Drug Utilization Review (DUR) Newsletter

COLORADO
Department of Health Care Policy & Financing

Select HCPF Medication Use Policy Updates

WINTER 2025

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The Chronic Pain Centers of Excellence

Stacey Hollen, PharmD, Pain Management Specialist
Judy Mooney, HCPF Chronic Pain Referral Coordinator

❖ The Problem

Since 2023, sixteen pain clinics have closed across the State of Colorado

Widespread pain clinic closures, limited specialist availability, and the complexities of opioid stewardship remain central challenges for prescribers caring for patients with chronic pain.

Primary care clinicians often must balance limited visit time, fragmented resources, and patient expectations with evolving evidence and safety concerns.

❖ The Solution

To support this work, a Chronic Pain Centers of Excellence initiative has been developed by Health First Colorado in partnership with University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences.

This program combines rapid-access clinical consultation, focused education, and connection to care to optimize chronic pain management and reduce opioid-related risk for Medicaid members across the care continuum.

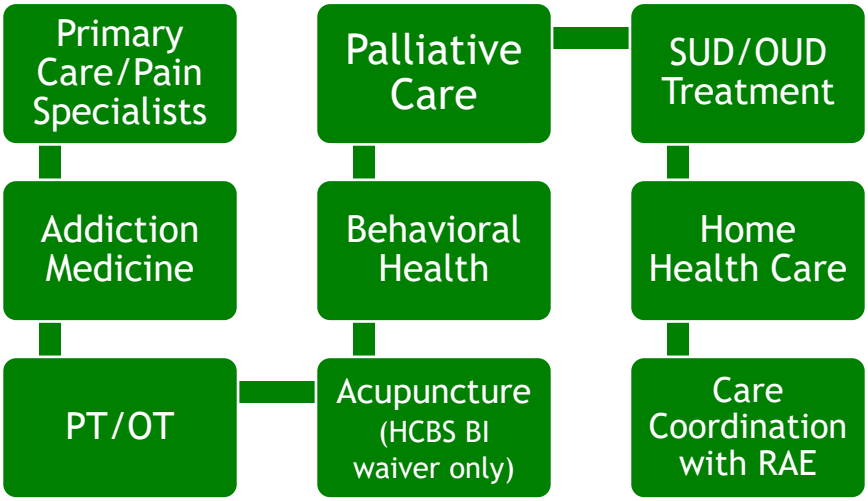
❖ Program Overview

The Chronic Pain Centers of Excellence is designed to enhance—not replace—care delivered in primary care and other outpatient settings. The goals of the program include:

- Improving access to evidence-based pain management for patients with chronic pain
- Supporting clinicians with appropriate opioid prescribing, risk mitigation, and tapering through coordinated peer-to-peer consults with pain management specialists
- Strengthening regional collaboration among prescribers and stakeholders
- Connection to care for patients with chronic pain → see **Figure 1** on Page 2

Centers of Excellence, continued from Page 1

Figure 1. Connection to care for patients with chronic pain



PT = physical therapy, OT = occupational therapy, HCBS BI = Home and Community Based Services Brain Injury, SUD = substance use disorder, OUD = opioid use disorder, RAE = Regional Accountable Entity

Central program components include curbside consults, formal referrals, and targeted provider education including CE/CME accredited on-demand webinars.

❖ **Rapid Clinical Support: Curbside Consults and Referrals**

A key feature of the program is timely access to pain and opioid expertise. To date, **95 referrals and consults** have been completed for Health First Colorado members with chronic pain.

These consults are designed to be practical and immediately actionable, and may include:

- Assistance with treatment planning for patients on long-term opioid therapy or complex, high-dose regimens
- Guidance on opioid tapering, opioid transitioning/rotation, or safe discontinuation
- Introducing or optimizing multimodal pain treatment strategies (including non-opioid and non-pharmacologic modalities)
- Expanding access to non-pharmacologic pain interventions such as physical therapy (PT), occupational therapy (OT), and behavioral health services
- Risk mitigation recommendations for significant medical or psychiatric comorbidities, polypharmacy management (such as concurrent benzodiazepines, sedatives, or muscle relaxants), and/or increased monitoring intensity (PDMP checks, naloxone co-prescribing, and follow-up frequency, for example)
- Support in treating/referring patients with co-occurring behavioral health or substance use concerns

Structured, peer-to-peer clinical reviews help normalize complex opioid decision making as a shared responsibility, reducing the sense of isolation many prescribers experience when managing patients on high-risk opioid regimens.

