

# Q3 2025 preferred drug list updates

## Rocky Mountain Health Plans

**Effective July 1, 2025**, we're making the following changes to the UnitedHealthcare Community Plan of Colorado Rocky Mountain Health Plans preferred drug list (PDL). Our Pharmacy and Therapeutics Committee updates this PDL quarterly.

### New medications on PDL

Medication	Description
<b>Accu-Chek® Aviva, Guide Glucose Meters and Test Strips</b>	Indicated for the monitoring of blood glucose control.
<b>Adbry® injection</b>	Indicated for the treatment of moderate-to-severe atopic dermatitis. <b>We require prior authorization.</b>
<b>Contour® Next meters and test strips, Contour® Plus Blue meters and Contour® Plus test strips</b>	Indicated for the monitoring of blood glucose control.
<b>estradiol/norethindrone tablets</b>	Indicated for the treatment of vasomotor symptoms, severe vulvar and vaginal atrophy due to menopause, or prevention of postmenopausal osteoporosis.
<b>epinephrine 0.15 mg and 0.3 mg injection</b>	Indicated in the emergency treatment of allergic reactions including anaphylaxis.
<b>lamotrigine ER tablets</b>	Indicated as adjunctive therapy for primary generalized tonic-clonic seizures and partial-onset seizures.
<b>levetiracetam ER tablets</b>	Indicated as adjunctive therapy for primary generalized tonic-clonic seizures and partial-onset seizures.
<b>methadone 5 mg and 10 mg tablets</b>	Indicated for the management of pain. <b>We require prior authorization.</b>
<b>ethinyl estradiol/norethindrone tablets</b>	Indicated for the treatment of vasomotor symptoms, severe vulvar and vaginal atrophy due to menopause, or prevention of postmenopausal osteoporosis.

## New medications on PDL (cont.)

Medication	Description
<b>olanzapine orally disintegrating tablets</b>	Indicated for the treatment of schizophrenia, manic or mixed episodes associated with bipolar disorder, and maintenance of bipolar disorder.
<b>paliperidone ER tablets</b>	Indicated for the acute and maintenance treatment of schizophrenia and schizoaffective disorder.
<b>risperidone orally disintegrating tablets</b>	Indicated for the treatment of schizophrenia or acute manic or mixed episodes associated with bipolar disorder.
<b>Sogroya® injection</b>	Indicated for replacement of endogenous growth hormone in adults with growth hormone deficiency. <b>We require prior authorization.</b>

## Changes to coverage

Medication	Description
<b>benznidazole tablets</b>	Indicated in pediatric patients for the treatment of Chagas disease. <b>We'll no longer require a diagnosis check.</b>
<b>clobazam tablets and suspension</b>	Indicated for adjunctive treatment of seizures associated with Lennox-Gastaut syndrome. <b>We'll no longer require a diagnosis check.</b>
<b>lacosamide tablets</b>	Indicated for the treatment of partial-onset seizures or primary generalized tonic-clonic seizures. <b>We'll no longer require prior authorization.</b>
<b>sevelamer carbonate tablets</b>	Indicated for the control of serum phosphorus in patients with chronic kidney disease on dialysis. <b>We'll no longer require step therapy.</b>

## Medication no longer on PDL

We're removing the following medication(s) from our PDL.

Medication	Description
<b>Dhivy® tablets</b>	Indicated for the treatment of Parkinson's disease, post-encephalitic parkinsonism and symptomatic parkinsonism. Alternatives include generic carbidopa and levodopa tablet. <b>We require prior authorization.</b>
<b>Duavee® tablets</b>	Indicated for the treatment of vasomotor symptoms due to menopause, or prevention of postmenopausal osteoporosis. Alternatives include preferred generic estrogen products. <b>We require prior authorization.</b>
<b>oxymorphone ER tablets</b>	Indicated for the relief of moderate to severe pain. Alternatives include generic morphine sulfate ER tablets, which require prior authorization. <b>We require prior authorization.</b>
<b>Premarin® tablets</b>	Indicated for the treatment of vasomotor symptoms, severe vulvar and vaginal atrophy due to menopause, or prevention of postmenopausal osteoporosis. Alternatives include preferred generic estrogen products. <b>We require prior authorization.</b>
<b>Premphase® tablets</b>	Indicated for the treatment of vasomotor symptoms, severe vulvar and vaginal atrophy due to menopause, or prevention of postmenopausal osteoporosis. Alternatives include preferred generic estrogen products. <b>We require prior authorization.</b>
<b>Prempro® tablets</b>	Indicated for the treatment of vasomotor symptoms, severe vulvar and vaginal atrophy due to menopause, or prevention of postmenopausal osteoporosis. Alternatives include preferred generic estrogen products. <b>We require prior authorization.</b>

## Medication no longer on PDL (cont.)

<b>Unithroid® tablets</b>	Indicated as replacement therapy for hypothyroidism. Alternative includes generic levothyroxine tablets. <b>We require prior authorization.</b>
<b>Vandazole® 0.75% gel</b>	Indicated for the treatment of bacterial vaginosis. Alternative includes generic metronidazole 0.75% vaginal gel. <b>We require prior authorization.</b>



### Medication alternatives

We may cover medication alternatives for medications not on our PDL. If you feel a medication alternative is medically appropriate for a patient, and you'd like to prescribe it, please do one of the following:

- Submit an electronic prescription using Optum Rx® ePrescribe
  - For more information, visit [Electronic Prescribing \(eRx\) to Optum Home Delivery](#) at [optum.com](https://optum.com)
- Write a new prescription and give it to your patient (where state regulations permit)

If a preferred alternative medication isn't medically appropriate for a patient, please request a PDL prior authorization exception by calling Optum Rx prescriber prior authorization at **800-310-6826**. If the medication meets our medical necessity criteria, we'll continue to cover it for that patient.



### More information

You can also view the changes on our [Pharmacy Resources and Physician Administered Drugs](#) page in the [Prescription Drug Lists, Drug Search and Updates](#) section.



### Questions?

If you have questions, call the Optum Rx pharmacy prior authorization line at **800-310-6826**.