

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
Accu-Chek® Aviva, Guide Glucose Meters and Test Strips	Indicated for the monitoring of blood glucose control.
Adbry® injection	Indicated for the treatment of moderate-to-severe atopic dermatitis. We require prior authorization.
Contour® Next meters and test strips, Contour® Plus Blue meters and Contour® Plus test strips	Indicated for the monitoring of blood glucose control.
estradiol/norethindrone tablets	Indicated for the treatment of vasomotor symptoms, severe vulvar and vaginal atrophy due to menopause, or prevention of postmenopausal osteoporosis.
epinephrine 0.15 mg and 0.3 mg injection	Indicated in the emergency treatment of allergic reactions including anaphylaxis.
lamotrigine ER tablets	Indicated as adjunctive therapy for primary generalized tonic-clonic seizures and partial-onset seizures.
levetiracetam ER tablets	Indicated as adjunctive therapy for primary generalized tonic-clonic seizures and partial-onset seizures.
methadone 5 mg and 10 mg tablets	Indicated for the management of pain. We require prior authorization.
ethinyl estradiol/norethindrone tablets	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
olanzapine orally disintegrating tablets	Indicated for the treatment of schizophrenia, manic or mixed episodes associated with bipolar disorder, and maintenance of bipolar disorder.
paliperidone ER tablets	Indicated for the acute and maintenance treatment of schizophrenia and schizoaffective disorder.
risperidone orally disintegrating tablets	Indicated for the treatment of schizophrenia or acute manic or mixed episodes associated with bipolar disorder.
Sogroya® injection	Indicated for replacement of endogenous growth hormone in adults with growth hormone deficiency. We require prior authorization.

Changes to coverage

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

Medication no longer on PDL

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

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

Medication no longer on PDL (cont.)

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



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](#)
- 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**.