

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 there is a clinical prior authorization associated with the drug. Some drugs are subject to both non-preferred and clinical prior authorizations.

HHSC makes PDL changes twice a year during the third or fourth week of 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.

Drugs with Drug Utilization Review Board-approved clinical prior authorization are hyperlinked within the list, as shown in the example below. Links will take the user to the specific drug or drug class clinical prior authorization criteria with a narrative explaining the purpose and requirements.

Table 1: PDL Example

<i>Therapeutic Class Name</i>		
Preferred Agents	Non-Preferred Agents	Prior Authorization Criteria
bacitracin ointment BACTROBAN (mupirocin) cream	BACITRACIN PACKET BACTROBAN (mupirocin) ointment	<ul style="list-style-type: none"> • 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 • Clinical Prior Authorization applies

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 makes recommendations for 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 27, 2022

PREFERRED DRUG LIST PUBLICATION LOG

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

January 27, 2022: Published

ACNE AGENTS, ORAL

Preferred Agents

Non-Preferred Agents

PA Criteria

Client must meet at least one of the listed PA criteria

ACCUTANE (isotretinoin)
 AMNESTEEM (isotretinoin)
 CLARAVIS (isotretinoin) isotretinoin
 MYORISAN (isotretinoin)
 ZENATANE (isotretinoin)

ABSORICA (isotretinoin)
 ABSORICA LD (isotretinoin)
 isotretinoin (Absorica)

- 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

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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ACNE AGENTS, TOPICAL		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Antibiotics		
clindamycin gel clindamycin pledgets clindamycin solution erythromycin gel, solution	AMZEEQ (minocycline) CLEOCIN-T (clindamycin) clindamycin foam clindamycin gel AG (Clindagel) clindamycin lotion erythromycin medicated swab	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Topical Acne Agents</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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ACNE AGENTS, TOPICAL <i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Benzoyl Peroxide		
benzoyl peroxide gel (Rx) benzoyl peroxide lotion (OTC) benzoyl peroxide wash	BENZEFOAM FOAM OTC (topical) benzoyl peroxide cleanser benzoyl peroxide cream benzoyl peroxide foam benzoyl peroxide gel benzoyl peroxide kit benzoyl peroxide towelette	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ Topical Acne Agents <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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ACNE AGENTS, TOPICAL <i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Retinoids		
tretinoin cream (Avita, Retin-A) tretinoin gel (Avita, Retin-A)	AKLIEF (trifarotene) adapalene ALTRENO (tretinoin) ARAZLO (tazarotene) ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene) FABIOR (tazarotene) tazarotene TAZORAC (tazarotene) tretinoin gel (Atralin) tretinoin microspheres	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Topical Retinoids</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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ACNE AGENTS, TOPICAL			
continued			
Preferred Agents	Non-Preferred Agents		PA Criteria
Client must meet at least one of the listed PA criteria			
Combination and Other Agents			
benzoyl peroxide/clindamycin (Duac) erythromycin/benzoyl peroxide	ACZONE (dapson)	sulfacetamide	<ul style="list-style-type: none">■ 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
	AZELEX (azelaic acid)	sulfacetamide sodium	
	BENZACLIN GEL (benzoyl peroxide/clindamycin)	sulfacetamide sodium/sulfur	
	adapalene/benzoyl peroxide (Epiduo/Epiduo Forte))	sulfacetamide/sulfur	
	clindamycin/benzoyl peroxide(Acanya)	sulfacetamide/sulfur/urea	<ul style="list-style-type: none">■ Treatment of stage-four advanced, metastatic cancer and associated conditions <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none">■ Retinoids■ Topical Acne Agents <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
	clindamycin/tretinoin	ZIANA (clindamycin/tretinoin)	
	dapsone		
	EPIDUO FORTE (benzoyl peroxide/adapalene)		

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ALZHEIMER'S AGENTS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Cholinesterase Inhibitors		<ul style="list-style-type: none">■ 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 <u>Dose Optimization</u> applies to some strengths where a "*" is noted "Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria"
donepezil 5, 10 mg tablet* donepezil ODT* EXELON (rivastigmine) transdermal	ARICEPT (donepezil)* donepezil 23 mg tablet* galantamine* galantamine ER RAZADYNE ER (galantamine ER) rivastigmine capsules rivastigmine transdermal	
NMDA Receptor Antagonist		
memantine tablets	memantine ER memantine solution memantine tablet dose pack NAMENDA (memantine) tablets NAMENDA XR (memantine)	
Cholinesterase Inhibitor/NMDA Receptor Antagonist Combinations		
	NAMZARIC (donepezil/memantine)	

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ANALGESICS, NARCOTIC – LONG ACTING		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
BUTRANS (buprenorphine) <u>fentanyl patch</u> (12, 25, 50, 75, 100 mcg) morphine ER (generic MS Contin) tramadol ER (Ultram ER) <u>XTAMPZA ER</u> (oxycodone)	<div> <div> <i>BELBUCA (buprenorphine)</i> <i>buprenorphine buccal</i> <i>buprenorphine patch</i> <i>CONZIP (tramadol)</i> <i><u>fentanyl patch</u> (37.5, 62.5, 87.5 mcg)</i> <i>hydrocodone ER</i> <i>hydromorphone ER</i> <i>HYSINGLA ER (hydrocodone)</i> <i>KADIAN (morphine)</i> <i>methadone</i> <i>MORPHABOND ER (morphine)</i> <i>morphine ER (generic Avinza, Kadian)</i> </div> <div> <i>MS CONTIN (morphine)</i> <i>NUCYNTA ER (tapentadol)</i> <i><u>oxycodone ER</u></i> <i><u>OXYCONTIN</u> (oxycodone)</i> <i>oxymorphone ER</i> <i>tramadol ER (generic Conzip, Ryzolt)</i> <i>ZOHYDRO ER (hydrocodone ER)</i> </div> </div>	<ul style="list-style-type: none"> ■ 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. <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Morphine Milligram Equivalent</u> ■ <u>Opiate Overutilization</u> ■ <u>Opiate/Benzodiazepine/Muscle Relaxant</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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ANALGESICS, NARCOTIC – SHORT ACTING (NON-PARENTERAL)		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
APAP/codeine hydrocodone/APAP hydrocodone/ibuprofen hydromorphone tablet morphine tablets morphine solution oxycodone solution oxycodone tablet oxycodone/APAP tramadol tramadol/APAP	<div> <div> ABSTRAL (fentanyl citrate) ACTIQ (fentanyl) APADAZ (benzhydrocodone/APAP) benzhydrocodone/APAP butalbital/ASA/caffeine/codeine butalbital/APAP/caffeine/codeine butorphanol carisoprodol/aspirin/codeine codeine dihydrocodeine/APAP/caffeine DILAUDID (hydromorphone) DSUVIA (sufentanil citrate) fentanyl buccal FENTORA (fentanyl) FIORICET W/CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/CODEINE (butalbital/ASA/caffeine/codeine) hydromorphone liquid hydromorphone suppositories levorphanol LORTAB (hydrocodone/APAP) meperidine morphine concentrated solution </div> <div> morphine disp syr, oral morphine suppositories NUCYNTA (tapentadol) OXAYDO (oxycodone) oxycodone/ASA oxycodone capsule oxycodone concentrate solution oxycodone syr (oral) oxymorphone pentazocine/naloxone PERCOCET (oxycodone/APAP) ROXICODONE (oxycodone) ULTRACET (tramadol/APAP) ULTRAM (tramadol) </div> </div>	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ Morphine Milligram Equivalent ■ Opiate Overutilization ■ Opiate/Benzodiazepine/Muscle Relaxant <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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ANDROGENIC AGENTS, TOPICAL		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
ANDROGEL (testosterone) pump	ANDRODERM (testosterone) ANDROGEL (testosterone) packet FORTESTA (testosterone) NATESTO (testosterone) TESTIM (testosterone) testosterone gel VOGELXO (testosterone)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Androgenic Agents</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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ANGIOTENSIN MODULATORS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Ace Inhibitors		
benazepril EPANED (enalapril) enalapril fosinopril* lisinopril quinapril ramipril*	ACCUPRIL (quinapril) ALTACE (ramipril)* captopril enalapril solution LOTENSIN (benazepril) moexepiril perindopril* PRINIVIL (lisinopril)	QBRELIS (lisinopril) solution trandolapril* VASOTEC (enalapril) ZESTRIL (lisinopril)
		<ul style="list-style-type: none"> ■ 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 <p><u>Dose Optimization</u> applies to some strengths where a “*” is noted</p> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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ANGIOTENSIN MODULATORS		
<i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
ACE Inhibitor/Diuretic Combinations		
enalapril/HCTZ lisinopril/HCTZ	ACCURETIC (quinapril/HCTZ) benazepril/HCTZ captopril/HCTZ fosinopril/HCTZ LOTENSIN HCT (benazepril/HCTZ) quinapril/HCTZ VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Duplicate Therapy</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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ANGIOTENSIN MODULATORS		
<i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Angiotensin II Receptor Blockers (ARBs)		
DIOVAN (valsartan)* irbesartan* losartan*	<div> <div> ATACAND (candesartan)* AVAPRO (irbesartan)* BENICAR (olmesartan)* candesartan* COZAAR (losartan)* EDARBI (azilsartan) </div> <div> eprosartan MICARDIS (telmisartan)* olmesartan* telmisartan* valsartan* </div> </div>	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ Duplicate Therapy <p>Dose Optimization applies to some strengths where a "*" is noted</p> <p>"Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria"</p>

