelto) (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Oral anti-coagulation medication is the preferred treatment when medically appropriate . Warfarin tablet is the first-line agent for when long-term or chronic anti-coagulation is necessary and desired.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Rivaroxaban (Xarelto) will be reviewed and evaluated with provider for possible change to Warfarin (Coumadin).

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-05
23 April 2019
Pharmacy
Quantity Limit Criteria for Cholestyramine Powder (Questran) (Can)

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Cholestyramine Powder (Questran) (Can) coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Cholestyramine Powder (Questran) (Can) will reject at the POS with a claim greater than one can per 28 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-06
23 April 2019
Pharmacy
Quantity Limit Criteria for Cholestyramine Powder Light (Questran Light) (Can)

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Cholestyramine Powder Light (Questran Light) (Can) coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and f or which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Cholestyramine Powder Light (Questran Light) (Can) will reject at the POS with a claim greater than one can per 28 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-07
23 April 2019
Pharmacy
Quantity Limit Criteria for Colestipol Tablets

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Colestipol Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Colestipol 1 gram tablets will reject at the POS with a claim greater than #120 tablets per 30 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-08
23 April 2019
Pharmacy
Prior Authorization Criteria for Clotrimazole Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Clotrimazole Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Clotrimazole Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-09
23 April 2019
Pharmacy
Prior Authorization Criteria for Clotrimazole/Betamethasone Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Clotrimazole/Betamethasone Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Clotrimazole/Betamethasone Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-10
23 April 2019
Pharmacy
Prior Authorization Criteria for Ketoconazole Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Ketoconazole Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Ketoconazole Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-11
23 April 2019
Pharmacy
Prior Authorization Criteria for Ketoconazole Shampoo

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Ketoconazole Shampoo coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Ketoconazole Shampoo (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-12
23 April 2019
Pharmacy
Prior Authorization Criteria for Miconazole Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Miconazole Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Miconazole Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-13
23 April 2019
Pharmacy
Prior Authorization Criteria for Miconazole Spray

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Miconazole Spray coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Miconazole Spray (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-14
23 April 2019
Pharmacy
Prior Authorization Criteria for Nystatin Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Nystatin Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for wh ich the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Nystatin Cream will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or medical necessity.

4.2. *Prior Authorizations*, when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-15
23 April 2019
Pharmacy
Prior Authorization Criteria for Nystatin Ointment

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Nystatin Ointment coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Nystatin Ointment will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations, when* granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-16
23 April 2019
Pharmacy
Prior Authorization Criteria for Nystatin Powder

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Nystatin Powder coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Nystatin Powder (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. 4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-17
23 April 2019
Pharmacy
Prior Authorization Criteria for Terbinafine Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Terbinafine Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Terbinafine Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-18
23 April 2019
Pharmacy
Prior Authorization Criteria for Tolnaftate Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Tolnaftate Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Tolnaftate Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-19
23 April 2019
Pharmacy
Prior Authorization Criteria for Albendazole (Albenza) Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Albendazole (Albenza) Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Albendazole (Albenza) Tablet (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be given for 3 fills of the prescribed quantity within a 365-day period. An evaluation of medical appropriateness will be required prior to approval for additional authorization.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-20
24 April 2019
Pharmacy
Prior Authorization Criteria for Permethrin 5% Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Permethrin 5% Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Permethrin 5% Cream will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Permethrin 1% liquid is first line agent and must have a documented failure through claims data prior to granting Prior Authorization for Permethrin 5% Cream for certain covered conditions.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be given for 3 fills of the prescribed quantity within a 365-day period. An evaluation of medical appropriateness will be required prior to approval for additional authorization.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-21
23 April 2019
Pharmacy
Prior Authorization Criteria for Hydrocortisone Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Hydrocortisone Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Hydrocortisone Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-22
23 April 2019
Pharmacy
Prior Authorization Criteria for Hydrocortisone Ointment

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Hydrocortisone Ointment coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropria te care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Hydrocortisone Ointment (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-23
23 April 2019
Pharmacy
Prior Authorization Criteria for Betamethasone Dipropionate Lotion

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Betamethasone Dipropionate Lotion coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Betamethasone Dipropionate Lotion (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-24
23 April 2019
Pharmacy
Prior Authorization Criteria for Betamethasone Valerate Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Betamethasone Valerate Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Betamethasone Valerate Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-25
23 April 2019
Pharmacy
Prior Authorization Criteria for Fluticasone Propionate Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Fluticasone Propionate Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Fluticasone Propionate Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-26
23 April 2019
Pharmacy
Prior Authorization Criteria for Mometasone Furoate Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Mometasone Furoate Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Mometasone Furoate Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations*, when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-27
23 April 2019
Pharmacy
Prior Authorization Criteria for Triamcinolone Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Triamcinolone Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Triamcinolone Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-28
23 April 2019
Pharmacy
Prior Authorization Criteria for Triamcinolone Ointment

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Triamcinolone Ointment coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1200 (139) (D) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provide to a Division client or CCO member in the Division or CCO's judgment.

2.7. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Triamcinolone Ointment (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-29
23 April 2019
Pharmacy
Prior Authorization Criteria for Triamcinolone Lotion

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Triamcinolone Lotion coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Triamcinolone Lotion (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-30
23 April 2019
Pharmacy
Prior Authorization Criteria for Fluticasone Propionate Ointment

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Fluticasone Propionate Ointment coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Fluticasone Propionate Ointment (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-31
23 April 2019
Pharmacy
Prior Authorization Criteria for Mometasone Furoate Ointment

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Mometasone Furoate Ointment coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Mometasone Furoate Ointment (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-32
23 April 2019
Pharmacy
Prior Authorization Criteria for Betamethasone Dipropionate Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Betamethasone Dipropionate Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Betamethasone Dipropionate Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-33
23 April 2019
Pharmacy
Prior Authorization Criteria for Fluocinonide Gel

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Fluocinonide Gel coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Fluocinonide gel (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations*, when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-34
23 April 2019
Pharmacy
Prior Authorization Criteria for Fluocinonide Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Fluocinonide Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Fluocinonide Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-35
23 April 2019
Pharmacy
Prior Authorization Criteria for Fluocinonide Solution

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Fluocinonide Solution coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Fluocinonide solution (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations*, when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-36
23 April 2019
Pharmacy
Prior Authorization Criteria for Betamethasone Dipropionate Ointment

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Betamethasone Dipropionate Ointment coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Betamethasone Dipropionate Ointment (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-37
23 April 2019
Pharmacy
Prior Authorization Criteria for Clobetasol Propionate Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Clobetasol Propionate Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Clobetasol Propionate Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-38
23 April 2019
Pharmacy
Prior Authorization Criteria for Clobetasol Propionate Solution

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Clobetasol Propionate Solution coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Clobetasol Propionate Solution (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations*, when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-39
23 April 2019
Pharmacy
Prior Authorization Criteria for Lidocaine/Prilocaine Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Lidocaine/Prilocaine Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

2.7. *Southern Oregon Opioid Prescriber Toolkit*, Regional CCO Collaborative For Safer Opioid Prescribing. 2016.

3. PROCEDURES:

3.1. Lidocaine/Prilocaine Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorization,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-40
23 April 2019
Pharmacy
Prior Authorization & Quantity Limit Criteria for Lidocaine Patches

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization and Quantity Limit Criteria* for Lidocaine Patches coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

2.7. *Southern Oregon Opioid Prescriber Toolkit*, Regional CCO Collaborative For Safer Opioid Prescribing. 2016.

3. PROCEDURES:

3.1. Lidocaine Patches (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. All prescriptions for Lidocaine patches will be reviewed for a possible change to Lidocaine 2% jelly

3.4. A *quantity limit* of up to 30 patches per 30 days is also in effect on Lidocaine Patches.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-41
23 April 2019
Pharmacy
Prior Authorization Criteria for Fluorouracil Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Fluorouracil Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Fluorouracil Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-42
23 April 2019
Pharmacy
Prior Authorization & Quantity Limit Criteria for Salon-pas Patches

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization and Quantity Limit Criteria* for Salon-pas Patches coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

2.7. *Southern Oregon Opioid Prescriber Toolkit*, Regional CCO Collaborative For Safer Opioid Prescribing. 2016.

3. PROCEDURES:

3.1. Salon-pas Patches (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. A *quantity limit* of 30 per 30 days is also in effect on Salon-pas Patches.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-43
23 April 2019
Pharmacy
Prior Authorization Criteria for Selenium Sulfide Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Selenium Sulfide Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2016).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Selenium Sulfide Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-44
23 April 2019
Pharmacy
Prior Authorization Criteria for Zinc Oxide Paste

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Zinc Oxide Paste coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Zinc Oxide Paste (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-45
23 April 2019
Pharmacy
Prior Authorization Criteria for Acarbose Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Acarbose Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

2.7. American Diabetes Association. Standards of medical care in diabetes - 2016. Diabetes Care. 2016;39(suppl 1):S1-S119.

2.8. Bennett WL, Maruthur NM, Singh S, et al. Comparative effectiveness and safety of medications for type 2 diabetes: an update including new drugs and 2 -drug combinations. Ann Intern Med. 2011;154:602-613.

3. PROCEDURES:

3.1. Acarbose Tablet (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Must have an A1C greater than or equal to 9%, but less than 10% or have failed a compliant 3 months of monotherapy of metformin to achieve A1C target and still be less than 10%.

3.4. Will not be covered for monotherapy and must be used in a dual therapy with Metformin.

3.5. Due to its rather modest impact on A1C, Acarbose Tablet is not a first line agent. A sulfonylurea must be tried and failed prior to requesting a *Prior Authorization* for Acarbose Tablet.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-46
23 April 2019
Pharmacy
Prior Authorization Criteria for Tradjenta (linagliptin) (DPP-4 Inhibitor) Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 4

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Tradjenta (linagliptin) (DPP-4 Inhibitor) Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

2.7. American Diabetes Association. Standards of medical care in diabetes - 2016. Diabetes Care. 2016;39(suppl 1):S1-S119.

2.8. Bennett WL, Maruthur NM, Singh S, et al. Comparative effectiveness and safety of medications for type 2 diabetes: an update including new drugs and 2 -drug combinations. Ann Intern Med. 2011;154:602-613.

3. PROCEDURES:

3.1. Tradjenta (linagliptin) (DPP-4 Inhibitor) (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Must have an A1C greater than or equal to 9%, but less than 10% and have a failure on a compliant 3-month dual therapy which included metformin and Alogliptin to achieve A1C target and still be less than 10%.

3.4. Will not be covered for dual therapy and must be used in a triple therapy which includes Metformin.

3.5. In addition to metformin required for coverage, a sulfonylurea, thiazolidinedione, GLP -1 receptor agonist or insulin (basil) must be used as part of the triple therapy due to Tradjenta (linagliptin) (DPP-4 Inhibitor) having a rather modest impact on A1C.

Start with Monotherapy unless:

A1C is greater than or equal to 9%, move to Dual Therapy.

A1C is greater than or equal to 10%, move to Combination Injectable Therapy.

Monotherapy	**Metformin**

Efficacy	High
Hypo Risk	Low Risk
Weight	Neutral/Loss
Side Effects	GI/Lactic Acidosis
Costs	Low

If A1C target not achieved after 3 months of compliant monotherapy, proceed to 2 -drug combination.

Dual Therapy	**Metformin +**

	Sulfonylurea	Thiazolidinedione	GLP-1 RA	Insulin (Basal)
Efficacy	High	High	High	Highest
Hypo Risk	Moderate Risk	Low Risk	Low Risk	High Risk
Weight	Gain	Gain	Loss	Gain
Side Effects	Hypoglycemia	Edema, HF	GI	Hypoglycemia
Costs	Low	Low	High	High

If A1C target not achieved after 3 months of compliant dual therapy, proceed to 3 -drug combination.

Triple Therapy	**Metformin +**

Sulfonylurea +	**TZD +**	**DPP-4 Inhibitor +**	**SGLT2 Inhibitor +**	**GLP-1 RA +**	**Insulin (Basal) +**
Add one additional medication from the appropriate column					
TZD	SU	SU	SU	SU	SU
Insulin	Insulin	TZD	TZD	TZD	TZD
GLP-1-RA	GLP-1-RA	Insulin	Insulin	Insulin	GLP-1-RA
DPP-4-I	DPP-4-I	SGLT2-I	GLP-1-RA	SGLT2-I	DPP-4-I
SGLT2-I	SGLT2-I		DPP-4-I		SGLT2-I

If A1C target not achieved after 3 months of compliant triple therapy and patient (1) on oral combination, move to basal insulin or GLP-1 RA, (2) on GLP-1 RA, add basal insulin, or (3) on optimally titrated basal Insulin, add GLP-1 RA or mealtime insulin. Metformin therapy should be maintained, while other oral agents may be discontinued on an individual basis to avoid unnecessarily complex or costly regimens (i.e., adding a fourth antihyperglycemic agent).

Combination Injectable Therapy	**Metformin + Basal Insulin +**

Rapid-Acting Insulin	GLP-1 RA

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-47
23 April 2019
Pharmacy
Prior Authorization Criteria for Nessina (alogliptin) (DPP-4 Inhibitor) Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 4

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Nessina (alogliptin) Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

2.7. American Diabetes Association. Standards of medical care in diabetes - 2016. Diabetes Care. 2016;39(suppl 1):S1-S119.

2.8. Bennett WL, Maruthur NM, Singh S, et al. Comparative effectiveness and safety of medications for type 2 diabetes: an update including new drugs and 2 -drug combinations. Ann Intern Med. 2011;154:602-613.

3. PROCEDURES:

3.1. Nessina (alogliptin) (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Must have an A1C greater than or equal to 9%, but less than 10% or have a failure on a compliant 3 month dual therapy which included metformin to achieve A1C target and still be less than 10%.

3.4. Will not be covered for dual therapy and must be used in a triple therapy which includes Metformin.

3.5. In addition to metformin required for coverage, a sulfonylurea, thiazolidinedione, GLP -1 receptor agonist or insulin (basil) must be used as part of the triple therapy due to Nessina (alogliptin) (DPP-4 Inhibitor) having a rather modest impact on A1C.

