



Colorado Department of Health Care Policy and Financing Preferred Drug List (PDL)

Effective November 1, 2009

Prior Authorization Forms: available online at <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132>

The PDL applies to Medicaid fee-for-service clients. It does not apply to clients enrolled in Rocky Mountain Health HMO or Denver Health Medicaid Choice.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria
ANTIEMETICS <i>Effective 1/1/09</i>	No Prior Authorization Required ondansetron tablets ondansetron ODT tablets ondansetron suspension ZOFRAN tablets ZOFRAN ODT tablets EMEND	Prior Authorization Required ANZEMET KYTRIL SANCUSO ALOXI ZOFRAN suspension	Non-preferred products will be approved for clients who have failed treatment with brand or generic Zofran within the last year. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)
ANTIHISTAMINES Newer Generation Antihistamines <i>Effective 7/1/09</i>	No Prior Authorization Required loratadine (generic OTC Claritin) cetirizine (generic OTC Zyrtec)	Prior Authorization Required ALLEGRA (fexofenadine) CLARINEX (desloratadine) CLARITIN (loratadine) – Brand fexofenadine (generic Allegra) XYZAL (levocetirizine) ZYRTEC (cetirizine) Brand	Non-preferred antihistamines will be approved for clients who have documented lack of efficacy with two preferred products in the last 6 months. Approval may also be granted for clients who are unable to take preferred products due to allergy, intolerable side effects or significant drug-drug interaction.
Antihistamine/Decongestant Combinations <i>Effective 7/1/09</i>	No Prior Authorization Required	Prior Authorization Required ALLEGRA-D (fexofenadine-D) CLARINEX-D (desloratadine-D) CLARITIN-D (loratadine-D) loratadine-D (generic Claritin-D) SEMPREX-D (acrivastine-D) ZYRTEC-D (cetirizine-D)	Non-preferred antihistamine/decongestant combinations will be approved for clients who have a diagnosis of seasonal or perennial allergic rhinitis or chronic sinusitis not controlled with nasal steroids alone.

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ANTIHYPERTENSIVES Angiotensin Receptor Blockers (ARBs) <i>Effective 7/1/09</i>	No Prior Authorization Required ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) COZAAR (losartan) DIOVAN (valsartan) MICARDIS (telmisartan)	Prior Authorization Required TEVETEN (eprosartan)	Non-preferred ARBs, ARB combinations, renin inhibitors, and rennin inhibitor combination products will be approved for clients who have failed treatment with one preferred product. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
ARB Combinations <i>Effective 7/1/09</i>	No Prior Authorization Required ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) BENICAR-HCT (olmesartan/HCTZ) HYZAAR-HCT (losartan/HCTZ) DIOVAN-HCT (valsartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ)	Prior Authorization Required TEVETEN-HCT (eprosartan/HCTZ) AZOR (amlodipine/olmesartan) EXFORGE (amlodipine/valsartan) VALTURNA (aliskiren/valsartan)	
Renin Inhibitors & Renin Inhibitor Combinations <i>Effective 7/1/09</i>	No Prior Authorization Required	Prior Authorization Required TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	