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continued			
Preferred Agents	Non-Preferred Agents	PA Criteria	
		Client must meet at least one of the listed PA criteria	
ARB/Diuretic Combinations		<ul style="list-style-type: none">■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none">■ Duplicate Therapy <p>Dose Optimization applies to some strengths where a “*” is noted</p> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>	
irbesartan/HCTZ losartan/HCTZ*	ATACAND-HCT (candesartan/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)		

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ANGIOTENSIN MODULATORS		
<i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
ARB/Neprilysin Inhibitor Combinations		
ENTRESTO (valsartan/sacubitril)		<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Duplicate Therapy</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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ANGIOTENSIN MODULATOR COMBINATIONS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
benazepril /amlodipine valsartan/amlodipine	AZOR (olmesartan/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	<ul style="list-style-type: none"> ■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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ANTI-ALLERGENS, ORAL		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
	<u>ORALAIR</u> (Sweet Vernal, Orchard, Perennial Rye, Timothy, & Kentucky Blue Grass mixed pollens allergen extract) <u>PALFORZIA MAINTENANCE SACHET</u> (peanut allergen powder) <u>PALFORZIA TITRATION CAPSULE</u> (peanut allergen powder)	<ul style="list-style-type: none"> ■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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Effective January 27, 2022

ANTIBIOTICS, GASTROINTESTINAL		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
FIRVANQ(vancomycin) metronidazole tablet neomycin tinidazole	<u>AEMCOLO (rifamycin)</u> DIFICID (fidaxomicin) FLAGYL (metronidazole) metronidazole capsule <u>nitazoxanide</u> paromomycin VANCOCIN (vancomycin) vancomycin <u>XIFAXAN (rifaximin)</u>	<ul style="list-style-type: none"> ■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIBIOTICS, INHALED		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
BETHKIS (tobramycin) CAYSTON (aztreonam) KITABIS PAK (tobramycin) TOBI PODHALER (tobramycin)	<u>ARIKAYCE</u> (amikacin) TOBI (tobramycin) solution tobramycin solution	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Antibiotics, Inhaled</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIBIOTICS, TOPICAL		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
bacitracin ointment mupirocin ointment triple antibiotic ointment	<i>bacitracin packet</i> <i>bacitracin/polymixin</i> <i>CENTANY (mupirocin)</i> <i>gentamicin</i> <i>mupirocin cream</i> <i>mupirocin ointment syringe</i> <i>neomycin/polymyxin/pramoxine</i> <i>XEPI (ozenoxacin)</i>	<ul style="list-style-type: none"> ■ 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

ANTIBIOTICS, VAGINAL		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
CLEOCIN (clindamycin) ovules CLINDESSE (clindamycin) NUVESSA (metronidazole)	<i>CLEOCIN (clindamycin) cream</i> <i>clindamycin</i> <i>METROGEL-VAGINAL (metronidazole)</i> <i>metronidazole</i> <i>SOLOSEC (secnidazole)</i> <i>VANDAZOLE (metronidazole)</i>	<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTICOAGULANTS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
ELIQUIS (apixaban) enoxaparin JANTOVEN (warfarin) PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban)	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin) SAVAYSA (edoxaban)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Duplicate Therapy</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTICONVULSANTS		
Preferred Agents		PA Criteria
		<i>Client must meet at least one of the listed PA criteria</i>
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)perseris FINTEPLA (fenfluramine) FYCOMPA (perampanel) GABITRIL (tiagabine) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) KLONOPIN (clonazepam) LAMICTAL (lamotrigine) tablet, ODT LAMICTAL XR (lamotrigine) lamotrigine tablet, ER, ODT levetiracetam levetiracetam XR	<ul style="list-style-type: none"> All of the agents in the Anticonvulsants class are preferred <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTICONVULSANTS <i>continued</i>			
Preferred Agents		Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
MYSOLINE (primidone)	TEGRETOL (carbamazepine)		<ul style="list-style-type: none"> All of the agents in the Anticonvulsants class are preferred
NAYZILAM (midazolam)	TEGRETOL XR (carbamazepine)		
ONFI (clobazam)	tiagabine		
oxcarbazepine	TOPAMAX (topiramate)		
OXTELLAR XR (oxcarbazepine)	topiramate		
phenobarbital	topiramate ER		
PHENYTEK (phenytoin)	TRILEPTAL (oxcarbazepine)		
phenytoin	TROKENDI XR (topiramate)		
primidone	valproic acid		
QUDEXY XR (topiramate)	VALTOCO (diazepam)		
ROWEEPR (levetiracetam)	vigabatrin		
rufinamide suspension	VIGADRONE (vigabatrin)		
rufinamide tablet	VIMPAT (lacosamide)		
SABRIL (vigabatrin)	XCOPRI (cenobamate)		
SPRITAM (levetiracetam)	ZARONTIN (ethosuximide)		
SUBVENITE (lamotrigine)	zonisamide		
SYMPAZAN (clobazam)			

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIDEPRESSANTS, OTHER		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
bupropion bupropion SR bupropion XL* mirtazapine* phenelzine trazodone venlafaxine ER capsules* venlafaxine IR	<div> APLENZIN (bupropion) bupropion XL(Forfivo XL) desvenlafaxine ER EFFEXOR XR (venlafaxine)* EMSAM (selegiline) FETZIMA (levomilnacipran) FORFIVO XL (bupropion) MARPLAN (isocarboxazid) NARDIL (phenelzine) nefazodone </div> <div> PRISTIQ (desvenlafaxine) REMERON (mirtazapine)* tranylcypromine TRINTELLIX (vortioxetine) venlafaxine ER tablets* VIIBRYD (vilazodone) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion)* </div>	<ul style="list-style-type: none"> ■ 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 <p><u>Dose Optimization</u> applies to some strengths where a "*" is noted</p> <p>"Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria"</p>

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIDEPRESSANTS, SSRIS			
Preferred Agents	Non-Preferred Agents		PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
citalopram* escitalopram tablets* fluoxetine IR fluvoxamine paroxetine* sertraline* conc, tablet	<i>BRISDELLE (paroxetine)</i> <i>CELEXA (citalopram)*</i> <i>escitalopram solution</i> <i>fluoxetine capsule DR</i> <i>fluoxetine 60mg tablets</i> <i>fluvoxamine ER</i> <i>LEXAPRO (escitalopram)*</i>	<i>paroxetine (Brisdelle)</i> <i>paroxetine CR*</i> <i>PAXIL (paroxetine)*</i> <i>PAXIL CR (paroxetine)*</i> <i>PEXEVA (paroxetine)</i> <i>PROZAC (fluoxetine)</i> <i>sertraline capsule</i> <i>ZOLOFT (sertraline)*</i>	<ul style="list-style-type: none"> ■ 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 <p><u>Dose Optimization</u> applies to some strengths where a “*” is noted</p> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

