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

Effective October 1, 2008

Prior Authorization Forms: available online at http://www.chcpf.state.co.us/HCPF/Pharmacy/nwPAList.asp

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
ANTIHISTAMINES Newer Generation Antihistamines	**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)	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 *Effective 7/1/08*	**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.

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization Criteria
ANTIHYPERTENSIVES Angiotensin Receptor Blockers (ARBs)	**No Prior Authorization Required** ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) COZAAR (losartan) DIOVAN (valsartan) MICARDIS (telmisartan)	**Prior Authorization Required** TEVETEN (eprosartan)	Non-preferred ARBs, renin inhibitors, and combination products will be approved for clients who have failed treatment with a preferred product. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
ARB Combinations	**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)	
Renin Inhibitors & Renin Inhibitor Combinations *Effective 7/1/08*	**No Prior Authorization Required**	**Prior Authorization Required** TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ)	

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization Criteria
Opioids Long Acting – Oral Opioids *Effective 7/1/08*	**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 a preferred agent in the last three months. **Grandfathering** 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
Proton Pump Inhibitors *Effective 2/1/08*	**No Prior Authorization Required** NEXIUM (esomeprazole) capsules PREVACID (lansoprazole) capsules PREVACID (lansoprazole) solutabs	**Prior Authorization Required** ACIPHEX (rabeprazole) NEXIUM (esomeprazole) packets omeprazole (generic Prilosec) PREVACID (lansoprazole) suspension PREVPAC (lansoprazole, amox, clarithromycin) PRILOSEC OTC (omeprazole) PROTONIX (pantoprazole) ZEGERID (omeprazole/Na bicarbonate)	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 12 months and client has a qualifying diagnosis, diagnosed by an appropriate diagnostic method. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **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 **Diagnosed by:** GI Specialist, Endoscopy, X-Ray, Biopsy, Blood test, or Breath test **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. **Children:** Aciphex, Protonix, and Zegerid will not be approved for clients less than 18 years of age.

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization Criteria
Respiratory Inhalants *Effective 7/1/08* Inhaled Anticholinergics & Anticholinergic Combinations	**No Prior Authorization Required** **Solutions** albuterol/ipratropium (generic Duoneb) ipratropium (generic Atrovent) **Inhalers** ATROVENT HFA (ipratropium) COMBIVENT (albuterol/ipratropium) SPIRIVA Handihaler (tiotropium)	**Prior Authorization Required** **Solutions** ATROVENT (ipratropium) solution DUONEB (albuterol/ipratropium)	Non-preferred anticholinergic inhalants will require a brand-name prior authorization
Inhaled Beta2 Agonists (short acting)	**No Prior Authorization Required** **Solutions** albuterol (generic) solution **Inhalers** MAXAIR (pirbuterol) autohaler PROAIR (albuterol) HFA inhaler PROVENTIL (albuterol) HFA inhaler VENTOLIN (albuterol) HFA inhaler	**Prior Authorization Required** **Solutions** ACCUNEB (albuterol) solution AIRET (albuterol) solution ALUPENT (metaproterenol) solution PROVENTIL (albuterol) solution VENTOLIN (albuterol) solution XOPENEX (levalbuterol) solution **Inhalers** ALUPENT (metaproterenol) Inhaler XOPENEX (levalbuterol) Inhaler	Non-preferred, short acting beta2 agonists will be approved for clients who have failed treatment with a preferred agent. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). **Grandfathering:** Clients currently stabilized on a non-preferred beta2 agonist can receive approval to continue that agent for one year if medically necessary.
Inhaled Beta2 Agonists (long acting)	**No Prior Authorization Required**	**Prior Authorization Required** **Solutions** BROVANA (Arformoterol) solution PERFOROMIST (formoterol) solution **Inhalers** FORADIL (formoterol) inhaler SEREVENT (salmeterol) inhaler	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. **Grandfathering:** Clients currently stabilized on a non-preferred agent can receive approval to continue that agent for one year if medically necessary.

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization Criteria
Respiratory Inhalants (Cont.) Inhaled Corticosteroids	**No Prior Authorization Required** **<u>Solutions</u>** PULMICORT (budesonide) respules **<u>Inhalers</u>** FLOVENT (fluticasone) HFA inhaler FLOVENT (fluticasone) diskus PULMICORT (budesonide) flexhaler QVAR (beclomethasone) inhaler	**Prior Authorization Required** **<u>Inhalers</u>** AEROBID (flunisolide) inhaler ASMANEX (mometasone) twisthaler AZMACORT (triamcinolone) inhaler	Non-preferred inhaled corticosteroids will be approved for clients who have failed treatment with two preferred agents. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions.) **Grandfathering:** Clients currently stabilized on a non-preferred agent can receive approval to continue that agent for one year if medically necessary.
Inhaled Corticosteroid Combinations *Effective 7/1/08*	**No Prior Authorization Required**	**Prior Authorization Required** ADVAIR (fluticasone/salmeterol) Diskus & HFA SYMBICORT (budesonide/formoterol)	Non-preferred corticosteroid combinations will be approved for clients with a diagnosis of asthma or COPD. **Automatic approval will occur when an appropriate diagnosis code is written on the prescription and entered into the pharmacy claim system at the point of sale. **Grandfathering:** Clients currently stabilized on a non-preferred agent can receive approval to continue that agent for one year if medically necessary.