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BISPHOSPHONATES (oral) <i>Effective 10/1/09</i>	No Prior Authorization Required ACTONEL 5mg, 30mg, 35mg, 75mg, 150mg tablets alendronate (generic) 5mg, 10mg, 35mg, and 70mg tablets	Prior Authorization Required ACTONEL w/Calcium BONIVA FOSAMAX (brand) FOSAMAX plus D etidronate	Non-preferred products will be approved for clients who have failed treatment with at least one strength of alendronate and at least one strength of ACTONEL. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
DIABETES MANAGEMENT CLASSES (oral) Biguanides <i>Effective 10/1/09</i>	No Prior Authorization Required metformin generic 500mg, 850mg, and 1000mg tablets metformin generic extended- release 500mg tablets	Prior Authorization Required FORTAMET GLUCOPHAGE (brand) GLUCOPHAGE XR (brand) GLUMETZA metformin ER 750mg RIOMET 500mg/5ml	Non-preferred products will be approved for clients who have failed treatment with two Preferred dosage forms. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Liquid metformin will be approved for clients: <ul style="list-style-type: none"> ➤ under the age of 12 ➤ with a feeding tube ➤ who have difficulty swallowing
Hypoglycemic Combinations <i>Effective 10/1/09</i>	No Prior Authorization Required	Prior Authorization Required ACTOPLUS MET AVANDAMET AVANDARYL DUETACT glipizide/metformin glyburide/metformin GLUCOVANCE (brand) METAGLIP PRANDIMET	Non-preferred products will be approved for clients who have been stable on the two individual ingredients for 3 months and have an adherence issue.
Meglitinides <i>Effective 10/1/09</i>	No Prior Authorization Required	Prior Authorization Required PRANDIN STARLIX	Non-preferred products will be approved for clients who have failed treatment with one Sulfonylurea (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
Sulfonylureas <i>Effective 10/1/09</i>	No Prior Authorization Required glimepiride (generic) glipizide (generic) glipizide ER (generic) glyburide (generic) micronized glyburide (generic)	Prior Authorization Required AMARYL (brand) DIABETA (brand) GLUCOTROL (brand) GLUCOTROL XL (brand) GLYCRON (brand) GLYCRON (brand) GLYNASE (brand) MICRONASE (brand)	Non-preferred products will be approved for clients who have failed treatment with two Preferred products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
Thiazolidinediones <i>Effective 10/1/09</i>	No Prior Authorization Required ACTOS	Prior Authorization Required AVANDIA	Non-preferred products will be approved for clients who have failed treatment with ACTOS in the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)

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<p>ERYTHROPOIESIS STIMULATING AGENTS</p> <p><i>Effective 10/1/09</i></p>	<p>*Must meet eligibility criteria PROCRIT</p>	<p>Prior Authorization Required ARANESP EPOGEN</p>	<p>*Eligibility Criteria for all agents in the class Clients must meet all criteria in one of the following four areas:</p> <ul style="list-style-type: none"> ➤ A diagnosis of cancer, currently receiving chemotherapy, with chemotherapy-induced anemia, and Hb of 10g/dL or lower. ➤ A diagnosis of chronic renal failure, and Hb of 11g/dL or lower ➤ A diagnosis of hepatitis C, currently taking Ribavirin and failed response to a reduction of Ribavirin dose, and Hb less than 10g/dL (or less than 11g/dL if symptomatic). ➤ A diagnosis of HIV, currently taking Zidovudine, Hb less than 10g/dL, and serum erythropoietin level of 500mUnits/mL or less. <p>Hb results must be from the last 30 days. Medication must be administered in the client's home or long-term care facility.</p> <p>Non-preferred products:</p> <ul style="list-style-type: none"> ➤ Same as above; and ➤ Failed treatment with Procrit. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
<p>GROWTH HORMONES</p> <p><i>Effective 4/1/09</i></p>	<p>No Prior Authorization Required</p> <p>GENOTROPIN NORDITROPIN TEV-TROPIN</p>	<p>Prior Authorization Required</p> <p>HUMATROPE NUTROPIN OMNITROPE SAIZEN SEROSTIM ZORBTIVE</p>	<p>Non-preferred Growth Hormones will be approved if both of the following criteria are met:</p> <ul style="list-style-type: none"> ▪ Client failed treatment with two preferred products within the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) ▪ Client has a qualifying diagnosis: <ul style="list-style-type: none"> ➤ Prader-Willi ➤ Chronic renal insufficiency/failure ➤ Turner's Syndrome ➤ Idiopathic short stature ➤ Hypopituitarism: as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma ➤ Somatotropin deficiency syndrome ➤ Wasting associated with AIDS or cachexia <p>★Nutropin will be approved for clients diagnosed with chronic renal insufficiency without having failed on a preferred product.</p> <p>Grandfathering Clients who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication.</p>