ANTIDEPRESSANTS, TRICYCLIC

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
amitriptyline doxepin imipramine nortriptyline capsule	<div> <div> <i>amoxapine</i> <i>ANAFRANIL (clomipramine)</i> <i>clomipramine</i> <i>desipramine</i> <i>imipramine pamoate</i> <i>maprotiline</i> <i>NORPRAMIN (desipramine)</i> <i>nortriptyline solution</i> </div> <div> <i>PAMELOR (nortriptyline)</i> <i>protriptyline-</i> <i>trimipramine</i> </div> </div>	<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIEMETIC-ANTIVERTIGO AGENTS (EXCLUDES INJECTABLES)		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Anticholinergics, Antihistamines, Dopamine Antagonists		<ul style="list-style-type: none">■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none">■ Antiemetic-Antivertigo Agents <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
dimenhydrinate meclizine metoclopramide solution, tablets phosphoric acid/dextrose/fructose prochlorperazine tablets promethazine syrup, tablets	ANTIVERT (meclizine) BONJESTA (doxylamine/pyridoxine) COMPRO (prochlorperazine) DICLEGIS (doxylamine/pyridoxine) doxylamine/pyridoxine GIMOTI (metoclopramide) metoclopramide ODT prochlorperazine suppositories promethazine suppositories REGLAN (metoclopramide) scopolamine patches Tigan (trimethobenzamide) TRANSDERM-SCOP (scopolamine) trimethobenzamide	
Cannabinoids		
	dronabinol MARINOL (dronabinol)	

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIEMETIC-ANTIVERTIGO AGENTS (EXCLUDES INJECTABLES) <i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
5-HT3 Receptor Antagonists		<ul style="list-style-type: none">■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none">■ <u>Antiemetic</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
<u>ondansetron</u>	<u>granisetron</u> <u>SANCUSO</u> (<i>granisetron</i>) <i>SUSTOL</i> (<i>granisetron</i>) <i>ZOFRAN</i> (<i>ondansetron</i>)	
Substance P Antagonists & Combinations		
	<i>AKYNZEO</i> (<i>netupitant/palonosetron</i>) <i>aprepitant</i> <i>EMEND</i> (<i>aprepitant</i>)	

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIFUNGALS, ORAL		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
clotrimazole fluconazole griseofulvin suspension ketoconazole NOXAFIL (posaconazole) tablet nystatin terbinafine	ANCOBON (flucytosine) BREXAFEMME (ibrexafungerp) CRESEMBA (isavuconazonium sulfate) DIFLUCAN (fluconazole) flucytosine griseofulvin tablets itraconazole NOXAFIL (posaconazole) susp posaconazole SPORANOX (itraconazole) TOLSURA (itraconazole) VFEND (voriconazole) voriconazole	<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIFUNGALS, TOPICAL		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Antifungals		<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ● <u>Antifungal Agents, Topical</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
clotrimazole ketoconazole shampoo miconazole cream, powder NYAMYC (nystatin) powder nystatin NYSTOP (nystatin) powder terbinafine tolnaftate cream, powder	<i>ALEVAZOL (clotrimazole)</i> <i>BENSAL HP (benzoic acid/salicylic acid)</i> <i>CICLODAN (ciclopirox)</i> <i>ciclopirox</i> <i>clotrimazole solution RX</i> <i>econazole</i> <i>ERTACZO (sertaconazole)</i> <i>EXELDERM (sulconazole)</i> <i>EXTINA (ketoconazole)</i> <i>FUNGOID (miconazole)</i> <i>JUBLIA (efinaconazole)</i> <i>KERYDIN (tavaborole)</i> <i>ketoconazole cream, foam</i> <i>KETODAN (ketoconazole)</i>	
	<i>LOPROX (ciclopirox)</i> <i>LOTIMIN AF (clotrimazole)</i> <i>LOTIMIN ULTRA (butenafine)</i> <i>luliconazole</i> <i>LUZU (luliconazole)</i> <i>MENTAX (butenafine)</i> <i>miconazole ointment, spray</i> <i>naftifine</i> <i>NAFTIN (naftifine)</i> <i>oxiconazole</i> <i>OXISTAT (oxiconazole)</i> <i>sulconazole</i> <i>tavaborole</i> <i>tolnaftate solution, spray</i> <i>VUSION (miconazole/ zinc/petrolatum)</i>	
Antifungal/Steroid Combinations		
clotrimazole/betamethasone cream	<i>clotrimazole/betamethasone lotion</i> <i>nystatin/triamcinolone</i> TRIAMAZOLE KIT (econazole/triamcinolone)	

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIHISTAMINES, FIRST GENERATION		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Antihistamines		
BANOPHEN (diphenhydramine) carbinoxamine liquid clorpheniramine IR tablets cyproheptadine syrup, tablet diphenhydramine capsules, liquid, tablet HISTEX (triprolidine) liquid, PD DROPS hydroxyzine PEDIACLEAR PD DROPS OTC (triprolidine) PEDIACLEAR-8 LIQUID OTC (pyrilamine maleate)	<div> <div>AHIST (chlorcyclizine)</div> <div>carbinoxamine tablets</div> <div>clemastine tablets</div> <div>diphenhydramine chew, elixir</div> <div>ED CHLORPRED (chlorpheniramine/phenylephrine)</div> <div>HISTEX (triprolidine)chew, PDX drop</div> <div>KARBINAL ER (carbinoxamine) suspension</div> </div> <div> <div>PEDIAVENT (dexbrompheniramine)</div> <div>RYCLORA (dexchlorpheniramine)</div> <div>RYVENT (carbinoxamine)</div> <div>triprolidine</div> <div>VANACLEAR (triprolidine) PD DROPS</div> <div>VISTARIL (hydroxyzine)</div> </div>	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Duplicate Therapy</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTI-HISTAMINES, MINIMALLY SEDATING		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Antihistamines		
cetirizine solution, tablets* loratadine solution, tablets	cetirizine chewable, capsule CLARINEX (desloratadine) desloratadine fexofenadine levocetirizine loratadine ODT, chew	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Duplicate Therapy</u> <p><u>Dose Optimization</u> applies to some strengths where a "*" is noted</p> <p>"Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria"</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIHISTAMINES, MINIMALLY SEDATING <i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Antihistamine/Decongestant Combinations		
	<i>cetirizine/pseudoephedrine</i> <i>CLARINEX-D (desloratadine/pseudoephedrine)</i> <i>fexofenadine/pseudoephedrine</i> <i>loratadine/pseudoephedrine</i> <i>SEMPREX-D (acrivastine/pseudoephedrine)</i>	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Duplicate Therapy</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIHYPERTENSIVES, SYMPATHOLYTICS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
CATAPRES-TTS (clonidine) clonidine IR tablets guanfacine IR methyldopa	CATAPRES (clonidine) clonidine transdermal <u>methyldopa / HCTZ</u>	<ul style="list-style-type: none"> ■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIHYPURICEMICS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
allopurinol MITIGARE (colchicine) probenecid probenecid/colchicine	colchicine COLCRYS (colchicine) febuxostat GLOPERBA (colchicine) ULORIC (febuxostat) ZYLOPRIM (allopurinol)	<ul style="list-style-type: none"> ■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIMIGRAINE AGENTS			
Preferred Agents	Non-Preferred Agents		PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Triptans			
IMITREX (sumatriptan) nasal rizatriptan sumatriptan injection kit sumatriptan syringe sumatriptan tablets sumatriptan vial ZOMIG (zolmitriptan) nasal	<i>almotriptan</i> <i>AMERGE (naratriptan)</i> <i>eletriptan</i> <i>FROVA (frovatriptan)</i> <i>frovatriptan</i> <i>IMITREX (sumatriptan) injection kit</i> <i>IMITREX (sumatriptan) tablets</i> <i>IMITREX (sumatriptan) vial</i> <i>MAXALT (rizatriptan)</i> <i>naratriptan</i>	<i>ONZETRA XSAIL (sumatriptan)</i> <i>RELPAX (eletriptan)</i> <i>sumatriptan nasal</i> <i>sumatriptan/naproxen</i> <i>TOSYMRA (sumatriptan)</i> <i><u>TREXIMET</u> (sumatriptan/naproxen)</i> <i>ZEMBRACE SYMTOUCH (sumatriptan)</i> <i>zolmitriptan tablets, nasal</i> <i>ZOMIG (zolmitriptan) tablets</i>	<ul style="list-style-type: none">■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIMIGRAINE AGENTS		
<i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Non-Triptans		
<u>AIMOVIG</u> (erenumab) <u>EMGALITY</u> (galcanezumab-gnlm) <u>UBRELVY</u> (ubrogepant)	<u>AJOVY</u> (fremanezumab-vfrm) <u>CAFERGOT</u> (ergotamine tartrate/caffeine) <u>CAMBIA</u> (diclofenac) D.H.E. 45 (dihydroergotamine) dihydroergotamine mesylate <u>EMGALITY</u> 100 mg (cluster headache) (galcanezumab-gnlm) MIGERGOT supp (ergotamine tartrate/caffeine) MIGRANAL (dihydroergotamine mesylate) <u>NURTEC ODT</u> (rimegepant) REYVOW (lasmiditan)	<ul style="list-style-type: none"> ■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIPARASITICS, TOPICAL		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
NATROBA (spinosad) permethrin VANALICE GEL OTC (piperonyl butoxide/pyrethrins)	CROTAN (crotamiton) ELIMITE (permethrin) EURAX (crotamiton) ivermectin lindane malathion OVIDE (malathion) piperonyl butoxide/pyrethrins piperonyl butox/pyrethr/permet SKLICE (ivermectin) spinosad	<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIPARKINSON’S AGENTS (ORAL/TRANSDERMAL)		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Anticholinergics		<ul style="list-style-type: none">■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
benztropine trihexyphenidyl		
COMT Inhibitors		
	COMTAN (<i>entacapone</i>) <i>entacapone</i> ONGENTYS (<i>opicapone</i>) TASMAR (<i>tolcapone</i>) <i>tolcapone</i>	
Dopamine Agonists		
pramipexole ropinirole	APOKYN (<i>apomorphine</i>) <i>bromocriptine</i> KYNMOBI (<i>apomorphine</i>) MIRAPEX ER (<i>pramipexole</i>) NEUPRO transdermal (<i>rotigotine</i>) PARLODEL (<i>bromocriptine</i>) <i>pramipexole ER</i> <i>ropinirole ER</i>	