The intent is to keep the primary prescriber at the center of care while providing real-time input that can be implemented within existing clinic workflows.

Centers of Excellence, continued from Page 2

❖ **Education and Opioid Stewardship**

The Centers of Excellence program emphasizes scalable, clinician-focused CE and CME accredited education on pain management and opioid safety.

- Ten live and ongoing on-demand webinars on opioid safety and pain management reaching 241 providers across the state of Colorado
- Topics covered: safe opioid prescribing, tapering approaches, integrating non-opioid therapies, risk mitigation, and a 2022 CDC Opioid Guideline deep dive
- One-on-one education with case-specific consultation and coaching

This dual strategy, **broad-based educational webinars** plus **individualized support**, allows clinicians to update their knowledge and immediately apply it to challenging real-world cases.

❖ **Stakeholder Outreach and Program Promotion**

To ensure that clinicians know how to access these resources, the team has undertaken extensive outreach and relationship-building.

- 49 meetings have been held with a wide range of partners
- Over 600 stakeholders have engaged with the program, including Health First Colorado members, primary care providers, specialists, behavioral health clinicians and community organizations, including those located in rural areas with access to limited resources

These efforts have increased awareness about how to quickly and easily initiate curbside consults, request referrals, and access available educational offerings. Rather than a series of disconnected clinic-level efforts, this broad engagement is helping to build a more coordinated regional approach to chronic pain and opioid safety.

❖ **Illustrative High-Impact Cases**

De-identified examples demonstrate how the program can change care trajectories for patients with complex clinical scenarios:

Case 1: High-Dose Opioids and Frequent Emergency Department (ED) Utilization

A patient with chronic low back pain had been on escalating doses of short-acting opioids for years, with concurrent sedating medications and frequent ED visits for pain crises.

- The prescriber requested a curbside consult for guidance on how to safely modify therapy.
- The Centers of Excellence team recommended a gradual opioid taper, consolidation of medications, and initiation of non-opioid agents plus physical therapy.
- Behavioral health was engaged to address anxiety and coping strategies during the taper.
- Over several months, the member's total opioid dose decreased, ED utilization declined, and the prescriber reported greater confidence in managing similar cases.

Centers of Excellence, continued from Page 3

Case 2: Chronic Pain with Co-Occurring Substance Use Risk

A member with musculoskeletal pain and a history suggestive of opioid misuse was reviewed.

- The recommendation was to transition from full agonist opioids to buprenorphine for analgesia and risk reduction, alongside structured functional goal-setting.
- The primary prescriber received one-on-one support on induction, dosing, and follow-up.
- With this change, the patient demonstrated more stable pain control, fewer early refill requests, and improved engagement in care.

These examples highlight how a structured, team-based model can support prescribers in making complex changes that might otherwise feel difficult to initiate.

❖ **What Makes This Program Unique**

Several features distinguish the Chronic Pain Centers of Excellence model:

- Low-barrier curbside access for rapid, case-specific clinical input
- Longitudinal follow-up for members (not a "one-and-done" program)
- Blended education strategy (webinars plus individualized coaching)
- Support for members and providers in rural areas where resources are limited
- Strong regional collaboration and outreach
- Connection to resources for Health First Colorado eligibility and benefit concerns

Together, these elements are designed to support clinicians in delivering safer, evidence-based chronic pain care within existing practice constraints

❖ **Projects in the Pipeline**

Building on current work, the program is exploring additional initiatives, including:

- Deepening behavioral health integration for patients with chronic pain and co-occurring mental health conditions or substance use disorders
- Developing targeted educational modules, such as buprenorphine use for chronic pain, perioperative management for patients on long-term opioid therapy, or DEA case review
- Enhancing data and outcomes tracking related to prescribing patterns, safety events, function, and quality of life
- Decreasing Emergency Department utilization for chronic pain-related management

