Texas Preferred Drug List

Preferred drugs are medications recommended by the Texas Drug Utilization Review Board for their efficaciousness, clinical significance, cost-effectiveness, and safety.

Formulary

Everyone enrolled in Medicaid adheres to the same formulary. The Medicaid formulary includes legend and over-the-counter drugs. Certain supplies and select vitamin and mineral products are also available as a pharmacy benefit. Some drugs are subject to one or both types of prior authorization: clinical or non-preferred. The **Formulary Drug Search** identifies the list of Medicaid-covered drugs and whether the drug requires prior authorization

Preferred Drug List

HHSC arranges the **Medicaid Preferred Drug List** by the therapeutic class and contains a subset of many, but not all, drugs on the Medicaid formulary. Drugs identified on the PDL as "preferred" are available without prior authorization unless clinical prior authorization is associated with the drug. Some drugs are subject to both non-preferred and clinical prior authorizations.

HHSC makes PDL changes twice a year during January and July. HHSC will announce other changes based on exceptional circumstances.

CHIP drugs are not subject to PDL requirements.

The PDL Criteria Guide explains the criteria used to evaluate prior authorization requests.

HHSC links drugs with Drug Utilization Review Board-approved clinical prior authorization within the list. Links will take the user to the specific drug or drug class clinical prior authorization criteria with a narrative explaining the purpose and requirements.

Pharmacy Prior Authorization

Each MCO administers pharmacy prior authorization services for people enrolled in Medicaid managed care. The Texas Prior Authorization Call Center administers traditional Medicaid prior authorizations

PDL Prior Authorization

Drugs identified as "non-preferred" require a PDL prior authorization. The PDL Criteria Guide explains the criteria used to evaluate the non-preferred prior authorization requests.

Clinical Prior Authorization

Clinical prior authorizations may apply to any individual drug or an entire drug class on the formulary, including some preferred and non-preferred drugs. HHSC requires MCOs to perform specific clinical prior authorizations. Usage of all other clinical prior authorizations will vary between MCOs at the discretion of each MCO. The Texas Medicaid Drug Utilization Board approves all criteria.

- Review the list of clinical prior authorizations allowable in Medicaid managed care
- Review the list of clinical prior authorizations active in Medicaid fee-for-service

The Clinical Prior Authorization Assistance Chart identifies which MCOs utilize each clinical prior authorization.

Obtaining Prior Authorization

Prescribing providers can help people enrolled in Medicaid receive medications quickly and conveniently with a few simple steps by contacting one of the following:

Medicaid Managed Care

Pharmacy prior authorization call centers vary by MCO. Refer to each MCO's prior authorization call center number and other contact information.

Traditional Medicaid

The **Texas Prior Authorization Call Center** accepts prior authorization requests by phone at 877-PA-TEXAS (877-728-3927) or online. Online submission is only available for non-preferred prior authorization requests.

- Online Account Registration Instructions
- Provider Quick Reference

Texas Drug Utilization Review Board

The board recommends the PDL and clinical prior authorizations four times a year. Close to 75 therapeutic classes are reviewed each year, with approximately one-quarter of the classes reviewed at each meeting:

- The January edition of the PDL includes decisions made at the July and October meetings
- The July edition of the PDL includes decisions made at the January and April meetings

Education

Texas Health Steps offers free online continuing education courses and the ***Prescriber's Guide to Texas Medicaid Outpatient Pharmacy Prior Authorization*** quick course.

Health and Human Services Commission
Texas Medicaid Preferred Drug List (PDL) and Prior Authorization (PA) Criteria

Effective: January 26, 2023

TABLE OF CONTENTS

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: **txvendordrug.com/formulary/formulary-search**. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

REVISION HISTORY

The PDL is published biannually (January, July). Recent changes to the PDL status are highlighted.

DATE	ISSUES/UPDATES
01/26/2023	Published

ACNE AGENTS, ORAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
ACCUTANE (isotretinoin)	ABSORICA (isotretinoin)
AMNESTEEM (isotretinoin)	ABSORICA LD (isotretinoin)
CLARAVIS (isotretinoin)	isotretinoin (Absorica)
isotretinoin	
MYORISAN (isotretinoin)	
ZENATANE (isotretinoin)	

ACNE AGENTS, TOPICAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies to all drugs in the class:

- Retinoids
- Topical Acne Agents

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIBIOTICS	
clindamycin gel	AMZEEQ (minocycline)
clindamycin pledgets	CLEOCIN-T (clindamycin)
clindamycin solution	clindamycin foam
erythromycin gel, solution	clindamycin gel AG (Clindagel)
	clindamycin lotion
	erythromycin medicated swab
BENZOYL PEROXIDE	
benzoyl peroxide gel (Rx)	BENZEFOAM FOAM OTC (topical)
benzoyl peroxide lotion (OTC)	benzoyl peroxide cleanser
benzoyl peroxide wash	benzoyl peroxide cream
	benzoyl peroxide foam
	benzoyl peroxide gel
	benzoyl peroxide kit
	benzoyl peroxide towelette
RETINOIDS	
tretinoin cream (Avita, Retin-A)	AKLIEF (trifarotene)
tretinoin gel (Avita, Retin-A)	adapalene
	ALTRENO (tretinoin)
	ARAZLO (tazarotene)
	ATRALIN (tretinoin)
	AVITA (tretinoin)
	DIFFERIN (adapalene)
	FABIOR (tazarotene)
	tazarotene
	tretinoin gel (Atralin)
	tretinoin microspheres
COMBINATION AND OTHER AGENTS	
benzoyl peroxide/clindamycin (Duac)	adapalene/benzoyl peroxide (Epiduo/Epiduo Forte)
EPIDUO FORTE (benzoyl peroxide/adapalene)	clindamycin/benzoyl peroxide (Acanya)

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PREFERRED AGENTS	NON-PREFERRED AGENTS
erythromycin/benzoyl peroxide	clindamycin/tretinoin
	dapsone
	DERMACINRX ATRIX CLEANSER OTC (TOPICAL)
	DERMACINRX ATRIX CREAM OTC (TOPICAL)
	DERMACINRX ATRIX SOLUTION OTC (TOPICAL)
	sulfacetamide
	sulfacetamide sodium
	sulfacetamide sodium/sulfur
	sulfacetamide/sulfur
	sulfacetamide/sulfur/urea
	TWYNEO (tretinoin/benzoyl peroxide)
	WINLEVI (clascoterone)
	ZIANA (clindamycin/tretinoin)

ALZHEIMER'S AGENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

PREFERRED AGENTS	NON-PREFERRED AGENTS
CHOLINESTERASE INHIBITORS	
donepezil 5, 10 mg tablet	ADLARITY (donepezil) transderm
donepezil ODT	ARICEPT (donepezil)
EXELON (rivastigmine) transdermal	donepezil 23 mg tablet
	galantamine
	galantamine ER
	RAZADYNE ER (galantamine ER)
	rivastigmine capsules
	rivastigmine transdermal
NMDA RECEPTOR ANTAGONIST	
memantine tablets	memantine ER
	memantine solution
	memantine tablet dose pack
	NAMENDA (memantine) tablets/titration pk
	NAMENDA XR (memantine)
CHOLINESTERASE INHIBITOR/NMDA RECEPTOR ANTAGONIST COMBINATIONS	
	NAMZARIC (donepezil/memantine)

ANALGESICS, NARCOTIC – LONG ACTING

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- Methadone oral solution will be authorized for patients less than 24 months of age.

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Opioid Policy Criteria
- Opiate Overutilization
- Opiate/Benzodiazepine/Muscle Relaxant

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
BUTRANS (buprenorphine)	BELBUCA (buprenorphine)
fentanyl patch (12, 25, 50, 75, 100 mcg)	buprenorphine buccal/film
morphine ER (generic MS Contin)	buprenorphine patch
tramadol ER (Ultram ER)	CONZIP (tramadol)
tramadol ER (generic Ryzolt)	fentanyl patch (37.5, 62.5, 87.5 mcg)
XTAMPZA ER (oxycodone)	hydrocodone ER
	hydromorphone ER
	HYSINGLA ER (hydrocodone)
	KADIAN (morphine)
	methadone
	methadone brand sol tablet
	morphine ER (generic Avinza, Kadian)
	MS CONTIN (morphine)
	NUCYNTA ER (tapentadol)
	oxycodone ER
	OXYCONTIN (oxycodone)
	oxymorphone ER
	tramadol ER (generic Conzip)
	ZOHYDRO ER (hydrocodone ER)

ANALGESICS, NARCOTIC – SHORT ACTING (NON-PARENTERAL)

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Opioid Policy Criteria
- Opiate Overutilization
- Opiate/Benzodiazepine/Muscle Relaxant

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
APAP/codeine	ACTIQ (fentanyl)
hydrocodone/APAP	APADAZ (benzhydrocodone/APAP)
hydromorphone tablet	benzhydrocodone/APAP
morphine tablets	butalbital/ASA/caffeine/codeine
morphine solution	butalbital/APAP/caffeine/codeine
oxycodone solution	butorphanol
oxycodone tablet	carisoprodol/aspirin/codeine
oxycodone/APAP tablet	codeine
tramadol 50mg	dihydrocodeine/APAP/caffeine
tramadol/APAP	DILAUDID (hydromorphone)
	DSUVIA (sufentanil citrate)
	fentanyl buccal
	FENTORA (fentanyl)
	FIORICET W/CODEINE (butalbital/APAP/caffeine/codeine)
	hydrocodone/ibuprofen
	hydromorphone liquid
	hydromorphone suppositories
	levorphanol
	LORTAB (hydrocodone/APAP)
	meperidine
	morphine concentrated solution
	morphine disp syr, oral
	morphine suppositories
	NUCYNTA (tapentadol)
	OXAYDO (oxycodone)
	oxycodone/APAP solution
	oxycodone/ASA
	oxycodone capsule
	oxycodone concentrate solution

PREFERRED AGENTS	NON-PREFERRED AGENTS
	oxycodone syr (oral)
	oxymorphone
	pentazocine/naloxone
	PERCOCET (oxycodone/APAP)
	PROLATE (oxycodone/APAP)
	QDOLO (tramadol)
	ROXICODONE (oxycodone)
	SEGLENTIS (celecoxib/tramadol)
	tramadol 100mg
	tramadol solution

ANDROGENIC AGENTS, TOPICAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Androgenic Agents

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANDRODERM (testosterone)	ANDROGEL (testosterone) packet
ANDROGEL (testosterone) pump	FORTESTA (testosterone)
	NATESTO (testosterone)
	TESTIM (testosterone)
	testosterone gel
	VOGELXO (testosterone)

ANGIOTENSIN MODULATORS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- Epaned will be authorized for patients six years of age and under

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ACE INHIBITORS	
benazepril	ACCUPRIL (quinapril)
EPANED (enalapril)	ALTACE (ramipril)
enalapril tablet	captopril
fosinopril	enalapril solution
lisinopril	LOTENSIN (benazepril)
quinapril	moexipril
ramipril	perindopril
	QBRELIS (lisinopril) solution
	trandolapril
	VASOTEC (enalapril)
	ZESTRIL (lisinopril)

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Duplicate Therapy

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ACE INHIBITOR/DIURETIC COMBINATIONS	
enalapril/HCTZ	ACCURETIC (quinapril/HCTZ)
lisinopril/HCTZ	benazepril/HCTZ
	captopril/HCTZ
	fosinopril/HCTZ
	LOTENSIN HCT (benazepril/HCTZ)
	quinapril/HCTZ
	VASERETIC (enalapril/HCTZ)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: **txvendordrug.com/formulary/formulary-search**. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	ZESTORETIC (lisinopril/HCTZ)
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBS)	
DIOVAN (valsartan)	ATACAND (candesartan)
irbesartan	AVAPRO (irbesartan)
losartan	BENICAR (olmesartan)
	candesartan
	COZAAR (losartan)
	EDARBI (azilsartan)
	eprosartan
	MICARDIS (telmisartan)
	olmesartan
	telmisartan
	valsartan
ARB/DIURETIC COMBINATIONS	
irbesartan/HCTZ	ATACAND-HCT (candesartan/HCTZ)
losartan/HCTZ	AVALIDE (irbesartan/HCTZ)
	BENICAR-HCT (olmesartan/HCTZ)
	candesartan/HCTZ
	DIOVAN-HCT (valsartan/HCTZ)
	EDARBYCLOR (azilsartan/chlorthalidone)
	HYZAAR (losartan/HCTZ)
	MICARDIS-HCT (telmisartan/HCTZ)
	olmesartan/HCTZ
	telmisartan /HCTZ
	valsartan/HCTZ
DIRECT RENIN INHIBITORS	
	aliskiren
	TEKTURNA (aliskerin)
DIRECT RENIN INHIBITOR/DIURETIC COMBINATIONS	
	TEKTURNA HCT (aliskerin/HCTZ)
ARB/NEPRILYSIN INHIBITOR COMBINATIONS	
ENTRESTO (valsartan/sacubitril)	

ANGIOTENSIN MODULATOR COMBINATIONS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
benazepril /amlodipine	AZOR (olmesartan/amlodipine)
valsartan/amlodipine	EXFORGE (valsartan/amlodipine)
	EXFORGE HCT (valsartan/amlodipine/HCTZ)
	LOTREL (benazepril/amlodipine)
	olmesartan/amlodipine
	olmesartan/amlodipine/HCTZ
	telmisartan/amlodipine
	trandolapril/verapamil
	TRIBENZOR (olmesartan/amlodipine/HCTZ)
	valsartan/amlodipine/HCTZ

ANTI-ALLERGENS, ORAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	ORALAIR (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass mixed pollens allergen extract)
	PALFORZIA MAINTENANCE SACHET (peanut allergen powder)
	PALFORZIA TITRATION CAPSULE (peanut allergen powder)

ANTIBIOTICS, GASTROINTESTINAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
FIRVANQ (vancomycin)	AEMCOLO (rifamycin)
metronidazole tablet	DIFICID (fidaxomicin)
neomycin	FLAGYL (metronidazole)
tinidazole	metronidazole capsule
	nitazoxanide
	paromomycin
	VANCOCIN (vancomycin)
	vancomycin
	XIFAXAN (rifaximin)

ANTIBIOTICS, INHALED

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Antibiotics, Inhaled

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
BETHKIS (tobramycin)	ARIKAYCE (amikacin)
CAYSTON (aztreonam)	TOBI (tobramycin) solution
KITABIS PAK (tobramycin)	tobramycin solution
TOBI PODHALER (tobramycin)	

ANTIBIOTICS, TOPICAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
bacitracin ointment	bacitracin packet
mupirocin ointment	bacitracin/polymixin
triple antibiotic ointment	CENTANY (mupirocin)
	gentamicin
	mupirocin cream
	mupirocin ointment syringe
	neomycin/polymyxin/pramoxine
	XEPI (ozenoxacin)

ANTIBIOTICS, VAGINAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
CLEOCIN (clindamycin) ovules	CLEOCIN (clindamycin) cream
CLINDESSE (clindamycin)	clindamycin
NUVESSA (metronidazole)	METROGEL-VAGINAL (metronidazole)
	metronidazole
	SOLOSEC (secnidazole)
	VANDAZOLE (metronidazole)
	XACIATO (clindamycin)

ANTICOAGULANTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Duplicate Therapy

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ELIQUIS (apixaban)	ARIXTRA (fondaparinux)
enoxaparin	dabigatran
JANTOVEN (warfarin)	fondaparinux
PRADAXA (dabigatran)	FRAGMIN (dalteparin)
warfarin	LOVENOX (enoxaparin)
XARELTO (rivaroxaban) tablet, dosepak	SAVAYSA (edoxaban)
	XARELTO (rivaroxaban) suspension

ANTICONVULSANTS

PA Criteria (client must meet at least one of the listed PA criteria):

- All of the agents in the Anticonvulsants class are preferred

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
APTIOM (eslicarbazine)	
BANZEL (rufinamide)	
BRIVIACT (brivaracetam)	
carbamazepine	
carbamazepine ER, XR	
CARBATROL (carbamazepine)	
CELONTIN (methsuximide)	
clobazam	
clonazepam	
DEPAKOTE (divalproex sodium)	
DEPAKOTE ER (divalproex sodium)	
DIACOMIT (stiripentol)	
DIASTAT (diazepam)	
DIASTAT ACUDIAL (diazepam)	
diazepam	
DILANTIN (phenytoin)	
DILANTIN INFATAB (phenytoin)	
divalproex	
divalproex ER	
ELEPSIA XR (levetiracetam)	
EPIDIOLEX (cannabidiol)	
EPITOL (carbamazepine)	
EPRONTIA (topiramate)	
EQUETRO (carbamazepine)	
ethosuximide	
felbamate	
FELBATOL (felbamate)	
FINTEPLA (fenfluramine)	
FYCOMPA (perampanel)	
GABITRIL (tiagabine)	
KEPPRA (levetiracetam)	
KEPPRA XR (levetiracetam)	
KLONOPIN (clonazepam)	
lacosamide	
LAMICTAL (lamotrigine) tablet, ODT	
LAMICTAL XR (lamotrigine)	

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PREFERRED AGENTS	NON-PREFERRED AGENTS
lamotrigine tablet, ER, ODT	
levetiracetam	
levetiracetam XR	
MYSOLINE (primidone)	
NAYZILAM (midazolam)	
ONFI (clobazam)	
oxcarbazepine	
OXTELLAR XR (oxcarbazepine)	
phenobarbital	
PHENYTEK (phenytoin)	
phenytoin	
primidone	
QUDEXY XR (topiramate)	
ROWEEPRA (levetiracetam)	
rufinamide suspension	
rufinamide tablet	
SABRIL (vigabatrin)	
SPRITAM (levetiracetam)	
SUBVENITE (lamotrigine)	
SYMPAZAN (clobazam)	
TEGRETOL (carbamazepine)	
TEGRETOL XR (carbamazepine)	
tiagabine	
TOPAMAX (topiramate)	
topiramate	
topiramate ER	
TRILEPTAL (oxcarbazepine)	
TROKENDI XR (topiramate)	
valproic acid	
VALTOCO (diazepam)	
vigabatrin	
VIGADRONE (vigabatrin)	
VIMPAT (lacosamide)	
XCOPRI (cenobamate)	
ZARONTIN (ethosuximide)	
zonisamide	

ANTIDEPRESSANTS, OTHER

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
bupropion	APLENZIN (bupropion)
bupropion SR	bupropion XL (Forfivo XL)
bupropion XL	desvenlafaxine ER
FORFIVO XL (bupropion)	EFFEXOR XR (venlafaxine)
mirtazapine	EMSAM (selegiline)
phenelzine	FETZIMA (levomilnacipran)
PRISTIQ (desvenlafaxine)	MARPLAN (isocarboxazid)
trazodone	NARDIL (phenelzine)
venlafaxine ER capsules	nefazodone
venlafaxine IR	REMERON (mirtazapine)
	tranylcypromine
	TRINTELLIX (vortioxetine)
	venlafaxine ER tablets
	VIIBRYD (vilazodone)
	vilazodone
	WELLBUTRIN SR (bupropion)
	WELLBUTRIN XL (bupropion)

ANTIDEPRESSANTS, SSRIS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
citalopram tablets, solution	BRISDELLE (paroxetine)
escitalopram tablets	CELEXA (citalopram)
fluoxetine capsule	citalopram 30mg capsules
fluvoxamine	escitalopram solution
paroxetine	fluoxetine capsule DR
sertraline conc, tablet	fluoxetine tablets
	fluvoxamine ER
	LEXAPRO (escitalopram)
	paroxetine (Brisdelle)
	paroxetine CR
	PAXIL (paroxetine)
	PAXIL CR (paroxetine)
	PEXEVA (paroxetine)
	PROZAC (fluoxetine)
	sertraline capsule
	ZOLOFT (sertraline)

ANTIDEPRESSANTS, TRICYCLIC

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
amitriptyline	amoxapine
doxepin	ANAFRANIL (clomipramine)
imipramine	clomipramine
nortriptyline capsule	desipramine
	imipramine pamoate
	NORPRAMIN (desipramine)
	nortriptyline solution
	PAMELOR (nortriptyline)
	protriptyline
	trimipramine

ANTIEMETIC-ANTIVERTIGO AGENTS (EXCLUDES INJECTABLES)

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

The following Clinical Prior Authorization may apply to drugs in the class:

- Antiemetic Agents

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTICHOLINERGICS, ANTIHISTAMINES, DOPAMINE ANTAGONISTS	
DICLEGIS (doxylamine/pyridoxine)	ANTIVERT (meclizine)
dimenhydrinate	BONJESTA (doxylamine/pyridoxine)
meclizine	COMPRO (prochlorperazine)
metoclopramide solution, tablets	doxylamine/pyridoxine
phosphoric acid/dextrose/fructose	GIMOTI (metoclopramide)
prochlorperazine tablets	metoclopramide ODT
promethazine syrup, tablets	prochlorperazine suppositories
TRANSDERM-SCOP (scopolamine)	promethazine suppositories
	REGLAN (metoclopramide)
	scopolamine patches
	Tigan (trimethobenzamide)
	trimethobenzamide
CANNABINOIDS	
	dronabinol
	MARINOL (dronabinol)
5-HT3 RECEPTOR ANTAGONISTS	
ondansetron	granisetron
	SANCUSO (granisetron)
	SUSTOL (granisetron)
SUBSTANCE P ANTAGONISTS AND COMBINATIONS	
	AKYNZEO (netupitant/palonosetron)
	aprepitant
	EMEND (aprepitant)

ANTIFUNGALS, ORAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
clotrimazole	ANCOBON (flucytosine)
fluconazole	BREXAFEMME (ibrexafungerp)
griseofulvin suspension	CRESEMBA (isavuconazonium sulfate)
ketoconazole	DIFLUCAN (fluconazole)
NOXAFIL (posaconazole) tablet	flucytosine
nystatin	griseofulvin tablets
terbinafine	itraconazole
VFEND (voriconazole) suspension	NOXAFIL (posaconazole) susp
	posaconazole
	SPORANOX (itraconazole)
	TOLSURA (itraconazole)
	VFEND (voriconazole) tablet
	VIVJOA (oteseconazole)
	voriconazole

ANTIFUNGALS, TOPICAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Antifungal Agents, Topical

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIFUNGALS	
clotrimazole	ALEVAZOL (clotrimazole)
ketoconazole shampoo	BENSAL HP (benzoic acid/salicylic acid)
miconazole cream, powder	CICLODAN (ciclopirox)
NYAMYC (nystatin) powder	ciclopirox
nystatin	clotrimazole solution RX
NYSTOP (nystatin) powder	DESENEX AERO POWDER OTC (miconazole)
terbinafine	econazole
tolnaftate cream, powder	ERTACZO (sertaconazole)
	EXELDERM (sulconazole)
	EXTINA (ketoconazole)
	FUNGOID (miconazole)
	JUBLIA (efinaconazole)
	KERYDIN (tavaborole)
	ketoconazole cream, foam
	KETODAN (ketoconazole)
	LOPROX (ciclopirox)
	LOTRIMIN AF(clotrimazole)
	LOTRIMIN ULTRA (butenafine)
	luliconazole
	LUZU (luliconazole)
	MENTAX (butenafine)
	miconazole ointment, spray
	MYCOZYL AC cream OTC (clotrimazole)
	naftifine
	NAFTIN (naftifine)
	oxiconazole
	OXISTAT (oxiconazole)
	sulconazole
	tavaborole
	tolnaftate solution, spray

PREFERRED AGENTS	NON-PREFERRED AGENTS
	VUSION (miconazole/zinc/petrolatum)
ANTIFUNGAL/STEROID COMBINATIONS	
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion
	nystatin/triamcinolone
	TRIAMAZOLE KIT (econazole/triamcinolone)

ANTIHISTAMINES, FIRST GENERATION

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure after no less than a 30-day trial of preferred drugs
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Duplicate Therapy

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIHISTAMINES	
BANOPHEN (diphenhydramine)	AHIST (chlorcyclizine)
carbinoxamine liquid, tablet	clemastine tablets
clorpheniramine IR tablets	diphenhydramine chew, elixir
cyproheptadine syrup, tablet	ED CHLORPRED (chlorpheniramine/phenylephrine)
diphenhydramine capsules, liquid, tablet	HISTEX (triprolidine) chew, PDX drop
HISTEX (triprolidine) liquid, PD DROPS	KARBINAL ER (carbinoxamine) suspension
hydroxyzine	PEDIAVENT (dexbrompheniramine)
PEDIACLEAR PD DROPS OTC (triprolidine)	RYCLORA (dexchlorpheniramine)
PEDIACLEAR-8 LIQUID OTC (pryrilamine maleate)	RYVENT (carbinoxamine)
	triprolidine
	VISTARIL (hydroxyzine)

ANTIHISTAMINES, MINIMALLY SEDATING

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure after no less than a 30-day trial of preferred drugs
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Duplicate Therapy

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIHISTAMINES	
cetirizine solution, tablets	cetirizine chewable, capsule
loratadine solution, tablets	CLARINEX (desloratadine)
	desloratadine
	fexofenadine
	levocetirizine
	loratadine ODT, chew

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure after no less than a 30-day trial of preferred drugs
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Duplicate Therapy

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIHISTAMINE/DECONGESTANT COMBINATIONS	
	cetirizine/pseudoephedrine
	CLARINEX-D (desloratadine/pseudoephedrine)
	fexofenadine/pseudoephedrine
	loratadine/pseudoephedrine

ANTIHYPERTENSIVES, SYMPATHOLYTICS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
CATAPRES-TTS (clonidine)	CATAPRES (clonidine)
clonidine IR tablets	clonidine ER
guanfacine IR	clonidine transdermal
methyldopa	methyldopa / HCTZ

ANTIHYPERURICEMICS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
allopurinol 100mg & 300mg tablets	allopurinol 200mg
COLCRYS (colchicine)	colchicine
probenecid	febuxostat
probenecid/colchicine	GLOPERBA (colchicine)
	MITIGARE (colchicine)
	ULORIC (febuxostat)
	ZYLOPRIM (allopurinol)

ANTIMIGRAINE AGENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization may apply to drugs in the class:

- Antimigraine Agents, Triptans

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
TRIPTANS	
IMITREX (sumatriptan) nasal	almotriptan
rizatriptan	AMERGE (naratriptan)
sumatriptan injection kit	eletriptan
sumatriptan tablets	FROVA (frovatriptan)
ZOMIG (zolmitriptan) nasal	frovatriptan
	IMITREX (sumatriptan) injection kit, tablets, vial
	MAXALT (rizatriptan)
	naratriptan
	ONZETRA XSAIL (sumatriptan)
	RELPAX (eletriptan)
	sumatriptan nasal, vial
	sumatriptan/naproxen
	TOSYMRA (sumatriptan)
	TREXIMET (sumatriptan/naproxen)
	ZEMBRACE SYMTOUCH (sumatriptan)
	zolmitriptan tablets, nasal
	ZOMIG (zolmitriptan) tablets
NON-TRIPTANS	
AIMOVIG (erenumab)	CAFERGOT (ergotamine tartrate/caffeine)
AJOVY (fremanezumab-vfrm)	CAMBIA (diclofenac)
EMGALITY (galcanezumab-gnlm)	D.H.E. 45 (dihydroergotamine)
NURTEC ODT (rimegepant)	dihydroergotamine mesylate
	ELYXYB SOLUTION (celecoxib)
	EMGALITY 100 mg (cluster headache) (galcanezumab-gnlm)
	MIGERGOT supp (ergotamine tartrate/caffeine)
	MIGRANAL (dihydroergotamine mesylate)
	QULIPTA (atogepant)
	REYVOW (lasmiditan)
	TRUDHESA (dihydroergotamine mesylate)
	UBRELVY (ubrogepant)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: **txvendordrug.com/formulary/formulary-search**. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIPARASITICS, TOPICAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
NATROBA (spinosad)	CROTAN (crotamiton)
permethrin	EURAX (crotamiton)
VANALICE GEL OTC (piperonyl butoxide/pyrethrins)	ivermectin
	lindane
	malathion
	OVIDE (malathion)
	piperonyl butoxide/pyrethrins
	piperonyl butox/pyrethr/permet
	SKLICE (ivermectin)
	spinosad

ANTIPARKINSON'S AGENTS (ORAL/TRANSDERMAL)

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTICHOLINERGICS	
benztropine	
trihexyphenidyl	
COMT INHIBITORS	
	COMTAN (entacapone)
	entacapone
	ONGENTYS (opicapone)
	TASMAR (tolcapone)
	tolcapone
DOPAMINE AGONISTS	
pramipexole	APOKYN (apomorphine)
ropinirole	apomorphine
	bromocriptine
	KYNMOBI (apomorphine)
	MIRAPEX ER (pramipexole)
	NEUPRO transdermal (rotigotine)
	PARLODEL (bromocriptine)
	pramipexole ER
	ropinirole ER
MAO-B INHIBITORS	
	AZILECT (rasagiline)
	rasagiline
	selegiline
	XADAGO (safinamide)
	ZELAPAR (selegiline)
OTHERS	
amantadine	carbidopa
carbidopa/levodopa tablets	carbidopa/levodopa ODT
carbidopa/levodopa ER	DHIVY (carbidopa/levodopa)
carbidopa/levodopa/entacapone	DUOPA (carbidopa/levodopa)
	GOCOVRI (amantadine)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: **txvendordrug.com/formulary/formulary-search**. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	INBRIJA (levodopa)
	LODOSYN (carbidopa)
	NOURIANZ (istradefylline)
	OSMOLEX ER (amantadine)
	RYTARY (carbidopa/levodopa)
	SINEMET (carbidopa/levodopa)
	STALEVO (levodopa/carbidopa/entacapone)

ANTIPSYCHOTICS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Antipsychotics

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIPSYCHOTICS	
aripiprazole tablets	ABILIFY (aripiprazole) tablets
chlorpromazine	ABILIFY MYCITE (aripiprazole)
clozapine	aripiprazole ODT, solution
fluphenazine	asenapine SL
haloperidol	CAPLYTA (lumateperone)
haloperidol decanoate	clozapine ODT
LATUDA (lurasidone)	CLOZARIL (clozapine)
olanzapine	FANAPT (iloperidone)
olanzapine ODT	fluphenazine decanoate
perphenazine	GEODON (ziprasidone) capsule, IM
quetiapine IR	HALDOL (haloperidol) decanoate
REXULTI (brexpiprazole)	haloperidol lactate injection
risperidone tablets , solution	INVEGA (paliperidone)
thioridazine	loxapine
thiothixene	molindone
trifluoperazine	NUPLAZID (pimavanserin)
VRAYLAR (cariprazine)	olanzapine IM
ziprasidone	paliperidone ER
	pimozide
	quetiapine ER
	RISPERDAL (risperidone)
	risperidone ODT
	SAPHRIS (asenapine)
	SECUADO (asenapine)
	SEROQUEL (quetiapine)
	SEROQUEL XR (quetiapine)
	VERSACLOZ (clozapine)
	ziprasidone IM
	ZYPREXA (olanzapine)
	ZYPREXA ZYDIS (olanzapine)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: **txvendordrug.com/formulary/formulary-search**. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIPSYCHOTIC/SSRI COMBINATIONS	
amitriptyline/perphenazine	olanzapine/fluoxetine
	SYMBYAX (olanzapine/fluoxetine)
ANTIPSYCHOTIC/SEROTONIN ANTAGNST COMBINATIONS	
	LYBALVI (olanzapine/samidorphan)
LONG-ACTING INJECTABLES	
ABILIFY MAINTENA (aripiprazole)	ZYPREXA RELPREVV (olanzapine)
ARISTADA (aripiprazole)	
ARISTADA INITIO (aripiprazole)	
INVEGA HAFYERA (paliperidone)	
INVEGA SUSTENNA (paliperidone)	
INVEGA TRINZA (paliperidone)	
PERSERIS (risperidone)	
RISPERDAL CONSTA (risperidone)	

ANTIVIRALS (ORAL/NASAL)

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIHERPETIC	
acyclovir	SITAVIG (acyclovir)
famciclovir	VALTREX (valacyclovir)
valacyclovir	ZOVIRAX (acyclovir)
ANTI-INFLUENZA	
oseltamivir	FLUMADINE (rimantadine)
	RELENZA (zanamivir)
	rimantadine
	TAMIFLU (oseltamivir)
	XOFLUZA (baloxavir)
ANTI-CMV	
VALCYTE (valganciclovir) solution	LIVTENCITY (maribavir)
valganciclovir tablets	VALCYTE (valganciclovir) tablets
	valganciclovir solution

ANTIVIRALS, TOPICAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
DENAVIR (penciclovir)	acyclovir cream, ointment
ZOVIRAX (acyclovir) cream, ointment	docosanol OTC
	XERESE (acyclovir/hydrocortisone)

ANXIOLYTICS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Anxiolytics
- Opiate/Benzodiazepine/Muscle Relaxant

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
alprazolam tablet	alprazolam ER
buspirone	alprazolam intensol
chlordiazepoxide	alprazolam ODT
clorazepate	ATIVAN (lorazepam)
diazepam solution	diazepam intensol
diazepam tablet	LOREEV XR (lorazepam)
lorazepam intensol	meprobamate
lorazepam tablet	oxazepam
	TRANXENE T-TAB (clorazepate)
	XANAX XR (alprazolam)
	XANAX (alprazolam) tablet

BETA BLOCKERS (ORAL)

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
BETA BLOCKERS	
acebutolol	BETAPACE/ AF (sotalol)
atenolol	betaxolol
bisoprolol	BYSTOLIC (nebivolol)
HEMANGEOL (propranolol)	CORGARD (nadolol)
metoprolol IR	INDERAL LA/XL (propranolol)
metoprolol XL	INNOPRAN XL (propranolol)
propranolol IR	KAPSPARGO (metoprolol succinate)
SORINE (sotalol)	LOPRESSOR (metoprolol)
sotalol	nadolol
	nebivolol
	pindolol
	propranolol ER
	SOTYLIZE (sotalol)
	TENORMIN (atenolol)
	timolol
	TOPROL XL (metoprolol succinate)
BETA BLOCKER COMBINATIONS	
atenolol/chlorthalidone	metoprolol/HCTZ
bisoprolol/HCTZ	propranolol/HCTZ
	TENORETIC (atenolol/HCTZ)
	ZIAC (bisoprolol/HCTZ)

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
BETA- AND ALPHA-BLOCKERS	
carvedilol	carvedilol ER
COREG CR (carvedilol)	COREG (carvedilol)
labetalol	

BILE SALTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drug
- Contraindication to preferred drug
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ursodiol tablet	BYLVAY (odevixibat) cap/pellet
	CHENODAL (chenodiol)
	CHOLBAM (cholic acid)
	LIVMARLI (maralixibat)
	OCALIVA (obeticholic acid)
	RELTONE (ursodiol)
	URSO (ursodiol)
	URSO FORTE (urosodiol)
	ursodiol capsule

BLADDER RELAXANT PREPARATIONS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
oxybutynin IR	darifenacin ER
oxybutynin ER	DETROL (tolterodine)
TOVIAZ (fesoterodine)	DETROL LA (tolterodine)
VESICARE (solifenacin)	DITROPAN XL (oxybutynin)
	flavoxate
	GELNIQUE (oxybutynin)
	MYRBETRIQ (mirabegron)
	OXYTROL (oxybutynin)
	solifenacin
	tolterodine
	tolterodine ER
	trospium
	trospium ER
	VESICARE LS (solifenacin)

BONE RESORPTION SUPPRESSION AND RELATED AGENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
BISPHOSPHONATES	
alendronate tablets	ACTONEL (risedronate)
	alendronate solution
	ATELVIA (risedronate)
	BONIVA (ibandronate) etidronate
	EVENITY (romosozumab-aqqg)
	FOSAMAX (alendronate)
	FOSAMAX PLUS D (alendronate/vitamin D)
	ibandronate
	risedronate
OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS	
EVISTA (raloxifene)	calcitonin nasal
FORTEO (teriparatide)	PROLIA (denosumab)
	raloxifene
	teriparatide
	TYMLOS (abaloparatide)

BPH AGENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

PREFERRED AGENTS	NON-PREFERRED AGENTS
ALPHA BLOCKERS	
alfuzosin	CARDURA (doxazosin)
doxazosin	FLOMAX (tamsulosin)
tamsulosin	RAPAFLO (silodosin)
terazosin	silodosin
5-ALPHA-REDUCTASE (5AR) INHIBITORS	
finasteride	AVODART (dutasteride)
	dutasteride
	PROSCAR (finasteride)
ALPHA BLOCKER/5AR INHIBITOR COMBINATIONS	
	dutasteride/tamsulosin
	JALYN (dutasteride/tamsulosin)
PHOSPHODIESTERASE 5 INHIBITORS	
	tadalafil

BRONCHODILATORS, BETA AGONIST

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Duplicate Therapy

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
INHALERS, SHORT-ACTING	
PROAIR HFA (albuterol)	albuterol HFA
PROVENTIL HFA (albuterol)	levalbuterol
VENTOLIN HFA (albuterol)	PROAIR DIGIHALER (albuterol)
	PROAIR RESPICLICK (albuterol)
	XOPENEX HFA (levalbuterol)
INHALERS, LONG-ACTING	
	SEREVENT (salmeterol)
	STRIVERDI RESPIMAT (olodaterol)
INHALATION SOLUTION	
albuterol	arformoterol
	BROVANA (arformoterol)
	formoterol
	levalbuterol
	PERFOROMIST (formoterol)
	XOPENEX (levalbuterol)
ORAL	
albuterol syrup	albuterol tablet
	albuterol ER
	metaproterenol
	terbutaline

CALCIUM CHANNEL BLOCKERS (ORAL)

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
SHORT-ACTING	
diltiazem	CARDIZEM (diltiazem)
verapamil	isradipine
	nicardipine
	nifedipine
	nimodipine
	NYMALIZE (nimodipine)
LONG-ACTING	
amlodipine	CALAN SR (verapamil)
CARTIA XT (diltiazem)	CARDIZEM CD (diltiazem)
DILT XR (diltiazem)	CARDIZEM LA (diltiazem)
diltiazem ER	diltiazem LA
felodipine ER	KATERZIA (amlodipine)
nifedipine ER	levamlodipine
TAZTIA XT (diltiazem)	MATZIM LA (diltiazem)
TIADYLT ER (diltiazem)	nisoldipine
verapamil ER capsules, tablets	NORLIQVA (amlodipine oral solution)
	NORVASC (amlodipine)
	PROCARDIA XL (nifedipine)
	SULAR (nisoldipine)
	TIAZAC (diltiazem)
	verapamil 360 mg capsules
	verapamil ER PM
	VERELAN (verapamil)
	VERELAN PM (verapamil)

CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS	
amoxicillin/clavulanate tablets, suspension	amoxicillin/clavulanate chewable, XR tablets
	AUGMENTIN XR (amoxicillin/clavulanate)
CEPHALOSPORINS – FIRST GENERATION	
cefadroxil capsules, suspension	cefadroxil tablets
cephalexin capsules, suspension	cephalexin tablets
CEPHALOSPORINS – SECOND GENERATION	
cefprozil suspension	cefaclor ER
cefprozil tablets	cefaclor IR capsules, suspension
cefuroxime tablets	
CEPHALOSPORINS – THIRD GENERATION	
cefdinir	cefixime
	cefpodoxime
	SUPRAX (cefixime)

COLONY STIMULATING FACTORS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
GRANIX (tbo-filgrastim) vial	FULPHILA (pegfilgrastim-jmdb)
NEUPOGEN (filgrastim) vial, syringe	GRANIX (tbo-filgrastim) syringe
NYVEPRIA (pegfilgrastim-apgf)	LEUKINE (sargramostim)
	NEULASTA (pegfilgrastim)
	NIVESTYM (filgrastim-aafi)
	RELEUKO (filgrastim-AYOW) syringe, vial
	UDENYCA (pegfilgrastim-cbqv)
	ZARXIO (filgrastim-sndz)
	ZIEXTENZO SYRINGE (pegfilgrastim-bmez)

COPD AGENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Duplicate Therapy

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTICHOLINERGICS	
ATROVENT HFA (ipratropium)	INCRUSE ELLIPTA (umeclidinium)
ipratropium inhalation solution	LONHALA MAGNAIR (glycopyrrolate)
SPIRIVA HANDIHALER (tiotropium)	SPIRIVA RESPIMAT (tiotropium)
	TUDORZA (aclidinium)
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS	
albuterol/ipratropium	BEVESPI AEROSPHERE (glycopyrrolate/formoterol)
ANORO ELLIPITA (umeclidinium/vilanterol)	DUAKLIR PRESSAIR (aclidinium/formoterol)
COMBIVENT RESPIMAT (albuterol/ipratropium)	YUPELRI (revefenacin)
STIOLTO RESPIMAT (tiotropium/olodaterol)	
PHOSPHODIESTERASE INHIBITORS	
	DALIRESP (roflumilast)

COUGH AND COLD AGENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Cough & Cold PA criteria

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

See separate **Preferred Cough and Cold Agent** listing.

CYTOKINE AND CAM ANTAGONISTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Cytokine and CAM Antagonists

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ENBREL (etanercept)	ACTEMRA (tocilizumab)
HUMIRA (adalimumab)	ARCALYST (rilonacept)
OTEZLA (apremilast)	CIBINQO (abrocitinib)
	CIMZIA (certolizumab)
	COSENTYX (secukinumab)
	ENSPRYNG (satralizumab-mwge)
	ILARIS (canakinumab)
	ILUMYA (tildrakizumab-asmn)
	KEVZARA (sarilumab)
	KINERET (anakinra)
	OLUMIANT (baricitinib)
	ORENCIA (abatacept)
	RINVOQ ER (upadacitinib)
	SILIQ (brodalumab)
	SIMPONI (golimumab)
	SKYRIZI (risankizumab-rzaa)
	SKYRIZI PEN (risankizumab-rzaa)
	STELARA (ustekinumab)
	TALTZ (ixekizumab)
	TREMFYA (guselkumab)
	XELJANZ (tofacitinib)
	XELJANZ soln (tofacitinib)
	XELJANZ XR (tofacitinib)

EPINEPHRINE, SELF-INJECTED

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred products
- Contraindication to preferred products
- Allergic reaction to preferred products
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
epinephrine (Mylan authorized generic EPIPEN and EPIPEN JR)	epinephrine (generic ADRENACLICK)
EPIPEN (epinephrine)	epinephrine (generic EPIPEN and EPIPEN JR)
EPIPEN JR (epinephrine)	SYMJEPI (epinephrine)

ERYTHROPOIESIS STIMULATING PROTEINS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Erythropoiesis-Stimulating Agents

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ARANESP (darbepoetin)	MIRCERA (PEG-EPO)
EPOGEN (RhUEPO)	PROCRIT (RhUEPO)
RETACRIT (RhUEPO)	REBLOZYL (luspatercept-aamt)

FLUOROQUINOLONES, ORAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
ciprofloxacin IR	BAXDELA (delafloxacin)
CIPRO (ciprofloxacin) suspension	CIPRO (ciprofloxacin) tablets
levofloxacin tablets	ciprofloxacin suspension
	levofloxacin solution
	moxifloxacin
	ofloxacin

GI MOTILITY, CHRONIC

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass (including OTC products)
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- GI Motility

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
AMITIZA (lubiprostone)	alosetron
LINZESS (linaclotide)	IBSRELA (tenapanor HCl)
MOVANTIK (naloxegol)	LOTRONEX (alosetron)
	lubiprostone
	MOTEGRITY (prucalopride)
	RELISTOR (methylnaltrexone) injection
	RELISTOR (methylnaltrexone) oral
	SYMPROIC (naldemedine)
	TRULANCE (plecanatide)
	VIBERZI (eluxadoline)

GLUCAGON AGENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
BAQSIMI (glucagon)	diazoxide suspension
glucagon injection	glucagon emergency kit (Fresenius)
glucagon emergency kit (Lilly)	GVOKE pen (glucagon)
GVOKE syringe (glucagon)	ZEGALOGUE SYRINGE (dasiglucagon)
PROGLYCEM (diazoxide)	
ZEGALOGUE AUTOINJECTOR (dasiglucagon)	

GLUCOCORTICOIDS, INHALED

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Duplicate Therapy

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
GLUCOCORTICOIDS	
ASMANEX (mometasone)	ALVESCO (ciclesonide)
budesonide respules	ARMONAIR DIGIHALER ((fluticasone)
FLOVENT HFA (fluticasone)	ARNUITY ELLIPTA (fluticasone)
PULMICORT FLEXHALER (budesonide)	ASMANEX HFA (mometasone)
	FLOVENT DISKUS (fluticasone)
	fluticasone HFA
	PULMICORT respules (budesonide)
	QVAR (beclomethasone)
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS	
ADVAIR (fluticasone/salmeterol)	AIRDUO DIGIHALER (fluticasone/salmeterol)
DULERA (mometasone/formoterol)	AIRDUO RESPICLICK (fluticasone/salmeterol)
SYMBICORT (budesonide/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)
	BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol)
	budesonide-formoterol
	fluticasone/salmeterol (Air Duo)
	fluticasone/vilanterol
	TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)
	WIXELA (fluticasone/salmeterol)

GLUCOCORTICOIDS, ORAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Duplicate Therapy

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
budesonide EC	ALKINDI SPRINKLE (hydrocortisone)
dexamethasone elixir, solution, tablets	CORTEF (hydrocortisone)
hydrocortisone	cortisone
methylprednisolone tablet dose pack	dexamethasone intensol
prednisolone sodium phosphate	DEXPAK (dexamethasone)
prednisolone	EMFLAZA (deflazacort)
prednisone solution, tablets	HEMADY (dexamethasone)
	MEDROL (methylprednisolone)
	methylprednisolone tablets
	MILLIPRED (prednisolone)
	ORTIKOS CAPSULE ER (budesonide)
	prednisolone sodium phosphate ODT, solution
	prednisone intensol
	prednisone tablet dose pack
	RAYOS DR (prednisone)
	TAPERDEX (dexamethasone)
	TARPEYO (budesonide)

GROWTH HORMONE

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Growth Hormone

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
GENOTROPIN	HUMATROPE
NORDITROPIN	NUTROPIN AQ
	OMNITROPE
	SAIZEN
	SEROSTIM
	SKYTROFA
	ZOMACTON
	ZORBTIVE

H. PYLORI TREATMENT

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
PYLERA (bismuth subcitrate/metronidazole/tetracycline)	lansoprazole/amoxicillin/clarithromycin
	OMECLAMOX PAK (omeprazole/amoxicillin/clarithromycin)
	TALICIA (omeprazole/amoxicillin/rifabutin)

HEMOPHILIA TREATMENT

PA Criteria (client must meet at least one of the listed PA criteria):

- All of the agents in the Hemophilia Treatment class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
FACTOR VIII	
ADVATE	
ADYNOVATE	
AFSTYLA	
ELOCTATE	
ESPEROCT	
HEMOFIL M	
HUMATE P	
JIVI	
KOATE DVI	
KOGENATE FS	
KOVALTRY	
NOVOEIGHT	
NUWIQ	
OBIZUR	
RECOMBINATE	
XYNTHA	
FACTOR IX	
ALPHANINE SD	
ALPROLIX	
BENEFIX	
IDELVION	
IXINITY	
PROFILNINE	
REBINYN	
RIXUBIS	
OTHER	
ALPHANATE (von Willebrand factor/Factor VIII)	
COAGADEX (Factor X)	
CORIFACT (Factor XIII)	
FEIBA NF (activated prothrombin complex)	
HEMLIBRA (emicizumab-kxwh)	
NOVOSEVEN RT (Factor VIIa)	
SEVENFACT (Factor VIIa-jncw)	
TRETTEN (Factor XIII)	
VOVENDI (von Willebrand factor)	
WILATE (von Willebrand factor/Factor VIII)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: **txvendordrug.com/formulary/formulary-search**. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

HEPATITIS C AGENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

PREFERRED AGENTS	NON-PREFERRED AGENTS
PEGYLATED INTERFERONS	
	PEGASYS (pegylated IFN alfa-2a)
POLYMERASE/PROTEASE INHIBITORS	
MAVYRET (glecaprevir/pibrentasvir)	EPCLUSA (sofosbuvir/velpatasvir)
	HARVONI (ledipasvir/sofosbuvir) tablets, pellet pack
	ledipasvir/sofosbuvir
	sofosbuvir/velpatasvir
	SOVALDI (sofosbuvir) tablets, pellet pack
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)
	VOSEVI (sofosbuvir, velpatasvir, voxilaprevir)
	ZEPATIER (elbasvir/grazoprevir)
RIBAVIRIN	
ribavirin capsule	
ribavirin tablet	

HEREDITARY ANGIOEDEMA (HAE) TREATMENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Hereditary Angioedema

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
BERINERT (C1 esterase inhibitor)	icatibant
CINRYZE (C1 esterase inhibitor)	ORLADEYO (berotralstat)
FIRAZYR (icatibant)	RUCONEST (C1 esterase inhibitor)
HAEGARDA (C1 esterase inhibitor)	SAJAZIR (icatibant)
KALBITOR (ecallantide)	TAKHZYRO (lanadelumab-flyo) syringe, vial

HIV/AIDS

PA Criteria (client must meet at least one of the listed PA criteria):

- All of the agents in the HIV/AIDS class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIRETROVIRAL SINGLE AGENT PRODUCTS	
abacavir	
APTIVUS (tipranavir)	
atazanavir	
didanosine	
EDURANT (rilpivirine)	
efavirenz	
emtricitabine	
EMTRIVA (emtricitabine)	
EPIVIR (lamivudine)	
etravirine	
fosamprenavir	
FUZEON (enfuvirtide)	
INTELENCE (etravirine)	
INVIRASE (saquinavir)	
ISENTRESS (raltegravir)	
lamivudine	
LEXIVA (fosamprenavir)	
maraviroc	
nevirapine	
NORVIR (ritonavir)	
PIFELTRO (doravirine)	
PREZCOBIX (darunavir/cobicistat)	
PREZISTA (darunavir)	
RETROVIR (zidovudine)	
REYATAZ (atazanavir)	
ritonavir	
RUKOBIA (fostemsavir)	
SELZENTRY (maraviroc)	
stavudine	
SUSTIVA (efavirenz)	
tenofovir disoproxil fumarate	
TIVICAY (dolutegravir)	
TYBOST (cobicistat)	
VIRACEPT (nelfinavir)	
VIRAMUNE (nevirapine)	
VIRAMUNE XR (nevirapine)	

PREFERRED AGENTS	NON-PREFERRED AGENTS
VIREAD (tenofovir disoproxil fumurate)	
ZIAGEN (abacavir)	
zidovudine	
ANTIRETROVIRAL COMBINATIONS	
abacavir/lamivudine	
abacavir/lamivudine/zidovudine	
ATRIPLA (efavirenz/emtricitabine/tenofovir)	
BIKTARVY (bictegravir/emtricitabine/tenofovir)	
CIMDUO (lamivudine/tenofovir DF)	
COMBIVIR (lamivudine/zidovudine)	
COMPLERA (emtricitabine/rilpivirine/tenfovir DF)	
DELSTRIGO (doravirine/lamivudine/ tenofovir DF)	
DESCOVY (emtricitabine/tenofovir alafenamide)	
DOVATO (dolutegravir/lamivudine)	
efavirenz/emtricitabine/tenofovir disoproxil fumarate	
efavirenz/lamivudine/tenofovir disoproxil fumarate (SYMFI LO)	
efavirenz/lamivudine/tenofovir disoproxil fumarate (SYMFI)	
emtricitabine/tenofovir disoproxil fumarate	
EPZICOM (abacavir/lamivudine)	
EVOTAZ (atazanavir/cobicistat)	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide)	
JULUCA (dolutegravir/rilpivirine)	
KALETRA (lopinavir/ritonavir)	
lamivudine/zidovudine	
lopinavir/ritonavir	
ODEFSEY (emtricitabine/rilpivirine/tenofovir alafenamide)	
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir DF)	
SYMFI (efavirenz/lamivudine/tenofovir DF)	
SYMFI LO (efavirenz/lamivudine/tenofovir DF)	
SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir DF)	
TEMIXYS (lamivudine/tenofovir DF)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	
TRIUMEQ PD (abacavir/dolutegravir/lamivudine)	
TRIZIVIR (abacavir/lamivudine/zidovudine)	
TRUVADA (emtricitabine/tenofovir DF)	

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
AMYLIN ANALOGS	
SYMLIN (pramlintide)	

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- DPP4 Inhibitor

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
INCRETIN ENHANCERS	
JANUMET (sitagliptin/metformin)	alogliptin
JANUVIA (sitagliptin)	alogilptin/metformin
JENTADUETO (linagliptin/metformin)	alogliptin/pioglitazone
KOMBIGLYZE XR (saxagliptin/metformin)	JANUMET XR (sitagliptin/metformin)
ONGLYZA (saxagliptin)	JENTADUETO XR (linagliptin/metformin)
TRADJENTA (linagliptin)	KAZANO (alogliptin /metformin)
	NESINA (alogliptin)
	OSENI (alogliptin /pioglitazone)

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- GLP-1 Receptor Antagonists

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
INCRETIN MIMETICS	
BYDUREON (exenatide ER) pens	ADLYXIN (lixisenatide)
BYETTA (exenatide)	BYDUREON BCISE (exenatide ER)
OZEMPIC (semaglutide)	MOUNJARO (tirzepatide)
TRULICITY (dulaglutide)	RYBELSUS (semaglutide)
VICTOZA (liraglutide)	

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- DPP4 Inhibitor

The following Clinical Prior Authorization applies **to all drugs** in the class:

- GLP-1 Receptor Antagonists

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
INCRETIN ENHANCERS/SGLT2 INHIBITOR COMBINATIONS	
GLYXAMBI (empagliflozin/linagliptin)	QTERN (dapagliflozin/saxagliptin)
TRIJARDY XR (empagliflozin/linagliptin/metformin)	STEGLUJAN (ertugliflozin/sitagliptin)
INCRETIN MIMETIC/INSULIN COMBINATIONS	
	SOLIQUA (lixisenatide/insulin glargine)
	XULTOPHY (liraglutide/insulin degludec)

HYPOGLYCEMICS, INSULIN

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
HUMALOG (insulin lispro) pens, vials (100 u/ml)	ADMELOG (insulin lispro)
HUMALOG JUNIOR KWIKPEN (insulin lispro)	AFREZZA (insulin)
HUMALOG MIX (insulin lispro/lispro protamine) pens, vials	APIDRA (insulin glulisine)
HUMULIN N (insulin) vials	BASAGLAR (insulin glargine)
HUMULIN R (insulin) vials	FIASP (insulin aspart)
HUMULIN R 500 UNITS/ML (insulin) pens, vials	HUMALOG 200 UNITS/ML
HUMULIN R 70/30 (insulin) pens, vials	HUMULIN N (insulin) pen
insulin aspart cartridge (AG)	insulin degludec pen
insulin aspart pen (AG)	insulin degludec vial
insulin aspart vial (AG)	insulin glargine vial
insulin aspart/insulin aspart protamine insulin pen (AG)	insulin glargine pen
insulin aspart/insulin aspart protamine vial (AG)	insulin glargine-YFGN pen
insulin lispro junior kwikpen (AG)	insulin glargine-YFGN vial
insulin lispro pen (AG)	insulin lispro protamine mix kwikpen (AG)
insulin lispro vial (AG)	LYUMJEV (insulin lispro)
LANTUS (insulin glargine)	MYXREDLIN (insulin regular in 0.9 % NaCl)
LEVEMIR (insulin detemir)	NOVOLIN (insulin) pens
NOVOLIN (insulin) vials	NOVOLIN 70/30 (insulin)
NOVOLOG (insulin aspart)	SEMGLEE (insulin glargine) pen, vial
NOVOLOG MIX (insulin aspart/aspart protamine)	TOUJEO (insulin glargine)
	TRESIBA (insulin degludec)

HYPOGLYCEMICS, MEGLITINIDES

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Duplicate Therapy

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
nateglinide	repaglinide/metformin
repaglinide	

HYPOGLYCEMICS, METFORMIN

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
GLUMETZA (metformin ER)	FORTAMET (metformin ER)
glyburide/metformin	glipizide/metformin
metformin	metformin ER (FORTAMET)
metformin ER (GLUCOPHAGE XR)	metformin ER (GLUMETZA)
	metformin (solution)
	RIOMET (metformin)
	RIOMET ER (metformin)

HYPOGLYCEMICS, SGLT2

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- SGLT2 Inhibitor

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
SUBCLASS	
FARXIGA (dapagliflozin)	STEGLATRO (ertugliflozin)
INVOKANA (canaglifozin)	
JARDIANCE (empagliflozin)	

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- SGLT2 Combinations

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
SGLT2 COMBINATIONS	
INVOKAMET (canagliflozin/metformin)	INVOKAMET XR (canagliflozin/metformin)
SYNJARDY (empagliflozin/metformin)	SEGLUROMET (ertugliflozin/metformin)
XIGDUO XR (dapagliflozin/metformin)	SYNJARDY XR (empagliflozin/metformin)

HYPOGLYCEMICS, TZD

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Thiazolidinediones

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
THIAZOLIDINEDIONES	
pioglitazone	ACTOS (pioglitazone)

PA Criteria (client must meet at least one of the listed PA criteria):

- Separate prescriptions for the individual components should be used instead of the combination drug.
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- For drugs in a therapeutic class and/or subclass with no preferred option, the provider must obtain a PDL prior authorization

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Thiazolidinediones

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
TZD COMBINATIONS	
	DUETACT (pioglitazone/glimepiride)
	pioglitazone/metformin
	pioglitazone/glimepiride

IMMUNE GLOBULINS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
GAMMAGARD (immune globulin)	ASCENIV (immune globulin)
GAMMAKED (immune globulin)	BIVIGAM (immune globulin)
GAMUNEX-C (immune globulin)	CUTAQUIG (immune globulin)
	CUVITRU (immune globulin)
	CYTOGAM (CMV immune globulin)
	FLEBOGAMMA DIF (immune globulin)
	GAMASTAN S-D (immune globulin)
	HEPAGAM B (hepatitis B immune globulin)
	HYQVIA (immune globulin)
	HIZENTRA (immune globulin) syringe
	HIZENTRA (immune globulin) vial
	OCTAGAM (immune globulin)
	PANZYGA (immune globulin)
	PRIVIGEN (immune globulin)
	VARIZIG (varicella-zoster immune globulin)
	XEMBIFY (immune globulin)

IMMUNOMODULATORS, ASTHMA

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- The PA criteria above apply to Dupixent for Asthma

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Immunomodulators, Asthma

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
FASENRA PEN (benralizumab)	NUCALA (mepolizumab)
XOLAIR (omalizumab) syringe	

IMMUNOMODULATORS, ATOPIC DERMATITIS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- Dupixent, in this therapeutic PDL class, is for Atopic Dermatitis indication. The clinical prior authorization linked here includes the product's other indications.

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ELIDEL (pimecrolimus)	ADBRY (tralokinumab)
EUCRISA (crisaborole)	DUPIXENT (dupilumab)
	OPZELURA (ruxolitinib)
	pimecrolimus
	tacrolimus

IMMUNOSUPPRESSIVES, ORAL/SQ

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
azathioprine	ASTAGRAF XL (tacrolimus)
cyclosporine, modified	AZASAN (azathioprine)
GENGRAF (cyclosporine modified) capsules, solution	BENLYSTA AUTOINJECTOR (belimumab.)
mycophenolate mofetil capsules, tablets	BENLYSTA SYRINGE (belimumab.)
NEORAL (cyclosporine, modified) capsules	CELLCEPT (mycophenolate mofetil)
RAPAMUNE (sirolimus) solution	cyclosporine capsule, softgel
RAPAMUNE (sirolimus) tablet	ENVARSUS XR (tacrolimus)
tacrolimus	everolimus tablet
	IMURAN (azathioprine)
	LUPKYNIS (voclosporin)
	mycophenolate mofetil suspension
	mycophenolic acid
	MYFORTIC (mycophenolic acid)
	NEORAL (cyclosporine, modified) solution
	PROGRAF (tacrolimus)
	REZUROCK (belumosudil)
	SANDIMMUNE (cyclosporine)
	sirolimus solution
	sirolimus tablet
	TAVNEOS (avacopan)
	ZORTRESS (everolimus)

INTRANASAL RHINITIS AGENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- The PA criteria above apply to Dupixent for Chronic Rhinosinusitis
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

PREFERRED AGENTS	NON-PREFERRED AGENTS
GLUCOCORTICOIDS	
fluticasone	BECONASE AQ (beclomethasone)
	budesonide
	flunisolide
	fluticasone OTC
	mometasone
	NASONEX (mometasone)
	OMNARIS (ciclesonide)
	QNASL (beclomethasone dipropionate)
	triamcinolone
	XHANCE (fluticasone)
OTHERS	
azelastine (generic ASTELIN)	ASTEPRO (azelastine)
	azelastine (generic ASTEPRO)
	ipratropium nasal spray
	olopatadine
	PATANASE (olopatadine)
COMBINATIONS	
	azelastine/fluticasone
	DYMISTA (azelastine/fluticasone)

IRON, ORAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

See separate **Preferred Oral Iron Drugs** listing.

LEUKOTRIENE MODIFIERS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Leukotriene Modifiers

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
montelukast tablets and chewable tablets	ACCOLATE (zafirlukast)
	montelukast granules
	SINGULAIR (montelukast)
	zafirlukast
	zileuton
	ZYFLO (zileuton)

LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS

PA Criteria (client must meet at least one of the listed PA criteria):

- 14-day treatment trial with a preferred drug within the past 180 days
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
clindamycin capsules	CLEOCIN (clindamycin)
clindamycin solution	linezolid suspension
linezolid tablet, IV	linezolid suspension AG
linezolid tablet, IV (AG)	LINCOCIN (lincomycin)
ZYVOX (linezolid) suspension	SIVEXTRO (tedizolid)
	ZYVOX (linezolid) tablet, injection

LIPOTROPICS, OTHER

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ADENOSINE TRIPHOSPHATE-CITRATE LYASE INHIBITOR	
	NEXLETOL (bempedoic acid)
	NEXLIZET (bempedoic acid/ezetimibe)
BILE ACID SEQUESTRANTS	
cholestyramine	colesevelam
COLESTID (colestipol) tablet	COLESTID (colestipol) granules
PREVALITE (cholestyramine/aspartame) packet, powder	colestipol granules
WELCHOL (colesevalam)	colestipol tablets
	QUESTRAN (cholestyramine)
	QUESTRAN LIGHT (cholestyramine)
CHOLESTEROL ABSORPTION INHIBITORS	
ZETIA (ezetimibe)	ezetimibe
FIBRIC ACID DERIVATIVES	
fenofibrate (generic Lofibra, Tricor)	ANTARA (fenofibrate,micronized)
gemfibrozil	fenofibrate (generic Antara, Fenoglide, Lipofen)
	fenofibric acid (generic Fibricor, Trilipix)
	FENOGLIDE (fenofibrate)
	LIPOFEN (fenofibrate)
	LOPID (gemfibrozil)
	TRICOR (fenofibrate)
	TRILIPIX (fenofibric acid)
HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA TREATMENTS	
	JUXTAPID (lomitapide)
NIACIN	
niacin OTC	niacin ER
	NIASPAN (niacin)
OMEGA-3 FATTY ACIDS	
omega-3 fatty acids	icosapent ethyl
	LOVAZA (omega-3 fatty acids)
	VASCEPA (icosapent ethyl)

PA Criteria (client must meet at least one of the listed PA criteria):

- Trial of atorvastatin, rosuvastatin, and ezetimibe
- Concurrent therapy of atorvastatin or rosuvastatin
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

Clinical prior authorizations applies to all PCSK9 inhibitors:

- Hyperlipidemia agents

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
PCSK9 INHIBITORS	
	PRALUENT (alirocumab)
	REPATHA (evolocumab)

LIPOTROPICS, STATINS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with at least two preferred drugs accounting for no less than 120 days of therapy combined
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Duplicate Therapy

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
STATINS	
atorvastatin	ALTOPREV (lovastatin)
LIPITOR (atorvastatin)	CRESTOR (rosuvastatin)
lovastatin	EZALLOR SPRINKLE (rosuvastatin)
pravastatin	fluvastatin
rosuvastatin	fluvastatin ER
simvastatin	LESCOL XL (fluvastatin)
	LIVALO (pitavastatin)
	ZOCOR (simvastatin)
	ZYPITAMAG (pitavastatin)
STATIN COMBINATIONS	
	atorvastatin/amlodipine
	CADUET (atorvastatin/amlodipine)
	simvastatin/ezetimibe
	VYTORIN (simvastatin/ezetimibe)

MACROLIDES (ORAL)

PA Criteria (client must meet at least one of the listed PA criteria):

- A 7-day treatment trial with at least one preferred agent in the last 180 days (Exception may apply when a preferred drug requires less than a 7-day treatment trial)
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For clients with diagnosis of Gastroparesis, Cerebral Palsy Gastroparesis, and GERD associated with Gastrostomy complications, a 90-day PA duration will be approved

PREFERRED AGENTS	NON-PREFERRED AGENTS
azithromycin	clarithromycin suspension
clarithromycin tablets	clarithromycin ER
ERYPED 200 (erythromycin)	E.E.S. (erythromycin) tablet
ERYPED 400 (erythromycin)	E.E.S. (erythromycin) 200 suspension
erythromycin base	ERY-TAB (erythromycin)
	ERYTHROCIN (erythromycin)
	erythromycin base filmtab
	erythromycin ethylsuccinate suspension
	ZITHROMAX (azithromycin)

MOVEMENT DISORDERS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- VMAT2 Inhibitors

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
AUSTEDO (deutetrabenazine)	XENAZINE (tetrabenazine)
INGREZZA (valbenazine)	
tetrabenazine	

MULTIPLE SCLEROSIS AGENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- All of the agents in the Multiple Sclerosis class are preferred

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
AMPYRA (dalfampridine)	
AUBAGIO (teriflunomide)	
AVONEX (interferon beta-1a)	
BAFIERTAM (monomethyl fumarate)	
BETASERON (interferon beta-1b)	
COPAXONE (glatiramer)	
dalfampridine	
dimethyl fumarate	
EXTAVIA (interferon beta-1b)	
GILENYA (fingolimod)	
glatiramer	
GLATOPA (glatiramer)	
KESIMPTA (ofatumumab)	
MAVENCLAD (cladribine)	
MAYZENT (siponimod)	
PLEGRIDY (peginterferon beta-1a)	
PONVORY STARTER PACK (ponesimod)	
PONVORY TABLET (ponesimod)	
REBIF (interferon beta-1a)	
TECFIDERA (dimethyl fumarate)	
VUMERITY (diroximel fumarate)	
ZEPOSIA (ozanimod)	

NEUROPATHIC PAIN

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ORAL AGENTS	
duloxetine (Cymbalta)	CYMBALTA (duloxetine)
gabapentin	DRIZALMA SPRINKLE (duloxetine)
LYRICA (pregabalin)	duloxetine (Irenka)
	GRALISE (gabapentin)
	HORIZANT (gabapentin enacarbil ER)
	LYRICA CR (pregabalin)
	NEURONTIN (gabapentin)
	pregabalin capsule
	pregabalin ER, solution
	SAVELLA (milnacipran)
TOPICAL AGENTS	
capsaicin OTC	lidocaine patch
LIDODERM (lidocaine)	QUTENZA (capsaicin/skin cleanser)
	ZTLIDO (lidocaine)

NSAIDS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Duplicate Therapy

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
NONSPECIFIC	
diclofenac potassium tablet	DAYPRO (oxaprozin)
diclofenac sodium	diclofenac potassium capsule
ibuprofen	diclofenac SR
indomethacin capsules	diflunisal
ketorolac	etodolac
naproxen EC	etodolac SR
naproxen sodium OTC	FELDENE (piroxicam)
naproxen tablets	fenoprofen
sulindac	flurbiprofen
	INDOCIN (indomethacin) suspension
	indomethacin ER capsules
	ketoprofen
	ketoprofen ER
	meclofenamate
	mefenamic acid
	nabumetone
	NALFON (fenoprofen)
	NAPRELAN CR (naproxen sodium)
	naproxen CR
	naproxen sodium (Rx)
	naproxen suspension
	oxaprozin
	piroxicam
	RELAFEN DS (nabumetone)
	tolmetin
	VIVLODEX (meloxicam, submicronized)
	ZIPSOR (diclofenac)
	ZORVOLEX (diclofenac)

PREFERRED AGENTS	NON-PREFERRED AGENTS
NSAID/GI PROTECTANT COMBINATIONS	
	ARTHROTEC (diclofenac/misoprostol)
	diclofenac/misoprostol
	DUEXIS (ibuprofen/famotidine)
	ibuprofen/famotidine
	naproxen/esomeprazole mag
	VIMOVO (naproxen/ esomeprazole)
TOPICAL NSAIDS	
diclofenac gel 1%	diclofenac solution
VOLTAREN gel (diclofenac)	diclofenac patch
	DICLOFEX DC (diclofenac/capsicum)
	FLECTOR (diclofenac)
	INDOCIN (indomethacin) suppositories
	ketorolac nasal spray
	LICART PATCH (diclofenac epolamine)
	PENNSAID (diclofenac)
	SPRIX NASAL SPRAY (ketorolac nasal spray)

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Duplicate Therapy
- Cox II Inhibitors

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
COX-II SELECTIVE	
meloxicam tablets	CELEBREX (celecoxib)
	celecoxib
	meloxicam capsules
	MOBIC (meloxicam)

ONCOLOGY, ORAL – BREAST

PA Criteria (client must meet at least one of the listed PA criteria):

- All of the agents in the Oncology, Oral – Breast class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
anastrozole	
ARIMIDEX (anastrozole)	
AROMASIN (exemestane)	
capecitabine	
cyclophosphamide	
exemestane	
FARESTON (toremifene)	
FEMARA (letrozole)	
IBRANCE (palbociclib)	
KISQALI (ribociclib)	
KISQALI/FEMARA KIT (ribociclib/letrozole)	
lapatinib	
letrozole	
NERLYNX (neratinib)	
PIQRAY (alpelisib)	
SOLTAMOX (tamoxifen)	
TALZENNA (talazoparib)	
tamoxifen	
toremifene	
TUKYSA (tucatinib)	
TYKERB (lapatinib)	
VERZENIO (abemaciclib)	
XELODA (capecitabine)	

ONCOLOGY, ORAL – HEMATOLOGIC

PA Criteria (client must meet at least one of the listed PA criteria):