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIPARKINSON’S AGENTS (ORAL/TRANSDERMAL)		
continued		
Preferred Agents	Non-Preferred Agents	PA Criteria Client must meet at least one of the listed PA criteria
MAO-B Inhibitors		<ul style="list-style-type: none">■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
	AZILECT (rasagiline) rasagiline selegiline XADAGO (safinamide) ZELAPAR (selegiline)	
Others		
amantadine carbidopa/levodopa tablets carbidopa/levodopa ER carbidopa/levodopa/entacapone	carbidopa carbidopa/levodopa ODT DUOPA (carbidopa/levodopa) <u>GOCOVRI</u> (amantadine) INBRIJA (levodopa) LODOSYN (carbidopa) NOURIANZ (istradefylline) <u>OSMOLEX ER</u> (amantadine) RYTARY (carbidopa/levodopa) SINEMET (carbidopa/levodopa) STALEVO (levodopa/carbidopa/entacapone)	

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIPSYCHOTICS				
Preferred Agents		Non-Preferred Agents		PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Antipsychotics				
aripiprazole tablets*	perphenazine	ABILIFY (aripiprazole) tablets*	pimozide	<ul style="list-style-type: none">■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none">■ Antipsychotics <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p> <p>Dose Optimization applies to some strengths where a “*” is noted</p>
chlorpromazine	quetiapine IR	ABILIFY MYCITE (aripiprazole)	quetiapine ER	
clozapine	risperidone tablets*, solution	aripiprazole ODT, solution	REXULTI (brexpiprazole)	
fluphenazine	thioridazine	asenapine SL	RISPERDAL (risperidone)*	
haloperidol	thiothixene	CAPLYTA (lumateperone)	risperidone ODT*	
haloperidol decanoate	trifluoperazine	clozapine ODT	SAPHRIS (asenapine)	
LATUDA (lurasidone)	VRAYLAR (cariprazine)	CLOZARIL (clozapine)	SECUADO (asenapine)	
olanzapine*	ziprasidone	FANAPT (iloperidone)	SEROQUEL (quetiapine)	
olanzapine ODT*		fluphenazine decanoate	SEROQUEL XR (quetiapine)	
		GEODON (ziprasidone) capsule, IM	VERSACLOZ (clozapine)	
		HALDOL (haloperidol) decanoate	ziprasidone IM	
		haloperidol lactate injection	ZYPREXA (olanzapine)*	
		INVEGA (paliperidone)	ZYPREXA ZYDIS (olanzapine)*	
		Loxapine		
		molindone		
		NUPLAZID (pimavanserin)		
		olanzapine IM		
		paliperidone ER		

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIPSYCHOTICS		
<i>Continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Antipsychotic/SSRI Combinations		
amitriptyline/perphenazine	olanzapine/fluoxetine SYMBYAX (olanzapine/fluoxetine)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ Antipsychotics <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIPSYCHOTICS		
<i>Continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Long-Acting Injectables		
ABILIFY MAINTENA (aripiprazole) ARISTADA (aripiprazole) ARISTADA INITIO (aripiprazole) INVEGA SUSTENNA (paliperidone) INVEGA TRINZA (paliperidone) PERSERIS (risperidone) <u>RISPERDAL CONSTA (risperidone)</u>	ZYPREXA RELPREVV (olanzapine)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Antipsychotics</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIVIRALS (ORAL/NASAL)		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Antiherpetic		<ul style="list-style-type: none">■ 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
acyclovir famciclovir valacyclovir	SITAVIG (acyclovir) VALTrex (valacyclovir) ZOVIRAX (acyclovir)	
Anti-influenza		
oseltamivir	FLUMADINE (rimantadine) RELENZA (zanamivir) rimantadine TAMIFLU (oseltamivir) XOFLUZA (baloxavir)	
Anti-CMV		
VALCYTE (valganciclovir) tablets, solution	valganciclovir tablets, solution	

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANTIVIRALS, TOPICAL		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
DENAVIR (penciclovir) ZOVIRAX (acyclovir) cream, ointment	acyclovir cream, ointment docosanol XERESE (acyclovir/hydrocortisone)	<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ANXIOLYTICS				
Preferred Agents		Non-Preferred Agents		PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
alprazolam tablet	diazepam solution	alprazolam ER	TRANXENE T-TAB (clorazepate)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ Anxiolytics ■ Opiate/Benzodiazepine/Muscle Relaxant <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
buspirone	diazepam tablet	alprazolam intensol	XANAX XR (alprazolam)	
chlordiazepoxide	lorazepam intensol	alprazolam ODT	XANAX (alprazolam) tablet	
clorazepate	lorazepam tablet	ATIVAN (lorazepam)		
		diazepam intensol		
		meprobamate		
		oxazepam		

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

BETA BLOCKERS (ORAL)		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Beta Blockers		<ul style="list-style-type: none">■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
acebutolol atenolol bisoprolol HEMANGEOL (propranolol) metoprolol IR metoprolol XL propranolol IR SORINE (sotalol) sotalol	BETAPACE/ AF (sotalol) betaxolol BYSTOLIC (nebivolol) CORCARD (nadolol) INDERAL LA/XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO (metoprolol succinate) LOPRESSOR (metoprolol) nadolol nebivolol pindolol propranolol ER SOTYLIZE (sotalol) TENORMIN (atenolol) timolol TOPROL XL (metoprolol succinate)	
Beta Blocker Combinations		
atenolol/chlorthalidone <u>bisoprolol/HCTZ</u>	<u>metoprolol/HCTZ</u> <u>nadolol</u> <u>-propranolol/HCTZ</u> <u>TENORETIC (atenolol/HCTZ)</u> <u>ZIAC (bisoprolol/HCTZ)</u>	

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

BETA BLOCKERS (ORAL) <i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Beta- and Alpha-Blockers		
carvedilol labetalol	carvedilol ER* COREG (carvedilol) COREG CR (carvedilol)*	<ul style="list-style-type: none"> ■ 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 <p><u>Dose Optimization</u> applies to some strengths where a "*" is noted</p> <p>"Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria"</p>

BILE SALTS

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
ursodiol tablet	CHENODAL (chenodiol) CHOLBAM (cholic acid) OCALIVA (obeticholic acid) URSO (ursodiol) URSO FORTE (urosodiol) ursodiol capsule	<ul style="list-style-type: none"> ■ Treatment failure with preferred drug ■ Contraindication to preferred drug ■ Allergic reaction to preferred drugs ■ Treatment of stage-four advanced, metastatic cancer and associated conditions