Start with Monotherapy unless:

A1C is greater than or equal to 9%, move to Dual Therapy.

A1C is greater than or equal to 10%, move to Combination Injectable Therapy.

Monotherapy	**Metformin**

Efficacy	High
Hypo Risk	Low Risk
Weight	Neutral/Loss
Side Effects	GI/Lactic Acidosis
Costs	Low

If A1C target not achieved after 3 months of compliant monotherapy, proceed to 2 -drug combination.

Dual Therapy	**Metformin +**

	Sulfonylurea	Thiazolidinedione	GLP-1 RA	Insulin (Basal)
Efficacy	High	High	High	Highest
Hypo Risk	Moderate Risk	Low Risk	Low Risk	High Risk
Weight	Gain	Gain	Loss	Gain
Side Effects	Hypoglycemia	Edema, HF	GI	Hypoglycemia
Costs	Low	Low	High	High

If A1C target not achieved after 3 months of compliant dual therapy, proceed to 3 -drug combination.

Triple Therapy	**Metformin +**

Sulfonylurea +	**TZD +**	**DPP-4 Inhibitor +**	**SGLT2 Inhibitor +**	**GLP-1 RA +**	**Insulin (Basal) +**
Add one additional medication from the appropriate column					
TZD	SU	SU	SU	SU	SU
Insulin	Insulin	TZD	TZD	TZD	TZD
GLP-1-RA	GLP-1-RA	Insulin	Insulin	Insulin	GLP-1-RA
DPP-4-I	DPP-4-I	SGLT2-I	GLP-1-RA	SGLT2-I	DPP-4-I
SGLT2-I	SGLT2-I		DPP-4-I		SGLT2-I

If A1C target not achieved after 3 months of compliant triple therapy and patient (1) on oral combination, move to basal insulin or GLP-1 RA, (2) on GLP-1 RA, add basal insulin, or (3) on optimally titrated basal Insulin, add GLP-1 RA or mealtime insulin. Metformin therapy should be maintained, while other oral agents may be discontinued on an individual basis to avoid unnecessarily complex or costly regimens (i.e., adding a fourth antihyperglycemic agent).

Combination Injectable Therapy	**Metformin + Basal Insulin +**

Rapid-Acting Insulin	GLP-1 RA

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations* when granted will be for 3 months (90 days), after which authorization will be re-evaluated every 90 days (12 months max).

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA*

Approved by: P&T Committee

Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-48
23 April 2019
Pharmacy
Quantity Limit Criteria for Nateglinide Tablets

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Nateglinide Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Nateglinide Tablet will reject at the POS with a claim greater than #90 tablets per 30 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-49
23 April 2019
Pharmacy
Prior Authorization Criteria for Steglatro (ertugliflozin) (SGLT-2 Inhibitor) Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 4

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Steglatro (ertugliflozin) tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

2.7. American Diabetes Association. Standards of medical care in diabetes - 2016. Diabetes Care. 2016;39(suppl 1):S1-S119.

2.8. Bennett WL, Maruthur NM, Singh S, et al. Comparative effectiveness and safety of medications for type 2 diabetes: an update including new drugs and 2 -drug combinations. Ann Intern Med. 2011;154:602-613.

3. PROCEDURES:

3.1. Steglatro (ertugliflozin) (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Must have an A1C greater than or equal to 9%, but less than 10% or have a failure on a compliant 3 month dual therapy which included metformin to achieve A1C target and still be less than 10%.

3.4. Will not be covered for dual therapy and must be used in a triple therapy which includes Metformin.

3.5. In addition to metformin required for coverage, a sulfonylurea, thiazolidinedione, GLP -1 receptor agonist or insulin (basil) must be used as part of the triple therapy due to Steglatro (ertugliflozin) (SGLT-2 Inhibitor) having a rather modest impact on A1C.

Start with Monotherapy unless:

A1C is greater than or equal to 9%, move to Dual Therapy.

A1C is greater than or equal to 10%, move to Combination Injectable Therapy.

Monotherapy	**Metformin**

Efficacy	High
Hypo Risk	Low Risk
Weight	Neutral/Loss
Side Effects	GI/Lactic Acidosis
Costs	Low

If A1C target not achieved after 3 months of compliant monotherapy, proceed to 2 -drug combination.

Dual Therapy	**Metformin +**

	Sulfonylurea	Thiazolidinedione	GLP-1 RA	Insulin (Basal)
Efficacy	High	High	High	Highest
Hypo Risk	Moderate Risk	Low Risk	Low Risk	High Risk
Weight	Gain	Gain	Loss	Gain
Side Effects	Hypoglycemia	Edema, HF	GI	Hypoglycemia
Costs	Low	Low	High	High

If A1C target not achieved after 3 months of compliant dual therapy, proceed to 3 -drug combination.

Triple Therapy	**Metformin +**

Sulfonylurea +	**TZD +**	**DPP-4 Inhibitor +**	**SGLT2 Inhibitor +**	**GLP-1 RA +**	**Insulin (Basal) +**
Add one additional medication from the appropriate column					
TZD	SU	SU	SU	SU	SU
Insulin	Insulin	TZD	TZD	TZD	TZD
GLP-1-RA	GLP-1-RA	Insulin	Insulin	Insulin	GLP-1-RA
DPP-4-I	DPP-4-I	SGLT2-I	GLP-1-RA	SGLT2-I	DPP-4-I
SGLT2-I	SGLT2-I		DPP-4-I		SGLT2-I

If A1C target not achieved after 3 months of compliant triple therapy and patient (1) on oral combination, move to basal insulin or GLP-1 RA, (2) on GLP-1 RA, add basal insulin, or (3) on optimally titrated basal Insulin, add GLP-1 RA or mealtime insulin. Metformin therapy should be maintained, while other oral agents may be discontinued on an individual basis to avoid unnecessarily complex or costly regimens (i.e., adding a fourth antihyperglycemic agent).

Combination Injectable Therapy	**Metformin + Basal Insulin +**

Rapid-Acting Insulin	GLP-1 RA

4. GUIDELINES:

4.1 Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2 *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5 UPDATES:

5.1 This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-50
24 April 2019
Pharmacy
Prior Authorization Criteria for Adlyxin (lixisenatide) (GLP-1 Agonist)

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 3

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Adlyxin (lixisenatide) (GLP-1 Agonist) coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

2.7. American Diabetes Association. Standards of medical care in diabetes - 2016. Diabetes Care. 2016;39(suppl 1):S1-S119.

2.8. Bennett WL, Maruthur NM, Singh S, et al. Comparative effectiveness and safety of medications for type 2 diabetes: an update including new drugs and 2 -drug combinations. Ann Intern Med. 2011;154:602-613.

3. PROCEDURES:

3.1. Adlyxin (lixisenatide) (GLP-1 Agonist). (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Must have an A1C greater than or equal to 9%, but less than 10% or have failed a compliant 3 months of monotherapy of metformin to achieve A1C target and still be less than 10%. For A1C over 10%, must be used in a combination injectable therapy that includes Basal Insulin.

3.4. Will not be covered for monotherapy and must be used in a dual therapy with Metformin or a combination injectable therapy.

3.5. When used in a dual therapy, a sulfonylurea must be tried and failed prior to requesting a *Prior Authorization* for Adlyxin (lixisenatide) (GLP-1 Agonist).

Start with Monotherapy unless:

A1C is greater than or equal to 9%, move to Dual Therapy.

A1C is greater than or equal to 10%, move to Combination Injectable Therapy.

Monotherapy	**Metformin**

Efficacy	High
Hypo Risk	Low Risk
Weight	Neutral/Loss
Side Effects	GI/Lactic Acidosis
Costs	Low

If A1C target not achieved after 3 months of compliant monotherapy, proceed to 2-drug combination.

Dual Therapy	**Metformin +**

	Sulfonylurea	Thiazolidinedione	GLP-1 RA	Insulin (Basal)
Efficacy	High	High	High	Highest
Hypo Risk	Moderate Risk	Low Risk	Low Risk	High Risk
Weight	Gain	Gain	Loss	Gain
Side Effects	Hypoglycemia	Edema, HF	GI	Hypoglycemia
Costs	Low	Low	High	High

If A1C target not achieved after 3 months of compliant dual therapy, proceed to 3 -drug combination.

Triple Therapy	**Metformin +**

Sulfonylurea +	**TZD +**	**DPP-4 Inhibitor +**	**SGLT2 Inhibitor +**	**GLP-1 RA +**	**Insulin (Basal) +**
Add one additional medication from the appropriate column					
TZD	SU	SU	SU	SU	SU
Insulin	Insulin	TZD	TZD	TZD	TZD
GLP-1-RA	GLP-1-RA	Insulin	Insulin	Insulin	GLP-1-RA
DPP-4-I	DPP-4-I	SGLT2-I	GLP-1-RA	SGLT2-I	DPP-4-I
SGLT2-I	SGLT2-I		DPP-4-I		SGLT2-I

If A1C target not achieved after 3 months of compliant triple therapy and patient (1) on oral combination, move to basal insulin or GLP-1 RA, (2) on GLP-1 RA, add basal insulin, or (3) on optimally titrated basal Insulin, add GLP-1 RA or mealtime insulin. Metformin therapy should be maintained, while other oral agents may be discontinued on an individual basis to avoid unnecessarily complex or costly regimens (i.e., adding a fourth antihyperglycemic agent).

Combination Injectable Therapy	**Metformin + Basal Insulin +**

Rapid-Acting Insulin	GLP-1 RA

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-51
23 April 2019
Pharmacy
Prior Authorization Criteria for Bydureon (exenatide) (GLP-1 Agonist)

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 3

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Bydureon (exenatide) (GLP-1 Agonist) coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

2.7. American Diabetes Association. Standards of medical care in diabetes - 2016. Diabetes Care. 2016;39(suppl 1):S1-S119.

2.8. Bennett WL, Maruthur NM, Singh S, et al. Comparative effectiveness and safety of medications for type 2 diabetes: an update including new drugs and 2 -drug combinations. Ann Intern Med. 2011;154:602-613.

3. PROCEDURES:

3.1. Bydureon (exenatide) (GLP-1 Agonist). (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Must have an A1C greater than or equal to 9%, but less than 10% or have failed a compliant 3 months of monotherapy of metformin to achieve A1C target and still be less than 10%. For A1C over 10%, must be used in a combination injectable therapy that includes Basal Insulin.

3.4. Will not be covered for monotherapy and must be used in a dual therapy with Metformin or a combination injectable therapy.

3.5. When used in a dual therapy, a sulfonylurea must be tried and failed prior to requesting a *Prior Authorization* for Bydureon (exenatide) (GLP-1 Agonist).

3.6. Documented trial and failure of at least three months on Adlyxin (Lixisenatide) will be required prior to consideration for approval.

Start with Monotherapy unless:

A1C is greater than or equal to 9%, move to Dual Therapy.
A1C is greater than or equal to 10%, move to Combination Injectable Therapy.

Monotherapy	**Metformin**

Efficacy	High
Hypo Risk	Low Risk
Weight	Neutral/Loss
Side Effects	GI/Lactic Acidosis
Costs	Low

If A1C target not achieved after 3 months of compliant monotherapy, proceed to 2 -drug combination.

Dual Therapy	**Metformin +**

	Sulfonylurea	Thiazolidinedione	GLP-1 RA	Insulin (Basal)
Efficacy	High	High	High	Highest
Hypo Risk	Moderate Risk	Low Risk	Low Risk	High Risk
Weight	Gain	Gain	Loss	Gain
Side Effects	Hypoglycemia	Edema, HF	GI	Hypoglycemia
Costs	Low	Low	High	High

If A1C target not achieved after 3 months of compliant dual therapy, proceed to 3 -drug combination.

Triple Therapy	**Metformin +**

Sulfonylurea +	**TZD +**	**DPP-4 Inhibitor +**	**SGLT2 Inhibitor +**	**GLP-1 RA +**	**Insulin (Basal) +**
Add one additional medication from the appropriate column					
TZD	SU	SU	SU	SU	SU
Insulin	Insulin	TZD	TZD	TZD	TZD
``GLP-1-RA	GLP-1-RA	Insulin	Insulin	Insulin	GLP-1-RA
DPP-4-I	DPP-4-I	SGLT2-I	GLP-1-RA	SGLT2-I	DPP-4-I
SGLT2-I	SGLT2-I		DPP-4-I		SGLT2-I

If A1C target not achieved after 3 months of compliant triple therapy and patient (1) on oral combination, move to basal insulin or GLP-1 RA, (2) on GLP-1 RA, add basal insulin, or (3) on optimally titrated basal Insulin, add GLP-1 RA or mealtime insulin. Metformin therapy should be maintained, while other oral agents may be discontinued on an individual basis to avoid unnecessarily complex or costly regimens (i.e., adding a fourth antihyperglycemic agent).

Combination Injectable Therapy	**Metformin + Basal Insulin +**

Rapid-Acting Insulin	GLP-1 RA

4. GUIDELINES:

4.1 Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2 *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5 UPDATES:

5.1 This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA*

Approved by: P&T Committee

Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-52
23 April 2019
Pharmacy
Prior Authorization Criteria for Insulin Pens

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Insulin Pen coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Insulin Pens (all products) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. A coverage determination will be required to evaluate the least costly option for the patient and if the pen is being used for strictly a matter of convenience.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. Approval will be granted for school children with multiple insulin dosing/coverage during the school day. This will not include the use of insulin pens for once a day basal insulin injections.

4.3. Approval will be granted for a member with a diagnosis such as CVA, MS, Severe OA or if a patient demonstrates an inability to safely use a syringe.

4.4. Approval will be granted for a member with severe visual impairment.

4.5. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-53
24 April 2019
Pharmacy
Step Therapy Criteria for Liothyronine Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Step Therapy Criteria* for Liothyronine Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Liothyronine Tablet (all strengths) will reject at the POS without a prior claim of Levothyroxine Tablet (any strength) in the prior 120 days.

