



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

Effective July 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
<b>ANTIHISTAMINES</b> Newer Generation Antihistamines	<b>No Prior Authorization Required</b>  loratadine (generic OTC Claritin) cetirizine (generic OTC Zyrtec)	<b>Prior Authorization Required</b>  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>	<b>No Prior Authorization Required</b>	<b>Prior Authorization Required</b>  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
<p><b>ANTIHYPERTENSIVES</b></p> <p>Angiotensin Receptor Blockers (ARBs)</p> <p>ARB Combinations</p> <p>Renin Inhibitors &amp; Renin Inhibitor Combinations</p> <p><i>Effective 7/1/08</i></p>	<p><b>No Prior Authorization Required</b></p> <p>ATACAND (candesartan)  AVAPRO (irbesartan)  BENICAR (olmesartan)  COZAAR (losartan)  DIOVAN (valsartan)  MICARDIS (telmisartan)</p> <p><b>No Prior Authorization Required</b></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><b>No Prior Authorization Required</b></p>	<p><b>Prior Authorization Required</b></p> <p>TEVETEN (eprosartan)</p> <p><b>Prior Authorization Required</b></p> <p>TEVETEN-HCT (eprosartan/HCTZ)</p> <p><b>Prior Authorization Required</b></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>
Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization Criteria
<p><b>Opioids</b></p> <p>Long Acting – Oral Opioids</p> <p><i>Effective 7/1/08</i></p>	<p><b>No Prior Authorization Required</b></p> <p>KADIAN (morphine ER)  methadone (generic Dolophine)  morphine ER (generic MS Contin)</p>	<p><b>Prior Authorization Required</b></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><b>Grandfathering</b>  Clients who are currently stabilized on a non-preferred, long-acting opioid may be approved to continue therapy with that agent.</p>

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization Criteria
<p><b>Proton Pump Inhibitors</b></p> <p><i>Effective 2/1/08</i></p>	<p><b>No Prior Authorization Required</b></p> <p>NEXIUM (esomeprazole) capsules  PREVACID (lansoprazole) capsules  PREVACID (lansoprazole) solutabs</p>	<p><b>Prior Authorization Required</b></p> <p>ACIPHEX (rabeprazole)  NEXIUM (esomeprazole) packets</p> <p>omeprazole (generic Prilosec)</p> <p>PREVACID (lansoprazole) suspension  PREVPAC  (lansoprazole, amox, clarithromycin)  PRILOSEC OTC (omeprazole)  PROTONIX (pantoprazole)  ZEGERID (omeprazole/Na bicarbonate)</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 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)</p> <p><b><u>Qualifying Diagnoses:</u></b>  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><b><u>Diagnosed by:</u></b>  GI Specialist, Endoscopy, X-Ray, Biopsy, Blood test, or Breath test</p> <p><b><u>Quantity Limits:</u></b>  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><b><u>Children:</u></b> 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
<b>Respiratory Inhalants</b>  Inhaled Anticholinergics & Anticholinergic Combinations	<b>No Prior Authorization Required</b>  <u>Solutions</u> albuterol/ipratropium (generic Duoneb) ipratropium (generic Atrovent)  <u>Inhalers</u> ATROVENT HFA (ipratropium) COMBIVENT (albuterol/ipratropium) SPIRIVA Handihaler (tiotropium)	<b>Prior Authorization Required</b>  <u>Solutions</u> ATROVENT (ipratropium) solution DUONEB (albuterol/ipratropium)	Non-preferred anticholinergic inhalants will require a brand-name prior authorization
Inhaled Beta2 Agonists (short acting)	<b>No Prior Authorization Required</b>  <u>Solutions</u> albuterol (generic) solution  <u>Inhalers</u> MAXAIR (pirbuterol) autohaler PROAIR (albuterol) HFA inhaler PROVENTIL (albuterol) HFA inhaler VENTOLIN (albuterol) HFA inhaler	<b>Prior Authorization Required</b>  <u>Solutions</u> ACCUNEB (albuterol) solution AIRET (albuterol) solution ALUPENT (metaproterenol) solution PROVENTIL (albuterol) solution VENTOLIN (albuterol) solution XOPENEX (levalbuterol) solution  <u>Inhalers</u> 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).  <b>Grandfathering:</b> 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)  <i>Effective 7/1/08</i>	<b>No Prior Authorization Required</b>	<b>Prior Authorization Required</b>  <u>Solutions</u> BROVANA (Arformoterol) solution PERFORMIST (formoterol) solution  <u>Inhalers</u> 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.  <b>Grandfathering:</b> 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
<b>Respiratory Inhalants (Cont.)</b>  Inhaled Corticosteroids	<b>No Prior Authorization Required</b>  <u>Solutions</u> PULMICORT (budesonide) respules  <u>Inhalers</u> FLOVENT (fluticasone) HFA inhaler FLOVENT (fluticasone) diskus PULMICORT (budesonide) flexhaler QVAR (beclomethasone) inhaler	<b>Prior Authorization Required</b>  <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.)  <b>Grandfathering:</b> Clients currently stabilized on a non-preferred agent can receive approval to continue that agent for one year if medically necessary.
Inhaled Corticosteroid Combinations  <i>Effective 7/1/08</i>	<b>No Prior Authorization Required</b>	<b>Prior Authorization Required</b>  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.  <b>Grandfathering:</b> 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
<b>Sedative-Hypnotics</b> (non-benzodiazepine)  <i>Effective 4/1/08</i>	<b>No Prior Authorization Required</b>  LUNESTA (eszopiclone) ROZEREM (ramelteon) zolpidem (generic Ambien)	<b>Prior Authorization Required</b>  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)  <b>Children:</b> Prior authorizations will be approved for clients 18 years of age and older.  <b>Quantity Limits:</b> Brand name Ambien, generic Ambien, and Sonata will only be approved for 14 tablets per months.  <b>Duplications:</b> 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  <i>Effective 7/1/08</i>	<b>No Prior Authorization Required</b>  baclofen (generic Lioresal) cyclobenzaprine (generic Flexeril) dantrolene (generic Dantrium) tizanidine (generic Zanaflex) methocarbamol (generic Robaxin)	<b>Prior Authorization Required</b>  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) SOMA (carisoprodol) VANADOM (carisoprodol) ZANAFLEX (tizanidine) – Brand	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 of 3 weeks for clients with acute, painful musculoskeletal conditions who have failed treatment with two preferred products.  <b><u>Tapering:</u></b> 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  <i>Effective 4/1/08</i>	<b>No Prior Authorization Required</b>  CRESTOR (rosuvastatin) LIPITOR (atorvastatin) pravastatin (generic Pravachol)	<b>Prior Authorization Required</b>  ALTOPREV (lovastatin ER) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) lovastatin (generic Mevacor) MEVACOR (lovastatin) PRAVACHOL (pravastatin) Brand simvastatin (generic Zocor) ZOCOR (simvastatin)  <b>Statin Combinations</b> 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.  <b>Children:</b> 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.  <b>Grandfathering:</b> Clients currently stabilized on a non-preferred statin or statin combination can receive approval to continue that agent for one year if medically necessary.