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INTRANASAL CORTICOSTEROIDS <i>Effective 4/1/09</i>	No Prior Authorization Required fluticasone (generic FLONASE) NASONEX VERAMYST	Prior Authorization Required BECONASE AQ FLONASE NASACORT AQ NASAREL OMNARIS RHINOCORT AQ	Non-preferred Intranasal Corticosteroids will be approved if the client has failed treatment with 2 preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). ★Rhinocort AQ will be approved for pregnant clients without failure of Preferred products.
LEUKOTRIENE MODIFIERS <i>Effective 4/1/09</i>	No Prior Authorization Required SINGULAIR	Prior Authorization Required ACCOLATE ZYFLO	Non-preferred Leukotrienes will be approved if both of the following criteria are met: <ul style="list-style-type: none"> ▪ Client failed treatment with Singulair in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) ▪ Client has a diagnoses of Asthma
OPHTHALMIC ALLERGY <i>Effective 4/1/09</i>	No Prior Authorization Required CROMOLYN PATANOL PATADAY ZADITOR	Prior Authorization Required ALAMAST ALAWAY ALOCRIL ALOMIDE ELESTAT EMADINE OPTIVAR	Non-preferred Ophthalmic Allergy medications will be approved if the client has failed treatment with two preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)
OPIOIDS Long Acting – Oral Opioids <i>Effective 7/1/09</i>	No Prior Authorization Required KADIAN (morphine ER) methadone (generic Dolophine) morphine ER (generic MS Contin)	Prior Authorization Required AVINZA (morphine ER) DOLOPHINE (methadone) - Brand MS CONTIN (morphine ER) - Brand ORAMORPH SR (morphine ER) - Brand OXYCONTIN (oxycodone ER) OPANA ER (oxymorphone ER)	Non-preferred, long-acting oral opioids will be approved for clients who have experienced lack of efficacy with one preferred agent in the last three months. <u>Grandfathering</u> Clients who are currently stabilized on a non-preferred, long-acting opioid may be approved to continue therapy with that agent.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria
<p>PROTON PUMP INHIBITORS</p> <p><i>Effective 1/1/09</i></p>	<p>No Prior Authorization Required</p> <p>PREVACID (lansoprazole) capsules PREVACID (lansoprazole) solutabs PRILOSEC OTC (omeprazole)</p>	<p>Prior Authorization Required</p> <p>ACIPHEX (rabeprazole) KAPIDEX (dexlansoprazole) NEXIUM (esomeprazole) packets NEXIUM (esomeprazole) capsules omeprazole (generic Prilosec) PREVACID (lansoprazole) suspension PROTONIX (pantoprazole) ZEGERID (omeprazole/Na bicarbonate)</p> <p>PREVPAC HELIDAC</p>	<p>Non-preferred proton pump inhibitors will be approved if all of the following criteria are met: Client failed treatment with two preferred products within the last 24 months and client has a qualifying diagnosis, diagnosed by an appropriate diagnostic method.</p> <p>Qualifying Diagnoses: Barrett's Esophagus, Duodenal Ulcer, Erosive Esophagitis, Gastric Ulcer, GERD, GI Bleed, Heartburn (for Prilosec OTC only), H. pylori, Hypersecretory Conditions (Zollinger-Ellison), NSAID-Induced Ulcer, Pediatric Esophagitis, Recurrent Aspiration Syndrome or Ulcerative GERD</p> <p>Diagnosed by: GI Specialist, Endoscopy, X-Ray, Biopsy, Blood test, or Breath test</p> <p>Quantity Limits: Non-preferred agents will be limited to once daily dosing except for the following diagnoses: Barrett's Esophagus, GI Bleed, H. pylori, Hypersecretory Conditions, or Spinal Cord Injury patients with any acid reflux diagnosis.</p> <p>Children: Aciphex, Protonix, and Zegerid will not be approved for clients less than 18 years of age.</p>
<p>RESPIRATORY INHALANTS</p> <p>Inhaled Anticholinergics & Anticholinergic Combinations</p> <p><i>Effective 7/1/09</i></p>	<p>No Prior Authorization Required</p> <p>Solutions albuterol/ipratropium (generic Duoneb) ipratropium (generic Atrovent)</p> <p>Inhalers ATROVENT HFA (ipratropium) COMBIVENT (albuterol/ipratropium) SPIRIVA Handihaler (tiotropium)</p>	<p>Prior Authorization Required</p> <p>Solutions ATROVENT (ipratropium) solution DUONEB (albuterol/ipratropium)</p>	<p>Non-preferred anticholinergic inhalants and anticholinergic combination inhalants will require a brand-name prior authorization.</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria
<p>RESPIRATORY INHALANTS (cont) Inhaled Beta2 Agonists (short acting)</p> <p><i>Effective 7/1/09</i></p>	<p>No Prior Authorization Required</p> <p><u>Solutions</u> albuterol (generic) solution</p> <p><u>Inhalers</u> PROAIR (albuterol) HFA inhaler PROVENTIL (albuterol) HFA inhaler VENTOLIN (albuterol) HFA inhaler</p>	<p>Prior Authorization Required</p> <p><u>Solutions</u> ACCUNEB (albuterol) solution AIRET (albuterol) solution ALUPENT (metaproterenol) solution PROVENTIL (albuterol) solution VENTOLIN (albuterol) solution XOPENEX (levalbuterol) solution</p> <p><u>Inhalers</u> ALUPENT (metaproterenol) Inhaler XOPENEX (levalbuterol) Inhaler MAXAIR (pirbuterol) autohaler</p>	<p>Non-preferred, short acting beta2 agonists will be approved for clients who have failed treatment with one preferred agent. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction).</p> <p>Grandfathering: Clients currently stabilized on a non-preferred short acting beta2 agonist can receive approval to continue that agent for one year if medically necessary.</p>
<p>Inhaled Beta2 Agonists (long acting)</p> <p><i>Effective 7/1/09</i></p>	<p>No Prior Authorization Required</p>	<p>Prior Authorization Required</p> <p><u>Solutions</u> BROVANA (Arformoterol) solution PERFOROMIST (formoterol) solution</p> <p><u>Inhalers</u> FORADIL (formoterol) inhaler SEREVENT (salmeterol) inhaler</p>	<p>Non-preferred, long acting beta2 agonists will be approved for clients with moderate to severe asthma who are currently using an inhaled corticosteroid and require add-on therapy, or for clients with moderate to very severe COPD.</p> <p>Grandfathering: Clients currently stabilized on a non-preferred long acting beta2 agonist can receive approval to continue that agent for one year if medically necessary.</p>
<p>Inhaled Corticosteroids</p> <p><i>Effective 7/1/09</i></p>	<p>No Prior Authorization Required</p> <p><u>Solutions</u> PULMICORT (budesonide) respules</p> <p><u>Inhalers</u> FLOVENT (fluticasone) HFA inhaler FLOVENT (fluticasone) 50mcg, 100mcg, and 250mcg diskus PULMICORT (budesonide) flexhaler QVAR (beclomethasone) inhaler</p>	<p>Prior Authorization Required</p> <p><u>Inhalers</u> AEROBID (flunisolide) inhaler ASMANEX (mometasone) twisthaler AZMACORT (triamcinolone) inhaler</p>	<p>Non-preferred inhaled corticosteroids will be approved for clients who have failed treatment with one preferred agent. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions.)</p> <p>Grandfathering: Clients currently stabilized on a non-preferred agent can receive approval to continue that agent for one year if medically necessary.</p>

