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 25, 2024

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.

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PDL CRITERIA EXCEPTIONS

HB 3286, Section 2, 88th Legislature, Regular Session, 2023, requires the Health and Human Services Commission (HHSC) to allow the following exceptions on the Preferred Drug List (PDL). Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section. The exceptions listed in HB 3286 include:

- Is contraindicated.
- Will likely cause an adverse reaction or physical or mental harm to the recipient.
- Is expected to be ineffective based on the known clinical characteristics of the recipient and the known characteristics of the prescription drug regimen.
- The recipient previously discontinued taking the preferred drug at any point in their clinical history and for any length of time due to ineffectiveness, diminished effect, or adverse event(s).

These exceptions will be notated by "*" in each PDL class section.

HB 3286, Section 2, 88th Legislature Regular Session, 2023, requires the Health and Human Services Commission (HHSC) to allow the following exceptions on the Preferred Drug List within the antipsychotic drug class. For the antipsychotic drug class, if the member was prescribed and is taking a non-preferred drug, the following PDL exception criteria will apply:

- The member was prescribed a non-preferred drug before being discharged from an inpatient facility.
- The member is stable on the non-preferred drug.
- The member is at risk of experiencing complications from switching from the non-preferred drug to another drug.

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

REVISION HISTORY

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

DATE	ISSUES/UPDATES
01/25/2024	Published

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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	
isotretinoin (Absorica)	
MYORISAN (isotretinoin)	
ZENATANE (isotretinoin)	

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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 (OTC)	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

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

PREFERRED AGENTS	NON-PREFERRED AGENTS
COMBINATION AND OTHER AGENTS	
benzoyl peroxide/clindamycin (Duac)	adapalene/benzoyl peroxide (Epiduo/Epiduo Forte)
EPIDUO FORTE (benzoyl peroxide/adapalene)	clindamycin/benzoyl peroxide (Acanya)
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)

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.

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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 tablets	ADLARITY (donepezil) transderm
donepezil ODT	ARICEPT (donepezil)
EXELON (rivastigmine) transdermal	donepezil 23 mg tablets
	galantamine
	galantamine ER
	rivastigmine capsules
	rivastigmine transdermal
NMDA RECEPTOR ANTAGONIST	
memantine tablets	memantine ER
	memantine solution
	memantine tablet dose pack
	NAMENDA (memantine) tablets/titration pack
	NAMENDA XR (memantine)
CHOLINESTERASE INHIBITOR/NMDA RECEPTOR ANTAGONIST COMBINATIONS	
	NAMZARIC (donepezil/memantine)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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 tablets
	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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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 tablets	benzhydrocodone/APAP
morphine tablets	butalbital/ASA/caffeine/codeine
morphine solution	butalbital/APAP/caffeine/codeine
oxycodone solution	butorphanol
oxycodone tablets	carisoprodol/aspirin/codeine
oxycodone/APAP tablets	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 syrup, oral
	morphine suppositories
	NUCYNTA (tapentadol)
	oxycodone/APAP solution
	oxycodone capsules

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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

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.

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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) packets
ANDROGEL (testosterone) pump	FORTESTA (testosterone)
testosterone gel pump (Androgel)	NATESTO (testosterone)
	TESTIM (testosterone)
	testosterone gel (Vogelxo, Axiron, Fortesta, Androgel pkt)
	VOGELXO (testosterone)

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.

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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 tablets	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)

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PREFERRED AGENTS	NON-PREFERRED AGENTS
	quinapril/HCTZ
	VASERETIC (enalapril/HCTZ)
	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)	

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*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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

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.

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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

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)	Grastek (grass pollen-timothy, standard)
PALFORZIA TITRATION CAPSULES (peanut allergen powder)	PALFORZIA MAINTENANCE SACHET (peanut allergen powder)
	Ragwitek (weed pollen-short ragweed)

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.

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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 tablets	DIFICID (fidaxomicin)
neomycin	FLAGYL (metronidazole)
tinidazole	metronidazole capsules
	nitazoxanide
	paromomycin
	VANCOCIN (vancomycin)
	vancomycin
	VOWST (fecal microbio spore,live-brpk)
	XIFAXAN (rifaximin)

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.

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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)	

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.

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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 packets
mupirocin ointment	bacitracin/polymixin
triple antibiotic ointment	CENTANY (mupirocin)
	gentamicin
	mupirocin cream
	neomycin/polymyxin/pramoxine
	XEPI (ozenoxacin)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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
metronidazole	METROGEL-VAGINAL (metronidazole)
NUVESSA (metronidazole)	SOLOSEC (secnidazole)
	VANDAZOLE (metronidazole)
	XACIATO (clindamycin)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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) capsules	FRAGMIN (dalteparin)
warfarin	LOVENOX (enoxaparin)
XARELTO (rivaroxaban) tablets, dosepak, suspension	PRADAXA (dabigatran) pellet pack
	SAVAYSA (edoxaban)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

PREFERRED AGENTS	NON-PREFERRED AGENTS
lacosamide	
LAMICTAL (lamotrigine) tablets, ODT	
LAMICTAL XR (lamotrigine)	
lamotrigine tablets, ER, ODT	
levetiracetam	
levetiracetam XR	
methsuximide	
MYSOLINE (primidone)	
NAYZILAM (midazolam)	
ONFI (clobazam)	
oxcarbazepine	
OXTELLAR XR (oxcarbazepine)	
phenobarbital	
PHENYTEK (phenytoin)	
phenytoin	
primidone	
QUDEXY XR (topiramate)	
ROWEEPRA (levetiracetam)	
rufinamide suspension	
rufinamide tablets	
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)	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ZARONTIN (ethosuximide)	
ZONISADE (zonisamide)	
zonisamide	
ZTALMY (ganaxolone)	

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.

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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 (Wellbutrin SR)	AUVELITY (dextromethorphan HBr/bupropion)
bupropion XL (Wellbutrin XL)	(((((bupropion XL (Forfivo XL)
FORFIVO XL (bupropion)	desvenlafaxine ER
mirtazapine	EFFEXOR XR (venlafaxine)
phenelzine	EMSAM (selegiline)
PRISTIQ (desvenlafaxine)	FETZIMA (levomilnacipran)
trazodone	MARPLAN (isocarboxazid)
venlafaxine ER capsules	NARDIL (phenelzine)
venlafaxine IR	nefazodone
VIIBRYD (vilazodone)	REMERON (mirtazapine)
VIIBRYD (vilazodone) DOSE PACK	tranylcypromine
	TRINTELLIX (vortioxetine)
	venlafaxine besylate ER
	venlafaxine ER tablets
	vilazodone
	WELLBUTRIN SR (bupropion)
	WELLBUTRIN XL (bupropion)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	CELEXA (citalopram)
escitalopram tablets	citalopram 30mg capsules
fluoxetine capsules, solution	escitalopram solution
fluvoxamine	fluoxetine capsules DR
paroxetine (Paxil)	fluoxetine tablets
sertraline concentration, tablets	fluvoxamine ER
	LEXAPRO (escitalopram)
	paroxetine (Brisdelle)
	paroxetine CR
	PAXIL (paroxetine)
	PAXIL CR (paroxetine)
	PEXEVA (paroxetine)
	PROZAC (fluoxetine)
	sertraline capsules
	ZOLOFT (sertraline)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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 capsules	desipramine
	imipramine pamoate
	NORPRAMIN (desipramine)
	nortriptyline solution
	PAMELOR (nortriptyline)
	protriptyline
	trimipramine

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.

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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	prochlorperazine suppositories
promethazine syrup, tablets	promethazine suppositories
TRANSDERM-SCOP (scopolamine)	REGLAN (metoclopramide)
	scopolamine patches
	trimethobenzamide
CANNABINOIDS	
	dronabinol
	MARINOL (dronabinol)
5-HT3 RECEPTOR ANTAGONISTS	
ondansetron	ANZEMET (dolasetron)
	granisetron
	SANCUSO (granisetron)
	SUSTOL (granisetron)
SUBSTANCE P ANTAGONISTS AND COMBINATIONS	
	AKYNZEO (netupitant/palonosetron)
	aprepitant
	EMEND (aprepitant)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)
posaconazole suspension, tablets, AG	flucytosine
nystatin	griseofulvin tablets /ultramicrosize
terbinafine	itraconazole
VFEND (voriconazole) suspension	NOXAFIL (posaconazole) suspension, suspdr packet, tablets
	ORAVIG (miconazole)
	SPORANOX (itraconazole)
	TOLSURA (itraconazole)
	VFEND (voriconazole) tablets
	VIVJOA (oteseconazole)
	voriconazole

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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, capsules
loratadine solution, tablets	CLARINEX (desloratadine)
	desloratadine
	fexofenadine
	levocetirizine
	loratadine ODT, chewable

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

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.

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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)	clonidine ER
clonidine transdermal	methyldopa / HCTZ
clonidine IR tablets	
guanfacine IR	
methyldopa	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)

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.

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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
- Antimigraine Agents, Ergot Derivatives

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
TRIPTANS	
IMITREX (sumatriptan) injection kit, nasal	almotriptan
rizatriptan	AMERGE (naratriptan)
sumatriptan tablets	eletriptan
ZOMIG (zolmitriptan) nasal	FROVA (frovatriptan)
	frovatriptan
	IMITREX (sumatriptan) tablets, vial
	MAXALT (rizatriptan)
	naratriptan
	ONZETRA XSAIL (sumatriptan)
	RELPAX (eletriptan)
	sumatriptan injection kit, 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)	D.H.E. 45 (dihydroergotamine)
EMGALITY (galcanezumab-gnlm)	diclofenac potassium powder
NURTEC ODT (rimegepant)	dihydroergotamine mesylate
UBRELVY (ubrogepant)	ELYXYB SOLUTION (celecoxib)
	EMGALITY 100 mg (cluster headache) (galcanezumab-gnlm)
	MIGERGOT supp (ergotamine tartrate/caffeine)
	MIGRANAL (dihydroergotamine mesylate)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	QULIPTA (atogepant)
	REYVOW (lasmiditan)
	TRUDHESA (dihydroergotamine mesylate)
	ZAVZPRET (zavegepant)

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

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

ANTIPSYCHOTICS

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

- Non-preferred drug usage prior to inpatient facility discharge
- Stability with non-preferred drug usage
- Complication risk with switch from non-preferred drug
- 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
CAPLYTA (lumateperone)	ABILIFY MYCITE (aripiprazole)
chlorpromazine	ADASUVE (inhalation)
clozapine	aripiprazole ODT, solution
fluphenazine	asenapine SL
haloperidol	clozapine ODT
haloperidol decanoate	CLOZARIL (clozapine)
lurasidone	FANAPT (iloperidone)
NUPLAZID (pimavanserin) capsules	fluphenazine decanoate
olanzapine	GEODON (ziprasidone) capsule, IM
olanzapine ODT	HALDOL (haloperidol) decanoate
perphenazine	haloperidol lactate injection
quetiapine IR	INVEGA (paliperidone)
REXULTI (brexpiprazole)	LATUDA (lurasidone)
risperidone tablets, solution	loxapine
thioridazine	NUPLAZID (pimavanserin) tablets
thiothixene	molindone
trifluoperazine	olanzapine IM
VRAYLAR (cariprazine)	paliperidone ER
ziprasidone	pimozide
	quetiapine ER
	RISPERDAL (risperidone)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	risperidone ODT
	SAPHRIS (asenapine)
	SECUADO (asenapine)
	SEROQUEL (quetiapine)
	SEROQUEL XR (quetiapine)
	VERSACLOZ (clozapine)
	ziprasidone IM
	ZYPREXA (olanzapine)
	ZYPREXA ZYDIS (olanzapine)
ANTIPSYCHOTIC/SSRI COMBINATIONS	
amitriptyline/perphenazine	olanzapine/fluoxetine
	SYMBYAX (olanzapine/fluoxetine)
ANTIPSYCHOTIC/SEROTONIN ANTAGNST COMBINATIONS	
	LYBALVI (olanzapine/samidorphan)
LONG-ACTING INJECTABLES	
ABILIFY ASIMTUFII (aripiprazole)	ZYPREXA RELPREVV (olanzapine)
ABILIFY MAINTENA (aripiprazole)	
ARISTADA (aripiprazole)	
ARISTADA INITIO (aripiprazole)	
INVEGA HAFYERA (paliperidone)	
INVEGA SUSTENNA (paliperidone)	
INVEGA TRINZA (paliperidone)	
PERSERIS (risperidone)	
RISPERDAL CONSTA (risperidone)	
UZEDY (risperidone)	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	
ANTI-INFLUENZA	
oseltamivir	FLUMADINE (rimantadine)
	RELENZA (zanamivir)
	rimantadine
	TAMIFLU (oseltamivir)
	XOFLUZA (baloxavir)
ANTI-CMV	
VALCYTE (valganciclovir) solution, tablets	LIVTENCITY (maribavir)
	VALCYTE (valganciclovir)
	valganciclovir solution, tablets

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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
	penciclovir
	XERESE (acyclovir/hydrocortisone)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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 tablets	alprazolam ER
buspirone	alprazolam intensol
chlordiazepoxide	alprazolam ODT
clorazepate	ATIVAN (lorazepam)
diazepam solution	diazepam intensol
diazepam tablets	LOREEV XR (lorazepam)
lorazepam intensol	meprobamate
lorazepam tablets	oxazepam
	XANAX XR (alprazolam)
	XANAX (alprazolam) tablets

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	

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.