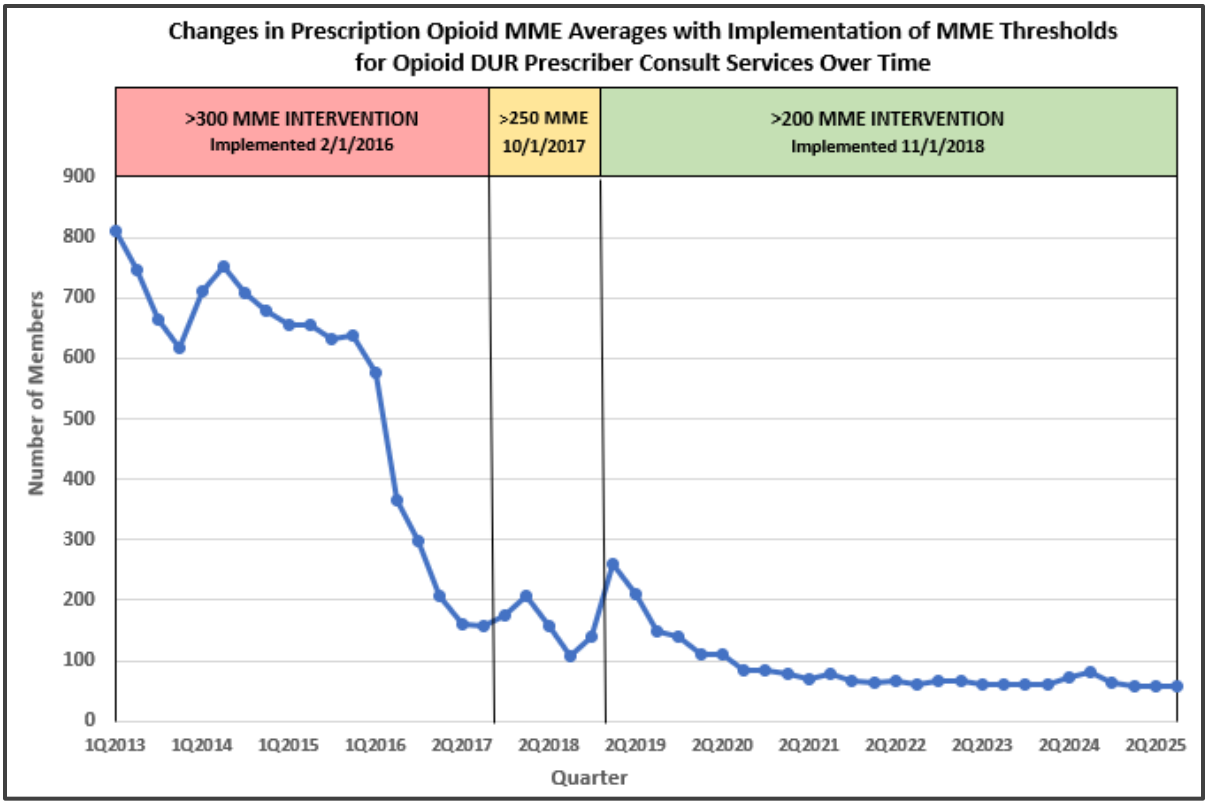
As these projects develop, the Chronic Pain Centers of Excellence aims to serve as a practical resource for prescribers facing the daily realities of managing chronic pain in a complex therapeutic and regulatory environment. For more information regarding the program, send an email to judy.mooney@state.co.us

Scan to initiate a HIPAA-compliant referral

Scan to access educational offerings

12-Year Reduction in Average Morphine Milligram Equivalents (MME) among Health First Colorado Members

The Health First Colorado DUR program has implemented various opioid policies over the years, in addition to regularly monitoring opioid prescribing and utilization, conducting opioid clinical module analyses, mailing educational letters to providers, and providing opioid related peer-to-peer provider consultation services. An analysis conducted using pharmacy claims data illustrates the overall decrease in average MME values in relation to the implementation of opioid policies over time.



The 2025-2026 Population Health/DUR Intern Team

Trey Smith, Bradyn McCarty, Michelle Shamroe, Jennifer Hayden, Zainab Ghafoori, Maddison Overlie

The Population Health Intern team provides essential support to the Health First Colorado program.

Under faculty mentorship, these highly motivated Doctor of Pharmacy (PharmD) students from the University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences gain one or two years of real-world experience in evidence based drug utilization review.

In addition to preparing reports, conducting drug information special projects and drafting prior authorization criteria sets, the intern team—sometimes behind the scenes—helps ensure that quarterly Health First Colorado DUR Board meetings run smoothly.

DUR Spotlight

by Zainab Ghafoori
PharmD Candidate
DUR Intern

Jim Leonard, PharmD

Dr. Jim Leonard is Deputy Director of the Pharmacy Office in the Department of Health Care Policy and Financing (HCPF).

In his early days, Dr. Leonard grew up in a neighborhood where the only store within walking distance was a pharmacy. This inspired him to pursue a career as a pharmacist to serve his community.

Dr. Leonard received his pharmacy degree from the University of Nebraska Medical Center. Prior to his work at HCPF, he facilitated the work of the P & T Committee and the Drug Utilization Review (DUR) Board. Dr. Leonard also operated a pharmacy with Salud Family Health, a Federally Qualified Health Center (FQHC), where the team created their own formulary for uninsured members. Dr. Leonard served as the pharmacy manager at Salud and was part of the clinical executive team, which prepared him for his current role. His current position offers him a unique opportunity to engage with a wide range of subject matter experts. He was recently involved in a CMS project through the Center for Medicare and Medicaid Innovation (CMMI) focused on expanding access to gene therapies for patients with sickle cell disease.

Dr. Leonard's favorite part of his job is building connections with others, including collaborating with pharmacy directors, negotiating value-based agreements with manufacturers, and engaging with pharmacy leaders across states and within the department. If Dr. Leonard could implement a major healthcare policy change, he would address the disconnect between drug pricing and the value medications provide to the healthcare system to improve affordability.

Outside of work, Dr. Leonard enjoys being a father to his three boys, camping with family, watching sports, and community volunteering. His advice to aspiring pharmacy leaders is to take advantage of opportunities as they arise and dive in headfirst—even if you don't feel completely prepared.

New Policies for Biosimilars

In July 2025, the Department began adding specific biosimilar agents to the Preferred Drug List (PDL) and changing policies related to the use of certain biosimilars. Adalimumab (including brand name Humira) and ustekinumab (including brand name Stelara) were the products most impacted by these initial changes. Preferred biosimilar products on the PDL effective January 1, 2026 include:

- **Adalimumab**
  - adalimumab-aacf syringe
  - adalimumab-aaty autoinjector
  - adalimumab-adbm pen
  - Amjevita (adalimumab-atto) syringe, autoinjector
  - Cyltezo (adalimumab-adbm) pen, syringe
  - Yuflyma (adalimumab-aaty) syringe, autoinjector
- **Ustekinumab**
  - Imuldosa (ustekinumab-slrf) autoinjector
  - Selarsdi (ustekinumab-aekn) autoinjector
  - Steqeyma (ustekinumab-stba) autoinjector

Since it is not possible to make an exact duplicate of an originator biologic product, biosimilars cannot be considered generic drugs.[1] However, as is the case with generic drugs, biosimilars can improve patient access and offer more affordable treatment options for Health First Colorado members.

Building Pillars to Save Lives in Heart Failure with Reduced Ejection Fraction

Robert L Page II, PharmD, MSPH

Overview

Heart failure (HF) is a clinical syndrome consisting of cardinal symptoms (such as breathlessness, ankle swelling and fatigue) that may be accompanied by signs such as elevated jugular venous pressure, pulmonary crackles and/or peripheral edema due to structural and/or functional abnormalities of the heart. These abnormalities result in elevated intracardiac pressures and/or inadequate cardiac output at rest and/or during exercise. Heart failure remains a leading global cause of mortality, morbidity and poor quality of life, with high use of resources and high healthcare costs.[1]

The Four Pillars of Guideline-Directed Therapy

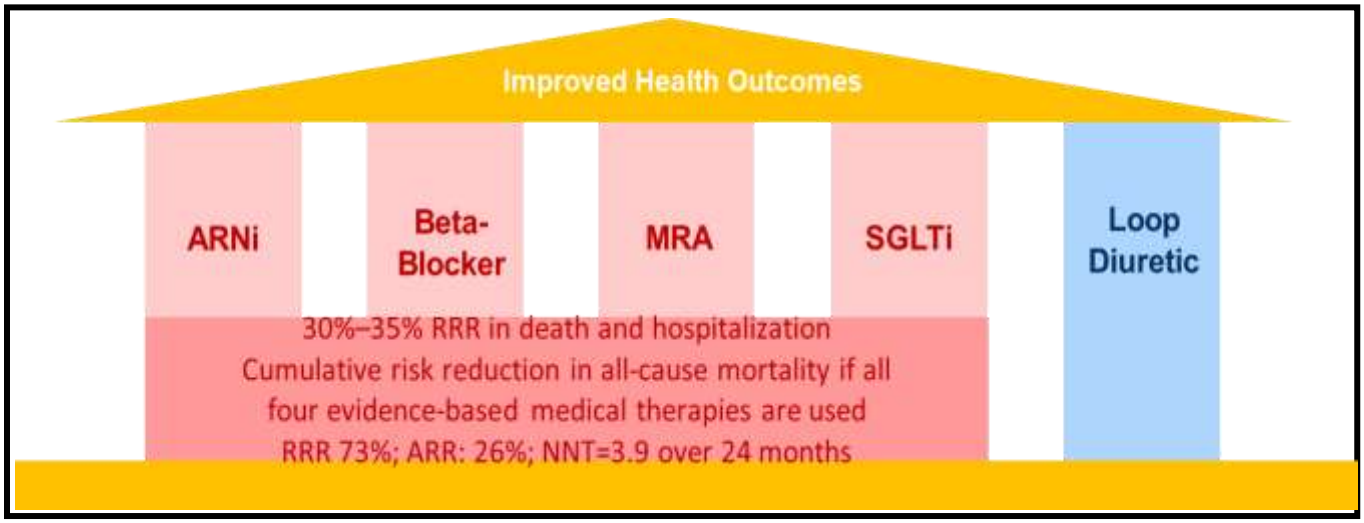
During recent years, improvements in medical therapy have changed the prognosis for patients with HF with reduced ejection fraction (HFrEF). The four pillars of guideline-directed medication therapy (GDMT) for HFrEF, also known as quadruple therapy, are now a fully established cornerstone and include:

- **ß-blockers** (specifically carvedilol, metoprolol succinate, and bisoprolol)
- **Angiotensin-converting enzyme inhibitors** (ACEi), **angiotensin receptor-neprilysin inhibitors** (ARNi) or **angiotensin receptor blockers** (ARB)
- **Mineralocorticoid receptor antagonists** (MRA)
- **Sodium-glucose cotransporter-2 inhibitors** (SGLT2i)[2-4]

When all four medication classes are prescribed at low doses and titrated appropriately—assuming no contraindications—the synergy of the combination can have an extremely significant positive impact on patient outcomes. Benefits may include improvement in health status within 1 to 8 weeks, reduction in HF hospitalization within 2 to 4 weeks, decreased mortality within 2 to 4 weeks, and reduction in re-hospitalization for HF in 2 to 4 weeks.[2-5]

In large meta-analyses of patients with HFrEF, the estimated relative risk reduction in death and hospitalization was 30-35%, with a cumulative risk reduction in all-cause mortality of 73% and a number-needed-to-treat (NNT) of 3.9 patients over 24 months in those receiving all four pillars.[2-5]

Figure 1. The Four Pillars of Heart Failure with Reduced Ejection Fraction.[2-4]



ARNi = angiotensin receptor-neprilysin inhibitor, ARR = absolute risk reduction, HF = heart failure, HFrEF = heart failure with reduced ejection fraction, MRA = mineralocorticoid receptor antagonist, NNT = number-needed-to-treat, RRR = relative risk reduction, SGLT2i = sodium-glucose cotransporter-2 inhibitor

Heart Failure, continued from Page 7

Initiation of Guideline-Directed Medical Therapy (GDMT)

In the case of drug initiation, a major error of omission is not to start all four pillars in patients with HFrEF at low doses simultaneously or to start each individual medication and titrate the dose slowly, which had been done in past iterations of the HF management guidelines. In the latter approach, several months will be needed to add and titrate all four pillars and, for some patients, they may not have months to live.[2-5]

Potential barriers to simultaneous initiation may be related to worries regarding hypotension, hyperkalemia, acute renal failure, polypharmacy, and cost.[2-5] Cost should not be a concern for Health First Colorado members, as all four pillars of therapy are currently covered on the Colorado preferred drug list with no prior authorization requirements.

Core principles for rapid and intensive guideline-directed medication therapy (GDMT).[2-5]

1. **The speed of GDMT initiation and titration matters**

   For quadruple medical therapies for HF with ejection fraction <40%, clinically and statistically significant benefits appear within days to weeks of initiation. Delaying initiation of any individual therapy in an eligible patient without contraindications or intolerance contributes to excess clinical risk.