3.2. Once the criteria for the *Step Therapy* is met, the coverage for the Liothyronine Tablet will remain in effect indefinitely unless there is a treatment break greater than 120 days (which can be re-established with a pharmacy override).

4. GUIDELINES:

4.1. Provider can request an override for the *Step Therapy* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Step Therapy* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-54
24 April 2019
Pharmacy
Prior Authorization Criteria for Testosterone Replacement Therapy

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Testosterone Replacement Therapy coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

2.7. The American Association of Clinical Endocrinologists and American College of Endocrinology Position Statement on the Association of Testosterone and Cardiovascular Risk (2015).

3. PROCEDURES:

3.1. The only approved formulary treatment option for Testosterone Replacement Therapy is Testosterone cypionate Vial.

3.2. Testosterone Cypionate Vial (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.3. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. Testosterone will only be approved for men with disorders of the testicles, pituitary gland or brain that cause hypogonadism and will not be approved solely to relieve the symptoms in men who have low testosterone for no reasons other than aging. It will also be approved for Gender Dysphoria.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

PrimaryHealth

GUIDELINE 8-55
24 April 2019
Pharmacy
Prior Authorization Criteria for Growth Hormone Replacement Therapy

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Growth Hormone Replacement Therapy coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

2.7. The American Association of Clinical Endocrinologists Position Statement Growth Hormone Usage in Short Children (2003).

3. PROCEDURES:

3.1. The only approved formulary treatment option for Growth Hormone Replacement Therapy is Somatropin Injectable.

3.2. Somatropin Injectable (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.3. Somatropin Injectable (all strengths) is classified as a specialty medication and requires dispensing by Cascade Health Alliance's contracted specialty pharmacy.

3.4. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. Somatropin Injectable (all strengths) will only be covered for use in children that are unusually short as defined as short without a known cause, (i.e, < -2.25 standard deviations below the mean and have an adult height prediction of less than 5'3" for boys and less than 4'11" for girls).

4.3. *Prior Authorizations, when* granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin, Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-56
24 April 2019
Pharmacy
Prior Authorization Criteria for Desmopressin Ampule; Spray; Solution; Tablet; Vial

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Desmopressin Ampule; Spray; Solution; Tablet; Vial coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for wh ich the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Desmopressin ampule; Spray; Solution; Tablet; Vial (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations, when* granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-57
24 April 2019
Pharmacy
Prior Authorization Criteria for Denusomab (Prolia) Infusion

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Denusomab (Prolia) coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Denusomab (Prolia) Infusion (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Oral medication is the preferred treatment for osteoporosis when medically appropriate. Alendronate or Ibandronate tablet are the first-line agents when treatment is necessary and desired.

3.3. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Denusomab (Prolia) Infusion will be reviewed and evaluated with provider for possible change to Alendronate or Ibandronate.

4.3. *Prior Authorizations,* when granted, will be for 2 injections, 180 days apart. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-58
24 April 2019
Pharmacy
Prior Authorization Criteria for Zoledronic Acid Infusion

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Zoledronic Acid Infusion coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for wh ich the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Zoledronic Acid Infusion (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Oral medication is the preferred treatment for osteoporosis when medically appropriate. Alendronate or Ibandronate tablet are the first-line agents when treatment is necessary and desired.

3.3. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Zoledronic Acid Infusion will be reviewed and evaluated with provider for possible change to Alendronate or Ibandronate.

4.3. *Prior Authorizations,* when granted, will be for one infusion (365 days). Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-59
24 April 2019
Pharmacy
Prior Authorization Criteria for Levofloxacin Ophthalmic Drops

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Levofloxacin Ophthalmic Drops coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for wh ich the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Levofloxacin Ophthalmic Drops (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. Levofloxacin Ophthalmic Drops (all strengths) is not a first-line agent on Cascade Health Alliance's formulary. Please see formulary for alternatives.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-60
24 April 2019
Pharmacy
Prior Authorization Criteria for Fluorometholone Ophthalmic Suspension Drops

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Fluoromethalone Ophthalmic Suspension Drops coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Fluorometholone Ophthalmic Suspension Drops (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. Fluorometholone Ophthalmic Suspension Drops (all strengths) is not a first-line agent on Cascade Health Alliance's formulary. Please see formulary for alternatives.

4.3. *Prior Authorizations*, when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-61
24 April 2019
Pharmacy
Prior Authorization Criteria for Cromolyn Ophthalmic Drops

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Cromolyn Ophthalmic Drops coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropr iate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for wh ich the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Cromolyn Ophthalmic Drops (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations, when* granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-62
24 April 2019
Pharmacy
Prior Authorization Criteria for Oxymetazoline Ophthalmic Drops

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Oxymetazoline Ophthalmic Drops coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Oxymetazoline Ophthalmic Drops (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-63
24 April 2019
Pharmacy
Prior Authorization Criteria for Dextran 70/hypromellose Ophthalmic Drops

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Dextran 70/hypromellose Ophthalmic Drops coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Dextran 70/hypromellose Ophthalmic Drops (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance GUIDELINE 8-64

24 April 2019

Pharmacy

Prior Authorization Criteria for Mineral Oil/White Petrolatum Ophthalmic Ointment

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Mineral Oil/White Petrolatum Ophthalmic Ointment coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Mineral Oil/White Petrolatum Ophthalmic Ointment (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-65
24 April 2019
Pharmacy
Prior Authorization Criteria for Sodium Chloride Ophthalmic Drops

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Sodium Chloride Ophthalmic Drops coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Sodium Chloride Ophthalmic Drops (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance GUIDELINE 8-66

24 April 2019

Pharmacy

Prior Authorization Criteria for Ciprofloxacin/Dexamethasone (Ciprodex) Otic Drops

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Ciprofloxacin/Dexamethasone (Ciprodex) Otic Drops coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Ciprofloxacin/Dexamethasone (Ciprodex) Otic Drops (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. Ciprofloxacin/Dexamethasone (Ciprodex) Otic Drops (all strengths) is not a first-line agent on Cascade Health Alliance's formulary. Please see formulary for alternatives.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-67
24 April 2019
Pharmacy
Prior Authorization Criteria for Carbamoxide Otic Drops

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Carbamoxide Otic Drops coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorize d representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for wh ich the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Carbamoxide Otic Drops (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-68
24 April 2019
Pharmacy
Prior Authorization Criteria for Cevimeline Capsule

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Cevimeline Capsule coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Cevimeline Capsule (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorization,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-69
24 April 2019
Pharmacy
Prior Authorization Criteria for Cromolyn Nasal Spray

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Cromolyn Nasal Spray coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Cromolyn Nasal Spray (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-70
24 April 2019
Pharmacy
Prior Authorization Criteria for Desmopressin Nasal Spray; Solution

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Desmopressin Nasal Spray; Solution coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Desmopressin Nasal Spray; Solution (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations, when* granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-71
April 24 2019
Pharmacy
Prior Authorization Criteria for Oxymetazoline Nasal Mist; Spray

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Oxymetazoline Nasal Mist; Spray coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Oxymetazoline Nasal Mist; Spray (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-72
24 April 2019
Pharmacy
Prior Authorization Criteria for Saline Spray

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Saline Spray coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Saline Spray (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations*, when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-73
24 April 2019
Pharmacy
Prior Authorization Criteria for Sumatriptan Nasal Spray

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Sumatriptan Nasal Spray coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropria te care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Sumatriptan Nasal Spray (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. Sumatriptan Nasal Spray is a first-line agent. Please refer to the Cascade Health Alliance Formulary for alternatives.

4.3. *Prior Authorization,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-74
24 April 2019
Pharmacy
Prior Authorization Criteria for Flunisolide Nasal Spray

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Flunisolide Nasal Spray coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropria te care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Flunisolide Nasal Spray (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization.*

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or medical necessity.

4.2. Prior Authorizations, when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-75
24 April 2019
Pharmacy
Prior Authorization Criteria for Fluticasone Nasal Spray

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Fluticasone Nasal Spray coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropria te care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Fluticasone Nasal Spray (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or medical necessity.

4.2. Prior Authorizations, when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to the rapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-76
24 April 2019
Pharmacy
Prior Authorization Criteria for Cetirizine Chewable Tablet; Solution; Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Cetirizine Chewable Tablet; Solution; Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Cetirizine Chewable Tablet; Solution; Tablet (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. A comorbidity of asthma will be granted a *Prior Authorization* even with a non-covered condition.

4.3. *Prior Authorizations, when* granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-77
24 April 2019
Pharmacy
Prior Authorization Criteria for Hydroxyzine HCL Solution; Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Hydroxyzine Solution; Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Hydroxyzine HCL Solution; Tablet (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. A comorbidity of anxiety will be granted a *Prior Authorization* even with a non-covered condition.

4.3. *Prior Authorizations*, when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-78
24 April 2019
Pharmacy
Prior Authorization Criteria for Hydroxyzine Pamoate Capsule

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Hydroxyzine Pamoate Capsule coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Hydroxyzine Pamoate Capsule (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. A comorbidity of anxiety will be granted a *Prior Authorization* even with a non-covered condition.

4.3. *Prior Authorizations*, when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-79
24 April 2019
Pharmacy
Prior Authorization Criteria for Loratadine Solution; Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Loratadine Solution; Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Loratadine Solution; Tablet (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. A comorbidity of asthma will be granted a *Prior Authorization* even with a non-covered condition.

4.3. *Prior Authorizations*, when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-80
24 April 2019
Pharmacy
Prior Authorization Criteria for Benzonatate Capsules

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Benzonatate Capsules coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for wh ich the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Benzonatate Capsules will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or medical necessity.

4.2. *Prior Authorizations*, when granted for covered conditions, will be for a period of up to 14 days. Further approvals will be contingent upon documented need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-81
24 April 2019
Pharmacy
Prior Authorization Criteria for Pseudoephedrine Liquid; Tablet; Tablet ER 12 HR

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Pseudoephedrine Liquid; Tablet; Tablet ER 12 HR coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Pseudoephedrine Liquid; Tablet; Tablet ER 12 HR (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 14 days. Further approvals will be contingent upon documented need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 24, 2019*

Cascade Health Alliance

GUIDELINE 8-82
25 April 2019
Pharmacy
Prior Authorization Criteria for Omeprazole Suspension (First-Omeprazole)

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Omeprazole Suspension (First-Omeprazole) coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Omeprazole Suspension (First-Omeprazole) (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization* for all prescriptions written for members older than 8 years of age.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 25, 2019*

Cascade Health Alliance

GUIDELINE 8-83
April 25, 2019
Pharmacy
Quantity Limit Criteria for Ondansetron HCL Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Ondansetron HCL Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Ondansetron HCL Tablet will reject at the POS with a claim greater than #30 tablets per 14 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 25, 2019*

Cascade Health Alliance

GUIDELINE 8-84
25 April 2019
Pharmacy
Quantity Limit Criteria for Ondansetron ODT Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Ondansetron ODT Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Ondansetron ODT Tablet will reject at the POS with a claim greater than #30 tablets per 14 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 25, 2019*

Cascade Health Alliance

GUIDELINE 8-85
25 April 2019
Pharmacy
Prior Authorization Criteria for Bismuth Subsalicylate Suspension; Chewable Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Bismusth Subsalicylate Suspension; Chewable Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Bismuth Subsalicylate Suspension; Chewable Tablet (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 25, 2019*

Cascade Health Alliance

GUIDELINE 8-86
25 April 2019
Pharmacy
Prior Authorization Criteria for Diphenoxylate/Atropine Liquid; Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Diphenolxylate/Atropine Liquid; Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Diphenolxylate/Atropine Liquid; Tablet (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 25, 2019*

Cascade Health Alliance

GUIDELINE 8-87
26 April 2019
Pharmacy
Prior Authorization Criteria for Loperamide Capsule; Liquid; Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Loperamide Capsule; Liquid; Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Loperamide Capsule; Liquid; Tablet (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 26, 2019*

Cascade Health Alliance

GUIDELINE 8-88
26 April 2019
Pharmacy
Prior Authorization Criteria for Glycerin Suppository

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Glycerin Suppository coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Glycerin Suppository (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 26, 2019*

Cascade Health Alliance

GUIDELINE 8-89
26 April 2019
Pharmacy
Prior Authorization Criteria for Polyethylene Glycol (PEG) 3350 Powder

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Polyethylene Glycol (PEG) 3350 Powder coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (139) (C) Not solely for the convenience of an OHP clien t or a provider of the service or medical supplies; and

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Polyethylene Glycol (PEG) 3350 Powder (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 26, 2019*

Cascade Health Alliance

GUIDELINE 8-90
26 April 2019
Pharmacy
Prior Authorization Criteria for Psyllium Husk Capsule

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Psyllium Husk Capsule coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Psyllium Husk Capsule (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 26, 2019*

Cascade Health Alliance

GUIDELINE 8-91
26 April 2019
Pharmacy
Prior Authorization Criteria for Sennosides Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Sennosides Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Sennosides Tablet (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations*, when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 26, 2019*

Cascade Health Alliance

GUIDELINE 8-92
26 April 2019
Pharmacy
Prior Authorization Criteria for Mesalamine (800mg only) tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Mesalamine (800mg only) tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for wh ich the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Mesalamine (800mg) Tablet will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Sulfasalazine tablet is the first-line agent and is on formulary with no restrictions.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Mesalamine (800mg) tablet will be reviewed and evaluated with provider for possible change to Sulfasalazine tablet.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 26, 2019*

Cascade Health Alliance

GUIDELINE 8-98
26 April 2019
Pharmacy
Prior Authorization Criteria for Mesalamine Enema

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Mesalamine Enema coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2016).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Mesalamine Enema (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Sulfasalazine tablet is the first-line agent and is on formulary with no restrictions.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Mesalamine Enema will be reviewed and evaluated with provider for possible change to Sulfasalazine tablet.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 26, 2019*

Revised by:

Cascade Health Alliance

GUIDELINE 8-94
26 April 2019
Pharmacy
Prior Authorization Criteria for Balsalazide Capsule

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Balsalazide Capsule coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Balsalazide Capsule (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Sulfasalazine tablet is the first-line agent and is on formulary with no restrictions.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Balsalazide Capsule will be reviewed and evaluated with provider for possible change to Sulfasalazine tablet.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 26, 2019*

Cascade Health Alliance GUIDELINE 8-95

26 April 2019

Pharmacy

Prior Authorization Criteria for Creon (lipase/protease/amylase) Capsule DR

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Creon Capsule DR coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Creon Capsule DR (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 26, 2019*

Cascade Health Alliance GUIDELINE 8-96

26 April 2019

Pharmacy

Prior Authorization Criteria for Zenpep (lipase/protease/amylase) Capsule DR

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Zenpep Capsule DR coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Zenpep Capsule DR (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 26, 2019*

Cascade Health Alliance

GUIDELINE 8-97
26 April 2019
Pharmacy
Quantity Limit Criteria for Doxycycline Hyclate Tablets

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Doxycycline Hyclate Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for wh ich the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Doxycycline Hyclate Tablet will reject at the POS with a claim greater than #28 tablets per 14 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for up to 30 days. Further approvals are contingent upon documented evidence of need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 26, 2019*

Cascade Health Alliance GUIDELINE 8-98

26 April 2019

Pharmacy

Quantity Limit Criteria for Doxycycline Monohydrate Capsule; Tablets

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Doxycycline Monohydrate Capsule; Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Doxycycline Monohydrate Capsule; Tablet will reject at the POS with a claim greater than #28 units per 14 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for up to 30 days. Further approvals are contingent upon documented evidence of need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 26, 2019*

Cascade Health Alliance GUIDELINE 8-99

26 April 2019

Pharmacy

Quantity Limit Criteria for Doxycycline Monohydrate Suspension

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Doxycycline Monohydrate Suspension coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for wh ich the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Doxycycline Monohydrate Suspension will reject at the POS with a claim greater than a 14-day supply.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for up to 30 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 26, 2019*

Cascade Health Alliance

GUIDELINE 8-100
26 April 2019
Pharmacy
Prior Authorization Criteria for Tetracycline Capsule

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Tetracycline Capsule coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and me dically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Tetracycline Capsule will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Prior Authorization* override is granted, it will be for a period of up to 14 days. Further approvals will be contingent upon documented evidence of need for continued treatment

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 26, 2019*

Cascade Health Alliance

GUIDELINE 8-101
26 April 2019
Pharmacy
Prior Authorization Criteria for Lantus

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 3

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Lantus coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the cl ient as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Lantus (all products) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. A coverage determination will be required to evaluate the least costly option for the patient and if the pen is being used for strictly a matter of convenience.

3.4. Lantus may be considered medically necessary for treatment of type 1 diabetes mellitus (T1DM) when the patient meets the diagnostic criteria for type 1 diabetes mellitus

3.5. Members with type 1 diabetes mellitus may receive Lantus after a trial of Basaglar for at least three months and be approved for the duration of their eligibility

3.6. Lantus may be considered medically necessary for treatment of type 2 diabetes mellitus (T2DM) when the patient meets the inclusion criteria of guideline 4.2

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. Approval will be granted for treatment of type 2 diabetes mellitus when the following inclusion criteria is satisfied:

A. A documented diagnosis of type 2 diabetes mellitus
B. Blood glucose is uncontrolled with a trial of alternative long acting insulin regimens
    1. a combination of NPH insulin with meal-time boluses of fast-acting insulin for at least 3 months.
    2. Basaglar for at least 3 months.

Control is defined as achieving and maintaining stability at patient-specific goal (such as <8% A1C).

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPH, MBA* **Approved by:** P&T Committee
Date: *April 26, 2019*

Cascade Health Alliance

GUIDELINE 8-102
29 April 2019
Pharmacy
Prior Authorization Criteria for Clotrimazole Troche

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Clotrimazole Troche coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Clotrimazole Troche (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for up to 30 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-103
29 April 2019
Pharmacy
Quantity Limit Criteria for Fluconazole Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Fluconazole Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Fluconazole Tablet will reject at the POS with a claim greater than #3 tablets per 30 days.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. *Prior Authorizations,* when granted, will be for up to 10 units in 30 days. Further approvals will be contingent upon documented evidence of need for continued treatment

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-104
April 29, 2019
Pharmacy
Prior Authorization Criteria for Griseofulvin Suspension; 500mg Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Griseofulvin Suspension; 500mg Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Griseofulvin Suspension; 500mg Tablet will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations* granted for covered conditions will be approved for the entire treatment or 30 days (whichever is shorter). Further approvals are contingent upon documented evidence of need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-105
29 April 2019
Pharmacy
Prior Authorization Criteria for Ketoconazole Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Ketoconazole Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Ketoconazole Tablet will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for up to 30 days. Further approvals will be contingent upon documented evidence of need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-106
29 April 2019
Pharmacy
Prior Authorization Criteria for Nystatin Suspension; Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Nystatin Suspension; Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Nystatin Suspension; Tablet will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for the entire length of treatment or 30 days (whichever is shorter). Further approvals will be contingent upon documented evidence of need for continued therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-107
29 April 2019
Pharmacy
Prior Authorization Criteria for Terbinafine Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Terbinafine Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Terbinafine Tablet will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-108
29 April 2019
Pharmacy
Prior Authorization Criteria for Clindamycin Cream; Suppository

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Clindamycin Cream; Suppository coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Clindamycin Cream; Suppository will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-109
25 April 2019
Pharmacy
Prior Authorization Criteria for Valacyclovir Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Valacyclovir Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Valacyclovir Tablet (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Acyclovir Capsule; Suspension; Tablet are the first-line agents and are on formulary with no restrictions.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Valacyclovir Tablet will be reviewed and evaluated with provider for possible change to Acyclovir Capsule; Suspension; Tablet.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 25, 2019*

Cascade Health Alliance

GUIDELINE 8-110
27 November 2019
Pharmacy
Prior Authorization Criteria for Hepatitis B Treatment

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Hepatitis B Treatment coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. All Hepatitis B medication (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Current formulary medications for the treatment of Hepatitis B are: Epivir and Viread.

3.4. All Hepatitis B medications must be filled through contracted Specialty Pharmacy.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for the entire duration of treatment or 12 months (whichever is shorter).

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *November 27, 2019*

Cascade Health Alliance

GUIDELINE 8-111
29 April 2019
Pharmacy
Prior Authorization Criteria for Hepatitis C Treatment

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 5

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Hepatitis C Treatment coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. All Hepatitis C medication (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Current formulary medications for the treatment of Hepatitis C are: Glecaprevir/Pibrentasivr (Mavyret) Tablet, Elbasvir/Grazoprevir (Zepatier) Tablet, Sofosbuvir/Velpatasvir (Epclusa), Sofosbuvir/Velpatasvir/Voxilaprevir (Vosevi) Tablet Peginterferon Alfa – 2a (Pegasus) and Ribavirin Capsule; Tablet.

3.4. All Hepatitis C medications must be filled through contracted Specialty Pharmacy.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code.	
2. Is the request for treatment of chronic Hepatitis C infection?	Yes: Go to #3	No: Pass to RPh. Deny; medical appropriateness.
3. Is expected survival from non-HCV-associated morbidities more than 1 year?	Yes: Go to #4	No: Pass to RPh. Deny; medical appropriateness.
5. Has all of the following pre-treatment testing been documented: a. Genotype testing in past 3 years; b. Baseline HCV RNA level in past 6 months; c. Current HIV status of patient d. Current HBV status of patient	Yes: Record results of each test and go to #5 Note: If the patient has HIV or HBV co-infection, it is highly recommended that a specialist be consulted prior to treatment.	No: Pass to RPh. Request updated testing.

e. Pregnancy test in past 30 days for a woman of child-bearing age; and f. History of previous HCV treatment and outcome? Note: Direct-acting antiviral agents can re-activate hepatitis B in some patients. Patients with history of HBV should be monitored carefully during and after treatment for flare-up of hepatitis. Prior to treatment with a DAA, all patients should be tested for HBsAG, HBsAb, and HBcAB status.	Currently treatment is not recommended during pregnancy due to lack of safety and efficacy data	
5. Which regimen is requested?	Document and go to #6	
6. Does the patient have HIV coinfection and is under treatment by a specialist with experience in HIV? Note: persons with HIV/HCV coinfection are at risk for rapidly progressing fibrosis	Yes: Go to #10	No: Go to #7
7. Does the patient have: a) A biopsy, imaging test (transient elastography [FibroScan®], acoustic radiation force impulse imaging [ARFI], or shear wave elastography [SWE]) to indicate portal fibrosis with septa (METAVIR F2) advanced fibrosis (METAVIR F3) or cirrhosis (METAVIR F4); **OR** Clinical, radiologic or laboratory evidence of complications of cirrhosis (ascites, portal hypertension, hepatic encephalopathy,	Yes: Go to #10 Note: Other imaging and blood tests are not recommended based on evidence of poor sensitivity and specificity compared to liver biopsy. However, if imaging testing is not regionally available, a serum test (FIBROSpect II; Fibrometer; enhanced liver fibrosis [ELF], Fibrosure) can be used to confirm METAVIR F2 or greater but cannot be used for denial. For results falling in a range (e.g. F1 to F2), fibrosis stage should be categorized as the higher F stage for the purpose of treatment, or require one additional, more specific test (per HERC AUROC values http://www.oregon.gov/OHA/HPA/CSI-	No: Go to #8

hepatocellular carcinoma, esophageal varices)?	HERC/Pages/Evidence-based-Reports-Blog.aspx?View=%7b2905450B-49B8-4A9B-AF17-5E1E03AB8B6B%7d&SelectedID=237) to be obtained to determine the stage of fibrosis. However, additional testing cannot be limited to biopsy. After one additional test, if a range still exists, the highest F score in the range will be used for determining coverage.	
8. Does the patient have one of the following extrahepatic manifestations of Hepatitis C? a) Lymphoproliferative disease, including type 2 or 3 cryoglobulinemia with end-organ manifestations (i.e., leukocytoclastic vasculitis); or b) Proteinuria, nephrotic syndrome, or membranoproliferative glomerulonephritis; or c) Porphyria cutanea tarda or lichen planus d) Lymphomas (B-cell non-Hodgkin lymphoma) e) Type 2 Diabetes	Yes: Go to #10	No: Go to #9
9. Is the patient in one of the following transplant settings: a) Listed for a transplant and treatment is essential to prevent recurrent hepatitis C infection post-transplant; or b) Post solid organ transplant?	Yes: Go to #10	No: Pass to RPh. Deny; medical appropriateness.
10. If METAVIR F4: Is the regimen prescribed by, or in consultation with, a hepatologist, gastroenterologist, or infectious disease specialist? OR If METAVIR	Yes: Go to #11	No: Pass to RPh. Deny; medical appropriateness. Forward to DMAP for further manual review to determine appropriateness of prescriber.

F3: Is the regimen prescribed by, OR is the patient in the process of establishing care with or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist? OR If METAVIR <F2: The regimen does not need to be prescribed by or in consultation with a specialist.		
11. Is there attestation that the patient and provider will comply with all case management interventions to promote the best possible outcome for the patient and adhere to monitoring requirements required by the Oregon Health Authority, including measuring and reporting of a post-treatment viral load?	Yes: Go to #12	No: Pass to RPh. Deny; medical appropriateness.
12. Is the prescribed drug: a) Elbasvir/grazoprevir for GT 1a infection; or b) Daclatasvir + sofosbuvir for GT 3 infection?	Yes: Go to #13	No: Go to #14
13. Has the patient had a baseline NS5a resistance test that documents a resistant variant to one of the agents in #16? Note: Baseline NS5A resistance testing is required.	Yes: Pass to RPh; deny for appropriateness	No: Go to #14 Document test and result.
14. Is the prescribed regimen include a NS3/4a protease inhibitor (elbasvir, glecaprevir, simeprevir, paritaprevir, voxilaprevir)?	Yes: Go to #15	No: Go to #16

15. Does the patient have moderate-severe hepatic impairment (Child-Pugh B or Child-Pugh C)?	Yes: Pass to RPh; deny for appropriateness	No: Go to #16
16. Is the prescribed regimen for the retreatment after failure of a DAA due to noncompliance or lost to follow-up?	Yes: Pass to RPh; Deny and refer to medical director for review	No: Go to #17
17. Is the prescribed drug regimen a recommended regimen based on the patient's genotype, treatment status (retreatment or treatment naïve) and cirrhosis status (see Table 1)?	Yes: Approve for 8-16 weeks based on duration of treatment indicated for approved regimen	No: Pass to RPh. Deny; medical appropriateness.

Table 1: Recommended Treatment Regimens for Chronic Hepatitis C.