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

BLADDER RELAXANT PREPARATIONS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
oxybutynin IR oxybutynin ER* TOVIAZ (fesoterodine) VESICARE (solifenacin)*	<div> <i>darifenacin ER</i> <i>DETROL (tolterodine)</i> <i>DETROL LA (tolterodine)*</i> <i>DITROPAN XL (oxybutynin)*</i> <i>flavoxate</i> <i>GELNIQUE (oxybutynin)</i> <i>MYRBETRIQ (mirabegron)</i> </div> <div> <i>OXYTROL (oxybutynin)</i> <i>solifenacin</i> <i>tolterodine</i> <i>tolterodine ER*</i> <i>trospium</i> <i>trospium ER</i> VESICARE LS (solifenacin) </div>	<ul style="list-style-type: none"> ■ 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 <p><u>Dose Optimization</u> applies to some strengths where a “*” is noted</p> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Bisphosphonates		<ul style="list-style-type: none">■ 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
alendronate tablets	ACTONEL (risedronate) alendronate solution ATELVIA (risedronate) BONIVA (ibandronate) etidronate EVENITY (romosozumab-aqqg) FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) ibandronate risedronate	
Other Bone Resorption Suppression and Related Agents		
<u>EVISTA (raloxifene)</u> <u>FORTEO (teriparatide)</u>	calcitonin nasal PROLIA (denosumab) <u>raloxifene</u> teriparatide TYMLOS (abaloparatide)	“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

BPH AGENTS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Alpha Blockers		<ul style="list-style-type: none">■ 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 <p><u>Dose Optimization</u> applies to some strengths where a “*” is noted</p> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
alfuzosin doxazosin* tamsulosin terazosin*	CARDURA (doxazosin)* FLOMAX (tamsulosin)* RAPAFLO (silodosin) silodosin	
5-Alpha-Reductase (5AR) Inhibitors		
finasteride	AVODART (dutasteride) dutasteride PROSCAR (finasteride)	
Alpha Blocker/5AR Inhibitor Combinations		
	dutasteride/tamsulosin JALYN (dutasteride/tamsulosin)	
Phosphodiesterase 5 Inhibitors		
	tadalafil	

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

BRONCHODILATORS, BETA AGONIST		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Inhalers, Short-Acting		<ul style="list-style-type: none">■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none">■ <u>Duplicate Therapy</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
PROAIR HFA (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	<i>albuterol HFA</i> <i>levalbuterol</i> <i>PROAIR DIGIHALER (albuterol)</i> <i>PROAIR RESPICLICK (albuterol)</i> <i>XOPENEX HFA (levalbuterol)</i>	
Inhalers, Long-Acting		
	<i>SEREVENT (salmeterol)</i> <i>STRIVERDI RESPIMAT (olodaterol)</i>	

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

BRONCHODILATORS, BETA AGONIST		
continued		
Preferred Agents	Non-Preferred Agents	PA Criteria Client must meet at least one of the listed PA criteria
Inhalation Solution		<ul style="list-style-type: none">■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none">■ Duplicate Therapy <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
albuterol	arformoterol BROVANA (arformoterol) formoterol levalbuterol PERFOROMIST (formoterol) XOPENEX (levalbuterol)	
Oral		
albuterol syrup	albuterol tablet albuterol ER metaproterenol terbutaline	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

CALCIUM CHANNEL BLOCKERS (ORAL)		
Preferred Agents	Non-Preferred Agents	
PA Criteria Client must meet at least one of the listed PA criteria		
Short-Acting		
diltiazem verapamil	CARDIZEM (diltiazem) Isradipine nicardipine nifedipine nimodipine NYMALIZE (nimodipine)	<ul style="list-style-type: none">■ 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
Long-Acting		
amlodipine* CARTIA XT (diltiazem) DILT XR (diltiazem) diltiazem ER felodipine ER nifedipine ER* TAZTIA XT (diltiazem) TIADYLT ER (diltiazem) verapamil ER capsules, tablets*	ADALAT CC (nifedipine)* CALAN SR (verapamil) CARDIZEM CD (diltiazem) CARDIZEM LA (diltiazem) diltiazem LA KATERZIA (amlodipine) MATZIM LA (diltiazem) nisoldipine* NORVASC (amlodipine)*	PROCARDIA XL (nifedipine)* SULAR (nisoldipine) TIAZAC (diltiazem) verapamil 360 mg capsules verapamil ER PM* VERELAN (verapamil) VERELAN PM (verapamil)
Dose Optimization applies to some strengths where a “*” is noted “Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”		

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Beta Lactam/Beta-Lactamase Inhibitor Combinations		<ul style="list-style-type: none">■ 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
amoxicillin/clavulanate tablets, suspension	<i>amoxicillin/clavulanate chewable, XR tablets</i> <i>AUGMENTIN XR (amoxicillin/clavulanate)</i>	
Cephalosporins – First Generation		
cefadroxil capsules, suspension cephalexin capsules, suspension	<i>cefadroxil tablets</i> <i>cephalexin tablets</i> <i>KEFLEX (cephalexin)</i>	

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)		
continued		
Preferred Agents	Non-Preferred Agents	PA Criteria Client must meet at least one of the listed PA criteria
Cephalosporins – Second Generation		<ul style="list-style-type: none">■ 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
cefprozil suspension cefprozil tablets cefuroxime tablets	cefaclor ER cefaclor IR capsules, suspension	
Cephalosporins – Third Generation		
cefdinir	cefixime cefpodoxime ceftibuten SUPRAX (cefixime)	

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

COLONY STIMULATING FACTORS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
FULPHILA (pegfilgrastim - jmdb) NEUPOGEN (filgrastim) vial, syringe	GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) NIVESTYM (filgrastim-aafi) NYVEPRIA (pegfilgrastim-apgf) UDENYCA (pegfilgrastim-cbqv) ZARXIO (filgrastim-sndz) ZIEXTENZO SYRINGE (pegfilgrastim-bmez)	<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

COPD AGENTS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Anticholinergics		<ul style="list-style-type: none">■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none">■ <u>Duplicate Therapy</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
ATROVENT HFA (ipratropium) ipratropium inhalation solution SPIRIVA HANDIHALER (tiotropium)	INCRUSE ELLIPTA (umeclidinium) LONHALA MAGNAIR (glycopyrrolate) SEEBRI NEOHALER (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) TUDORZA (aclidinium)	
Anticholinergic-Beta Agonist Combinations		
albuterol/ipratropium ANORO ELLIPITA (umeclidinium/vilanterol) COMBIVENT RESPIMAT (albuterol/ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI AEROSPHERE (glycopyrrolate/formoterol) DUAKLIR PRESSAIR (aclidinium/formoterol) YUPELRI (revefenacin)	
Phosphodiesterase Inhibitors		
	DALIRESP (roflumilast)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

COUGH AND COLD AGENTS

See Separate Preferred Cough and Cold Agent Listing.

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

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

- [Cough & cold PA criteria](#)

“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

CYTOKINE AND CAM ANTAGONISTS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
ENBREL (etanercept) HUMIRA (adalimumab) OTEZLA (apremilast)	<div> <div> ACTEMRA (tocilizumab) ARCALYST (rilonacept) CIMZIA (certolizumab) COSENTYX (secukinumab) ENSPRYNG (satralizumab-mwge) ILARIS (canakinumab) ILUMYA (tildrakizumab-asmn) KEVZARA (sarilumab) KINERET (anakinra) OLUMIANT (baricitinib) ORENCIA (abatacept) </div> <div> RINVOQ ER (upadacitinib) SILIQ (brodalumab) SIMPONI (golimumab) SKYRIZI (risankizumab-rzaa) SKYRIZI PEN (risankizumab-rzaa) STELARA (ustekinumab) TALTZ (ixekizumab) TREMFYA (guselkumab) XELJANZ (tofacitinib) XELJANZ soln (tofacitinib) XELJANZ XR (tofacitinib) </div> </div>	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ Cytokine and CAM Antagonists <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

EPINEPHRINE, SELF-INJECTED		
Preferred Agents	<i>Non-Preferred Agents</i>	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
epinephrine (Mylan authorized generic EPIPEN and EPIPEN JR)	<i>epinephrine (generic ADRENALCLIK)</i> epinephrine (generic EPIPEN and EPIPEN JR) <i>EPIPEN (epinephrine)</i> <i>EPIPEN JR (epinephrine)</i> <i>SYMJEPI (epinephrine)</i>	<ul style="list-style-type: none"> ■ Treatment failure with preferred products ■ Contraindication to preferred products ■ Allergic reaction to preferred products ■ Treatment of stage-four advanced, metastatic cancer and associated conditions

