



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

Effective January 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	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 <i>Effective 7/1/08</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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<p>ANTIHYPERTENSIVES</p> <p>Angiotensin Receptor Blockers (ARBs)</p> <p>ARB Combinations</p> <p>Renin Inhibitors & Renin Inhibitor Combinations</p> <p><i>Effective 7/1/08</i></p>	<p>No Prior Authorization Required</p> <p>ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) COZAAR (losartan) DIOVAN (valsartan) MICARDIS (telmisartan)</p> <p>No Prior Authorization Required</p> <p>ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) BENICAR-HCT (olmesartan/HCTZ) HYZAAR-HCT (losartan/HCTZ) DIOVAN-HCT (valsartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ)</p> <p>No Prior Authorization Required</p>	<p>Prior Authorization Required</p> <p>TEVETEN (eprosartan)</p> <p>Prior Authorization Required</p> <p>TEVETEN-HCT (eprosartan/HCTZ)</p> <p>Prior Authorization Required</p> <p>TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ)</p>	<p>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.)</p>

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<p>OPIOIDS Long Acting – Oral Opioids</p> <p><i>Effective 7/1/08</i></p>	<p>No Prior Authorization Required</p> <p>KADIAN (morphine ER) methadone (generic Dolophine) morphine ER (generic MS Contin)</p>	<p>Prior Authorization Required</p> <p>AVINZA (morphine ER) DOLOPHINE (methadone) - Brand MS CONTIN (morphine ER) - Brand ORAMORPH SR (morphine ER) - Brand OXYCONTIN (oxycodone ER) OPANA ER (oxymorphone ER)</p>	<p>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.</p> <p>Grandfathering Clients who are currently stabilized on a non-preferred, long-acting opioid may be approved to continue therapy with that agent.</p>
<p>PRONTON 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) NEXIUM (esomeprazole) packets NEXIUM (esomeprazole) capsules omeprazole (generic Prilosec) PREVACID (lansoprazole) suspension PROTONIX (pantoprazole) ZEGERID (omeprazole/Na bicarbonate)</p> <p>PREVPAC (lansoprazole, amoxicillin and clarithromycin)</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. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</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>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria
RESPIRATORY INHALANTS <i>Effective 7/1/08</i> Inhaled Anticholinergics & Anticholinergic Combinations	<p align="center">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 align="center">Prior Authorization Required</p> <p>Solutions ATROVENT (ipratropium) solution DUONEB (albuterol/ipratropium)</p>	<p>Non-preferred anticholinergic inhalants will require a brand-name prior authorization</p>
Inhaled Beta2 Agonists (short acting)	<p align="center">No Prior Authorization Required</p> <p>Solutions albuterol (generic) solution</p> <p>Inhalers MAXAIR (pirbuterol) autohaler PROAIR (albuterol) HFA inhaler PROVENTIL (albuterol) HFA inhaler VENTOLIN (albuterol) HFA inhaler</p>	<p align="center">Prior Authorization Required</p> <p>Solutions ACCUNEB (albuterol) solution AIRET (albuterol) solution ALUPENT (metaproterenol) solution PROVENTIL (albuterol) solution VENTOLIN (albuterol) solution XOPENEX (levalbuterol) solution</p> <p>Inhalers ALUPENT (metaproterenol) Inhaler XOPENEX (levalbuterol) Inhaler</p>	<p>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).</p> <p>Grandfathering: Clients currently stabilized on a non-preferred beta2 agonist can receive approval to continue that agent for one year if medically necessary.</p>
Inhaled Beta2 Agonists (long acting)	<p align="center">No Prior Authorization Required</p>	<p align="center">Prior Authorization Required</p> <p>Solutions BROVANA (Arformoterol) solution PERFOROMIST (formoterol) solution</p> <p>Inhalers 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 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.)</p> <p>Inhaled Corticosteroids</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) 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 two preferred agents. (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>
<p>Inhaled Corticosteroid Combinations</p> <p><i>Effective 7/1/08</i></p>	<p>No Prior Authorization Required</p>	<p>Prior Authorization Required</p> <p>ADVAIR Diskus & HFA (fluticasone/salmeterol)</p> <p>SYMBICORT (budesonide/formoterol)</p>	<p>Non-preferred corticosteroid combinations will be approved for clients with a diagnosis of asthma or COPD.</p> <p>**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.</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>
<p>SEDATIVE- HYPNOTICS (non-benzodiazepine)</p> <p><i>Effective 4/1/08</i></p>	<p>No Prior Authorization Required</p> <p>LUNESTA (eszopiclone) ROZEREM (ramelteon) zolpidem (generic Ambien)</p>	<p>Prior Authorization Required</p> <p>AMBIEN (zolpidem) - Brand AMBIEN CR (zolpidem) SONATA (zaleplon)</p>	<p>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)</p> <p>Children: Prior authorizations will be approved for clients 18 years of age and older.</p> <p>Quantity Limits: Brand name Ambien, generic Ambien, and Sonata will only be approved for 14 tablets per months.</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 7/1/08</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) DANTRIUM (dantrolene) – Brand FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) – Brand LIORESAL (baclofen) – Brand NORFLEX (orphenadrine) PARAFLEX (chlorzoxazone) PARAFON FORTE (chlorzoxazone) REMULAR (chlorzoxazone) ROBAXIN (methocarbamol) – Brand SKELAXIN (metaxalone) ZANAFLEX (tizanidine) – Brand</p> <p>SOMA (carisoprodol), VANADOM (carisoprodol), RELA (carisoprodol) – A PA will only be granted for short-term use or tapering.</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>STATINS & STATIN COMBINATIONS</p> <p><i>Effective 4/1/08</i></p>	<p>No Prior Authorization Required</p> <p>CRESTOR (rosuvastatin) LIPITOR (atorvastatin) pravastatin (generic Pravachol)</p>	<p>Prior Authorization Required</p> <p>ALTOPREV (lovastatin ER) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) lovastatin (generic Mevacor) MEVACOR (lovastatin) PRAVACHOL (pravastatin) Brand simvastatin (generic Zocor) ZOCOR (simvastatin)</p> <p>Statin Combinations CADUET (amlodipine/atorvastatin) VYTORIN (ezetimibe/simvastatin) ADVICOR (niacin ER/lovastatin)</p>	<p>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.</p> <p>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.</p> <p>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.</p>

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization Criteria
<p>STIMULANTS</p> <p><i>Effective 10/1/2008</i></p>	<p>No Prior Authorization Required</p> <p>CONCERTA VYVANSE ADDERALL XR FOCALIN XR amphetamine (generic ADDERALL) methylphenidate (generic RITALIN)</p>	<p>Prior Authorization Required</p> <p>PROVIGIL STRATTERA DEXEDRINE FOCALIN METADATE CD DAYTRANA METADATE ER RITALIN (brand only) ADDERALL (brand only)</p>	<p>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.</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. ▪ 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. <p>And</p> <p>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. ▪ 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. <p>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.</p> <p>Provigil: Clients will not need to fail on two Preferred products if they meet the FDA approved indications and age limitation.</p>

			<p>Grandfathering Clients who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication.</p>
Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization Criteria
<p>TRIPTANS <i>Effective 1/1/09</i></p>	<p>No Prior Authorization Required</p> <p>IMITREX tablets, nasal spray and injection sumatriptan tablets, nasal spray and injection (once available) MAXALT tablets MAXALT MLT tablets</p>	<p>Prior Authorization Required</p> <p>AXERT AMERGE FROVA RELMAX ZOMIG TREMIMET</p>	<p>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> <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>