Genotype 1		
DAA-Treatment naive	Non-cirrhotic	EBV/GZR x 12 weeks** SOF/VEL x 12 weeks G/P x 8 weeks
	Compensated Cirrhosis	EBV/GZR x 12 weeks** SOF/VEL x 12 weeks G/P x 12 weeks
	Decompensated Cirrhosis	SOF/VEL + RBV x 12 week
Treatment experienced (Prior PEG/RBV)	Non-cirrhotic	EBV/GZR x 12 weeks** SOF/VEL x 12 weeks G/P x 8 weeks
	Compensated cirrhosis	EBV/GRZ 12weeks** SOF/VEL x 12 weeks G/P x 12 weeks
Treatment Experienced (Prior sofosbuvir)	Non-cirrhotic or compensated cirrhosis	SOF/VEL x 12 weeks G/P x 12 weeks
Treatment Experienced (Prior NS3A/4A inhibitor)	Non-cirrhotic or compensated cirrhosis	SOF/VEL x 12 weeks EBV/GZR + RBV x 12 weeks** G/P x 12 weeks
Treatment Experienced (prior NS5A-containing regimen)	Non-cirrhotic or compensated cirrhosis	G/P x 16 weeks
Genotype 2		
Naïve	Non-cirrhotic	SOF/VEL x 12 weeks G/P x 8 weeks
	Compensated cirrhosis	SOF/VEL x 12 weeks G/P x 12 weeks

	Decompensated	SOF/VEL + RBV x 12 weeks
Treatment Experienced (prior PEG/RBV)	Non-cirrhotic	SOF/VEL x 12 weeks G/P x 8 weeks
	Compensated cirrhosis	SOF/VEL x 12 weeks G/P x 12 weeks
Treatment Experienced (SOF + RBV)	Non-cirrhotic or compensated cirrhosis	SOF/VEL x 12 weeks G/P x 12 weeks
Treatment Experienced (prior NS5A-containing regimen)	Non-cirrhotic or compensated cirrhosis	SOF/VEL/VOX x 12 weeks
Genotype 3		
Naïve	Non-cirrhotic	SOF/VEL X 12 weeks G/P x 8 weeks
	Compensated cirrhosis	SOF/VEL + RBV x 12 weeks G/P x 12 weeks
	Decompensated Cirrhosis	SOF/VEL + RBV x 12 weeks
Treatment Experienced (prior PEG/RBV only)	Non-cirrhotic or compensated cirrhosis	SOF/VEL x 12 weeks G/P x 16 weeks
Treatment Experienced (SOF + RBV)	Non-cirrhotic or compensated cirrhosis	G/P x 16 weeks
Experienced (prior NS5A-containing regimen	Non-cirrhotic or compensated cirrhosis	SOF/VEL/VOX x 12 weeks
Genotype 4		
Treatment Naïve	Non-cirrhotic	SOF/VEL x 12 weeks EBV/GZR x 12 weeks G/P x 8 weeks
	Compensated cirrhosis	SOF/VEL x 12 weeks EBV/GZR x 12 weeks G/P x 12 weeks
	Decompensated Cirrhosis	SOF/VEL + RBV x 12 week
Treatment Experienced (prior PEG/RBV only)	Non-cirrhotic	SOF/VEL x 12 weeks EBV/GZR x 12 weeks G/P x 8 weeks
	Compensated cirrhosis	SOF/VEL x 12 weeks EBV/GZR x 12 weeks G/P x 12 weeks
Treatment Experienced (prior NS5A-containing regimen OR sofosbuvir)	Non-cirrhotic or compensated cirrhosis	SOF/VEL/VOX x 12 weeks
Genotype 5/6		
Treatment Naïve or Experienced (prior PEG-IFN/RBV only)	Non-cirrhotic	SOF/VEL x 12 weeks G/P x 8 weeks
	Compensated cirrhosis	SOF/VEL x 12 weeks G/P x 12 weeks
	Decompensated cirrhosis	SOF/VEL + RBV x 12 weeks
Experienced (prior NS5A-containing regimen OR sofosbuvir)	Non-cirrhotic or compensated cirrhosis	SOF/VEL/VOX x 12 weeks

Abbreviations: CTP = Child-Turcotte-Pugh; DAA = direct acting antiviral; DCV = daclatasvir; EBV/GZR = elbasvir/grazoprevir;G/P = glecaprevir and pibrentasvir PEG = pegylated interferon;; RAV = resistance-associated variant; RBV = ribavirin; SOF = sofosbuvir; SOF/VEL = sofosbuvir/velpatasvir; SOF/VEL/VOX = sofosbuvir/velpatasvir/voxilaprevir **No baseline NS5A RAVs. For genotype 1a patients with baseline NAS5A RAVs, extend duration to 16 weeks. ±Evidence is insufficient if the addition of RBV may benefit subjects with GT3 and cirrhosis. If RBV is not used with regimen, then baseline RAV testing should be done prior to treatment to rule out the Y93 polymorphism.
^ Rarely, genotyping assays may indicate the presence of a mixed infection (e.g., genotypes 1a and 2). Treatment data for mixed genotypes with direct-acting antivirals are limited. However, in these cases, a pangenotypic regimen is appropriate.
Ribavirin-containing regimens are absolutely contraindicated in pregnant women and in the male partners of women who are pregnant. Documented use of two forms of birth control in patients and sex partners for whom a ribavirin containing regimen is chosen is required.
Regimens other than glecaprevir/pibrentasvir (G/P;) and elbasvir/grazoprevir (EBV/GZR) should not be used in patients with severe renal impairment (GRF < 30 mL/min) or end stage renal disease requiring dialysis.
All regimens containing a protease inhibitor (elbasvir, glecaprevir, simeprevir, paritaprevir, voxilaprevir) should not be used in patients with moderate to severe hepatic impairment (CTP B and C).
There is limited data supporting DAA regimens in treatment- experienced patients with decompensated cirrhosis. These patients should be handled on a case by case basis with the patient, prescriber, and CCO or FFS medical director.

4.2 *Prior Authorizations* granted for covered conditions will be approved for the entire treatment

5. UPDATES:

5.1 This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-112
29 April 2019
Pharmacy
Prior Authorization Criteria for Palivizumab (Synagis) Injectable

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Palivizumab (Synagis) Injectable coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Palivizumab (Synagis) Injectable (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list and a review for medical appropriateness.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, for covered conditions will be approved for the entire treatment or 90 days (whichever is shorter). Further approvals will be contingent upon documented evidence of need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-113
29 April 2019
Pharmacy
Prior Authorization Criteria for HIV Anti-retroviral Treatment

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for HIV Anti-retroviral Treatment coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. HIV Anti-retroviral Treatment (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list and a review for medical appropriateness.

3.3. All HIV Anti-retroviral medications must be filled through contracted Specialty Pharmacy.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days at a time.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-114
29 April 2019
Pharmacy
Prior Authorization Criteria for Antineoplastic Medication

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Antineoplastic Medication coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. All Antineoplastic Medication (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list and a review for medical appropriateness.

3.3. All Antineoplastic medications must be filled through contracted Specialty Pharmacy.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations*, when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-115
29 April 2019
Pharmacy
Prior Authorization Criteria for Pramipexole Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Pramipexole Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Pramipexole Tablet (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-116
29 April 2019
Pharmacy
Prior Authorization Criteria for Ropinirole Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Ropinirole Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Ropinirole Tablet (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-117
April 29, 2019
Pharmacy
Prior Authorization Criteria for Multiple Sclerosis Agents

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Multiple Sclerosis Agents coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Multiple Sclerosis Agents (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Current formulary medications for the treatment of Multiple Sclerosis are: Dimethyl Fumarate (Tecfidera) Capsule, Fingolimod (Gilenya) Capsule, Glatiramer (Glatopa /Copaxone) Syringe, Interferon Beta-1a (Avonex) Kit; Pen and Interferon Beta-1b (Extavia) Kit; Vial.

3.4. All Multiple Sclerosis Agents must be filled through contracted Specialty Pharmacy.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-118
29 April 2019
Pharmacy
Prior Authorization Criteria for Memantine IR Tablets; Solution

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Memantine IR Tablets; Solution coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for wh ich the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Memantine IR Tablets; Solution (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-119
29 April 2019
Pharmacy
Prior Authorization Criteria for Galantamine Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Galantamine Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Galantamine Tablet (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Must have tried and failed Donepezil ODT; Tablet and Memantine IR Tablets; Solution.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-120
29 April 2019
Pharmacy
Prior Authorization Criteria for Galantamine ER Capsule

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Galantamine ER Capsule coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Galantamine ER Capsule (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Must have tried and failed Galantamine IR Capsule.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-121
29 April 2019
Pharmacy
Age Restriction Edit Criteria for Fluoride Treatment

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Age Restriction Edit Criteria* for Fluoride Treatment coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Fluoride Treatment (Tablet; Solution - all strengths) will reject at the POS with a rejection notice to the pharmacy for an *Age Restriction Edit – Must be < 18 years of age*. All products covered must be generic, no brand exceptions.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Age Restriction Edit* if there is a medically appropriate concern or for medical necessity.

4.2. *Overrides* granted for covered conditions will be approved for the entire treatment or 180 days (whichever is shorter). Further approvals will be contingent upon documented evidence of need for continued therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-122
April 29, 2019
Pharmacy
Prior Authorization Criteria for Cyanocobalamin (Vitamin B12) Injectable

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Cyanocobalamin (Vitamin B12) coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Cyanocobalamin (Vitamin B12) coverage (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-123
29 April 2019
Pharmacy
Prior Authorization Criteria for Levocarnitine Solution; Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Levocarnitine Solution; Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Levocarnitine Solution; Tablet coverage (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-124
29 April 2019
Pharmacy
Prior Authorization Criteria for Diclofenac (Voltaren) 1% Gel

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Diclofenac (Voltaren) 1% Gel coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Diclofenac (Voltaren) 1% Gel will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or medical necessity.

4.2. Approval will be granted for when the following inclusion criteria is satisfied:

1. There is clinical documentation that treatment with a formulary oral NSAID has been tried and is ineffective -or-
2. There is clinical documentation that all oral NSAIDs cannot be tolerated

4.3. *Prior Authorizations,* when granted, will be given for 100gm per 30 days (up to 3 fills). Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-125
29 April 2019
Pharmacy
Prior Authorization Criteria for Celecoxib Capsule

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Celecoxib Capsule coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for wh ich the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Celecoxib Capsule (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Celecoxib Capsule (all strengths) is not the first-line agent for Anti-Inflammatory Treatment. Must have tried and failed two other formulary Anti-Inflammatory Medications.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted*,* will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-126
29 April 2019
Pharmacy
Prior Authorization Criteria for Opioids Greater Than 90MEDD Restriction

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Opioids Greater Than 90MEDD Restriction coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Opioids Greater Than 90MEDD Restriction (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Hard Halt indicating that a cumulative amount over 90MED has been reached*.

3.2. This can be from one or multiple opioid prescriptions

3.3. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.4. Certain conditions (e.g., cancer, palliative care or end of life) are exempt from these criteria.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations*, when granted, will be for up to 90 days. Further approvals are contingent upon documented evidence of need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-127
April 29, 2019
Pharmacy
Prior Authorization Criteria for Fentanyl Patch

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Fentanyl Patch coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Fentanyl Patch (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Certain conditions (e.g., cancer, palliative care or end of life) are exempt from these criteria.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations*, when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-128
29 April 2019
Pharmacy
Quantity Limit Criteria for Sumatriptan Succinate Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Sumatriptan Succinate Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for wh ich the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Sumatriptan Succinate Tablet (all strengths) will reject at the POS with a claim greater than #9 tablets per 30 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-129
29 April 2019
Pharmacy
Quantity Limit Criteria for Sumatriptan Succinate Nasal Spray

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Sumatriptan Succinate Nasal Spray coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Sumatriptan Succinate Nasal Spray will reject at the POS with a claim greater than #6 per 30 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created By: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-130
29 April 2019
Pharmacy
Quantity Limit Criteria for Naratriptan Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Naratriptan Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriatenes s or appropriateness of the service.

3. PROCEDURES:

3.1. Naratriptan Tablet (all strengths) will reject at the POS with a claim greater than #9 tablets per 30 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-131
29 April 2019
Pharmacy
Quantity Limit Criteria for Butalbital/Acetaminophen/Caffeine (50-325-40) Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Butalbital/Acetaminophen/Caffeine (50-325-40) Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Butalbital/Acetaminophen/Caffeine (50-325-40) Tablet (all strengths) will reject at the POS with a claim greater than #30 tablets per 30 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-132
29 April 2019
Pharmacy
Quantity Limit Criteria for Butalbital/Aspirin/Caffeine (50-325-40) Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Butalbital/Aspirin/Caffeine (50-325-40) Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Butalbital/Aspirin/Caffeine (50-325-40) Tablet (all strengths) will reject at the POS with a claim greater than #30 tablets per 30 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-133
29 April 2019
Pharmacy
Quantity Limit Criteria for Colchicine Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Colchicine Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Colchicine Tablet (all strengths) will reject at the POS with a claim greater than #30 tablets per 180 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-134
29 April 2019
Pharmacy
Quantity Limit Criteria for Rizatriptan ODT; Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Rizatriptan ODT; Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Rizatriptan ODT; Tablet (all strengths) will reject at the POS with a claim greater than #12 tablets per 30 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-135
29 April 2019
Pharmacy
Prior Authorization Criteria for Adalimumab (Humira) Injectable

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 4

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Adalimumab (Humira) Injectable coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Adalimumab (Humira) Injectable (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Biologicals such as Humira Injectable, are not considered first-line agents under the OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. Adalimumab (Humira) may be considered medically necessary when at least one of criteria A through G below is met.

A. A diagnosis of **ankylosing spondylitis** (AS) when established by or in consultation with a rheumatologist and consistent with diagnostic criteria and practice guidelines as accepted by the American College of Rheumatology.

B. A diagnosis of **chronic plaque psoriasis** (PsO) when established by or in consultation with a dermatologist or rheumatologist consistent with diagnostic criteria and practice guidelines as accepted by the American College of Rheumatology and all of criteria 1 through 2 below are met.
   1. Chart notes support involvement of at least 10% of the body surface area or there is significant functional disability. And/or hand, foot or mucous membrane involvement
   2. Treatment with at least one oral DMARD was ineffective, not tolerated, or is contraindicated.

C. A diagnosis of **Crohn's disease** (CD) when established by or in consultation with a gastroenterologist, and at least one of criteria 1 through 3 below is met.
   1. Fistulizing Crohn's disease.
   2. Acute treatment of an exacerbation when at least one of criteria a through c below is met.
      a. Treatment with an adequate course of systemic corticosteroids (e.g. 40 to 60 mg prednisone daily for 7 to 14 days) has been ineffective or is contraindicated.
      b. The patient has been unable to taper an adequate course of systemic corticosteroids without experiencing worsening of disease.
      c. The patient is experiencing breakthrough disease (e.g. active disease flares) while stabilized for at least 2 months on an oral DMARD.