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ERYTHROPOIESIS STIMULATING PROTEINS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
<u>ARANESP</u> (darbepoetin) RETACRIT (RhUEPO)	<u>EPOGEN</u> (RhUEPO) MIRCERA (PEG-EPO) <u>PROCRIT</u> (RhUEPO) REBLOZYL (<i>luspatercept-aamt</i>)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Erythropoiesis-Stimulating Agents</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

FLUOROQUINOLONES, ORAL

Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
ciprofloxacin IR ciprofloxacin suspension levofloxacin tablets	<i>BAXDELA (delafloxacin)</i> <i>CIPRO (ciprofloxacin) tablets</i> <i>CIPRO (ciprofloxacin) suspension</i> <i>levofloxacin solution</i> <i>moxifloxacin</i> <i>ofloxacin</i>	<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

GI MOTILITY, CHRONIC		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
AMITIZA (lubiprostone) LINZESS (linaclotide) MOVANTIK (naloxegol)	<i>alosetron</i> <i>LOTRONEX (alosetron)</i> <i>lubiprostone</i> <i>MOTEGRITY (prucalopride)</i> <i>RELISTOR (methylnaltrexone) injection</i> <i>RELISTOR (methylnaltrexone) oral</i> <i>SYMPROIC (naldemedine)</i> <i>TRULANCE (plecanatide)</i> <i>VIBERZI (eluxadoline)</i>	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ GI Motility <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

GLUCAGON AGENTS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
BAQSIMI (glucagon) glucagon injection glucagon emergency kit (Lilly) PROGLYCEM (diazoxide)	diazoxide suspension glucagon emergency kit (Fresenius) GVOKE pen, syringe (glucagon) ZEGALOGUE AUTOINJECTOR (dasiglucagon) ZEGALOGUE SYRINGE (dasiglucagon)	<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

GLUCOCORTICOIDS, INHALED		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Glucocorticoids		
ASMANEX (mometasone) budesonide respules FLOVENT HFA (fluticasone)	ALVESCO (ciclesonide) ARMONAIR DIGIHALER ((fluticasone) ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) FLOVENT DISKUS (fluticasone) PULMICORT FLEXHALER (budesonide) PULMICORT respules (budesonide) QVAR (beclomethasone)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ Duplicate Therapy <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

GLUCOCORTICOIDS, INHALED		
<i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Glucocorticoid/Bronchodilator Combinations		
ADVAIR (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT (budesonide/formoterol)	AIRDUO DIGIHALER (fluticasone/salmeterol) AIRDUO RESPICLICK (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanterol) BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol) budesonide-formoterol fluticasone/salmeterol (Air Duo) TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol) WIXELA (fluticasone/salmeterol)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Duplicate Therapy</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

GLUCOCORTICOIDS, ORAL		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
budesonide EC dexamethasone elixir, solution, tablets hydrocortisone methylprednisolone tablet dose pack prednisolone sodium phosphate prednisolone prednisone solution, tablets	ALKINDI SPRINKLE (hydrocortisone) CORTEF (hydrocortisone) cortisone dexamethasone intensol DEXPAK (dexamethasone) EMFLAZA (deflazacort) ENTOCORT EC (budesonide) HEMADY (dexamethasone) MEDROL (methylprednisolone) methylprednisolone tablets MILLIPRED (prednisolone) ORTIKOS CAPSULE ER (budesonide) prednisolone sodium phosphate ODT, solution prednisone intensol prednisone tablet dose pack RAYOS DR (prednisone) TAPERDEX (dexamethasone)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Duplicate Therapy</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

GROWTH HORMONE		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
GENOTROPIN NORDITROPIN	HUMATROPE NUTROPIN AQ OMNITROPE SAIZEN SEROSTIM ZOMACTON ZORBTIVE	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ Growth Hormone <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

H. PYLORI TREATMENT		
Preferred Agents	<i>Non-Preferred Agents</i>	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
PYLERA (bismuth subcitrate/metronidazole/tetracycline)	<i>lansoprazole/amoxicillin/clarithromycin</i> <i>OMECLAMOX PAK (omeprazole/amoxicillin/clarithromycin)</i> <i>TALICIA (omeprazole/amoxicillin/rifabutin)</i>	<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HEMOPHILIA TREATMENT		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Factor VIII		<ul style="list-style-type: none">All of the agents in the Hemophilia Treatment class are preferred
ADVATE	KOATE DVI	
ADYNOVATE	KOGENATE FS	
AFSTYLA	KOVALTRY	
ELOCTATE	NOVOEIGHT	
ESPEROCT	NUWIQ	
HEMOFIL M	OBIZUR	
HUMATE P	RECOMBINATE	
JIVI	XYNTHA	
Factor IX		
ALPHANINE SD	REBINYN	
ALPROLIX	RIXUBIS	
BENEFIX		
IDELVION		
IXINITY		
PROFILNINE		
Other		
ALPHANATE (von Willebrand factor/Factor VIII)		
COAGADEX (Factor X)		
CORIFACT (Factor XIII)		
FEIBA NF (activated prothrombin complex)		
HEMLIBRA (emicizumab-kxwh)		
NOVOSEVEN RT (Factor VIIa)		
SEVENFACT (Factor VIIa-jncw)		
TRETTEN (Factor XIII)		
VOVENDI (von Willebrand factor)		
WILATE (von Willebrand factor/Factor VIII)		

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HEPATITIS C AGENTS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Pegylated Interferons		<ul style="list-style-type: none">■ 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
	PEGASYS (pegylated IFN alfa-2a)	
Polymerase/Protease Inhibitors		
EPCLUSA (sofosbuvir/velpatasvir) MAVYRET (glecaprevir/pibrentasvir) VOSEVI (sofosbuvir, velpatasvir, voxilaprevir)	HARVONI (ledipasvir/sofosbuvir) tablets, pellet pack ledipasvir/sofosbuvir sofosbuvir/velpatasvir SOVALDI (sofosbuvir) tablets, pellet pack VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir) ZEPATIER (elbasvir/grazoprevir)	<p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none">■ Manual Prior Authorization

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HEPATITIS C AGENTS		
<i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Ribavirin		
ribavirin capsule ribavirin tablet	RIBASPHERE 400, 600 mg ribavirin dose pack	<ul style="list-style-type: none"> ■ 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

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HEREDITARY ANGIOEDEMA (HAE) TREATMENTS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
BERINERT (C1 esterase inhibitor) CINRYZE (C1 esterase inhibitor) HAEGARDA (C1 esterase inhibitor) icatibant KALBITOR (ecallantide) SAJAZIR (icatibant)	FIRAZYR (icatibant) ORLADEYO (berotralstat) RUCONEST (C1 esterase inhibitor) TAKHZYRO (lanadelumab-flyo)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Hereditary Angioedema</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HIV/AIDS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Antiretroviral Single Agent Products		<ul style="list-style-type: none"> All of the agents in the HIV/AIDS class are preferred
abacavir APTIVUS (tipranavir) atazanavir CRIXIVAN (indinavir) didanosine EDURANT (rilpivirine) efavirenz EMTRIVA (emtricitabine) EPIVIR (lamivudine) fosamprenavir FUZEON (enfuvirtide) INTELENCE (etravirine) INVIRASE (saquinavir) ISENTRESS (raltegravir) lamivudine LEXIVA (fosamprenavir) nevirapine NORVIR (ritonavir) PIFELTRO (doravirine) PREZCOBIX (darunavir/cobicistat) PREZISTA (darunavir) RETROVIR (zidovudine)	REYATAZ (atazanavir) ritonavir RUKOBIA (fostemsavir) SELZENTRY (maraviroc) stavudine SUSTIVA (efavirenz) tenofovir disoproxil fumarate TIVICAY (dolutegravir) TROGARZO (ibalizumab-uiyk) TYBOST (cobicistat) VIRACEPT (nelfinavir) VIRAMUNE (nevirapine) VIRAMUNE XR (nevirapine) VIREAD (tenofovir disoproxil fumarate) ZIAGEN (abacavir) zidovudine	