   Remembering that HF is an extreme-risk condition, clinicians should harness the early and fully additive clinical benefits of these therapies to ensure rapid initiation of quadruple therapy among patients without absolute contraindications. Titrating to target doses is important in HFrEF, but only after all 4 therapies have been initiated. Early separation of major cardiac event curves occurs while patients are assigned initial or low doses.[6] Thus, the highest therapeutic priority for HFrEF is prescribing at least low doses of all four mortality-reducing therapies for all patients who do not have absolute contraindications, as tolerated and without delay.

2. **In-hospital initiation of GDMT is essential**

   Leveraging a teachable moment and the early onset of clinical benefit for each foundational therapy, in-hospital initiation of comprehensive GDMT is the most evidence-based strategy for improving post-discharge mortality and readmission. Beyond directly reducing clinical risk, in-hospital initiation is also a consistent and powerful tool for implementation and adherence. Deferring in-hospital initiation of any GDMT in an eligible patient is consistently associated with never initiation or substantial delay.

3. **Absolute benefits of GDMT are generally greater among patients who are older, frail, and have common comorbidities**

   Relative benefits of GDMT in randomized controlled trials are consistent across the spectrum of clinical risk. Yet, because patients who are older, frail, and with certain comorbidities have higher underlying baseline risk, consistent relative risk reductions generally translate to greater absolute risk reductions and lower numbers needed to treat. Use of GDMT for HF in clinical practice has historically followed a risk-treatment paradox whereby patients at greatest risk are less likely to receive appropriate therapy despite being eligible. Barring absolute contraindication, patients with older age, frailty, and multimorbidity often have the most to lose in absolute risk reduction by withholding therapy. Clinicians should recognize and overcome this tendency to not prescribe GDMT.[7]

4. **Clinicians and patients should recognize potential risks of omitting GDMT**

   Concerns about potential side effects or intolerance may dominate shared decision-making conversations between patients and clinicians, particularly when patients have stable or mild symptoms and the rationale for medication changes is less intuitive. In contrast, potential side effects of not initiating or intensifying GDMT, including higher risks of death and hospitalization and worsening symptoms, may receive less attention despite being definitively proven with strong evidence. Likewise, for patients hospitalized for worsening HF, clinicians may too readily attribute hospitalization to patients' dietary lapses or medication nonadherence. Instead, clinicians should scrutinize the upstream clinic visits and highlight gaps in GDMT, if present, as the overarching triggers for hospitalization. Given the extreme absolute risks associated with a diagnosis of HF, hospitalization should not be unexpected when therapies proven to prevent hospitalization are not prescribed.[8]

Heart Failure, continued from Page 8

Figure 2. Initial Dosing and Monitoring of the Four Pillars of Guideline-Directed Medical Therapy in Heart Failure with Reduced Ejection Fraction.[2-4]

Pillar	Beta blocker	ARNi, ARB, ACEi	MRA	SGLT-2 inhibitor
Monitoring	• Monitor HR (goal HR between 50 bpm and 60 bpm) • Monitor BP and lightheadedness	• Monitor BP and lightheadedness • Check serum potassium • Use with caution in patients with SBP less than 90 mmHg	• Minimal BP effects • Check creatinine and potassium • Monitor potassium at day 3 and after 7 days, then once weekly for first month, then monthly	• Monitor for genital yeast infections • Minimal BP effects • Risk for euglycemic DKA • Monitor fluid intake
Dosing Considerations	Carvedilol (β1, β2, α1 inhibition) Starting dose: 3.125 mg BID • Generic available Metoprolol succinate (β1 inhibition) Starting dose: 12.5 mg to 25 mg daily • Generic available Bisoprolol (β1 inhibition) Starting dose: 1.25 mg daily • Generic available Clinical considerations: • Titrate dose every 1 to 2 weeks by doubling the dose as tolerated • Consider bisoprolol in those with bronchospastic disease • Higher doses are associated with incremental improvement in LVEF • Avoid in patients with heart block	ARNi (sacubitril/valsartan) Starting dose: 24/26 mg BID or half this dose • Avoid with any history of angioedema • Can initiate *de novo* • Greater mortality benefit compared to ACE-I • Monitor for hypotension • Generic available ARB Starting dose • losartan 25 mg BID • valsartan 80 mg BID • candesartan 4 mg daily • Less cough compared to ACE-I • Direct switch to ARNi *(no washout needed)* • Generic available ACEi Starting dose • lisinopril 5 to 10 mg daily • captopril 12.5 to 25 mg TID • enalapril 5 to 10 mg BID • 36-hour washout before ARNi • Generic available Clinical Considerations: Titrate dose every 1 to 2 weeks by doubling the dose as BP tolerates • High versus low doses do not show a difference in mortality, but higher doses are associated with reductions in hospitalization • Mortality reductions between ACE-I and ARBs are comparable	Spironolactone Starting dose: 12.5 to 25 mg daily • Gynecomastia occurs in 10-15% of men • Sexual side effects: low libido, abnormal menses • Greater mortality benefit compared to ACE-I • Generic available Eplerenone • Starting dose: 12.5 to 25 mg daily • More selective, so fewer sexual side effects • Generic available Clinical Considerations: • Avoid with eGFR less than 30 mL/min/m^2 • Avoid if serum potassium greater than 5.0 mEq/L • Could consider a potassium binder for mild hyperkalemia. • No difference in mortality between high versus lower MRA doses	Empagliflozin *(on the PDL)* or dapagliflozin Starting dose: 10 mg daily • No dose titration • Generic available for dapagliflozin Clinical considerations: • Avoid with eGFR less than 20 mL/min/m^2 • Avoid or use with extreme caution in patients with type 1 diabetes • Avoid if hemoglobin A1c is greater than 9%