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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 tablets	BYLVAY (odevixibat) cap/pellet
	CHENODAL (chenodiol)
	CHOLBAM (cholic acid)
	LIVMARLI (maralixibat)
	OCALIVA (obeticholic acid)
	RELTONE (ursodiol)
	URSO (ursodiol)
	URSO FORTE (urosodiol)
	ursodiol capsules

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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
MYRBETRIQ (mirabegron) tablets/granules	darifenacin ER
oxybutynin IR	DETROL (tolterodine)
oxybutynin ER	DETROL LA (tolterodine)
TOVIAZ (fesoterodine)	DITROPAN XL (oxybutynin)
VESICARE (solifenacin)	fesoterodine
	flavoxate
	GELNIQUE (oxybutynin)
	GEMTESA (vibegron)
	OXYTROL (oxybutynin)
	solifenacin
	tolterodine
	tolterodine ER
	trospium
	trospium ER
	VESICARE LS (solifenacin)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)
	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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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
	ENTADFI (finasteride/tadalafil)
	JALYN (dutasteride/tamsulosin)
PHOSPHODIESTERASE 5 INHIBITORS	
	tadalafil

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)
XOPENEX HFA (levalbuterol)	PROAIR RESPICLICK (albuterol)
INHALERS, LONG-ACTING	
SEREVENT (salmeterol)	STRIVERDI RESPIMAT (olodaterol)
INHALATION SOLUTION	
albuterol	arformoterol
XOPENEX (levalbuterol)	BROVANA (arformoterol)
	formoterol
	levalbuterol
	PERFOROMIST (formoterol)
ORAL	
albuterol syrup	albuterol tablets
	albuterol ER
	terbutaline

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	levamlodipine
KATERZIA (amlodipine)	MATZIM LA (diltiazem)
nifedipine ER	nisoldipine
TAZTIA XT (diltiazem)	NORLIQVA (amlodipine oral solution)
TIADYLT ER (diltiazem)	NORVASC (amlodipine)
verapamil ER capsules, tablets	PROCARDIA XL (nifedipine)
	SULAR (nisoldipine)
	TIAZAC (diltiazem)
	verapamil 360 mg capsules
	verapamil ER PM
	VERELAN (verapamil)
	VERELAN PM (verapamil)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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 125 susp (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 tablets, suspension	SUPRAX (cefixime)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	FYLNETRA (pegfilgrastim-pbbk)
NYVEPRIA (pegfilgrastim-apgf)	GRANIX (tbo-filgrastim) syringe
	LEUKINE (sargramostim)
	NEULASTA (pegfilgrastim)
	NIVESTYM (filgrastim-aafi)
	RELEUKO (filgrastim-AYOW) syringe, vial
	ROLVEDON SYRINGE (eflapegrastim-xnst)
	STIMUFEND SYRINGE (pegfilgrastim-fpgk)
	UDENYCA (pegfilgrastim-cbqv)
	ZARXIO (filgrastim-sndz)
	ZIEXTENZO SYRINGE (pegfilgrastim-bmez)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)	TUDORZA (aclidinium)
SPIRIVA RESPIMAT (tiotropium)	
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	
roflumilast	DALIRESP (roflumilast)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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
- Dextromethorphan Overutilization

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

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

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)	adalimumab-ADAZ kit, pen kit
OTEZLA (apremilast)	adalimumab-FKJP kit, pen kit
	AMJEVITA (adalimumab-atto)
	ARCALYST (rilonacept)
	CIBINQO (abrocitinib)
	CIMZIA (certolizumab)
	CYTELZO (adalimumab-ADBM) kit, pen kit
	COSENTYX (secukinumab)
	ENSPRYNG (satralizumab-mwge)
	HADLIMA (adalimumab-BWWD) kit, pen kit
	HULIO (adalimumab-FKJP) kit, pen kit
	HYRIMOZ (adalimumab-ADAZ) kit, pen kit
	IDACIO (adalimumab-AACF) kit, pen kit
	ILARIS (canakinumab)
	ILUMYA (tildrakizumab-asmn)
	KEVZARA (sarilumab)
	KINERET (anakinra)
	OLUMIANT (baricitinib)
	ORENCIA (abatacept)
	RINVOQ ER (upadacitinib)
	SILIQ (brodalumab)
	SIMPONI (golimumab)
	SKYRIZI (risankizumab-rzaa)
	SKYRIZI ON-BODY (risankizumab-rzaa)
	SKYRIZI PEN (risankizumab-rzaa)
	SOTYKTU (deucravacitinib)
	STELARA (ustekinumab)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	TALTZ (ixekizumab)
	TREMFYA (guselkumab)
	XELJANZ (tofacitinib)
	XELJANZ soln (tofacitinib)
	XELJANZ XR (tofacitinib)
	YUFLYMA (adalimumab-AATY)
	YUSIMRY (adalimumab-AQVH)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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
Auvi Q (epinephrine)	epinephrine (generic ADRENACLICK)
epinephrine (Mylan authorized generic EPIPEN and EPIPEN JR)	epinephrine (generic EPIPEN and EPIPEN JR)
EPIPEN (epinephrine)	SYMJEPI (epinephrine)
EPIPEN JR (epinephrine)	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)
lubiprostone	LOTRONEX (alosetron)
MOVANTIK (naloxegol)	MOTEGRITY (prucalopride)
	RELISTOR (methylnaltrexone) injection
	RELISTOR (methylnaltrexone) oral
	SYMPROIC (naldemedine)
	TRULANCE (plecanatide)
	VIBERZI (eluxadoline)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	GVOKE syringe/vial (glucagon)
GVOKE pen (glucagon)	ZEGALOGUE AUTOINJECTOR (dasiglucagon)
PROGLYCEM (diazoxide)	ZEGALOGUE SYRINGE (dasiglucagon)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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 DISKUS (fluticasone)	ARNUITY ELLIPTA (fluticasone)
FLOVENT HFA (fluticasone)	ASMANEX HFA (mometasone)
PULMICORT FLEXHALER (budesonide)	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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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 / tab ds pk
prednisolone sodium phosphate tablets	DEXPAK (dexamethasone)
prednisolone solution	EMFLAZA (deflazacort)
prednisone solution, tablets	HEMADY (dexamethasone)
	MEDROL (methylprednisolone)
	methylprednisolone tablets
	MILLIPRED (prednisolone)
	prednisolone tablets (MILLIPRED)
	prednisolone sodium phosphate ODT, solution
	prednisone intensol
	prednisone tablet dose pack
	RAYOS DR (prednisone)
	TAPERDEX (dexamethasone)
	TARPEYO (budesonide)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	NGENLA
SKYTROFA	NUTROPIN AQ
	OMNITROPE
	SAIZEN
	SEROSTIM
	SOGROYA
	ZOMACTON

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	
ALTUVIIIO	
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)	
HEMGENIX (etranacogene dezaparvovec-drlb)	
HEMLIBRA (emicizumab-kxwh)	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

PREFERRED AGENTS	NON-PREFERRED AGENTS
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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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 capsules	
ribavirin tablets	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	
darunavir	
didanosine	
EDURANT (rilpivirine)	
efavirenz	
emtricitabine	
EMTRIVA (emtricitabine)	
EPIVIR (lamivudine)	
etravirine	
fosamprenavir	
FUZEON (enfuvirtide)	
INTELENCE (etravirine)	
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	
SUNLENCA (lenacapavir sodium) tablets	
tenofovir disoproxil fumarate	
TIVICAY (dolutegravir)	
TYBOST (cobicistat)	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

PREFERRED AGENTS	NON-PREFERRED AGENTS
VIRACEPT (nelfinavir)	
VIRAMUNE XR (nevirapine)	
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)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	
TRIUMEQ PD (abacavir/dolutegravir/lamivudine)	
TRIZIVIR (abacavir/lamivudine/zidovudine)	
TRUVADA (emtricitabine/tenofovir DF)	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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
JANUMET XR (sitagliptin/metformin)	alogilptin/metformin
JANUVIA (sitagliptin)	alogliptin/pioglitazone
JENTADUETO (linagliptin/metformin)	KAZANO (alogliptin /metformin)
JENTADUETO XR (linagliptin/metformin)	NESINA (alogliptin)
KOMBIGLYZE XR (saxagliptin/metformin)	OSENI (alogliptin /pioglitazone)
ONGLYZA (saxagliptin)	saxagliptin
TRADJENTA (linagliptin)	saxagliptin/metformin ER

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	
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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)	glipizide/metformin
glyburide/metformin	metformin ER (FORTAMET)
metformin	metformin ER (GLUMETZA)
metformin ER (GLUCOPHAGE XR)	metformin 625 MG
	metformin (solution)
	RIOMET (metformin)
	RIOMET ER (metformin)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)	INPEFA (sotagliflozin)
INVOKANA (canaglifozin)	STEGLATRO (ertugliflozin)
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)	SEGLUROMET (ertugliflozin/metformin)
INVOKAMET XR (canagliflozin/metformin)	SYNJARDY XR (empagliflozin/metformin)
SYNJARDY (empagliflozin/metformin)	
XIGDUO XR (dapagliflozin/metformin)	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)
HIZENTRA (immune globulin) syringe	CUVITRU (immune globulin)
HIZENTRA (immune globulin) vial	CYTOGAM (CMV immune globulin)
	FLEBOGAMMA DIF (immune globulin)
	GAMASTAN S-D (immune globulin)
	HEPAGAM B (hepatitis B immune globulin)
	HYQVIA (immune globulin)
	OCTAGAM (immune globulin)
	PANZYGA (immune globulin)
	PRIVIGEN (immune globulin)
	VARIZIG (varicella-zoster immune globulin)
	XEMBIFY (immune globulin)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	TEZSPIRE PEN (tezepelumab-ekko)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)
tacrolimus	OPZELURA (ruxolitinib)
	pimecrolimus

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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 capsules, softgel
RAPAMUNE (sirolimus) tablets	ENVARSUS XR (tacrolimus)
tacrolimus	everolimus tablets
	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 tablets
	TAVNEOS (avacopan)
	ZORTRESS (everolimus)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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
	OMNARIS (ciclesonide)
	QNASL (beclomethasone dipropionate)
	triamcinolone
	XHANCE (fluticasone)
OTHERS	
azelastine (generic ASTELIN)	azelastine (generic ASTEPRO)
	ipratropium nasal spray
	olopatadine
	PATANASE (olopatadine)
COMBINATIONS	
	azelastine/fluticasone
	DYMISTA (azelastine/fluticasone)
	RYALTRIS (olopatadine HCl/mometasone)

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.

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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.

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	clindamycin injection
linezolid tablets, IV	LINCOCIN (lincomycin)
linezolid tablets, IV (AG)	lincomycin
ZYVOX (linezolid) suspension	linezolid suspension
	linezolid suspension AG
	SIVEXTRO (tedizolid)
	SYNERCID (quinupristin/dalfopristin)
	ZYVOX (linezolid) tablets, injection

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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) tablets	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
OMEGA-3 FATTY ACIDS	
omega-3 fatty acids	icosapent ethyl

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

PREFERRED AGENTS	NON-PREFERRED AGENTS
VASCEPA (icosapent ethyl)	LOVAZA (omega-3 fatty acids)

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) Pen	
REPATHA (evolocumab)	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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 400 (erythromycin)	E.E.S. (erythromycin) tablets
erythromycin base	E.E.S. (erythromycin) 200 suspension
erythromycin ethylsuccinate 200 suspension	ERYPED 200 (erythromycin)
	ERY-TAB (erythromycin)
	ERYTHROCIN (erythromycin)
	erythromycin base filmtab
	erythromycin ethylsuccinate 400 suspension
	ZITHROMAX (azithromycin)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)	tetrabenazine
AUSTEDO XR (deutetrabenazine)	
INGREZZA (valbenazine)	
XENAZINE (tetrabenazine)	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)	
fingolimod	
GILENYA (fingolimod)	
glatiramer	
GLATOPA (glatiramer)	
KESIMPTA (ofatumumab)	
MAVENCLAD (cladribine)	
MAYZENT (siponimod)	
PLEGRIDY (peginterferon beta-1a)	
PONVORY STARTER PACK (ponesimod)	
PONVORY TABLETS (ponesimod)	
REBIF (interferon beta-1a)	
TASCENSO ODT (fingolimod lauryl sulfate)	
TECFIDERA (dimethyl fumarate)	
teriflunomide	
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) capsules	duloxetine (Irenka)
	GRALISE (gabapentin)
	HORIZANT (gabapentin enacarbil ER)
	LYRICA CR (pregabalin)
	LYRICA (pregabalin) solution
	NEURONTIN (gabapentin)
	pregabalin capsules
	pregabalin ER, solution
	SAVELLA (milnacipran)
TOPICAL AGENTS	
capsaicin OTC	QUTENZA (capsaicin/skin cleanser)
	ZTLIDO (lidocaine)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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 tablets	DAYPRO (oxaprozin)
diclofenac sodium	diclofenac potassium capsules
ibuprofen	diclofenac SR
indomethacin capsules	diflunisal
ketorolac	etodolac
naproxen EC	etodolac SR
naproxen sodium OTC	FELDENE (piroxicam)
naproxen tablets	fenoprofen
sulindac	flurbiprofen
	indomethacin ER capsules
	ketoprofen
	ketoprofen ER
	Lofena (diclofenac)
	meclofenamate
	mefenamic acid
	nabumetone
	NALFON (fenoprofen)
	NAPRELAN CR (naproxen sodium)
	naproxen CR
	naproxen sodium (Rx)
	naproxen suspension
	oxaprozin
	piroxicam
	RELAFEN DS (nabumetone)
	tolmetin

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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 patch
	diclofenac sodium pump
	diclofenac solution
	FLECTOR (diclofenac)
	ketorolac nasal spray
	LICART PATCH (diclofenac epolamine)
	PENNSAID (diclofenac)

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	
celecoxib capsules, AG	CELEBREX (celecoxib)
meloxicam tablets	meloxicam capsules

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.

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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)	
ORSERDU (elacestrant HCl)	
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) capsules/tablets	
COPIKTRA (duvelisib)	
DAURISMO (glasdegib)	
GLEEVEC (imatinib)	
HYDREA (hydroxyurea)	
hydroxyurea	
ICLUSIG (ponatinib)	
IDHIFA (enasidenib)	
imatinib	
IMBRUVICA (ibrutinib) capsules/suspension/tablets	
INQOVI (decitabine/cedazuridine)	
INREBIC (fedratinib)	
JAKAFI (ruxolitinib)	
lenalidomide	
LEUKERAN (chlorambucil)	
MATULANE (procarbazine)	
melphalan	
mercaptopurine	
MYLERAN (busulfan)	
NINLARO (ixazomib)	
ONUREG (azacytidine)	
POMALYST (pomalidomide)	
PURIXAN (mercaptopurine)	
REVLIMID (lenalidomide)	
REZLIDHIA (olutasidenib)	
RYDAPT (midostaurin)	
SCEMBLIX (asciminib)	
SPRYCEL (dasatinib)	
TABLOID (thioguanine)	
TASIGNA (nilotinib)	
THALOMID (thalidomide)	

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.

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PREFERRED AGENTS	NON-PREFERRED AGENTS
TIBSOVO (ivosidenib)	
tretinoin	
VANFLYTA (quizartinib dihydrochloride)	
VENCLEXTA (venetoclax)	
VONJO (pacritinib)	
XOSPATA (gilteritinib)	
XPOVIO (selinexor)	
ZOLINZA (vorinostat)	
ZYDELIG (idelalisib)	

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.

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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)	
KRAZATI (adagrasib)	
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)	
JAYPIRCA (pirtobrutinib)	
KOSELUGO (selumetinib)	
LONSURF (trifluridine/tipiracil)	
LYNPARZA (olaparib)	
LYTGOBI (futibatinib)	
PEMAZYRE (pemigatinib)	
QINLOCK (ripretinib)	
RUBRACA (rucaparib)	
STIVARGA (regorafenib)	
TAZVERIK (tazemetostat)	
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	
CASODEX (bicalutamide)	
EMCYT (estramustine)	
ERLEADA (apalutamide)	
flutamide	
nilutamide	
NUBEQA (darolutamide)	
ORGOVYX (relugolix)	
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	
FOTIVDA (tivozanib HCl)	
INLYTA (axitinib)	
LENVIMA (Lenvatinib)	
NEXAVAR (sorafenib)	
sorafenib	
sunitinib	
SUTENT (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	MAXITROL (neomycin/polymyxin/ dexamethasone)
sulfacetamide/prednisolone	neomycin/bacitracin/polymyxin/hydrocortisone
TOBRADEX (tobramycin/dexamethasone) ointment	neomycin/polymyxin/hydrocortisone
TOBRADEX (tobramycin/dexamethasone) suspension	TOBRADEX ST (tobramycin/dexamethasone)
tobramycin/dexamethasone suspension, AG	ZYLET (tobramycin/loteprednol)

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.

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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)	
gentamicin	
tobramycin	
TOBREX (tobramycin) ointment	
QUINOLONES	
ciprofloxacin	BESIVANCE (besifloxacin)
moxifloxacin (**Vigamox**) ophthalmic, AG	CILOXAN (ciprofloxacin)
ofloxacin	gatifloxacin
	moxifloxacin (**Moxeza**)
	OCUFLOX (ofloxacin)
	VIGAMOX (moxifloxacin)
	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

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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 OTC (olopatadine)
	ZADITOR OTC (ketotifen)
	ZERVIATE (cetirizine)

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.

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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)
	INVELTYS (loteprednol)
	LOTEMAX (loteprednol) gel
	loteprednol
	MAXIDEX (dexamethasone)
	PRED FORTE (prednisolone)
	PRED MILD (prednisolone)
	prednisolone sodium phosphate

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.