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HIV/AIDS <i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Antiretroviral Combinations		<ul style="list-style-type: none"> All of the agents in the HIV/AIDS class are preferred
abacavir/lamivudine abacavir/lamivudine/zidovudine ATRIPLA (efavirenz/emtricitabine/tenofovir) BIKTARVY (bictegravir/emtricitabine/tenofovir) CIMDUO (lamivudine/tenofovir DF) COMBIVIR (lamivudine/zidovudine) COMPLERA (emtricitabine/rilpivirine/tenofovir DF) DELSTRIGO (doravirine/lamivudine/tenofovir DF) DESCOVY (emtricitabine/tenofovir alafenamide) DOVATO (dolutegravir/lamivudine) EPZICOM (abacavir/lamivudine) EVOTAZ (atazanavir/cobicistat)	GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide) JULUCA (dolutegravir/rilpivirine) KALETRA (lopinavir/ritonavir) lamivudine/zidovudine lopinavir/ritonavir ODEFSEY (emtricitabine/rilpivirine/tenofovir alafenamide) STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir DF) SYMFI (efavirenz/lamivudine/tenofovir DF) SYMFI LO (efavirenz/lamivudine/tenofovir DF) SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir DF) TEMIXYS (lamivudine/tenofovir DF) TRIUMEQ (abacavir/dolutegravir/lamivudine) TRIZIVIR (abacavir/lamivudine/zidovudine) TRUVADA (emtricitabine/tenofovir DF)	

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Amylin Analogs		
SYMLIN (pramlintide)		<ul style="list-style-type: none"> ■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS		
<i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Incretin Enhancers		
JANUMET (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) ONGLYZA (saxagliptin) TRADJENTA (linagliptin)	<i>alogliptin</i> <i>alogliptin/metformin</i> <i>alogliptin/pioglitazone</i> <i>JANUMET XR (sitagliptin/metformin)</i> <i>JENTADUETO XR (linagliptin/metformin)</i> <i>KAZANO (alogliptin /metformin)</i> <i>NESINA (alogliptin)</i> <i>OSENI (alogliptin /pioglitazone)</i>	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ DPP4 Inhibitor <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS		
<i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Incretin Mimetics		
BYDUREON (exenatide ER) pens, vials BYETTA (exenatide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	ADLYXIN (<i>lixisenatide</i>) BYDUREON BCISE (<i>exenatide ER</i>) OZEMPIC (<i>semaglutide</i>) RYBELSUS (<i>semaglutide</i>)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ GLP-1 Receptor Antagonists <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS		
continued		
Preferred Agents	Non-Preferred Agents	PA Criteria
		Client must meet at least one of the listed PA criteria
Incretin Enhancers/SGLT2 Inhibitor Combinations		<ul style="list-style-type: none">■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none">■ DPP4 Inhibitor <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none">■ GLP-1 Receptor Antagonists <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
GLYXAMBI (empagliflozin/linagliptin)	QTERN (dapagliflozin/saxagliptin) STEGLUJAN (ertugliflozin/sitagliptin) TRIJARDY XR (empagliflozin/linagliptin/metformin)	
Incretin Mimetic/Insulin Combinations		
	SOLIQUA (lixisenatide/insulin glargine) XULTOPHY (liraglutide/insulin degludec)	

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HYPOGLYCEMICS, INSULIN		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
HUMALOG (insulin lispro) pens, vials HUMALOG JUNIOR KWIKPEN (insulin lispro) HUMALOG MIX (insulin lispro/lispro protamine) pens, vials HUMULIN N (insulin) vials HUMULIN R (insulin) vials HUMULIN R 500 UNITS/ML (insulin) pens, vials HUMULIN R 70/30 (insulin) pens, vials INSULIN ASPART CARTRIDGE (AG) INSULIN ASPART PEN (AG) INSULIN ASPART VIAL (AG) INSULIN ASPART/INSULIN ASPART PROTAMINE INSULIN PEN (AG) INSULIN ASPART/INSULIN ASPART PROTAMINE VIAL (AG) INSULIN LISPRO JUNIOR KWIKPEN (AG) INSULIN LISPRO PEN (AG) INSULIN LISPRO PROTAMINE MIX KWIKPEN (AG) INSULIN LISPRO VIAL (AG) LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLIN (insulin) vials NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	ADMELOG (insulin lispro) AFREZZA (insulin) APIDRA (insulin glulisine) BASAGLAR (insulin glargine) FIASP (insulin aspart) HUMALOG 200 UNITS/ML HUMULIN N (insulin) pen LYUMJEV (insulin lispro) NOVOLIN (insulin) pens NOVOLIN 70/30 (insulin) SEMGLEE (insulin glargine) pen, vial TOUJEO (insulin glargine) TRESIBA (insulin degludec)	<ul style="list-style-type: none"> ■ 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

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HYPOGLYCEMICS, MEGLITINIDES		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
nateglinide repaglinide	repaglinide/metformin STARLIX (nateglinide)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Duplicate Therapy</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HYPOGLYCEMICS, METFORMIN		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
glyburide/metformin metformin metformin ER (GLUCOPHAGE XR) metformin ER (GLUMETZA)	FORTAMET (metformin ER) glipizide/metformin GLUMETZA (metformin ER) metformin ER (FORTAMET) RIOMET (metformin) RIOMET ER (metformin)	<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HYPOGLYCEMICS, SGLT2		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	STEGLATRO (ertugliflozin)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ SGLT2 Inhibitor <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HYPOGLYCEMICS, SGLT2 <i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
SGLT2 Combinations		
SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin)	INVOKAMET (canagliflozin/metformin) INVOKAMET XR (canagliflozin/metformin) SEGLUROMET (ertugliflozin/metformin) SYNJARDY XR (empagliflozin/metformin)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ SGLT2 Combinations <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HYPOGLYCEMICS, TZD		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Thiazolidinediones		
pioglitazone	ACTOS (pioglitazone)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ Thiazolidinediones <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

HYPOGLYCEMICS, TZD <i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
TZD Combinations		
	ACTOPLUS MET XR (pioglitazone/metformin) DUETACT (pioglitazone/glimepiride) pioglitazone/metformin pioglitazone/glimepiride	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ Thiazolidinediones <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

IMMUNE GLOBULINS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
CYTOGAM (CMV immune globulin) GAMMAGARD (immune globulin) GAMMAKED (immune globulin) GAMUNEX-C (immune globulin) HIZENTRA (immune globulin) vial	<i>ASCENIV (immune globulin)</i> <i>BIVIGAM (immune globulin)</i> <i>CUTAQUIG (immune globulin)</i> <i>CUVITRU (immune globulin)</i> <i>FLEBOGAMMA DIF (immune globulin)</i> <i>HYQVIA (immune globulin)</i> <i>HIZENTRA (immune globulin) syringe</i> <i>OCTAGAM (immune globulin)</i> <i>PANZYGA (immune globulin)</i>	<ul style="list-style-type: none"> ■ 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

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

IMMUNOMODULATORS, ASTHMA		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
FASENRA PEN (benralizumab)	NUCALA (mepolizumab)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class: <u>Immunomodulators, Asthma</u></p> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

IMMUNOMODULATORS, ATOPIC DERMATITIS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
EUCRISA (crisaborole)	DUPIXENT (dupilumab) ELIDEL (pimecrolimus) pimecrolimus PROTOPIC (tacrolimus) tacrolimus	<ul style="list-style-type: none"> ■ 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. <p>"Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria"</p>

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

IMMUNOSUPPRESSIVES, ORAL/SQ		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
azathioprine cyclosporine, modified GENGRAF (cyclosporine modified) capsules, solution mycophenolate mofetil capsules, tablets NEORAL (cyclosporine, modified) capsules RAPAMUNE (sirolimus) solution RAPAMUNE (sirolimus) tablet tacrolimus	<div> <div> ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) BENLYSTA AUTOINJECTOR (belimumab.) BENLYSTA SYRINGE (belimumab.) CELLCEPT (mycophenolate mofetil) cyclosporine capsule, softgel ENVARSUS XR (tacrolimus) everolimus tablet IMURAN (azathioprine) LUPKYNIS (voclosporin) </div> <div> mycophenolate mofetil suspension mycophenolic acid MYFORTIC (mycophenolic acid) NEORAL (cyclosporine, modified) solution PROGRAF (tacrolimus) SANDIMMUNE (cyclosporine) sirolimus solution sirolimus tablet ZORTRESS (everolimus) </div> </div>	<ul style="list-style-type: none"> ■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

INTRANASAL RHINITIS AGENTS		
Preferred Agents	Non-Preferred Agents	PA Criteria
		Client must meet at least one of the listed PA criteria
Glucocorticoids		<ul style="list-style-type: none">■ 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
fluticasone	BECONASE AQ (beclomethasone) budesonide flunisolide fluticasone OTC mometasone NASONEX (mometasone) OMNARIS (ciclesonide) QNASL (beclomethasone dipropionate) triamcinolone XHANCE (fluticasone)	
Others		
azelastine (generic ASTELIN)	ASTEPRO (azelastine) azelastine (generic ASTEPRO) ipratropium nasal spray olopatadine PATANASE (olopatadine)	
Combinations		
	azelastine/fluticasone DYMISTA (azelastine/fluticasone)	

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

IRON, ORAL

See Separate Listing of Preferred Oral Iron Drugs.