D. A diagnosis of **juvenile idiopathic arthritis** (JIA) when established by or in consultation with a rheumatologist, and consistent with diagnostic criteria and practice guidelines as accepted by the American College of Rheumatology, and there is clinical documentation that methotrexate was ineffective after at least a 12 week treatment course at optimal or maximal doses, or that methotrexate was not tolerated or is contraindicated.

E. A diagnosis of **psoriatic arthritis** (PsA) when established by or in consultation with a dermatologist or rheumatologist. Need to meet following criteria:
   1. At least 10% of body surface involved; and/or,
   2. Hand, foot or mucous membrane involvement
   3. First line agents include topical agents, oral retinoids, phototherapy and methotrexate. Use of other systemic agents should be limited to those who fail, have contraindications to, or do not have access to first line agents.

F. A diagnosis of **rheumatoid arthritis** (RA) when established by or in consultation with a rheumatologist, and consistent with diagnostic criteria and practice guidelines as accepted by the American College of Rheumatology, and there is clinical documentation that methotrexate was ineffective after at least a 12 week treatment at optimal or maximal doses, or that methotrexate (or another DMARD) was not tolerated or is contraindicated.

G. A diagnosis of **ulcerative colitis** (UC) when established by or in consultation with a gastroenterologist and the following criteria is met:
   1. Treatment with an adequate course of systemic corticosteroids (e.g. 40 to 60 mg prednisone daily for 7 to 14 days) has been ineffective or is contraindicated.
   2. Treatment with at least one aminosalicylate (e.g. mesalamine, sulfasalazine) has been ineffective, not tolerated, or is contraindicated.
   3. Treatment with at least one oral DMARD has been ineffective, not tolerated, or is contraindicated.

4.3. *Prior Authorizations,* when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

Note: Maximal doses of methotrexate are defined as 15mg to 25mg per week depending on the patient's tolerance and consistent with practice guidelines as accepted by the American College of Rheumatology.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-136
29 April 2019
Pharmacy
Prior Authorization Criteria for Etanercept (Enbrel) Injectable

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 4

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Etanercept (Enbrel) Injectable coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Etanercept (Enbrel) Injectable (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Biologicals such as Etanercept (Enbrel) Injectable, are not considered first-line agents under the OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. Etanercept (Enbrel) may be considered medically necessary when at least one of criteria A through E below is met.

A. A diagnosis of **ankylosing spondylitis** (AS) when established by or in consultation with a rheumatologist and consistent with diagnostic criteria and practice guidelines as accepted by the American College of Rheumatology.

B. A diagnosis of **chronic plaque psoriasis** (PsO) as defined as moderate-to-severe when established by or in consultation with a dermatologist or rheumatologist consistent with diagnostic criteria and practice guidelines as accepted by the American College of Rheumatology and all of criteria 1 through 2 below are met.
   1. Chart notes support involvement of at least 10% of the body surface area or there is significant functional disability. And/or hand, foot or mucous membrane involvement
   2. Treatment with at least one oral DMARD was ineffective, not tolerated, or is contraindicated.

C. A diagnosis of **polyarticular juvenile idiopathic arthritis** (PJIA) when established by or in consultation with a rheumatologist, and consistent with diagnostic criteria and practice guidelines as accepted by the American College of Rheumatology, and there is clinical documentation that methotrexate was ineffective after at least a 12 week treatment course at optimal or maximal doses, or that methotrexate was not tolerated or is contraindicated.

D. A diagnosis of **psoriatic arthritis** (PsA) when established by or in consultation with a dermatologist or rheumatologist. Need to meet following criteria:
   1. At least 10% of body surface involved; and/or,
   2. Hand, foot or mucous membrane involvement

3. First line agents include topical agents, oral retinoids, phototherapy and methotrexate. Use of other systemic agents should be limited to those who fail, have contraindications to, or do not have access to first line agents.

E. A diagnosis of **rheumatoid arthritis** (RA) when established by or in consultation with a rheumatologist, and consistent with diagnostic criteria and practice guidelines as accepted by the American College of Rheumatology, and there is clinical documentation that methotrexate was ineffective after at least a 12 week treatment at optimal or maximal doses, or that methotrexate (or another DMARD) was not tolerated or is contraindicated.

4.3. *Prior Authorizations*, when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive respon se to therapy.

Note: Maximal doses of methotrexate are defined as 15mg to 25mg per week depending on the patient's tolerance and consistent with practice guidelines as accepted by the American College of Rheumatology.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-137
28 July 2020
Pharmacy
Prior Authorization Criteria for Olodaterol (Striverdi Respimat) Inhaler

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Olodaterol (Striverdi Respimat) Inhaler coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Olodaterol (Striverdi Respimat) Inhaler (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. A medication therapy management (MTM) review will be made of the member's medication profile to identify areas of possible therapy overlap (e.g., Symbicort, Advair) by the clinical team.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. If no areas of concern or overlap are identified in the MTM, a *Prior Authorization* can be granted.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *July 28, 2020*

Cascade Health Alliance

GUIDELINE 8-138
29 April 2019
Pharmacy
Prior Authorization Criteria for Budesonide Nebulizer Solution

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Budesonide Nebulizer Solution coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Budesonide Nebulizer Solution (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization needed for age > 5 years old*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. It is requested that children greater than 5 years of age use a metered dose inhaler (MDI) whenever possible.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-139
April 29, 2019
Pharmacy
Prior Authorization Criteria for Fluticasone Propionate (Flovent HFA)

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Fluticasone Propionate (Flovent HFA) Inhaler coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Fluticasone Propionate (Flovent HFA) Inhaler will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. A documented try and failure of either QVAR or Pulmicort Flexhaler must occur for an override for the Fluticasone Propionate (Flovent HFA) Inhaler.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance GUIDELINE 8-140

29 April 2019

Pharmacy

Prior Authorization Criteria for Budesonide/Formoterol Fumarate (Symbicort) Inhaler

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Budesonide/Formoterol Fumarate (Symbicort) Inhaler coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Budesonide/Formoterol Fumarate (Symbicort) Inhaler (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. A medication therapy management (MTM) review will be made of the member's medication profile to identify areas of possible therapy overlap.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. If no areas of concern or overlap are identified in the MTM, a *Prior Authorization* can be granted.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-141
29 April 2019
Pharmacy
Prior Authorization Criteria for tiotropium (Spiriva) Inhaler

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for tiotropium (Spiriva) Inhaler coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Tiotropium (Spiriva) Inhaler (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. A medication therapy management (MTM) review will be made of the member's medication profile to identify areas of possible therapy overlap.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. If no areas of concern or overlap are identified in the MTM, a *Prior Authorization* can be granted.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-142
29 April 2019
Pharmacy
Prior Authorization Criteria for Ipratropium (Atrovent) Inhaler

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Ipratropium (Atrovent) Inhaler coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Ipratropium (Atrovent) Inhaler (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. A medication therapy management (MTM) review will be made of the member's medication profile to identify areas of possible therapy overlap.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. If no areas of concern or overlap are identified in the MTM, a *Prior Authorization* can be granted.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-143
29 April 2019
Pharmacy
Quantity Limit Criteria for Epinephrine Injectable

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Epinephrine Injectable coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Epinephrine Injectable will reject at the POS after claims greater than 4 fills in 365 days with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. More than 4 fills in 365 days will require a coverage determination for a covered condition under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* exception is granted it will be for 2 pens. An evaluation of medical appropriateness will be required prior to approval for additional authorization.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-144
April 29, 2019
Pharmacy
Smoking Cessation Nicotine Replacement Therapy Prior Authorization Criteria

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 3

1. **PURPOSE:** This guideline establishes standards for *Prior Authorization* criteria for Nicotine Replacement Therapy (NRT) coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. NRT is intended to help members reduce their need for Nicotine gradually over a specified period of time (current NRT is contained in the Formulary under Tobacco Cessation Agents and include: Nicotine Gum, Nicotine Patch, Nicotine Lozenge, Nicotine Nasal Spray, Nicotine Inhaler, Zyban and Chantix).

3.2. Members will be covered with prescribed NRT for two quit attempts per year of any combination of the formulary options (e.g., 1 attempt of nicotine patches and 1 attempt of Chantix). Each quit attempt will be for 3 months.

4. GUIDELINES:

4.1. Nicotine Gum (2mg and 4mg in any combination) will have a maximum quantity limit of 720 pieces per month and a 6 month (two quit attempts) per year total benefit with no prior authorization required.

4.2. Nicotine Patches (7mg, 14mg and 21mg in any combination) will have a maximum quantity limit of 30 per month and a 6 month (two quit attempts) per year total benefit with no prior authorization required.

4.3. Nicotine Lozenges (2mg and 4mg in any combination) will have a maximum quantity limit of 600 pieces per month and a 6 month (two quit attempts) per year total benefit with no prior authorization required.

4.4. If a combination of patches, gum and lozenges are prescribed, the patches will still require no prior authorization. However, the lozenges and gum will require an authorization for a quantity limit evaluation.

4.5. Chantix (Varenicline) will require a prior authorization and will not be approved with any concurrent therapy using nicotine products (e.g., gum, patches, lozenges). A quit attempt using Chantix will be determined to be 90 days total.

4.6. Zyban (Bupropion SR) will require a prior authorization and will require an ICD-10 code for smoking cessation. Zyban (Buproprion SR) will be covered with nicotine patches if prescribed, but no other smoking cessation products will be covered concurrently (e.g., Chantix, gum, lozenges).

4.7. Nicotine Inhalers (10mg) will require a prior authorization and step therapy. Two attempts must be made with a combination of the following: Nicotine gum, nicotine patches, nicotine lozenges, Chantix or Zyban. Using a combination of two products for one attempt will not count as two attempts for this product. Nicotine inhalers (10mg) will have a maximum quantity limit of 960 cartridges per month and a 6 month (two quit attempts) per year total benefit.

4.8. Nicotine nasal spray will require a prior authorization and step therapy. Two attempts must be made with a combination of the following: Nicotine gum, nicotine patches, nicotine lozenges, Chantix or Zyban. Using a combination of two products for one attempt will not count as two attempts for this product. Nicotine nasal spray will have a maximum quantity limit of 12 bottles per month and a 6 month (two quit attempts) per year total benefit.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with CHA OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance GUIDELINE 8-145

29 April 2019

Pharmacy

Age Restriction Edit Criteria for Extended Release ADHD Medications (Stimulants)

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Age Restriction Edit Criteria* for Extended Release ADHD Medication (Stimulants) coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Extended Release ADHD Medication (Stimulants) (Tablet; Capsule - all strengths) will reject at the POS with a rejection notice to the pharmacy for an *Age Restriction Edit – Must be < 19 years of age*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. All students attending primary education are exempt and a will be granted an *Override*.

4. GUIDELINES:

4.1. Provider can request an override for the *Age Restriction Edit* if there is a medically appropriate concern or for medical necessity.

4.2. *Age Restriction Edit Overrides,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-146
29 April 2019
Pharmacy
Quantity Limit Criteria for Extended Release ADHD Medications (Stimulants)

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Extended Release ADHD medication (Stimulants) coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Extended Release ADHD medication (Stimulants) (Tablet; Capsule - all strengths) will reject at the POS with a claim greater than #30 Tablet; Capsule per 30 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-147
5 February 2020
Pharmacy
Prior Authorization Criteria for Buprenorphine/Naloxone (Suboxone) Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Buprenorphine/Naloxone (Suboxone) Tablet; Film coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Buprenorphine/Naloxone (Suboxone) Tablet (all strengths) will reject for a day supply in excess of 14 days (after an initial fill of up to 30 days) at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *February 5, 2020*

Cascade Health Alliance

GUIDELINE 8-148
29 April 2019
Pharmacy
Quantity Limit Criteria for Naloxone Spray (Narcan)

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Naloxone Spray (Narcan) coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Naloxone Spray (Narcan) will reject at the POS after claims greater than 2 fills in 90 days with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. More than 2 fills in 90 days will require a coverage determination for a covered condition under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for up to two units (1 box). Further approvals will be contingent upon documented evidence of need.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-149
29 April 2019
Pharmacy
Prior Authorization Criteria for Estradiol (Estrace) Cream

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Estradiol (Estrace) Cream coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Estradiol (Estrace) Cream (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Oral medication is the preferred treatment when medically appropriate. Estradiol Tablet is the first-line agent for when long-term treatment is necessary and desired.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Estradiol (Estrace) Cream will be reviewed and evaluated with provider for possible change to Estradiol Tablet.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-150
29 April 2019
Pharmacy
Prior Authorization Criteria for Estradiol Vaginal Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Estradiol Vaginal Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Estradiol Vaginal Tablet will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Oral medication is the preferred treatment when medically appropriate. Estradiol Oral Tablet is the first-line agent for when long-term treatment is necessary and desired.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Estradiol Vaginal Tablet will be reviewed and evaluated with provider for possible change to Estradiol Oral Tablet.

4.3. *Prior Authorizations*, when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-151
29 April 2019
Pharmacy
Prior Authorization Criteria for Estradiol Patches

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Estradiol Patches coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Estradiol Patches (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Oral medication is the preferred treatment when medically appropriate. Estradiol Tablet is the first-line agent for when long-term treatment is necessary and desired.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Estradiol Patches will be reviewed and evaluated with provider for possible change to Estradiol Tablet.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-152
29 April 2019
Pharmacy
Prior Authorization Criteria for Estradiol (Estring) Vaginal Ring

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Estradiol (Estring) Vaginal Ring coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Estradiol (Estring) Vaginal Ring (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Oral medication is the preferred treatment when medically appropriate. Estradiol Tablet is the first-line agent for when long-term treatment is necessary and desired.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Estradiol (Estring) Vaginal Ring will be reviewed and evaluated with provider for possible change to Estradiol Tablet.