ACEi = angiotensin converting enzyme inhibitor, ARB = angiotensin receptor blocker, ARNi = angiotensin receptor-neprilysin inhibitor, BID = twice daily, BP = blood pressure, DKA = diabetic ketoacidosis, HR = heart rate, eGFR = estimated glomerular filtration rate, LVEF = left ventricular ejection fraction, MRA = mineralocorticoid receptor antagonist, PDL = preferred drug list, SBP = systolic blood pressure, SGLT2i = sodium-glucose cotransporter-2 inhibitor, TID = three times daily.

The highest therapeutic priority for HFrEF is prescribing at least low doses of all four mortality-reducing therapies for all patients who do not have absolute contraindications, as tolerated, and without delay.

Announcement Column

Pharmacy Office updates

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October 1, 2025 changes in preferred insulin products

Effective October 1, the following insulin products became preferred products on the Preferred Drug List (PDL) for Health First Colorado (Colorado's Medicaid program). These products do not require a prior authorization.

- **Humalog** (insulin lispro) vial
- **Humulin N 100 units/mL** Kwikpen

Also effective October 1, the following branded insulins also became preferred products on the Health First Colorado PDL when submitted with an appropriate, accepted DAW code. Pharmacies may use *DAW 9 - Substitution Allowed by Prescriber but Plan Requests Brand*. Claims for both brand and generic agents do not require a prior authorization.

- **Novolog** (insulin aspart) cartridge, Flexpen, vial
- **Novolog Mix** (insulin aspart protamine and insulin aspart) Flexpen, vial
- **Tresiba** (insulin degludec) 100 units/mL vial

Additional prior authorization criteria for preferred and non-preferred medications may be found on the Colorado Medicaid preferred drug list at https://www.colorado.gov/hcpf/pharmacy-resources.

For questions regarding rejected claims or prior authorization, please call the Prime Therapeutics Help Desk (**1-800-424-5725**).

DUR Spotlight

by Maddison Overlie
PharmD Candidate
DUR Intern

Stephanie Cho, PharmD, BCPS

Dr. Stephanie Cho is the newest member of the Health First Colorado Drug Utilization Review (DUR) Board. She currently practices as a clinical pharmacy specialist in the Department of Dermatology at Kaiser Permanente.

Before pursuing a career in pharmacy, Dr. Cho explored several diverse interests. Having trained in ballet and dance, she initially considered a career in physical therapy. When she realized that path was not the right fit, she interned at Kaiser Permanente to gain firsthand experience in the healthcare field. This opportunity ultimately helped guide her toward pharmacy and led her back to Kaiser Permanente several years later, bringing her journey full circle.

After earning her Doctor of Pharmacy degree from the University of Colorado, Dr. Cho completed a PGY1 residency at the Michael E. DeBakey VA Medical Center in Texas. She returned to Colorado to complete a PGY2 residency in ambulatory care. After nearly eight years in primary care practice, she specialized in dermatology.