- All of the agents in the Oncology, Oral – Hematologic class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
ALKERAN (melphalan)	
BOSULIF (bosutinib)	
BRUKINSA (zanubrutinib)	
CALQUENCE (acalabrutinib)	
COPIKTRA (duvelisib)	
DAURISMO (glasdegib)	
FARYDAK (panobinostat)	
GLEEVEC (imatinib)	
HYDREA (hydroxyurea)	
ICLUSIG (ponatinib)	
IDHIFA (enasidenib)	
imatinib	
IMBRUVICA (ibrutinib)	
INQOVI (decitabine/cedazuridine)	
INREBIC (fedratinib)	
JAKAFI (ruxolitinib)	
LEUKERAN (chlorambucil)	
MATULANE (procarbazine)	
melphalan	
mercaptopurine	
MYLERAN (busulfan)	
NINLARO (ixazomib)	
ONUREG (azacytidine)	
POMALYST (pomalidomide)	
PURIXAN (mercaptopurine)	
REVLIMID (lenalidomide)	
RYDAPT (midostaurin)	
SCEMBLIX (asciminib)	
SPRYCEL (dasatinib)	
TABLOID (thioguanine)	
TASIGNA (nilotinib)	
THALOMID (thalidomide)	
TIBSOVO (ivosidenib)	
tretinoin	
UKONIQ (umbralisib)	
VENCLEXTA (venetoclax)	
VONJO (pacritinib)	

PREFERRED AGENTS	NON-PREFERRED AGENTS
XOSPATA (gilteritinib)	
XPOVIO (selinexor)	
ZOLINZA (vorinostat)	
ZYDELIG (idelalisib)	

ONCOLOGY, ORAL – LUNG

PA Criteria (client must meet at least one of the listed PA criteria):

- All of the agents in the Oncology, Oral – Lung class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
ALECENSA (alectinib)	
ALUNBRIG (brigatinib)	
erlotinib	
EXKIVITY (mobocertinib)	
GAVRETO (pralsetinib)	
GILOTRIF (afatinib)	
HYCAMTIN (topotecan)	
IRESSA (gefitinib)	
LORBRENA (lorlatinib)	
LUMAKRAS (sotorasib)	
RETEVMO (selpercatinib)	
ROZLYTREK (entrectinib)	
TABRECTA (capmatinib)	
TAGRISSO (osimertinib)	
TARCEVA (erlotinib)	
TEPMETKO (tepotinib)	
VIZIMPRO (dacomitinib)	
XALKORI (crizotinib)	
ZYKADIA (ceritinib)	

ONCOLOGY, ORAL – OTHER

PA Criteria (client must meet at least one of the listed PA criteria):

- All of the agents in the Oncology, Oral – Other class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
AYVAKIT (avapritinib)	
BALVERSA (erdafitinib)	
CAPRELSA (vandetanib)	
COMETRIQ (cabozantinib)	
KOSELUGO (selumetinib)	
LONSURF (trifluridine/tipiracil)	
LYNPARZA (olaparib)	
PEMAZYRE (pemigatinib)	
QINLOCK (ripretinib)	
RUBRACA (rucaparib)	
STIVARGA (regorafenib)	
TAZVERIK (tazemetostat)	
TEMODAR (temozolomide)	
temozolomide	
TRUSELTIQ (infigratinib)	
TURALIO (pexidartinib)	
VITRAKVI (larotrectinib)	
ZEJULA (niraparib)	

ONCOLOGY, ORAL – PROSTATE

PA Criteria (client must meet at least one of the listed PA criteria):

- All of the agents in the Oncology, Oral – Prostate class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
abiraterone	
bicalutamide	
EMCYT (estramustine)	
ERLEADA (apalutamide)	
EULEXIN (flutamide)	
flutamide	
nilutamide	
NUBEQA (darolutamide)	
XTANDI (enzalutamide)	
YONSA (abiraterone)	
ZYTIGA (abiraterone)	

ONCOLOGY, ORAL – RENAL CELL

PA Criteria (client must meet at least one of the listed PA criteria):

- All of the agents in the Oncology, Oral – Renal Cell class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
AFINITOR (everolimus)	
CABOMETYX (cabozantinib)	
everolimus	
INLYTA (axitinib)	
LENVIMA (Lenvatinib)	
NEXAVAR (sorafenib)	
SUTENT (sunitinib)	
sunitinib	
VOTRIENT (pazopanib)	
WELIREG (belzutifan)	

ONCOLOGY, ORAL – SKIN

PA Criteria (client must meet at least one of the listed PA criteria):

- All of the agents in the Oncology, Oral – Skin class are preferred

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
BRAFTOVI (encorafenib)	
COTELLIC (cobimetinib)	
ERIVEDGE (vismodegib)	
MEKINIST (trametinib)	
MEKTOVI (binimetinib)	
ODOMZO (sonidegib)	
TAFINLAR (dabrafenib)	
ZELBORAF (vemurafenib)	

OPHTHALMICS, ANTIBIOTIC – STEROID COMBINATIONS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
neomycin/polymyxin/dexamethasone	BLEPHAMIDE (sulfacetamide/prednisolone)
sulfacetamide/prednisolone	BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone)
TOBRADEX (tobramycin/dexamethasone) ointment	MAXITROL (neomycin/polymyxin/ dexamethasone)
TOBRADEX (tobramycin/dexamethasone) suspension	neomycin/bacitracin/polymyxin/hydrocortisone
	neomycin/polymyxin/hydrocortisone
	PRED-G (gentamicin/prednisolone)
	TOBRADEX ST (tobramycin/dexamethasone)
	tobramycin/dexamethasone
	ZYLET (tobramycin/loteprednol)

OPHTHALMIC ANTIBIOTICS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

PREFERRED AGENTS	NON-PREFERRED AGENTS
AMINOGLYCOSIDES	
GENTAK (gentamicin)	TOBREX (tobramycin) solution
gentamicin	
tobramycin	
TOBREX (tobramycin) ointment	
QUINOLONES	
ciprofloxacin	BESIVANCE (besifloxacin)
ofloxacin	CILOXAN (ciprofloxacin)
VIGAMOX (moxifloxacin)	gatifloxacin
	levofloxacin
	MOXEZA (moxifloxacin)
	moxifloxacin
	OCUFLOX (ofloxacin)
	ZYMAXID (gatifloxacin)
MACROLIDES	
erythromycin	AZASITE (azithromycin)
OTHER, ANTIFUNGAL	
	NATACYN (natamycin)
OTHER, MISC	
bacitracin/polymyxin	bacitracin
POLYCIN (bacitracin/polymyxin B sulfate)	neomycin/bacitracin/polymyxin
polymyxin/trimethoprim	neomycin/polymyxin/gramicidin
	POLYTRIM (polymyxin/trimethoprim)
	sulfacetamide ointment, solution

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
cromolyn	ALOCRIL (nedocromil)
olopatadine OTC (Pataday Once Daily)	ALOMIDE (lodoxamide)
olopatadine OTC (Pataday Twice a Day)	ALREX (loteprednol)
PATADAY XS ONCE DAILY OTC (olopatadine)	azelastine
	bepotastine
	BEPREVE (bepotastine)
	epinastine
	ketotifen
	LASTACAFT (alcaftadine)
	LASTACAFT (alcaftadine) OTC
	olopatadine
	PATADAY (olopatadine)
	PATADAY OTC (olopatadine)
	PATANOL (olopatadine)
	ZADITOR OTC (ketotifen)
	ZERVIATE (cetirizine)

OPHTHALMICS, ANTI-INFLAMMATORIES

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
NSAIDS	
diclofenac	ACULAR (ketorolac)
ketorolac	ACULAR LS (ketorolac)
	ACUVAIL (ketorolac)
	bromfenac
	BROMSITE (bromfenac)
	flurbiprofen
	ILEVRO (nepafenac)
	ketorolac LS
	NEVANAC (nepafenac)
	PROLENSA (bromfenac)
STEROIDS	
DUREZOL (difluprednate)	dexamethasone
Lotemax (loteprednol) drops, ointment	difluprednate
prednisolone acetate	FLAREX (fluorometholone)
	fluorometholone
	FML (fluorometholone)
	FML FORTE (fluorometholone)
	FML S.O.P. (fluorometholone)
	INVELTYS (loteprednol)
	LOTEMAX (loteprednol) gel
	loteprednol
	MAXIDEX (dexamethasone)
	PRED FORTE (prednisolone)
	PRED MILD (prednisolone)
	prednisolone sodium phosphate

OPHTHALMICS, ANTI-INFLAMMATORY IMMUNOMODULATORS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
RESTASIS (cyclosporine)	CEQUA (cyclosporine)
XIIDRA (lifitegrast)	cyclosporine
	EYSUVIS (loteprednol etabonate)
	RESTASIS MULTIDOSE (cyclosporine)
	TYRVAYA (varenicline)

OPHTHALMICS, GLAUCOMA AGENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

PREFERRED AGENTS	NON-PREFERRED AGENTS
SYMPATHOMIMETICS	
brimonidine	ALPHAGAN P (brimonidine)
pilocarpine	apraclonidine
	brimonidine P
	IOPIDINE (apraclonidine)
	VUITY (pilocarpine)
BETA BLOCKERS	
carteolol	betaxolol
levobunolol	BETIMOL (timolol)
timolol	BETOPTIC S (betaxolol)
	ISTALOL (timolol)
	timolol (Istalol)
	timolol PF (Timoptic Ocudose)
	TIMOPTIC (timolol)
	TIMOPTIC XE (timolol)
CARBONIC ANHYDRASE INHIBITORS	
AZOPT (brinzolamide)	brinzolamide
dorzolamide	TRUSOPT (dorzolamide)
RHO KINASE INHIBITORS	
RHOPRESSA (netarsudil)	
ROCKLATAN (netarsudil/latanoprost)	
PROSTAGLANDIN ANALOGS	
latanoprost	bimatoprost
TRAVATAN-Z (travoprost)	LUMIGAN (bimatoprost)
	tafluprost
	travoprost
	VYZULTA (latanoprostene bunod)
	XALATAN (latanoprost)
	XELPROS (latanoprost)
	ZIOPTAN (tafluprost)
COMBINATION AGENTS	
COMBIGAN (brimonidine/timolol)	brimonidine tartrate/timolol

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: **txvendordrug.com/formulary/formulary-search**. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PREFERRED AGENTS	NON-PREFERRED AGENTS
dorzolamide/timolol	COSOPT (dorzolamide/timolol)
SIMBRINZA (brinzolamide/brimonidine)	COSOPT PF (dorzolamide/timolol)
	dorzolamide/timolol
MISCELLANEOUS	
	phospholine iodide

OPIATE DEPENDENCE TREATMENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies to drugs with an "*" in the class:

- Duplicate Therapy
- Opiate/Benzodiazepine/Muscle Relaxant

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
buprenorphine *	
buprenorphine/naloxone *	
KLOXXADO (naloxone) nasal	
LUCEMYRA (lofexidine)	
naloxone syringe, vial, nasal spray	
naltrexone	
NARCAN (naloxone) nasal	
SUBOXONE (buprenorphine/naloxone) film*	
VIVITROL (naltrexone)	
ZIMHI (naloxone)	
ZUBSOLV (buprenorphine/naloxone)*	

OTIC ANTIBIOTICS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
CIPRODEX (ciprofloxacin/dexamethasone)	CIPRO HC (ciprofloxacin/hydrocortisone)
neomycin/polymyxin/hydrocortisone	ciprofloxacin
ofloxacin	ciprofloxacin/dexamethasone
	ciprofloxacin HCl/fluocinolone
	CORTISPORIN-TC (colistin sulfate - neomycin sulfate - thonzonium bromide - hydrocortisone acetate otic suspension)
	OTIPRIO (ciprofloxacin)
	OTOVEL (ciprofloxacin/fluocinolone)

OTIC ANTI-INFECTIVES/ANESTHETICS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
acetic acid	acetic acid/hydrocortisone

PAH AGENTS (ORAL, INHALATION)

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Pulmonary HTN Agents

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ADCIRCA (tadalafil)	ADEMPAS (riociguat)
LETAIRIS (ambrisentan)	ALYQ (tadalafil)
REVATIO (sildenafil)	ambrisentan
TRACLEER (bosentan) tablet	bosentan
	OPSUMIT (macitentan)
	ORENITRAM ER (treprostinil)
	sildenafil suspension (generic Revatio)
	sildenafil tablet (generic Revatio)
	tadalafil (generic Adcirca)
	TRACLEER (bosentan) suspension
	TYVASO Inhalation (treprostinil)
	TYVASO DPI (treprostinil)
	UPTRAVI (selexipag)
	VENTAVIS Inhalation (iloprost)

PANCREATIC ENZYMES

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
CREON (pancrelipase)	PERTZYE (pancrelipase)
PANCREAZE (pancrelipase)	VIOKACE (pancrelipase)
ZENPEP (pancrelipase)	

PEDIATRIC VITAMIN PREPARATIONS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

See separate **Preferred Pediatric Vitamin Preparations** listing.

PENICILLINS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
amoxicillin	
ampicillin	
dicloxacillin	
penicillin VK	

PHOSPHATE BINDERS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drug
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- Diagnosis of ESRD, hyperphosphatemia AND at least one of the following:
  - Hypercalcemia (corrected serum calcium > 10.2 mg/dL)
  - Plasma PTH levels < 150 pg/mL on two consecutive measurements
  - Dialysis patients with severe vascular and/or soft tissue calcifications

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
calcium acetate	AURYXIA (ferric citrate)
RENAGEL (sevelamer HCl)	FOSRENOL (lanthanum)
RENVELA (sevelamer carbonate)	lanthanum
	PHOSLYRA (calcium acetate)
	sevelamer
	sevelamer carbonate
	VELPHORO (sucroferric oxyhydroxide)

PLATELET AGGREGATION INHIBITORS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drug
- Contraindication to preferred drug
- Allergic reaction to preferred drug
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
aspirin/dipyridamole	dipyridamole
BRILINTA (ticagrelor)	EFFIENT (prasugrel)
clopidogrel	PLAVIX (clopidogrel)
prasugrel	ZONTIVITY (vorapaxar)

POTASSIUM BINDERS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drug
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Lokelma (sodium zirconium cyclosilicate)	Veltassa (patiromer calcium sorbitex)
sodium polystyrene sulfonate	

PRENATAL VITAMINS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- Prenatal vitamins are covered only for females less than 50 years of age.