4.3. *Prior Authorizations*, when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-153
29 April 2019
Pharmacy
Prior Authorization Criteria for Estradiol/Norethindrone Acetate Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Estradiol/Norethindrone Acetate Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Estradiol/Norethindrone Acetate Tablet (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-154
April 29, 2019
Pharmacy
Prior Authorization Criteria for Norelgestromin/Ethinyl Estradiol (Xulane) Patch

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Norelgestromin/Ethinyl Estradiol (Xulane) Patch coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Norelgestromin/Ethinyl Estradiol (Xulane) Patch (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Oral Contraceptives are the preferred treatment when medically appropriate. Must have a documented failure with two formulary Oral Contraceptives.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations*, when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-155
29 April 2019
Pharmacy
Oral Contraceptives Policy

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 1

1. PURPOSE: This guideline establishes criteria for dispensing 12 months of Oral Contraceptives.

2. REFERENCES: No external publications are sources for this guideline.

3. PROCEDURES:

3.1. Cascade Health Alliance will cover Oral Contraceptives that are on the formulary for up to 12 months.

3.2. In addition to our regular providers available to our members (e.g., PCP, well-woman checkup), oral contraceptives can be prescribed by pharmacists who have been trained by Oregon State University program "Comprehensive Contraceptive Education and Training for the Prescribing Pharmacist."

4. GUIDELINES:

4.1. All new starts of Oral Contraceptives will fill for 3 months at one month at a time, once a patient is stable on the new prescription. The remaining 9 months can be filled for the total 12 month prescription.

4.1.1. New starts are considered, all patients starting Oral Contraceptive therapy for the first time, change in dose/strength or change in products.

4.2. All refills where the patient has met the initial criteria (4.1) will be eligible for a 12 month fill of a current prescription for Oral Contraceptives.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA*
Date: *April 29, 2019*

Approved by: P&T Committee

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Apixaban (Eliquis) tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Apixaban (Eliquis) (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Warfarin tablet is the first-line agent for when long-term or chronic anti-coagulation is necessary and desired.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Apixaban (Eliquis) will be reviewed and evaluated with provider for possible change to Warfarin (Coumadin).

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-157
27 November 2019
Pharmacy
Quantity Limit Criteria for Gabapentin Tablets/Capsules

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Gabapentin Tablet/Capsule coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Gabapentin tablets/capsules will reject at the POS with a claim greater than #90 tablets per 30 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* to accommodate appropriate dosing.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh* **Approved by:** P&T Committee
Date: *November 27, 2019*

Cascade Health Alliance GUIDELINE 8-158

30 April 2019

Pharmacy

Prior Authorization Criteria for Mometasone Furoate/Formoterol Fumarate (Dulera) Inhaler

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Mometasone Furoate/Formoterol Fumarate (Dulera) Inhaler coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and fo r which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Mometasone Furoate/Formoterol Fumarate (Dulera) Inhaler (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. A medication therapy management (MTM) review will be made of the member's medication profile to identify areas of possible therapy overlap.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. If no areas of concern or overlap are identified in the MTM, a *Prior Authorization* can be granted.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 30, 2019*

Cascade Health Alliance

GUIDELINE 8-159
30 April 2019
Pharmacy
Prior Authorization Criteria for umeclidinium (Incruse Ellipta) Inhaler

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. **PURPOSE:** This guideline establishes standards for *Prior Authorization Criteria* for *umeclidinium* (Incruse Ellipta) Inhaler coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. *Umeclidinium* (Incruse Ellipta) Inhaler will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. A medication therapy management (MTM) review will be made of the member's medication profile to identify areas of possible therapy overlap.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. If no areas of concern or overlap are identified in the MTM, a *Prior Authorization* can be granted.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 30, 2019*

Cascade Health Alliance

GUIDELINE 8-160
27 November 2019
Pharmacy
Prior Authorization Criteria for tiotropium bromide-olodaterol (Stiolto) Inhaler

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for *tiotropium bromide-olodaterol (Stiolto*) Inhaler coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. *Tiotropium bromide-olodaterol (Stiolto*) Inhaler will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Documented evidence of a trial/fail or contraindication to Bevespi must be demonstrated prior to approval.

3.4. A medication therapy management (MTM) review will be made of the member's medication profile to identify areas of possible therapy overlap.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. If no areas of concern or overlap are identified in the MTM, a *Prior Authorization* can be granted.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *November 27, 2019*

Cascade Health Alliance

GUIDELINE 8-161
30 April 2019
Pharmacy
Prior Authorization Criteria for Podofilox (Condylox) 0.5% solution

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Podofilox (Condylox) 0.5% Solution coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Podofilox (Condylox) 0.5% solution will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 30 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 30, 2019*

Cascade Health Alliance

GUIDELINE 8-162
30 April 2019
Pharmacy
Prior Authorization Criteria for Nitro-Bid Ointment

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Nitro-Bid Ointment coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Nitro-Bid Ointment will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *May 30, 2019*

Cascade Health Alliance

GUIDELINE 8-163
23 April 2019
Pharmacy
Prior Authorization Criteria for Levemir Insulin

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Levemir Insulin coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Levemir Insulin (vials and Flextouch pens) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Basaglar is the first line treatment option for basal insulin.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-164
23 April 2019
Pharmacy
Prior Authorization Criteria for Humulin R U-500

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Humulin R U-500 insulin coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Humulin R U-500 will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Humulin R U-500 will be reviewed and evaluated with provider for possible change to Humulin R U-100.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-165
23 April 2019
Pharmacy
Prior Authorization Criteria for Lidocaine Viscous 2%

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Lidocaine Viscous 2% solution coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Lidocaine Viscous 2% will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 30 days. Further approvals will be contingent upon documented evidence of need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-166
23 April 2019
Pharmacy
Prior Authorization Criteria for Suprep

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Suprep Bowel Prep coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Suprep Bowel Prep will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for one kit (354ml).

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-167
23 April 2019
Pharmacy
Prior Authorization Criteria for Erythromycin (all oral formulations)

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Erythromycin (all oral formulations) coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Erythromycin (all oral formulations) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity (resistance to other antibiotics, etc.).

4.2. *Prior Authorizations,* when granted, will be for up to a 14-day supply. Further approvals will be contingent upon documented evidence of need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-168
23 April 2019
Pharmacy
Prior Authorization Criteria for Benzonatate capsules

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Benzonatate capsule coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Benzonatate capsules (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity (upper respiratory infection, etc.).

4.2. *Prior Authorizations,* when granted, will be for a period of up to 10 days. Further approvals will be contingent upon documented evidence of need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-169
29 April 2019
Pharmacy
Age Restriction Edit Criteria for Clindamycin suspension

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Age Restriction Edit Criteria* for Clindamycin Suspension (75mg/5ml) coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Clindamycin Suspension (75mg/5ml) will reject at the POS with a rejection notice to the pharmacy for an *Age Restriction Edit – Must be < 8years of age*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Age Restriction Edit* if there is a medically appropriate concern or for medical necessity.

4.2. *Overrides* granted for covered conditions will be approved for up to a 14-day supply. Further approvals will be contingent upon documented evidence of need for continued therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-170
23 April 2019
Pharmacy
Quantity Limit Criteria for Azithromycin 500mg tablets

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Azithromycin 500mg tablets coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Azithromycin 500mg tablets will reject at the POS with a claim greater than 3 tablets for 3 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 10 days. Further approvals will be contingent upon documented evidence of need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-171
23 April 2019
Pharmacy
Prior Authorization Criteria for Clonazepam tablets

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Clonazepam tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Clonazepam tablets (all strengths) will reject at the POS after an initial fill of up to 4 weeks in the past 180 days with a rejection notice to the pharmacy for a *Prior Authorization*

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-172
23 April 2019
Pharmacy
Prior Authorization Criteria for Sildenafil 20mg tablets

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Sildenafil 20mg tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Sildenafil 20mg tablets will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-173
23 April 2019
Pharmacy
Quantity Limit Criteria for Levalbuterol MDI

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Levalbuterol multi-dose inhaler coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically approp riate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Levalbuterol MDI will reject at the POS with a claim greater than one inhaler per 25 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-174
29 April 2019
Pharmacy
Age Restriction Edit Criteria for Tylenol with Codeine Elixir

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Age Restriction Edit Criteria* for Tylenol with Codeine Elixir coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Tylenol with Codeine Elixir will reject at the POS with a rejection notice to the pharmacy for an *Age Restriction Edit – Must be < 8 years of age*. All products covered must be generic, no brand exceptions.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Age Restriction Edit* if there is a medically appropriate concern or for medical necessity.

4.2. *Overrides* granted for covered conditions will be approved for up to 7 days. Further approvals will be contingent upon documented evidence of need for continued therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance GUIDELINE 8-175

29 April 2019

Pharmacy

Age Restriction Edit Criteria for Hydrocodone-Acetaminophen (Hycet) solution

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Age Restriction Edit Criteria* for Hydrocodone-Acetaminophen (Hycet) solution coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Hydrocodone-Acetaminophen (Hycet) solution will reject at the POS with a rejection notice to the pharmacy for an *Age Restriction Edit – Must be < 8 years of age*. All products covered must be generic, no brand exceptions.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Age Restriction Edit* if there is a medically appropriate concern or for medical necessity.

4.2. *Overrides* granted for covered conditions will be approved for up to 7 days. Further approvals will be contingent upon documented evidence of need for continued therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-176
23 April 2019
Pharmacy
Prior Authorization Criteria for Salsalate tablets

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Salsalate tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Salsalate (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-177
23 April 2019
Pharmacy
Quantity Limit Criteria for Albuterol MDI

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Albuterol multi-dose inhaler coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Albuterol MDI will reject at the POS with a claim greater than one inhaler per 25 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-178
23 April 2019
Pharmacy
Quantity Limit Criteria for Ipratropium-Albuterol nebulizing solution

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Ipratropium-Albuterol nebulizing solution coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Ipratropium-Albuterol nebulizing solution will reject at the POS with a claim greater than 90ml per 25 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-179
23 April 2019
Pharmacy
Prior Authorization Criteria for Humalog insulin

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Humalog insulin coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Humalog insulin (pens and vials) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Admelog insulin is the preferred treatment option when medically appropriate.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Humalog insulin will be reviewed and evaluated with provider for possible change to Admelog insulin.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-180
23 April 2019
Pharmacy
Prior Authorization Criteria for Methergine 0.2mg tablets

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Methergine 0.2mg tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Methergine 0.2mg tablets will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted, will be for a period of up to 7 days.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *April 23, 2019*

Cascade Health Alliance

GUIDELINE 8-181
16 July 2019
Pharmacy
Prior Authorization Criteria for Piroxicam Capsule

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Piroxicam Capsule coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Piroxicam Capsule (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Piroxicam Capsule (all strengths) is not the first-line agent for Anti-Inflammatory Treatment. Must have tried and failed two other formulary Anti-Inflammatory Medications.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations,* when granted*,* will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *July 16, 2019*

Cascade Health Alliance

GUIDELINE 8-182
25 November 2019
Pharmacy
Prior Authorization Criteria for Novolog insulin

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Novolog insulin coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Novolog insulin vials will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. Admelog insulin is the preferred treatment option when medically appropriate.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. All prescriptions for Novolog insulin will be reviewed and evaluated with provider for possible change to Admelog insulin.

4.3. PATIENTS ON AN INSULIN PUMP WILL BE APPROVED FOR NOVOLOG

4.4. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *November 25, 2019*

Cascade Health Alliance

GUIDELINE 8-183
27 November 2019
Pharmacy
Quantity Limit Criteria for Meloxicam Tablets

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Meloxicam Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Meloxicam tablets will reject at the POS with a claim greater than #30 tablets per 30 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh* **Approved by:** P&T Committee
Date: *November 27, 2019*

Cascade Health Alliance

GUIDELINE 8-184
29 April 2019
Pharmacy
Quantity Limit Criteria for Cyclobenzaprine 10mg Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Cyclobenzaprine 10mg Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Cyclobenzaprine 10mg Tablet will reject at the POS with claims (fills) adding up to greater than 120 days per 365 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 29, 2019*

Cascade Health Alliance

GUIDELINE 8-185
29 April 2019
Pharmacy
Quantity Limit Criteria for Methocarbamol Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Methocarbamol Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Methocarbamol Tablet (all strengths) will reject at the POS with claims (fills) adding up to greater than 120 days per 365 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *April 29, 2019*

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 3

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for New Drugs

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. New Drugs are drugs not in an existing drug class on the preferred drug list (formulary) with costs exceeding $5,000 per claim or $5,000 per month based on WAC (wholesale acquisition cost) and will reject at the POS with a rejection notice to the pharmacy as product not covered on plan's formulary.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. Prior authorization will be required until the Pharmacy and Therapeutics Committee can review the drug for appropriate coverage. New drug criteria will apply until drug specific criteria is developed or for a maximum of 3 months, whichever is less.

Approval Criteria		
1. What diagnosis is being treated?	Record ICD-10 code.	
2. Is this an FDA approved indication?	Yes: Go to #3	No: Pass to RPh. Deny for medical appropriateness
3. Is the drug being used for an OHP-funded diagnosis?	Yes: Go to #4	No: Pass to RPh. Deny; not funded by the OHP.
4. Is baseline monitoring recommended for efficacy or safety and has the provider submitted documentation of recommended monitoring parameters?	Yes: Go to #5	No: Pass to RPh. Deny for medical appropriateness
5. Does the requested therapy have an orphan drug designation and is this the only FDA-approved therapy for the funded condition?	Yes: Approve for up to 3 months or length of treatment (whichever is less)	No: Go to #6
6. Pass to RPh. The prescriber must provide documentation that alternative drugs approved by the FDA for the funded condition are not appropriate due to history of therapeutic failure, an adverse event, or a contraindication. Otherwise, the prescriber must provide medical literature supporting use for the funded condition. RPh may use clinical judgement to approve drug for up to 3 months or deny request based on documentation provided by the prescriber.		