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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) vial	CEQUA (cyclosporine)
XIIDRA (lifitegrast)	cyclosporine
	EYSUVIS (loteprednol etabonate)
	MIEBO (perfluorohexyloctane/PF)
	RESTASIS MULTIDOSE (cyclosporine)
	TYRVAYA (varenicline)
	VERKAZIA (cyclosporine)

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.

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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	
RHO KINASE INHIBITORS	
RHOPRESSA (netarsudil)	
ROCKLATAN (netarsudil/latanoprost)	
PROSTAGLANDIN ANALOGS	
latanoprost	bimatoprost
TRAVATAN-Z (travoprost)	IYUZEH (latanoprost/PF)
	LUMIGAN (bimatoprost)
	tafluprost
	travoprost
	VYZULTA (latanoprostene bunod)
	XALATAN (latanoprost)

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.

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PREFERRED AGENTS	NON-PREFERRED AGENTS
	XELPROS (latanoprost)
	ZIOPTAN (tafluprost)
COMBINATION AGENTS	
COMBIGAN (brimonidine/timolol)	brimonidine tartrate/timolol
dorzolamide/timolol	COSOPT (dorzolamide/timolol)
SIMBRINZA (brinzolamide/brimonidine)	COSOPT PF (dorzolamide/timolol)
	dorzolamide/timolol
MISCELLANEOUS	
	phospholine iodide

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.

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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	
OPVEE SPRAY (nalmefene HCl) nasal	
SUBOXONE (buprenorphine/naloxone) film*	
VIVITROL (naltrexone)	
ZIMHI (naloxone)	
ZUBSOLV (buprenorphine/naloxone)*	

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.

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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)
ciprofloxacin/dexamethasone otic, AG	ciprofloxacin
neomycin/polymyxin/hydrocortisone	ciprofloxacin HCl/fluocinolone
ofloxacin	CORTISPORIN-TC (colistin sulfate - neomycin sulfate - thonzonium bromide - hydrocortisone acetate otic suspension)
	OTOVEL (ciprofloxacin/fluocinolone)

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.

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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

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.

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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) tablets	bosentan
	OPSUMIT (macitentan)
	ORENITRAM ER (treprostinil) tablets, titration kit
	sildenafil suspension (generic Revatio)
	sildenafil tablets (generic Revatio)
	tadalafil (generic Adcirca)
	TADLIQ (tadalafil) suspension
	TRACLEER (bosentan) suspension
	TYVASO Inhalation (treprostinil)
	TYVASO DPI (treprostinil)
	UPTRAVI (selexipag)
	VENTAVIS Inhalation (iloprost)

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.

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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)
ZENPEP (pancrelipase)	VIOKACE (pancrelipase)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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.

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

PHOSPHATE BINDERS

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
- 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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

POTASSIUM BINDERS

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
Lokelma (sodium zirconium cyclosilicate)	Veltassa (patiromer calcium sorbitex)
sodium polystyrene sulfonate	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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.

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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
DEXILANT (dexlansoprazole)	ACIPHEX (rabeprazole)
NEXIUM suspension packet (esomeprazole)	dexlansoprazole DR
omeprazole RX	esomeprazole
pantoprazole	KONVOMEP (omeprazole/sodium bicarbonate)
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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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
	brimonidine gel
	FINACEA (azelaic acid)
	ivermectin
	metronidazole lotion
	NORITATE (metronidazole)
	RHOFADE (oxymetazoline)
	ROSADAN KIT (metronidazole)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	
temazepam 15, 30 mg	DAYVIGO (lemborexant)
triazolam	estazolam
	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
	quazepam
	QUVIVIQ (daridorexant)
	ramelteon
	ROZEREM (ramelteon)
	SILENOR (doxepin)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	tasimelteon
	zolpidem ER/SL/capsules

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)	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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 tablets	AMRIX (cyclobenzaprine ER)*
carisoprodol (except 250 mg)*	baclofen solution, suspension
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*
	SOMA (carisoprodol)*
	tizanidine capsules
	ZANAFLEX (tizanidine)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	
nicotine lozenge	
nicotine patch	
varenicline tartrate dose pack, tablets	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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	desonide
PROCTOSOL-HC (hydrocortisone)	fluocinolone oil
	hydrocortisone lotion (Rx)
	TEXACORT (hydrocortisone) solution
MEDIUM POTENCY	
fluticasone propionate cream, ointment	betamethasone valerate foam
mometasone cream, ointment, solution	BESER KIT (fluticasone)
	clocortolone cream
	CLODERM (clocortolone)
	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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	fluocinonide
	halcinonide
	HALOG (halcinonide)
	HALOG SOLUTION (halcinonide)
	KENALOG aerosol (triamcinolone)
	TOPICORT (desoximetasone)
	triamcinolone acetonide aerosol
	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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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) suspension	armodafinil
FOCALIN XR (dexmethylphenidate)	AZSTARYS (serdexmethylphenidate/dexmethyl)
JORNAY PM (methylphenidate ER)	COTEMPLA XR ODT (methylphenidate)
METHYLIN (methylphenidate) solution	DESOXYN (methamphetamine)
methylphenidate IR	DEXEDRINE (dextroamphetamine)
QUILLIVANT XR (methylphenidate)	dexmethylphenidate ER
VYVANSE (lisdexamfetamine)	dextroamphetamine ER
VYVANSE (lisdexamfetamine) chewable tablets	dextroamphetamine solution
	DYANAVEL XR (amphetamine) tablets
	EVEKEO (amphetamine)
	FOCALIN (dexmethylphenidate)
	methamphetamine
	methylphenidate CD
	methylphenidate chewable tablets
	methylphenidate ER
	methylphenidate patch
	methylphenidate solution
	modafinil
	MYDAYIS (amphetamine salt combination ER)
	NUVIGIL (armodafinil)
	PROCENTRA (dextroamphetamine)
	PROVIGIL (modafinil)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	QUILLICHEW ER (methylphenidate)
	RITALIN (methylphenidate)
	RITALIN LA (methylphenidate ER)
	SUNOSI (solriamfetol)
	WAKIX (pitolisant)
	XELSTRYM (dextroamphetamine) transdermal
	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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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 capsules	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
	doxycycline monohydrate 40, 75, 150 mg capsules
	doxycycline monohydrate tablets
	minocycline tablets
	minocycline ER
	MINOLIRA ER (minocycline)
	MORGIDOX KIT (doxycycline/skin cleanser no19)
	NUZYRA tablets (omadacycline)
	ORACEA (doxycycline)
	SOLODYN (minocycline)
	TARGADOX (doxycycline hyclate)
	tetracycline
	VIBRAMYCIN (doxycycline) capsules, syrup
	XIMINO (minocycline)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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) tablets	DOPTELET (avatrombopag)
	MULPLETA (lusutrombopag)
	PROMACTA (eltrombopag) suspension
	TAVALISSE (fostamatinib)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)	carglumic acid
CARBAGLU (carglumic acid)	RAVICTI (glycerol phenylbutyrate)
PHEBURANE (sodium phenylbutyrate)	sodium phenylbutyrate powder/ tablets

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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)	

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.

*Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 5 of the PDL Document after the Table of Contents.

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/PHENYLEPHRINE TABLET OTC (ORAL)	guaifenesin/phenylephrine HCl
GUAIFENESIN 400 MG TABLET OTC (ORAL)	guaifenesin	GUAIFENESIN/PHENYLEPHRINE TABLET OTC (ORAL)	guaifenesin/pseudoephedrne HCl
GUAIFENESIN LIQUID OTC (ORAL)	guaifenesin	GUAIFENESIN/PHENYLEPHRINE/APAP TABLET OTC (ORAL)	guaifen/phenyleph/acetaminophn
GUAIFENESIN TABLET ER OTC (ORAL)	guaifenesin	GUAIFENESIN/PSEUDOEPHEDRNE TABLET OTC (ORAL)	guaifenesin/pseudoephedrne HCl
GUAIFENESIN/PSE TABLET ER OTC (ORAL)	guaifenesin/pseudoephedrne HCl	HISTEX-PE LIQUID OTC (ORAL)	phenylephrine HCl/triprolidine
MUCUS-CHEST CONGESTION LIQUID OTC (ORAL)	guaifenesin	IBUPROFEN/PSE CAPSULE OTC (ORAL)	ibuprofen/pseudoephedrine HCl
NASOPEN PE LIQUID OTC (ORAL)	thonzylamine/phenylephrine	IBUPROFEN/PSE TABLET OTC (ORAL)	ibuprofen/pseudoephedrine HCl
PHENYLEPHRINE/BROMPHENIRAMINE SOLUTION OTC (ORAL)	brompheniramine/phenylephrine	LOHIST-D LIQUID OTC (ORAL)	chlorpheniramine/pseudoephed
POLY HIST FORTE TABLET OTC (ORAL)	doxylamine/phenylephrine HCl	NAPROXEN/PSE TABLET OTC (ORAL)	naproxen sodium/pseudoephedrin
PSE/TRIPROLIDINE TABLET OTC (ORAL)	triprolidine/pseudoephedrine	NOHIST-LQ LIQUID OTC (ORAL)	chlorpheniramine/phenylephrine
RYNEX PE SOLUTION OTC (ORAL)	brompheniramine/phenylephrine	PHENYLEPHRINE/APAP TABLET OTC (ORAL)	phenylephrine HCl/acetaminophn
		PHENYLEPHRINE/APAP/CHLORPHENIRAMINE TABLET OTC (ORAL)	phenylephrine/acetaminophn/cpm
		PHENYLEPHRINE/BROMPHENIRAMINE TABLET OTC (ORAL)	brompheniramine/phenylephrine
		POLY-VENT IR TABLET OTC (ORAL)	guaifenesin/pseudoephedrne HCl
		RYMED TABLET OTC (ORAL)	dexchlorpheniram/phenylephrine
		RYNEX PSE LIQUID OTC (ORAL)	brompheniramin/pseudoephedrine
		SINUS RELIEF SPRAY OTC (NASAL)	phenylephrine HCl

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	HYDROCODONE/CHLORPHENIRAMINE SUSPENSION ER 12H (ORAL)	hydrocodone/chlorphen p-stirex
PROMETHAZINE/CODEINE SYRUP (ORAL)	promethazine HCl/codeine	HYDROCODONE/HOMATROPINE SYRUP (ORAL)	hydrocodone bit/homatrop me-br
		HYDROCODONE/HOMATROPINE TABLET (ORAL)	hydrocodone bit/homatrop me-br

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	DAY MULTI-SYMP FLU-SEVERE COLD POWDER PACK OTC (ORAL)	d-methorphan/PE/acetaminophen
BENZONATATE CAPSULE (ORAL)	benzonatate	DEXCHLORPHENIRAMINE/PSE/CHLOPHEDIANOL LIQUID OTC (ORAL)	dexchlorphenir/pse/chlophedian
BROM-PSE-DM SYRUP (ORAL)	brompheniramine/pseudoephed/DM	DEXCHLORPHENIRAMINE/PSE/DM LIQUID OTC (ORAL)	dexchlorphen/phenylephrine/DM
BROMPHENIRAMINE/PHENYLEPHRINE/DM SOLUTION OTC (ORAL)	brompheniram/phenylephrine/DM	DM/APAP/CHLORPHENIRAMINE TABLET OTC (ORAL)	dextromethorphn/acetaminoph/cp
DECONEX DMX TABLET OTC (ORAL)	guaifen/dextromethorphan/PE	DM/APAP/DOXYLAMINE CAPSULE OTC (ORAL)	DM/acetaminophen/doxylamine
DEXTROMETHORPHAN CAPSULE OTC (ORAL)	dextromethorphan HBr	DM/APAP/DOXYLAMINE LIQUID OTC (ORAL)	DM/acetaminophen/doxylamine
DEXTROMETHORPHAN SUSPENSION ER 12H OTC (ORAL)	dextromethorphan polistirex	DM/CHLORPHENIRAMINE TABLET OTC (ORAL)	chlorpheniramine/dextromethorp
DURAFLU TABLET OTC (ORAL)	pseudoeph/DM/guaifen/acetamin	DM/PHENYLEPHRINE/APAP CAPSULE OTC (ORAL)	d-methorphan/PE/acetaminophen
ED-A-HIST DM LIQUID OTC (ORAL)	chlorpheniramine/phenyleph/DM	DM/PHENYLEPHRINE/APAP LIQUID OTC (ORAL)	d-methorphan/PE/acetaminophen
GUAIFEN/DEXTROMETHORPHAN/PE OTC (ORAL)	guaifen/dextromethorphan/PE	DM/PHENYLEPHRINE/APAP TABLET OTC (ORAL)	d-methorphan/PE/acetaminophen
GUAIFENESIN/DM LIQUID OTC (ORAL)	guaifenesin/dextromethorphan	DOXYLAMINE/DM SOLUTION OTC (ORAL)	dextromethorphan hb/doxylamine
GUAIFENESIN/DM TABLET ER 12H OTC (ORAL)	guaifenesin/dextromethorphan	ED A-HIST DM TABLET OTC (ORAL)	chlorpheniramine/phenyleph/DM
GUAIFENESIN/DM/PHENYLEPHRINE LIQUID OTC (ORAL)	guaifen/dextromethorphan/PE	GUAIFENESIN/DM TABLET OTC (ORAL)	guaifenesin/dextromethorphan
GUAIFENESIN/DM/PHENYLEPHRINE SYRUP OTC (ORAL)	guaifen/dextromethorphan/PE	M-END DMX LIQUID OTC (ORAL)	dexbromphen/pseudoephedrine/DM
HISTEX-DM SYRUP OTC (ORAL)	triprolidine/phenylephrine/DM	MUCUS DM MAX TABLET ER 12H OTC (ORAL)	guaifenesin/dextromethorphan
LOHIST-DM LIQUID OTC (ORAL)	brompheniram/phenylephrine/DM	NINJACOF LIQUID OTC (ORAL)	pyrilamine/chlophedianol
NOHIST-DM LIQUID OTC (ORAL)	chlorpheniramine/phenyleph/DM	PHENYLEPHRINE/DM/APAP/GUAIFENESIN CAPLET OTC (ORAL)	phenylephrine/DM/acetaminop/GG
POLY-HIST DM LIQUID OTC (ORAL)	thonzylamine/phenylephrine/DM	PHENYLEPHRINE/DM/APAP/GUAIFENESIN LIQUID OTC (ORAL)	phenylephrine/DM/acetaminop/GG
POLY-VENT DM TABLET OTC (ORAL)	guaifenesin/DM/pseudoephedrine		
POLYTUSSIN DM OTC (ORAL)	d-methorphan/pe/dexbromphenir		
PROMETHAZINE/DM SYRUP (ORAL)	promethazine/dextromethorphan		
RYNEX DM SOLUTION OTC (ORAL)	brompheniram/phenylephrine/DM		
VANACOF DM LIQUID OTC (ORAL)	guaifen/dextromethorphan/PE		
VANACOF DMX 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	ACCRUFER (ORAL)	ferric maltol
FERROUS FUMARATE/FA/MULTIVITAMIN & MINERALS CAPSULE (ORAL)	mv-mins no.73/iron fum/folic	CORVITE 150 TABLET (ORAL)	iron,carb/folate6/mv,min no.41
FERROUS FUMARATE/IRON POLYSACCHARIDES/FA/MULTIVITAMIN CAPSULE (ORA	iron fm,ps no.1/folic/mv no.18	CORVITE FE TABLET (ORAL)	iron/folate no.6/mv,mins no.40
FERROUS GLUCONATE TABLET OTC (ORAL)	ferrous gluconate	FEOSOL TABLET OTC (ORAL)	iron polysacch/iron heme polyp
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 POLYSACCHARIDES CAPSULE OTC (ORAL)	iron polysaccharide complex	FERROUS SULFATE/ASCORBIC ACID/FA TABLET ER OTC (ORAL)	ferrous sulfate/vit C/folic ac
		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.17 WITH FLUORIDE CHEW (ORAL)	pedi multivit no.17 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.219/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
PNV NO.15/IRON FUM & PS CMP/FA (ORAL)	mvn-min 74/iron fum/iron/FA	CITRANATAL B-CALM (ORAL)	prenatal 48/iron/folic acid/B6
PNV WITH CA,NO.72/IRON/FA (ORAL)	PNV,calcium 72/iron/folic acid	COMPLETENATE CHEW TABLET (ORAL)	prenatal vit 14/iron fum/folic
PNV2/IRON B-G SUC-P/FA/OMEGA-3 (ORAL)	PNV cmb 52/iron/FA/omega-3/dha	FE C/FA (ORAL)	multivit-min69/iron/folic acid
PRENATAL VIT #76/IRON,CARB/FA (ORAL)	prenatal vit,calc76/iron/folic	NESTABS (ORAL)	prenatal vit86/iron/folic acid
PRENATE ENHANCE (ORAL)	prenatal vit68/iron/FA no6/dha	NESTABS DHA (ORAL)	prenatal 87/iron bis/folic/dha
SELECT-OB + DHA (ORAL)	prenatal vit 33/iron/folic/dha	OB COMPLETE ONE (ORAL)	PNV 85/iron/folic/dha/fish oil
TRICARE (ORAL)	prenatal vit103/iron fum/folic	OB COMPLETE PETITE (ORAL)	prenatal56/iron/folic acid/dha
TRINATAL RX 1 (ORAL)	prenatal vit27,calcium/iron/FA	OB COMPLETE PREMIER (ORAL)	PNV83/iron,carb,asp/folic acid
VITAFOL NANO (ORAL)	prenatal no.75/iron/folate no1	OB COMPLETE TABLET (ORAL)	multivit-min69/iron/folic acid
VITAFOL TAB CHEW (ORAL)	PNV 112/iron/folic/om3/dha/epa	PNV COMBO#47/IRON/FA #1/DHA (ORAL)	multivit 47/iron/folate 1/dha
VITAFOL ULTRA (ORAL)	PNV 67/iron ps/folate no.1/dha	PNV NO.118/IRON FUMARATE/FA CHEW TABLET (ORAL)	PNV no.118/iron fumarate/FA
VITAFOL-OB (ORAL)	prenatal vit 10/iron fum/folic	PNV W-CA NO.40/IRON FUM/FA CMB NO.1 (ORAL)	prenatal,calc.40/iron/folate 1
VITAFOL-OB+DHA (ORAL)	prenatal vit 10/iron/folic/dha	PNV WITH CA NO.68/IRON/FA NO.1/DHA (ORAL)	mv-mins 71/iron/folic no.1/dha
VITAFOL-ONE (ORAL)	prenatal 26/iron ps/folic/dha	PNV#16/IRON FUM & PS/FA/OM-3 (ORAL)	mvn-min75/iron/iron ps/om3/dha
		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 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
		WESTGEL DHA (ORAL)	prenatal 93/iron/folate 9/dha