See separate **Preferred Prenatal Vitamins** listing.

PROGESTATIONAL AGENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drug
- Contraindication to preferred drug
- Allergic reaction to preferred drug
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
MAKENA AUTO INJECTOR (hydroxyprogesterone)	hydroxyprogesterone

PROGESTINS FOR CACHEXIA

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drug
- Contraindication to preferred drug
- Allergic reaction to preferred drug
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
megestrol suspension, tablets	megestrol ES suspension (generic Megace ES)

PROTON PUMP INHIBITORS (ORAL)

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure after no less than a 30-day trial of each preferred drug
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- Prevacid Solutabs will be approved for children 10 years of age and under

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Proton Pump Inhibitor

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
NEXIUM suspension (esomeprazole)	ACIPHEX (rabeprazole)
omeprazole Rx	DEXILANT (dexlansoprazole)
pantoprazole	esomeprazole
PROTONIX (pantoprazole) suspension	lansoprazole
	NEXIUM capsules (esomeprazole)
	NEXIUM OTC (esomeprazole)
	omeprazole OTC
	omeprazole/sodium bicarbonate
	pantoprazole suspension
	PREVACID (lansoprazole)
	PRILOSEC (omeprazole)suspension
	PROTONIX tablets (pantoprazole)
	rabeprazole
	ZEGERID (omeprazole/sodium bicarbonate)

ROSACEA AGENTS, TOPICAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure after no less than a 30-day trial of every preferred drug
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Rosacea Agents, Topical

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
metronidazole cream, gel	azelaic acid
	EPSOLAY (benzoyl peroxide)
	FINACEA (azelaic acid)
	ivermectin
	METROCREAM (metronidazole)
	METROGEL (metronidazole)
	metronidazole lotion
	MIRVASO (brimonidine)
	NORITATE (metronidazole)
	RHOFADE (oxymetazoline)
	ROSADAN KIT (metronidazole)
	SOOLANTRA (ivermectin)
	ZILXI (minocycline)

SEDATIVE HYPNOTICS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Anxiolytics and Sedatives/Hypnotics
- Opiate/Benzodiazepine/Muscle Relaxant

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
BENZODIAZEPINES	
flurazepam	DAYVIGO (lemborexant)
temazepam 15, 30 mg	estazolam
triazolam	HALCION (triazolam)
	RESTORIL (temazepam)
	temazepam 7.5, 22.5 mg

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
OTHERS	
eszopiclone	AMBIEN (zolpidem)
zaleplon	AMBIEN CR (zolpidem)
zolpidem	BELSOMRA (suvorexant)
	doxepin
	EDLUAR (zolpidem)
	HETLIOZ (tasimelteon)
	HETLIOZ LQ (tasimelteon)
	LUNESTA (eszopiclone) ramelteon
	QUVIVIQ (daridorexant)
	ROZEREM (ramelteon)
	SILENOR (doxepin)
	zolpidem ER/SL

SICKLE CELL ANEMIA TREATMENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies to drugs with an "*" in the class:

- Sickle Cell Anemia Treatments

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
DROXIA (hydroxyurea)	
ENDARI (glutamine)	
hydroxyurea	
OXBRYTA (voxelotor)*	
SIKLOS (hydroxyurea)	

SKELETAL MUSCLE RELAXANTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies to drugs with an "*" in the class:

- Opiate/Benzodiazepine/Muscle Relaxant

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
baclofen tablet	AMRIX (cyclobenzaprine ER)*
carisoprodol (except 250 mg)*	baclofen solution
cyclobenzaprine*	carisoprodol 250 mg*
methocarbamol*	carisoprodol compound
tizanidine tablets	chlorzoxazone*
	cyclobenzaprine ER
	DANTRIUM (dantrolene)
	dantrolene
	FEXMID (cyclobenzaprine)*
	FLEQSUVY (baclofen suspension)
	LORZONE (chlorzoxazone)*
	LYVISPAH (baclofen)
	metaxolone*
	NORGESIC FORTE (orphenadrine/aspririn/caffeine)
	orphenadrine*
	SKELAXIN (metaxolone)*
	SOMA (carisoprodol)*
	tizanidine capsules
	ZANAFLEX (tizanidine)

SMOKING CESSATION

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
bupropion SR	NICOTROL (nicotine)
CHANTIX (varenicline)	NICOTROL NS (nicotine)
nicotine gum	varenicline tartrate
nicotine lozenge	
nicotine patch	

STEROIDS, TOPICAL

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
LOW POTENCY	
DERMA-SMOOTHE/FS (fluocinolone)	alclometasone
hydrocortisone cream, ointment	AQUA GLYCOLIC (hydrocortisone/skin cleanser)
hydrocortisone/aloe cream	CAPEX(fluocinolone) shampoo
PROCTOSOL-HC (hydrocortisone)	desonide
	fluocinolone oil
	hydrocortisone lotion (Rx)
	SCALPICIN (hydrocortisone)
	TEXACORT (hydrocortisone) solution
MEDIUM POTENCY	
fluticasone propionate cream, ointment	betamethasone valerate foam
mometasone cream, ointment, solution	BESER KIT (fluticasone)
	clocortolone cream
	CLODERM (clocortolone)
	CUTIVATE (fluticasone)
	fluocinolone acetonide
	flurandrenolide
	fluticasone propionate lotion
	hydrocortisone butyrate
	hydrocortisone valerate
	LOCOID (hydrocortisone butyrate)
	LUXIQ (betamethasone)
	PANDEL (hydrocortisone probutate)
	prednicarbate
	SYNALAR (fluocinolone)
HIGH POTENCY	
betamethasone dipropionate lotion	amcinonide
betamethasone dipropionate/propylene glycol cream	betamethasone dipropionate cream, gel, ointment
betamethasone valerate cream, ointment	betamethasone dipropionate/ propylene glycol lotion, ointment
triamcinolone acetonide cream, lotion, ointment	betamethasone valerate lotion
	desoximetasone
	diflorasone
	DIPROLENE (betamethasone dipropionate)

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PREFERRED AGENTS	NON-PREFERRED AGENTS
	fluocinonide
	HALOG (halcinonide)
	HALOG SOLUTION (halcinonide)
	KENALOG aerosol (triamcinolone)
	PSORCON diflorasone
	SANADERMRX (triamcinolone/dimeth/silicone)
	TOPICORT (desoximetasone)
	triamcinolone acetonide aerosol
	TRIANEX (triamcinolone)
	VANOS (fluocinonide)
VERY HIGH POTENCY	
clobetasol emollient	APEXICON E (diflorasone)
clobetasol propionate cream, gel, ointment, solution	BRYHALI (halobetasol propionate)
halobetasol cream, ointment	clobetasol lotion, shampoo
	clobetasol propionate foam, spray
	CLOBEX (clobetasol)
	CLODAN (clobetasol)
	halobetasol foam
	IMPEKLO LOTION (clobetasol propionate)
	LEXETTE (halobetasol propionate)
	OLUX (clobetasol)
	TEMOVATE (clobetasol)
	TOVET (clobetasol)
	ULTRAVATE (halobetasol propionate)

STIMULANTS AND RELATED AGENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
STIMULANTS	
ADDERALL XR (amphetamine salt combination)	ADHANSIA XR (methylphenidate)
amphetamine salt combination IR	ADZENYS XR ODT (amphetamine)
CONCERTA (methylphenidate)	ADZENYS ER (amphetamine) suspension
DAYTRANA (methylphenidate)	amphetamine salt combination ER
dexmethylphenidate IR	amphetamine sulfate
dextroamphetamine IR	APTENSIO XR (methylphenidate)
DYANAVEL XR (amphetamine)	armodafinil
FOCALIN XR (dexmethylphenidate)	AZSTARYS (serdexmethylphenidate/dexmethyl)
JORNAY PM (methylphenidate ER)	COTEMPLA XR ODT (methylphenidate)
METHYLIN (methylphenidate) solution	DESOXYN (methamphetamine)
methylphenidate IR	DEXEDRINE (dextroamphetamine)
QUILLICHEW ER (methylphenidate)	dexmethylphenidate ER
QUILLIVANT XR (methylphenidate)	dextroamphetamine ER
VYVANSE (lisdexamfetamine)	dextroamphetamine solution
VYVANSE (lisdexamfetamine) chewable tablets	EVEKEO (amphetamine)
	FOCALIN (dexmethylphenidate)
	methamphetamine
	methylphenidate CD
	methylphenidate chewable tablets
	methylphenidate ER
	methylphenidate solution
	modafinil
	MYDAYIS (amphetamine salt combination ER)
	NUVIGIL (armodafinil)
	PROCENTRA (dextroamphetamine)
	PROVIGIL (modafinil)
	RITALIN (methylphenidate)
	RITALIN LA (methylphenidate ER)
	SUNOSI (solriamfetol)
	WAKIX (pitolisant)
	ZENZEDI (dextroamphetamine)

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- ADHD Agents

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
NON-STIMULANTS	
atomoxetine	clonidine ER
guanfacine ER	INTUNIV (guanfacine ER)
	QELBREE (viloxazine)
	STRATTERA (atomoxetine)

TETRACYCLINES

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
doxycycline hyclate capsule	demeclocycline
doxycycline monohydrate 50, 100 mg capsules, suspension	DORYX (doxycycline hyclate)
doxycycline monohydrate 50, 100 mg capsules (AG)	doxycycline hyclate IR
minocycline capsules	doxycycline hyclate DR
VIBRAMYCIN (doxycycline) suspension	doxycycline monohydrate 40, 75, 150 mg capsules
	doxycycline monohydrate tablets
	minocycline tablets
	minocycline ER
	MINOLIRA ER (minocycline)
	MORGIDOX KIT (doxycycline/skin cleanser no19)
	NUZYRA tablet (omadacycline)
	ORACEA (doxycycline)
	SOLODYN (minocycline)
	TARGADOX (doxycycline hyclate)
	tetracycline
	VIBRAMYCIN (doxycycline) capsule, syrup
	XIMINO (minocycline)

THROMBOPOIESIS STIMULATING PROTEINS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
PROMACTA (eltrombopag) tablet	DOPTELET (avatrombopag)
	MULPLETA (lusutrombopag)
	PROMACTA (eltrombopag) suspension
	TAVALISSE (fostamatinib)

ULCERATIVE COLITIS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
ORAL	
DELZICOL (mesalamine)	APRISO (mesalamine)
LIALDA (mesalamine)	ASACOL HD (mesalamine)
PENTASA (mesalamine)	AZULFIDINE (sulfasalazine)
sulfasalazine	balsalazide
sulfasalazine DR	budesonide DR
	COLAZAL (balsalazide)
	DIPENTUM (olsalazine)
	mesalamine
	mesalamine DR/ER
	UCERIS (budesonide)
RECTAL	
CANASA (mesalamine)	mesalamine (Canasa)
	mesalamine (SFROWASA)
	mesalamine kit (ROWASA)
	UCERIS (budesonide)

UREA CYCLE DISORDERS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

The following Clinical Prior Authorization applies **to all drugs** in the class:

- Urea Cycle Disorders

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
BUPHENYL (sodium phenylbutyrate)	CARBAGLU (carglumic acid)
	carglumic acid
	RAVICTI (glycerol phenylbutyrate)
	sodium phenylbutyrate powder

UTERINE DISORDER TREATMENTS

PA Criteria (client must meet at least one of the listed PA criteria):

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
MYFEMBREE (relugolix /estradiol/norethindrn)	
ORIAHNN (elagolix/estradiol/norethindrn)	
ORILISSA (elagolix)	

APPENDICES

For all classes listed below the standard PA criteria apply:

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

COUGH AND COLD ORAL

Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
ALA-HIST IR TABLET OTC (ORAL)	dexbrompheniramine maleate	DEXBROMPHENIRAMINE/PHENYLEPHRINE OTC (ORAL)	dexbrompheniramin/phenylephrin
ALA-HIST PE TABLET OTC (ORAL)	dexbrompheniramin/phenylephrin	DIPHENHYDRAMINE/PHENYLEPHRINE/APAP POWDER PACK OTC (ORAL)	diphenhyd/phenyleph/acetaminop
DECONEX IR TABLET OTC (ORAL)	guaifenesin/phenylephrine HCl	DOXYLAMINE/PHENYLEPHRINE OTC (ORAL)	doxylamine/phenylephrine HCl
ED A-HIST TABLET OTC (ORAL)	chlorpheniramine/phenylephrine	ED A-HIST LIQUID OTC (ORAL)	chlorpheniramine/phenylephrine
ED BRON GP LIQUID OTC (ORAL)	guaifenesin/phenylephrine HCl	GUAIFENESIN/PSEUDOEPHEDRNE TABLET OTC (ORAL)	guaifenesin/pseudoephedrne HCl
GUAIFENESIN 400 MG TABLET OTC (ORAL)	guaifenesin	HISTEX-PE LIQUID OTC (ORAL)	phenylephrine HCl/triprolidine
GUAIFENESIN LIQUID OTC (ORAL)	guaifenesin	LOHIST-D LIQUID OTC (ORAL)	chlorpheniramine/pseudoephed
GUAIFENESIN TABLET ER OTC (ORAL)	guaifenesin	NOHIST-LQ LIQUID OTC (ORAL)	chlorpheniramine/phenylephrine
GUAIFENESIN/PSE TABLET ER OTC (ORAL)	guaifenesin/pseudoephedrne HCl	PHENYLEPHRINE/APAP TABLET OTC (ORAL)	phenylephrine HCl/acetaminophn
MUCUS-CHEST CONGESTION LIQUID OTC (ORAL)	guaifenesin	PHENYLEPHRINE/APAP/CHLORPHENIRAMINE TABLET OTC (ORAL)	phenylephrine/acetaminophn/cpm
NASOPEN PE LIQUID OTC (ORAL)	thonzylamine/phenylephrine	PHENYLEPHRINE/BROMPHENIRAMINE TABLET OTC (ORAL)	brompheniramine/phenylephrine
POLY HIST FORTE TABLET OTC (ORAL)	doxylamine/phenylephrine HCl	POLY-VENT IR TABLET OTC (ORAL)	guaifenesin/pseudoephedrne HCl
PSE/CHLORPHENIRAMINE TABLET OTC (ORAL)	chlorpheniramine/pseudoephed	RESCON TABLET OTC (ORAL)	dexchlorpheniramin/pseudoephed
PSE/TRIPROLIDINE TABLET OTC (ORAL)	triprolidine/pseudoephedrine	RESCON-GG LIQUID OTC (ORAL)	guaifenesin/phenylephrine HCl
RYNEX PE SOLUTION OTC (ORAL)	brompheniramine/phenylephrine	RYMED TABLET OTC (ORAL)	dexchlorpheniram/phenylephrine
		RYNEX PSE LIQUID OTC (ORAL)	brompheniramin/pseudoephedrine
		STAHIST AD TABLET OTC (ORAL)	chlorcyclizine/pseudoephedrine