5. UPDATES:

5.1 This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *November 27, 2019*

Cascade Health Alliance

GUIDELINE 8-187
27 November 2019
Pharmacy
Prior Authorization Criteria for Non-Formulary Drugs

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 3

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Non-Formulary Drugs

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. All Non-Formulary Drugs will reject at the POS with a rejection notice to the pharmacy as product not covered on plan's formulary.

3.2. Current formulary alternatives are available at: https://cascadehealthalliance.com/wp-content/uploads/2019/09/2019-CHA-Formulary-updated-9_25_2019-2nd-edit.pdf

3.3. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2 *Prior Authorizations* granted for covered conditions will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

Approval Criteria		
1. What diagnosis is being treated? 2. Is this an FDA approved indication?	Record ICD-10 code. Yes: Go to #3	No: Pass to RPh. Deny for medical appropriateness
3. Is this an OHP-funded diagnosis?	Yes: Go to #4	No: Go to #5
4. 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 provider of covered alternatives in class.	No: Approve until anticipated formal review by the P&T committee, for 3 months, or for the length of the prescription, whichever is less.

5. RPh Only: All other indications need to be evaluated as to whether they are a funded diagnosis on the OHP prioritized list.

- If funded and clinic provides supporting literature: Approve until anticipated formal review the P&T committee, for 3 months, or for the length of the prescription, whichever is less.
- If not funded: Deny: not funded by the OHP.

5. UPDATES:

5.1 This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *November 27, 2019*

Cascade Health Alliance

GUIDELINE 8-188
February 18, 2020
Pharmacy
Prior Authorization Criteria for Morphine Sulfate ER Tablet (MS Contin)

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Morphine Sulfate ER Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Morphine Sulfate ER Tablet will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Certain conditions (e.g., cancer, palliative care or end of life) are exempt from these criteria.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations*, when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *February 18, 2020*

Cascade Health Alliance

GUIDELINE 8-189
18 May 2020
Pharmacy
Prior Authorization Criteria for Neomycin-Polymyxin B-Hydrocortisone (Cortisporin) Otic Drops

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Neomycin-Polymyxin B-Hydrocortisone (Cortisporin) Otic Drops coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Neomycin-Polymyxin B-Hydrocortisone (Cortisporin) Otic Drops (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. Neomycin-Polymyxin B-Hydrocortisone (Cortisporin) Otic Drops (all strengths) is not a first-line agent on Cascade Health Alliance's formulary. Please see formulary for alternatives.

4.3. *Prior Authorizations,* when granted, will be for a period of up to 30 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *May 18, 2020*

Cascade Health Alliance

GUIDELINE 8-190
28 July 2020
Pharmacy
Prior Authorization Criteria for Glucagon Nasal Powder (Baqsimi)

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Glucagon Nasal Powder (Baqsimi) coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Glucagon Nasal Powder (Baqsimi) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. Glucagon Nasal Powder (Baqsimi) is indicated for the treatment of severe hypoglycemia in patients that are at least 4 years old AND when the patient is unable to eat.

4.3. A diagnosis of insulin dependency must be documented

4.4. *Prior Authorizations,* when granted, will be for one unit.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *July 28, 2020*

Cascade Health Alliance

GUIDELINE 8-191
28 July 2020
Pharmacy
Prior Authorization Criteria for CGRP Inhibitors

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for CGRP Inhibitors coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. CGRP Inhibitors will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code.	
2. Is this an FDA-approved indication?	**Yes**: Go to #3	**No:** Pass to RPh. Deny; medical appropriateness
3. Is the diagnosis funded by OHP?	**Yes:** Go to #4	**No:** Pass to RPh. Deny; not funded by the OHP.
4. Is this a request for renewal of a previously approved Fee-For-Service prior authorization of a CGRP antagonist for management of migraine headache?	**Yes:** Go to **Renewal Criteria**	**No:** Go to #5
5. Is there documentation that the patient has experienced 4 or more migraine days in the previous month?	**Yes:** Document migraine days per month _____ Go to #6	**No:** Pass to RPh. Deny; medical appropriateness
6. Do chart notes indicate headaches are due to medication overuse?	**Yes:** Pass to RPh. Deny; medical appropriateness.	**No:** Go to #7
7. Has the patient failed an adequate trial (≥6 weeks with a documented adherence of ≥80%) of an FDA-approved migraine prophylaxis medication from each of the following classes: beta-blockers, anticonvulsants, and tricyclic antidepressants? OR Does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity to each of the above migraine prophylaxis classes?	**Yes:** Document agents used and dates _____ _____ Go to #8	**No:** Pass to RPh. Deny; medical appropriateness
8. Has the patient received an injection with botulinum toxin for headache treatment once in the previous 2 months?	**Yes:** Pass to RPh. Deny; medical appropriateness	**No:** Go to #9
9. Is the medication being prescribed by or in consultation with a neurologist or headache specialist?	**Yes:** Approve for 3 months	**No:** Pass to RPh. Deny; medical appropriateness

Renewal Criteria		
1. Do chart notes indicate headaches are due to medication overuse?	**Yes:** Pass to RPh. Deny; medical appropriateness.	**No:** Go to #2
2. Has the patient experienced a documented positive response to therapy, as demonstrated by a reduction in migraine headache frequency and/or intensity from baseline?	**Yes:** Document response Approve for up to 6 months (e.g. minimum 2 doses for treatment given every 3 months)	**No:** Pass to RPh. Deny; medical appropriateness

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *July 28, 2020*

Cascade Health Alliance

GUIDELINE 8-192
1 October 2020
Pharmacy
Prior Authorization Criteria for Basgalar

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 3

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Basaglar coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Basgalar (all products) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. A coverage determination will be required to evaluate the least costly option for the patient and if the pen is being used for strictly a matter of convenience.

3.4. Basaglar may be considered medically necessary for treatment of type 1 diabetes mellitus (T1DM) when the patient meets the diagnostic criteria for type 1 diabetes mellitus

3.5. Members with type 1 diabetes mellitus may receive Basaglar after a trial of Semglee for at least three months and be approved for the duration of their eligibility

3.6. Basaglar may be considered medically necessary for treatment of type 2 diabetes mellitus (T2DM) when the patient meets the inclusion criteria of guideline 4.2

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. Approval will be granted for treatment of type 2 diabetes mellitus when the following inclusion criteria is satisfied:

A. A documented diagnosis of type 2 diabetes mellitus
B. Blood glucose is uncontrolled with a trial of alternative long acting insulin regimens
    1. a combination of NPH insulin with meal-time boluses of fast-acting insulin for at least 3 months.
    2. Semglee for at least 3 months.

Control is defined as achieving and maintaining stability at patient-specific goal (such as <8% A1C).

4.3. *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPH, MBA* **Approved by:** P&T Committee
Date: *October 1, 2020*

Cascade Health Alliance

GUIDELINE 8-193
23 December 2020
Pharmacy
Quantity Limit Criteria for Famotidine Suspension

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Famotidine Suspension coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Famotidine Suspension will reject at the POS with claims (fills) adding up to greater than 90 days per 365 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or for medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *December 23, 2020*

Cascade Health Alliance

GUIDELINE 8-194
16 December 2020
Pharmacy
Prior Authorization Criteria for Segluromet (ertugliflozin-metformin) (SGLT-2 Inhibitor) Tablet

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 4

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Segluromet (ertugliflozin-metformin) tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

2.7. American Diabetes Association. Standards of medical care in diabetes - 2016. Diabetes Care. 2016;39(suppl 1):S1-S119.

2.8. Bennett WL, Maruthur NM, Singh S, et al. Comparative effectiveness and safety of medications for type 2 diabetes: an update including new drugs and 2 -drug combinations. Ann Intern Med. 2011;154:602-613.

3. PROCEDURES:

3.1. Segluromet (ertugliflozin-metformin) (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

3.3. Must have an A1C greater than or equal to 9%, but less than 10% or have a failure on a compliant 3-month dual therapy which included metformin to achieve A1C target and still be less than 10%.

3.4. Will not be covered for dual therapy and must be used in a triple therapy which includes Metformin.

3.5. In addition, a sulfonylurea, thiazolidinedione, GLP-1 receptor agonist or insulin (basil) must be used as part of the triple therapy due to Segluromet (ertugliflozin-metformin) (SGLT-2 Inhibitor) having a rather modest impact on A1C.

Start with Monotherapy unless:

A1C is greater than or equal to 9%, move to Dual Therapy.

A1C is greater than or equal to 10%, move to Combination Injectable Therapy.

Monotherapy	**Metformin**

Efficacy	High
Hypo Risk	Low Risk
Weight	Neutral/Loss
Side Effects	GI/Lactic Acidosis
Costs	Low

If A1C target not achieved after 3 months of compliant monotherapy, proceed to 2 -drug combination.

Dual Therapy	**Metformin +**

	Sulfonylurea	Thiazolidinedione	GLP-1 RA	Insulin (Basal)
Efficacy	High	High	High	Highest
Hypo Risk	Moderate Risk	Low Risk	Low Risk	High Risk
Weight	Gain	Gain	Loss	Gain
Side Effects	Hypoglycemia	Edema, HF	GI	Hypoglycemia
Costs	Low	Low	High	High

If A1C target not achieved after 3 months of compliant dual therapy, proceed to 3-drug combination.

Triple Therapy	**Metformin +**

Sulfonylurea +	**TZD +**	**DPP-4 Inhibitor +**	**SGLT2 Inhibitor +**	**GLP-1 RA +**	**Insulin (Basal) +**
Add one additional medication from the appropriate column					
TZD	SU	SU	SU	SU	SU
Insulin	Insulin	TZD	TZD	TZD	TZD
GLP-1-RA	GLP-1-RA	Insulin	Insulin	Insulin	GLP-1-RA
DPP-4-I	DPP-4-I	SGLT2-I	GLP-1-RA	SGLT2-I	DPP-4-I
SGLT2-I	SGLT2-I		DPP-4-I		SGLT2-I

If A1C target not achieved after 3 months of compliant triple therapy and patient (1) on oral combination, move to basal insulin or GLP-1 RA, (2) on GLP-1 RA, add basal insulin, or (3) on optimally titrated basal Insulin, add GLP-1 RA or mealtime insulin. Metformin therapy should be maintained, while other oral agents may be discontinued on an individual basis to avoid unnecessarily complex or costly regimens (i.e., adding a fourth antihyperglycemic agent).

Combination Injectable Therapy	**Metformin + Basal Insulin +**

Rapid-Acting Insulin	GLP-1 RA

4. GUIDELINES:

4.1 Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2 *Prior Authorizations,* when granted, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5 UPDATES:

5.1 This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *December 16, 2020*

Cascade Health Alliance

GUIDELINE 8-195
23 December 2020
Pharmacy
Quantity Limit Criteria for Baclofen 10mg and 20mg Tablets

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Baclofen 10mg and 20mg Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Baclofen 10mg and 20mg tablets will reject at the POS with claims (fills) adding up to greater than 120 days per 365 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *December 23, 2020*

Cascade Health Alliance

GUIDELINE 8-196
23 December 2020
Pharmacy
Quantity Limit Criteria for Tizanidine 2mg and 4mg Tablets

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee
Pages: 2

1. PURPOSE: This guideline establishes standards for *Quantity Limit Criteria* for Tizanidine 2mg and 4mg Tablet coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.3. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.4. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Tizanidine 2mg and 4mg Tablets will reject at the POS with claims (fills) adding up to greater than 120 days per 365 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee

Date: *December 23, 2020*

Cascade Health Alliance

GUIDELINE 8-197
23 December 2020
Pharmacy
Quantity Limit Criteria for First-Omeprazole

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy | Approved by: Pharmaceuticals and Therapies (P&T) Committee | Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Omeprazole Suspension (First-Omeprazole) coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Omeprazole Suspension (First-Omeprazole) will reject at the POS with claims (fills) adding up to greater than 90 days per 365 days.

4. GUIDELINES:

4.1. Provider can request an override for the *Quantity Limit* if there is a medically appropriate concern or for medical necessity.

4.2. In the event a *Quantity Limit* override is granted, it will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of need for continued treatment.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *December 23, 2020*

Cascade Health Alliance

GUIDELINE 8-198
5 January 2021
Pharmacy
Prior Authorization Criteria for Docusate Sodium (all formulations)

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

OPR: Director of Pharmacy

Approved by: Pharmaceuticals and Therapies (P&T) Committee

Pages: 2

1. PURPOSE: This guideline establishes standards for *Prior Authorization Criteria* for Docusate Sodium coverage determination.

1.1. Pharmacy policy is designed to provide cost effective, efficient, and medically appropriate care based on current medical practice guidelines with consideration of medical necessity, review of medical literature and government approval status.

2. REFERENCES:

2.1. MedImpact current contract (December, 2019).

2.2. Oregon Health Plan Prioritized List.

2.3. 410-120-1200 (2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

A. Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);

B. Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

2.4. OAR 410-120-1200 (2) (N) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

2.5. OAR 410-120-1200 (2) (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

2.6. OAR 410-120-1320 (3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

3. PROCEDURES:

3.1. Docusate Sodium (all strengths) will reject at the POS with a rejection notice to the pharmacy for a *Prior Authorization*.

3.2. A coverage determination will be required to evaluate the ICD 10 code for covered conditions under the current OHP prioritized list.

4. GUIDELINES:

4.1. Provider can request an override for the *Prior Authorization* if there is a medically appropriate concern or for medical necessity.

4.2. *Prior Authorizations*, when granted for covered conditions, will be for a period of up to 90 days. Further approvals will be contingent upon documented evidence of positive response to therapy.

5. UPDATES:

5.1. This guideline will be reviewed by the Director of Pharmacy in accordance with OI 8-00, *Pharmacy Guidelines*.

Created by: *Amin Surani, RPh, MBA* **Approved by:** P&T Committee
Date: *January 5, 2021*