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization Criteria
<p>RESPIRATORY INHALANTS (cont) Inhaled Corticosteroid Combinations</p> <p><i>Effective 7/1/09</i></p>	<p>No Prior Authorization Required</p> <p>ADVAIR Diskus (fluticasone/salmeterol)</p>	<p>Prior Authorization Required</p> <p>ADVAIR HFA (fluticasone/salmeterol) SYMBICORT (budesonide/formoterol)</p>	<p>Non-preferred inhaled corticosteroid combination inhalants will be approved for clients meeting both of the following criteria:</p> <ul style="list-style-type: none"> • Client has a qualifying diagnosis of asthma or COPD. • Client cannot take preferred drug due to lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. <p>Grandfathering: Clients currently stabilized on a non-preferred agent can receive approval to continue that agent for one year if medically necessary.</p>
<p>SEDATIVE- HYPNOTICS (non-benzodiazepine)</p> <p><i>Effective 4/1/09</i></p>	<p>No Prior Authorization Required</p> <p>AMBIEN CR (zolpidem) ROZEREM (ramelteon) zolpidem (generic Ambien)</p>	<p>Prior Authorization Required</p> <p>LUNESTA (eszopiclone) AMBIEN (zolpidem) - Brand SONATA (zaleplon) EDLUAR (zolpidem)</p>	<p>Non-preferred sedative hypnotics will be approved for clients who have failed treatment with two preferred agents in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)</p> <p>Children: Prior authorizations will be approved for clients 18 years of age and older.</p> <p>Duplications: Only one agent in this drug class will be approved at a time. Approval will not be granted for clients currently taking a long-acting benzodiazepine such as Halcion (Triazolam) or Restoril (temazepam).</p>