COUGH AND COLD NASAL

Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
OXYMETAZOLINE 12 HR NASAL SPRAY OTC (NASAL)	oxymetazoline HCl		

COUGH AND COLD, NARCOTIC

Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
GUAIFENESIN/CODEINE LIQUID OTC (ORAL)	codeine phosphate/guaifenesin	GUAIFENESIN/PSE/CODEINE SYRUP OTC (ORAL)	pseudoephed/codeine/guaifen
PROMETHAZINE/CODEINE SYRUP (ORAL)	promethazine HCl/codeine	HYDROCODONE/CHLORPHENIRAMINE SUSPENSION ER 12H (ORAL)	hydrocodone/chlorphen p-stirex
		HYDROCODONE/HOMATROPINE SYRUP (ORAL)	hydrocodone bit/homatrop me-br
		HYDROCODONE/HOMATROPINE TABLET (ORAL)	hydrocodone bit/homatrop me-br
		NINJACOF-XG LIQUID OTC (ORAL)	codeine phosphate/guaifenesin

COUGH AND COLD, NON-NARCOTIC			
Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
ALA-HIST DM LIQUID OTC (ORAL)	d-methorphan/pe/dexbromphenir	CHLO TUSS LIQUID OTC (ORAL)	dexbromphen/pseudoeph/chlophed
ALAHIST CF TABLET OTC (ORAL)	d-methorphan/pe/dexbromphenir	DM/APAP/CHLORPHENIRAMINE TABLET OTC (ORAL)	dextromethorphn/acetaminoph/cp
BENZONATATE CAPSULE (ORAL)	benzonatate	DM/APAP/DOXYLAMINE CAPSULE OTC (ORAL)	DM/acetaminophen/doxylamine
BROM-PSE-DM SYRUP (ORAL)	brompheniramine/pseudoephed/DM	DM/APAP/DOXYLAMINE LIQUID OTC (ORAL)	DM/acetaminophen/doxylamine
BROMPHENIRAMINE/PHENYLEPHRINE/DM SOLUTION OTC (ORAL)	brompheniram/phenylephrine/DM	DM/CHLORPHENIRAMINE TABLET OTC (ORAL)	chlorpheniramine/dextromethorp
BROTAPP DM ELIXIR OTC (ORAL)	brompheniramine/pseudoephed/DM	DM/PHENYLEPHRINE/APAP CAPSULE OTC (ORAL)	d-methorphan/PE/acetaminophen
DECONEX DMX TABLET OTC (ORAL)	guaifen/dextromethorphan/PE	DM/PHENYLEPHRINE/APAP LIQUID OTC (ORAL)	d-methorphan/PE/acetaminophen
DEXTROMETHORPHAN CAPSULE OTC (ORAL)	dextromethorphan HBr	DM/PHENYLEPHRINE/APAP TABLET OTC (ORAL)	d-methorphan/PE/acetaminophen
DEXTROMETHORPHAN SUSPENSION ER 12H OTC (ORAL)	dextromethorphan polistirex	DM/PSE/CHLORPHENIRAMINE LIQUID OTC (ORAL)	chlorpheniramin/pseudoephed/DM
ED-A-HIST DM LIQUID OTC (ORAL)	chlorpheniramine/phenyleph/DM	DURAFLU TABLET OTC (ORAL)	pseudoeph/DM/guaifen/acetamin
GUAIFEN/DEXTROMETHORPHAN/PE OTC (ORAL)	guaifen/dextromethorphan/PE	ED A-HIST DM TABLET OTC (ORAL)	chlorpheniramine/phenyleph/DM
GUAIFENESIN/DM LIQUID OTC (ORAL)	guaifenesin/dextromethorphan	GUAIFENESIN/DM TABLET OTC (ORAL)	guaifenesin/dextromethorphan
GUAIFENESIN/DM TABLET ER 12H OTC (ORAL)	guaifenesin/dextromethorphan	M-END DMX LIQUID OTC (ORAL)	dexbromphen/pseudoephedrine/DM
GUAIFENESIN/DM/PHENYLEPHRINE LIQUID OTC (ORAL)	guaifen/dextromethorphan/PE	MUCUS DM MAX TABLET ER 12H OTC (ORAL)	guaifenesin/dextromethorphan
GUAIFENESIN/DM/PHENYLEPHRINE SYRUP OTC (ORAL)	guaifen/dextromethorphan/PE	NINJACOF LIQUID OTC (ORAL)	pyrilamine/chlophedianol
HISTEX-DM SYRUP OTC (ORAL)	triprolidine/phenylephrine/DM	PHENYLEPHRINE/DM/APAP/GUAIFENESIN CAPLET OTC (ORAL)	phenylephrine/DM/acetaminop/GG
LOHIST-DM LIQUID OTC (ORAL)	brompheniram/phenylephrine/DM	POLYTUSSIN DM OTC (ORAL)	dexchlorphen/phenylephrine/DM
NOHIST-DM LIQUID OTC (ORAL)	chlorpheniramine/phenyleph/DM	RESCON-DM LIQUID OTC (ORAL)	chlorpheniramin/pseudoephed/DM
POLY-HIST DM LIQUID OTC (ORAL)	thonzylamine/phenylephrine/DM	VANACOF DMX LIQUID OTC (ORAL)	guaifen/dextromethorphan/PE
POLY-VENT DM TABLET OTC (ORAL)	guaifenesin/DM/pseudoephedrine		
PROMETHAZINE/DM SYRUP (ORAL)	promethazine/dextromethorphan		
RYNEX DM SOLUTION OTC (ORAL)	brompheniram/phenylephrine/DM		
VANACOF DM LIQUID OTC (ORAL)	guaifen/dextromethorphan/PE		
VANACOF LIQUID OTC (ORAL)	dexchlorphenir/pse/chlophedian		
VANATAB DM TABLET OTC (ORAL)	guaifen/dextromethorphan/PE		

IRON, ORAL

Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
FERROUS FUMARATE TABLET OTC (ORAL)	ferrous fumarate	CORVITE 150 TABLET (ORAL)	iron,carb/folate6/mv,min no.41
FERROUS FUMARATE/FA/MULTIVITAMIN & MINERALS CAPSULE (ORAL)	iron fum/folic acid/mv,min 15	CORVITE FE TABLET (ORAL)	iron/folate no.6/mv,mins no.40
FERROUS FUMARATE/IRON POLYSACCHARIDES/FA/MULTIVITAMIN CAPSULE (ORA	iron fm,ps no.1/folic/mv no.18	FEOSOL TABLET OTC (ORAL)	iron polysacch/iron heme polyp
FERROUS GLUCONATE TABLET OTC (ORAL)	ferrous gluconate	FER-IN-SOL DROPS OTC (ORAL)	ferrous sulfate
FERROUS SULFATE DROPS OTC (ORAL)	ferrous sulfate	FERGON TABLET OTC (ORAL)	ferrous gluconate
FERROUS SULFATE SOLUTION OTC (ORAL)	ferrous sulfate	FERIVA 21-7 (ORAL)	iron/C/folate/B12/zinc/succin
FERROUS SULFATE TABLET OTC (ORAL)	ferrous sulfate	FERIVA FA CAPSULE (ORAL)	iron/C/folate/B12/biot/cupric
FERROUS SULFATE, DRIED TABLET ER OTC (ORAL)	ferrous sulfate, dried	FERRIMIN 150 TABLET OTC (ORAL)	ferrous fumarate
IRON CARBONYL/ASCORBIC ACID TABLET OTC (ORAL)	iron,carbonyl/ascorbic acid	FERROUS SULFATE/ASCORBIC ACID/FA TABLET ER OTC (ORAL)	ferrous sulfate/vit C/folic ac
IRON POLYSACCHARIDES CAPSULE OTC (ORAL)	iron polysaccharide complex	IROSPAN TABLET (ORAL)	iron bg,ps/folic/B,C no.12/suc
		NEPHRON FA TABLET (ORAL)	vit B comp C no.24/iron/folic
		TARON FORTE CAPSULE (ORAL)	iron bg,ps/vitC/B12/FA/calcium

PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
MULTIVITAMINS WITH FLUORIDE DROPS (ORAL)	pedi multivit no.2 w-fluoride	FLORIVA CHEW (ORAL)	pedi multivit no.85/fluoride
MULTIVITS WITH IRON & FLUORIDE DROPS (ORAL)	pedi multivit 45/fluoride/iron	FLORIVA PLUS DROPS OTC (ORAL)	pedi multivit no.161/fluoride
PEDI MVI NO.16 WITH FLUORIDE TAB CHEW (ORAL)	pedi multivit no.16 w-fluoride	FLUORIDE/VITAMINS A,C,AND D DROPS (ORAL)	ped mvit A,C,D3 no.21/fluoride
		POLY-VI-FLOR CHEW (ORAL)	pedi multivit no.205/fluoride
		POLY-VI-FLOR DROPS (ORAL)	pedi multivit 213 w-fluoride
		POLY-VI-FLOR WITH IRON CHEW (ORAL)	ped multivit 205/fluoride/iron
		POLY-VI-FLOR WITH IRON DROPS (ORAL)	ped multivit 214/fluoride/iron
		QUFLORA (ORAL)	pedi multivit 84 with fluoride
		QUFLORA (ORAL)	pedi multivit no.63 w-fluoride
		QUFLORA (ORAL)	pedi multivit no.83 w-fluoride
		QUFLORA FE (ORAL)	ped multivit 142/iron/fluoride
		QUFLORA FE (ORAL)	ped multivit 151/iron/fluoride
		QUFLORA OTC (ORAL)	pedi multivit no.157/fluoride
		TRI-VI-FLORO DROPS (ORAL)	ped mvit A,C,D3 no.38/fluoride
		TRI-VITAMIN WITH FLUORIDE (ORAL)	ped mvit A,C,D3 no.21/fluoride

PRENATAL VITAMINS

Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
PNV2/IRON B-G SUC-P/FA/OMEGA-3 (ORAL)	PNV cmb 52/iron/FA/omega-3/dha	CITRANATAL B-CALM (ORAL)	prenatal 48/iron/folic acid/B6
SELECT-OB + DHA (ORAL)	prenatal vit 33/iron/folic/dha	COMPLETENATE CHEW TABLET (ORAL)	prenatal vit 14/iron fum/folic
TRICARE (ORAL)	prenatal vit103/iron fum/folic	FE C/FA (ORAL)	multivit-min69/iron/folic acid
TRINATAL RX 1 (ORAL)	prenatal vit27,calcium/iron/FA	NESTABS (ORAL)	prenatal vit86/iron/folic acid
VITAFOL NANO (ORAL)	prenatal no.75/iron/folate no1	NESTABS DHA (ORAL)	prenatal 87/iron bis/folic/dha
VITAFOL TAB CHEW (ORAL)	PNV 112/iron/folic/om3/dha/epa	OB COMPLETE ONE (ORAL)	PNV 85/iron/folic/dha/fish oil
VITAFOL ULTRA (ORAL)	PNV 67/iron ps/folate no.1/dha	OB COMPLETE PETITE (ORAL)	prenatal56/iron/folic acid/dha
VITAFOL-OB (ORAL)	prenatal vit 10/iron fum/folic	OB COMPLETE PREMIER (ORAL)	PNV83/iron,carb,asp/folic acid
VITAFOL-OB+DHA (ORAL)	prenatal vit 10/iron/folic/dha	OB COMPLETE TABLET (ORAL)	multivit-min69/iron/folic acid
VITAFOL-ONE (ORAL)	prenatal 26/iron ps/folic/dha	PNV COMBO#47/IRON/FA #1/DHA (ORAL)	multivit 47/iron/folate 1/dha
		PNV NO.118/IRON FUMARATE/FA CHEW TABLET (ORAL)	PNV no.118/iron fumarate/FA
		PNV NO.15/IRON FUM & PS CMP/FA (ORAL)	mvn-min 74/iron fum/iron/FA
		PNV W-CA NO.40/IRON FUM/FA CMB NO.1 (ORAL)	prenatal,calc.40/iron/folate 1
		PNV WITH CA NO.68/IRON/FA NO.1/DHA (ORAL)	mv-mins 71/iron/folic no.1/dha
		PNV WITH CA,NO.72/IRON/FA (ORAL)	PNV,calcium 72/iron/folic acid
		PNV#16/IRON FUM & PS/FA/OM-3 (ORAL)	mvn-min75/iron/iron ps/om3/dha
		PRENATAL VIT #76/IRON,CARB/FA (ORAL)	prenatal vit,calc76/iron/folic
		PRENATE AM (ORAL)	multivit 38/folate no.6/ginger
		PRENATE CHEWABLE TABLET (ORAL)	multivitamin no.36/folate no.6

		PRENATE DHA (ORAL)	prenatal 78/iron/folate 1/dha
		PRENATE ELITE (ORAL)	prenatal 114/iron a-g/folate 1
		PRENATE ENHANCE (ORAL)	prenatal vit68/iron/FA no6/dha
		PRENATE ESSENTIAL (ORAL)	multivit no.40/iron/folat1/dha
		PRENATE MINI (ORAL)	prenatal vit 87/iron/folic/dha
		PRENATE PIXIE (ORAL)	prenatal vit 85/iron/FA 1/dha
		PRENATE RESTORE (ORAL)	prenatal vit69/iron/folate6/dh
		PRENATE STAR (ORAL)	prenatal no.77/iron asp gly/FA
		SELECT-OB TAB CHEW (ORAL)	prenatal vit128/iron/folic acd
		TRISTART DHA (ORAL)	prenatal 93/iron/folate 9/dha
		VP-PNV-DHA (ORAL)	prenatal no.52/iron/FA/dha
		WESTGEL DHA (ORAL)	prenatal 93/iron/folate 9/dha