Dr. Cho is passionate about advancing patient care in dermatology through collaboration and education. Unique aspects of her work include helping to manage biologic therapies and closely monitor patients for potential drug-related adverse effects. She actively mentors and precepts students and aims to give back to the pharmacy profession through her service on the Health First Colorado DUR Board and involvement in the Kent M. Nelson Clinical Pharmacy Scholarship Program.

Outside of her pharmacist role, Dr. Cho enjoys spending time with her family, traveling, and exploring new cuisines whenever possible.
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Upcoming Therapeutic Class Reviews

Q1 February DUR (January P&T) *Effective 4/1*

Non-Opioid Analgesics, Oral & Topical

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)
Oral/Non-Oral

Opioids, Short-Acting

Opioids, Long-Acting

Fentanyl Preparations

Buprenorphine, Injectable

Anticonvulsants, Oral

Newer Generation Antidepressants

Monoamine Oxidase Inhibitors (MAOIs)

Tricyclic Antidepressants (TCAs)

Anti-Parkinson's Agents
Dopa decarboxylase Inhibitors, Dopamine Precursors, Combos, MAO-B Inhibitors, Dopamine Agonists, Other Parkinson's Agents

Benzodiazepines (non-sedative hypnotic)

Anxiolytics, non-Benzodiazepine

Atypical Antipsychotics
Oral And Long-acting Injectable

Lithium Agents

Neurocognitive Disorder Agents

Sedative Hypnotics, Non-Benzodiazepines

Sedative Hypnotics, Benzodiazepines

Movement Disorder Agents

Skeletal Muscle Relaxants

Stimulants and Related Agents

Triptans, Ditans, and Other Migraine Agents
Oral and Non-Oral

Calcitonin Gene-Related Peptide Inhibitors

Multiple Sclerosis Agents
Disease Modifying Therapies, Symptom Management Therapies, Dopamine Agonists

Ophthalmic, Allergy

Ophthalmics, Immunomodulators

Ophthalmics, Anti-Inflammatory
NSAIDs and Corticosteroids

Ophthalmics, Glaucoma Agents
Beta Blockers, Carbonic Anhydrase Inhibitors, Prostaglandin Analogues, Alpha-2 Adrenergic Agonists, Other Ophthalmic Agents, Glaucoma Agents, and Combinations

Q2 May DUR (April P&T) *Effective 7/1*

Cardiovascular Agents
Alpha Blockers
Beta Blockers & Combinations
Beta Blockers, Antiarrhythmic
Calcium Channel Blockers & Combinations
Calcium Channel Blockers, Dihydropyridine (DHPs)
Calcium Channel Blockers, Non-Dihydropyridine

Angiotensin modulators and combinations
ACEis, ACE-I Combinations, ARBs, ARB Combinations
Renin Inhibitors & Combinations

Pulmonary Arterial Hypertension (PAH) Therapies
Phosphodiesterase Inhibitors, Endothelin Antagonists, Prostacyclin Analogues and Receptor Agonists, Guanylate Cyclase (sGC) Stimulators

Lipotropics
Bile Acid Sequestrants, Fibrates, Other Lipotropics

Statins & Statin Combinations

Movement Disorder Agents

Acne Agents, Topical

Acne Agents, Oral Isotretinoins

Antipsoriatics, Oral and Topical

Immunomodulators, Topical
Atopic Dermatitis and Antineoplastic Agents

Tetracyclines

Rosacea Agents

Topical Steroids
Low Potency, Medium Potency, High Potency
Very High Potency

Bile Salts

Antiemetics, Oral and Non-Oral

GI Motility, Chronic

***H. pylori* Treatments**

Hemorrhoidal and Related Anorectal Agents

Pancreatic Enzymes

Proton Pump Inhibitors (PPIs)

Non-Biologic Ulcerative Colitis Agents
Oral and Rectal

Anticoagulants
Oral and Parenteral

Antiplatelet Agents

Colony Stimulating Factors

Erythropoiesis Stimulating Agents (ESAs)

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New Policies for Biosimilars

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Building Pillars to Save Lives in Heart Failure with Reduced Ejection Fraction

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Images

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Our mission is to improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.
https://hcpf.colorado.gov

Future Health First Colorado DUR Board Meetings

(all open sessions begin at 1:00 pm Mountain Time)

TENTATIVE DATES

February 10, 2026
May 5, 2026
August 11, 2026
November 10, 2026

For more information, visit https://hcpf.colorado.gov/drug-utilization-review-board

DUR Newsletter Editor: Julia Rawlings, PharmD