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization Criteria
<p>SKELETAL MUSCLE RELAXANTS</p> <p><i>Effective 7/1/09</i></p>	<p>No Prior Authorization Required</p> <p>baclofen (generic Lioresal) cyclobenzaprine (generic Flexeril) dantrolene (generic Dantrium) tizanidine (generic Zanaflex) methocarbamol (generic Robaxin)</p>	<p>Prior Authorization Required</p> <p>AMRIX ER (cyclobenzaprine ER) chlorzoxazone (generic Parafon Forte) DANTRIUM (dantrolene) – Brand FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) – Brand LIORESAL (baclofen) – Brand NORFLEX (orphenadrine) orphenadrine (generic Norflex) PARAFLEX (chlorzoxazone) PARAFON FORTE (chlorzoxazone) REMULAR (chlorzoxazone) ROBAXIN (methocarbamol) – Brand SKELAXIN (metaxalone) ZANAFLEX (tizanidine) – Brand</p> <p>SOMA (carisoprodol), VANADOM (carisoprodol), RELA (carisoprodol)</p>	<p>Non-preferred skeletal muscle relaxants will be approved for clients who have documented lack of efficacy with two preferred agents in the last 6 months. Approval may also be granted for clients who are unable to take preferred products due to allergy, intolerable side effects or significant drug-drug interaction.</p> <p>Authorization for any carisoprodol product will be given for a maximum 3 week one time authorization for clients with acute, painful musculoskeletal conditions who have failed treatment with two Preferred products.</p> <p><u>Tapering:</u> Due to potential withdrawal symptoms, tapering is recommended when discontinuing high doses of carisoprodol. A one month approval will be granted for clients tapering off of carisoprodol.</p> <p>★ A PA will only be granted for any carisoprodol product for short-term use or tapering.</p>
<p>STATINS & STATIN COMBINATIONS</p> <p><i>Effective 4/1/09</i></p>	<p>No Prior Authorization Required</p> <p>CRESTOR (rosuvastatin) LIPITOR (atorvastatin) pravastatin (generic Pravachol) simvastatin (generic Zocor)</p>	<p>Prior Authorization Required</p> <p>ALTOPREV (lovastatin ER) ALTOCOR (lovastatin ER) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) lovastatin (generic Mevacor) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin)</p> <p>Statin Combinations CADUET (amlodipine/atorvastatin) VYTORIN (ezetimibe/simvastatin) ADVICOR (niacin ER/lovastatin) SIMCOR (niacin/simvastatin)</p>	<p>Non-preferred Statin/Statin combinations will be approved if the client has failed treatment with one preferred product in the last 24 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</p> <p>Children: Altoprev, Advicor and Vytorin will be approved for clients 18 years of age and older. Caduet, fluvastatin and lovastatin will be approved for clients 10 years of age and older.</p>