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization Criteria
Sedative-Hypnotics (non-benzodiazepine) *Effective 4/1/08*	**No Prior Authorization Required** LUNESTA (eszopiclone) ROZEREM (ramelteon) zolpidem (generic Ambien)	**Prior Authorization Required** AMBIEN (zolpidem) - Brand AMBIEN CR (zolpidem) SONATA (zaleplon)	Non-preferred sedative hypnotics will be approved for clients who have failed treatment with two preferred agents in the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **<u>Children:</u>** Prior authorizations will be approved for clients 18 years of age and older. **<u>Quantity Limits:</u>** Brand name Ambien, generic Ambien, and Sonata will only be approved for 14 tablets per months. **<u>Duplications:</u>** 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).

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization Criteria
Skeletal Muscle Relaxants *Effective 7/1/08*	**No Prior Authorization Required** baclofen (generic Lioresal) cyclobenzaprine (generic Flexeril) dantrolene (generic Dantrium) tizanidine (generic Zanaflex) methocarbamol (generic Robaxin)	**Prior Authorization Required** AMRIX ER (cyclobenzaprine ER) DANTRIUM (dantrolene) – Brand FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) – Brand LIORESAL (baclofen) – Brand NORFLEX (orphenadrine) PARAFLEX (chlorzoxazone) PARAFON FORTE (chlorzoxazone) RELA (carisoprodol) REMULAR (chlorzoxazone) ROBAXIN (methocarbamol) – Brand SKELAXIN (metaxalone) VANADOM (carisoprodol) ZANAFLEX (tizanidine) – Brand SOMA (carisoprodol) – PA will only be granted for short-term use or tapering.	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. Authorization for carisoprodol 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. **<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.
Therapeutic Drug Class	**Preferred Agents**	**Non-Preferred Agents**	**Prior Authorization Criteria**
Statins & Statin Combinations *Effective 4/1/08*	**No Prior Authorization Required** CRESTOR (rosuvastatin) LIPITOR (atorvastatin) pravastatin (generic Pravachol)	**Prior Authorization Required** ALTOPREV (lovastatin ER) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) lovastatin (generic Mevacor) MEVACOR (lovastatin) PRAVACHOL (pravastatin) Brand simvastatin (generic Zocor) ZOCOR (simvastatin) **Statin Combinations** CADUET (amlodipine/atorvastatin) VYTORIN (ezetimibe/simvastatin) ADVICOR (niacin ER/lovastatin)	Non-preferred statins or statin combinations will be approved for clients who have failed Lipitor or Crestor for a period of at least three months at the maximum dose (Lipitor 80mg or Crestor 40mg) unless the client experienced intolerable side effects or a contraindication exists. Non-preferred statins will be approved for clients who have failed any dose of Pravastatin for a period of at least three months unless the client experienced intolerable side effects or a contraindication exists. **Children:** Altoprev, Advicor and Vytorin will be approved for clients 18 years of age and older. Caduet, fluvastatin, lovastatin and simvastatin will be approved for clients 10 years of age and older. **Grandfathering:** Clients currently stabilized on a non-preferred statin or statin combination can receive approval to continue that agent for one year if medically necessary.

Stimulants *Effective 10/1/2008*	**No Prior Authorization Required** **CONCERTA** **VYVANSE** **ADDERALL XR** **FOCALIN XR** **amphetamine (generic ADDERALL)** **methylphenidate (generic RITALIN)**	**Prior Authorization Required** **PROVIGIL** **STRATTERA** **DEXEDRINE** **FOCALIN** **MEDTADATE CD** **DAYTRANA** **METADATE ER** **RITALIN (brand only)** **ADDERALL (brand only)**	Non-preferred stimulants 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 Provigil and Strattera. Please see the criteria below for Provigil and Strattera. 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. In addition: Non-Preferred agents will only be approved for FDA and official compendium indications. ▪ 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. ▪ Daytrana will be approved for clients who have difficulty swallowing and a diagnosis of ADD, ADHD, Narcolepsy, Multiple Sclerosis related fatigue, or traumatic brain injury. ▪ 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. And Non-Preferred agents will only be approved for FDA approved age limitations. ▪ Provigil will be approved for clients 16 years of age and older. ▪ Adderall, Adderall XR, 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. **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, tics, Tourette's syndrome, anxiety or OCD. If a client does not have one of these additional conditions, the client will need to fail on two Preferred products. **Provigil:** Clients will not need to fail on two Preferred products if they meet the FDA approved indications and age limitation. **<u>Grandfathering</u>** Clients who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication.