



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

Effective July 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) 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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<p>ANTIHYPERTENSIVES</p> <p>Angiotensin Receptor Blockers (ARBs)</p> <p>ARB Combinations</p> <p>Renin Inhibitors & Renin Inhibitor Combinations</p> <p><i>Effective 7/1/09</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) AZOR (amlodipine/olmesartan) EXFORGE (amlodipine/valsartan)</p> <p>Prior Authorization Required</p> <p>TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ)</p>	<p>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.)</p>

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GROWTH HORMONES <i>Effective 4/1/09</i>	No Prior Authorization Required GENOTROPIN NORDITROPIN TEV-TROPIN	Prior Authorization Required HUMATROPE NUTROPIN OMNITROPE SAIZEN SEROSTIM ZORBTIVE	Non-preferred Growth Hormones will be approved if both of the following criteria are met: <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><u>Grandfathering</u> Clients who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication.</p>
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). <p>★Rhinocort AQ will be approved for pregnant clients without failure of Preferred products.</p>
LEUKOTRIENE MODIFIERS <i>Effective 4/1/09</i>	No Prior Authorization Required SINGULAIR	Prior Authorization Required ACCOLATE	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

		ZYFLO	<p>months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</p> <ul style="list-style-type: none"> Client has a diagnoses of Asthma
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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.
PROTON PUMP INHIBITORS <i>Effective 1/1/09</i>	No Prior Authorization Required PREVACID (lansoprazole) capsules PREVACID (lansoprazole) solutabs PRILOSEC OTC (omeprazole)	Prior Authorization Required ACIPHEX (rabeprazole) KAPIDEX (dexlansoprazole) NEXIUM (esomeprazole) packets NEXIUM (esomeprazole) capsules omeprazole (generic Prilosec) PREVACID (lansoprazole) suspension 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 24 months and client has a qualifying diagnosis, diagnosed by an appropriate diagnostic method. <u>Qualifying Diagnoses:</u> 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 <u>Diagnosed by:</u> GI Specialist, Endoscopy, X-Ray, Biopsy, Blood test, or Breath

		PREVPAC HELIDAC	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 <i>Effective 7/1/09</i> 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 and anticholinergic combination inhalants will require a brand-name prior authorization.
Inhaled Beta2 Agonists (short acting)	No Prior Authorization Required Solutions albuterol (generic) solution Inhalers 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 MAXAIR (pirbuterol) autohaler	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). 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>Inhaled Beta2 Agonists (long acting)</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>Therapeutic Drug Class</p>	<p>Preferred Agents</p>	<p>Non-Preferred Agents</p>	<p>Prior Authorization Criteria</p>
<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) 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>
<p>Inhaled Corticosteroid Combinations <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)</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>Tapering: 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</p>	<p>No Prior Authorization Required</p>	<p>Prior Authorization Required</p>	<p>Non-preferred Statin/Statin combinations will be approved if the</p>

<p>COMBINATIONS</p> <p><i>Effective 4/1/09</i></p>	<p>CRESTOR (rosuvastatin) LIPITOR (atorvastatin) pravastatin (generic Pravachol) simvastatin (generic Zocor)</p>	<p>ALTOPREV (lovastatin ER) ALTOCOR (lovastatin ER) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) lovastatin (generic Mevacor) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin) Statin Combinations CADUET (amlodipine/atorvastatin) VYTORIN (ezetimibe/simvastatin) ADVICOR (niacin ER/lovastatin) SIMCOR (niacin/simvastatin)</p>	<p>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>
<p>Therapeutic Drug Class</p>	<p>Preferred Agents</p>	<p>Non-Preferred Agents</p>	<p>Prior Authorization Criteria</p>
<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>ADDERALL (brand only) DAYTRANA DEXEDRINE dexmethylphenidate (generic Focalin) FOCALIN PROVIGIL METADATE CD METADATE ER RITALIN (brand only) STRATTERA</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. 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, 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.</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
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 RELPAX TREXIMET 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) 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