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization Criteria
<p>STIMULANTS and ADHD</p> <p><i>Effective 10/1/2009</i> <i>(see note for mixed-amphetamine XR)</i></p>	<p>No Prior Authorization Required (as long as age limitations are met)</p> <p>CONCERTA dexamethylphenidate (generic Focalin) FOCALIN XR methylphenidate (generic RITALIN) methylphenidate SR (generic for Ritalin SR) mixed-amphetamine salts (generic Adderall) mixed-amphetamine salts XR (generic Adderall XR – effective 11/1/2009) VYVANSE</p>	<p>Prior Authorization Required</p> <p>ADDERALL (brand only) ADDERALL XR (brand) DAYTRANA DEXEDRINE FOCALIN (brand) PROVIGIL METADATE CD METADATE ER RITALIN (brand only) STRATTERA INTUNIV (guanfacine)</p>	<p>Non-preferred agents will be approved for clients who have documented lack of efficacy with two Preferred products in the last 6 months; however, certain exceptions exist for Daytrana, Nuvigil, Provigil and Strattera (see criteria below). Also, clients age 3-5 only need to fail on one Preferred product. Approval may also be granted for clients who are unable to take Preferred products due to allergy, intolerable side effects, contraindications or significant drug-drug interaction.</p> <p>In addition: Non-Preferred agents will only be approved for FDA and official compendium indications.</p> <ul style="list-style-type: none"> ▪ Strattera will be approved for clients with a diagnosis of ADHD and ADD. ▪ Provigil will be approved for Narcolepsy, Obstructive Sleep Apnea/Hypopnea Syndrome, Shift Work Sleep Disorder, Multiple Sclerosis related fatigue or ADHD. ▪ Nuvigil will be approved for obstructive sleep apnea/hypopnea syndrome, narcolepsy and shift work sleep disorder. ▪ All other Non-Preferred products will be approved for clients with a diagnosis of ADD, ADHD, Narcolepsy, Multiple Sclerosis related fatigue, or traumatic brain injury. <p>And Non-Preferred agents will only be approved for FDA approved age limitations.</p> <ul style="list-style-type: none"> ▪ Provigil will be approved for clients 16 years of age and older. ▪ Nuvigil will be approved for clients 17 years of age and older. ▪ Adderall, Dexedrine and Dextrostat will be approved for clients 3 years of age and older. ▪ All other medications in this class will be approved for clients 6 years of age and older. <p>Daytrana: Daytrana will be approved for clients without failure on two Preferred products if the client has difficulty swallowing. Strattera: Clients with ADD or ADHD will not need to fail on two Preferred products if the client also has one of the following conditions: history of substance abuse (or family history of substance abuse), tics, Tourette’s syndrome, anxiety, low weight or OCD. If a client does not have one of these additional conditions, the client will need to fail on two Preferred products. Only one capsule per day per strength will be approved.</p> <p>**CONTINUES ON NEXT PAGE**</p>

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization Criteria
STIMULANTS (cont) <i>Effective 10/1/2009</i>			<p>Nuvigil: Clients will not need to fail on two Preferred products if they meet the FDA approved indications and age limitation. Only one tablet per day will be approved.</p> <p>Provigil: Clients will not need to fail on two Preferred products if they meet the FDA approved indications and age limitation. Only one tablet per day will be approved.</p> <p><u>Grandfathering</u> Clients who have been previously stabilized on a Non-preferred stimulant product can receive approval to continue on the medication, including brand name Adderall XR.</p>
TRIPTANS <i>Effective 1/1/09</i>	No Prior Authorization Required IMITREX tablets, nasal spray and injection sumatriptan tablets, nasal spray and injection (once available) MAXALT tablets MAXALT MLT tablets	Prior Authorization Required AXERT AMERGE FROVA RELPA TREMIMET ZOMIG	Non-preferred products will be approved for clients who have failed treatment with one preferred product within the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) <p>This class will also have quantity limits for the Preferred and Non-preferred products. For more information, please see the Drug Quantity Limits document at: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132</p>