AdvancedHealth
Bridging the Future of Healthcare

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Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Drug Use Criteria

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Applies to all medications that require prior authorization. EPSDT does not require coverage of treatments, services, or items that are experimental or investigational. EPSDT applies to members 20 years of age and younger.

GUIDELINE FOR USE:

1. Is the member 21 years of age or older?
    a. If yes, go to appropriate drug use criteria or deny as below the Oregon Health Plan funded line, if appropriate.
    b. If no, go to #2.

2. Is there a formulary medication for the condition being requested?
    a. If yes, send request to provider requesting change to formulary medication.
    b. If no, go to #3

3. Does the medication requested have FDA approval for condition being requested and/or supported by compendium?
    a. If yes, go to #4
    b. If no, deny as not meeting criteria. Medications that are experimental or investigational are not a covered service.

4. Is there documentation that the condition is of sufficient severity that it impacts the member's health (e.g., quality of life, function, growth, development, ability to participate in school, perform activities of daily living, etc.)?
    a. If yes, approve for up to 12 months.
    b. If no, send for MD review to determine medical appropriateness and/or medical necessity.

References:

1. Oregon Administrative Rule 410-120-000 (101)
2. EPSDT- A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. June 2014. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/epsdt_coverage_guide_103.pdf
3. Prioritized List of Health Services January 1, 2024. https://www.oregon.gov/oha/HPA/DSI-HERC/PrioritizedList/1-1-2024%20Prioritized%20List%20of%20Health%20Services.pdf
4. Statement of Intent 4: Role of the Prioritized List in Coverage

Approved by Advanced Health Pharmacy and Therapeutics Committee 4/28/2023, 4/10/2024