- 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

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LEUKOTRIENE MODIFIERS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
montelukast chewable tablets, tablets	<i>ACCOLATE (zafirlukast)</i> montelukast granules <i>SINGULAIR (montelukast)</i> zafirlukast zileuton ZYFLO (zileuton)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Leukotriene Modifiers</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
clindamycin capsules clindamycin solution linezolid	CLEOCIN (clindamycin) LINCOCIN (lincomycin) SIVEXTRO (tedizolid) ZYVOX (linezolid)	<ul style="list-style-type: none"> ■ 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

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Effective January 27, 2022

LIPOTROPICS, OTHER		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Adenosine Triphosphate-Citrate Lyase Inhibitor		<ul style="list-style-type: none">■ 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
	NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe)	
Bile Acid Sequestrants		
cholestyramine colestipol tablets PREVALITE (cholestyramine/aspartame) packet, powder	colesevalam COLESTID (colestipol) colestipol granules QUESTRAN (cholestyramine) QUESTRAN LIGHT (cholestyramine) WELCHOL (colesevalam)	
Cholesterol Absorption Inhibitors		
ZETIA (ezetimibe)	ezetimibe	
Fibric Acid Derivatives		
fenofibrate (generic Lofibra, Tricor) gemfibrozil	ANTARA (fenofibrate, micronized) fenofibrate (generic Antara, Fenoglide, Lipofen) fenofibric acid (generic Fibracor, Trilipix) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid)) LIPOFEN (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate) TRILIPIX (fenofibric acid)	

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HEALTH AND HUMAN SERVICES COMMISSION
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Effective January 27, 2022

LIPOTROPICS, OTHER		
continued		
Preferred Agents	Non-Preferred Agents	PA Criteria
		Client must meet at least one of the listed PA criteria
Homozygous Familial Hypercholesterolemia Treatments		<ul style="list-style-type: none">■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
	<u>JUXTAPID</u> (<i>lomitapide</i>)	
Niacin		
niacin OTC	<u>niacin ER</u> <u>NIASPAN</u> (<i>niacin</i>)	
Omega-3 Fatty Acids		
<u>omega-3 fatty acids</u>	<i>icosapent ethyl</i> <u>LOVAZA</u> (<i>omega-3 fatty acids</i>) <i>VASCEPA</i> (<i>icosapent ethyl</i>)	

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HEALTH AND HUMAN SERVICES COMMISSION
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Effective January 27, 2022

LIPOTROPICS, OTHER <i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
PCSK9 Inhibitors		
	<u>PRALUENT</u> (alirocumab) <u>REPATHA</u> (evolocumab)	<ul style="list-style-type: none"> ■ 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 <p>Clinical prior authorizations applies to all PCSK9 inhibitors:</p> <ul style="list-style-type: none"> ■ <u>PCSK9 Inhibitors</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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Effective January 27, 2022

LIPOTROPICS, STATINS		
Preferred Agents	Non-Preferred Agents	PA Criteria
		Client must meet at least one of the listed PA criteria
Statins		<ul style="list-style-type: none">■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none">■ <u>Duplicate Therapy</u> <p><u>Dose Optimization</u> applies to some strengths where a “*” is noted</p> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
atorvastatin* lovastatin* pravastatin* rosuvastatin* simvastatin*	ALTOPREV (lovastatin) CRESTOR (rosuvastatin)* EZALLOR SPRINKLE (rosuvastatin) fluvastatin* fluvastatin ER LESCOL XL (fluvastatin) LIPITOR (atorvastatin)*	
Statin Combinations		
	atorvastatin/amlodipine CADUET (atorvastatin/amlodipine) simvastatin/ezetimibe VYTORIN (simvastatin/ezetimibe)	

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MACROLIDES (ORAL)		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
azithromycin clarithromycin tablets E.E.S. (erythromycin) 200 suspension ERYPED 400 (erythromycin) erythromycin base	<div> <i>clarithromycin suspension</i> <i>clarithromycin ER</i> <i>E.E.S. (erythromycin) tablet</i> ERYPED 200 (erythromycin) <i>ERY-TAB (erythromycin)</i> <i>ERYTHROCIN (erythromycin)</i> </div> <div> <i>erythromycin base filmtab</i> <i>erythromycin ethylsuccinate suspension</i> <i>ZITHROMAX (azithromycin)</i> </div>	<ul style="list-style-type: none"> ■ 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

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MOVEMENT DISORDERS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
AUSTEDO (deutetrabenazine) INGREZZA (valbenazine) tetrabenazine	XENAZINE (tetrabenazine)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>VMAT2 Inhibitors</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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MULTIPLE SCLEROSIS AGENTS

Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
<p> AMPYRA (dalfampridine) AUBAGIO (teriflunomide) AVONEX (interferon beta-1a) BAFIERTAM (monomethyl fumarate) BETASERON (interferon beta-1b) COPAXONE (glatiramer) dalfampridine dimethyl fumarate EXTAVIA (interferon beta-1b) GILENYA (fingolimod) glatiramer GLATOPA (glatiramer) KESIMPTA (ofatumumab) MAVENCLAD (cladribine) MAYZENT (siponimod) PLEGRIDY (peginterferon beta-1a) PONVORY STARTER PACK (ponesimod) PONVORY TABLET (ponesimod) REBIF (interferon beta-1a) TECFIDERA (dimethyl fumarate) VUMERITY (diroxime fumarate) ZEPOSIA (ozanimod) </p>		<p> ■ All of the agents in the Multiple Sclerosis class are preferred </p> <p> “Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria” </p>

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HEALTH AND HUMAN SERVICES COMMISSION
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NEUROPATHIC PAIN		
Preferred Agents	Non-Preferred Agents	PA Criteria
		Client must meet at least one of the listed PA criteria
Oral Agents		<ul style="list-style-type: none">■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
duloxetine (Cymbalta) gabapentin pregabalin capsule	CYMBALTA (duloxetine) <i>DRIZALMA SPRINKLE (duloxetine)</i> <i>duloxetine (Irenka)</i> GRALISE (gabapentin) <i>HORIZANT (gabapentin enacarbil ER)</i> <i>LYRICA (pregabalin)</i> LYRICA CR (pregabalin) NEURONTIN (gabapentin) <i>pregabalin ER, solution</i> SAVELLA (milnacipran)	
Topical Agents		
capsaicin OTC	lidocaine patch LIDODERM (lidocaine) <i>QUTENZA (capsaicin/skin cleanser)</i> <i>ZTLIDO (lidocaine)</i>	

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

NSAIDS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Nonspecific		
diclofenac potassium ibuprofen indomethacin capsules naproxen EC naproxen sodium OTC naproxen tablets	DAYPRO (oxaprozin) diclofenac sodium diclofenac SR diflunisal etodolac etodolac SR FELDENE (piroxicam) fenoprofen flurbiprofen INDOCIN (indomethacin) suspension indomethacin ER capsules ketoprofen ketoprofen ER	<div> <div> ketorolac meclofenamate mefenamic acid nabumetone NALFON (fenoprofen) NAPRELAN CR (naproxen sodium) NAPROSYN (naproxen) naproxen CR naproxen sodium (Rx) naproxen suspension oxaprozin piroxicam RELAFEN DS (nabumetone) sulindac tolmetin VIVLODEX (meloxicam, submicronized) ZIPSOR (diclofenac) ZORVOLEX (diclofenac) </div> <div> <ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ Duplicate Therapy <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p> </div> </div>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

NSAIDS <i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
NSAID/GI Protectant Combinations		
	<p>ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol DUEXIS (ibuprofen/famotidine) ibuprofen/famotidine naproxen/esomeprazole mag VIMOVO (naproxen/ esomeprazole)</p>	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ Duplicate Therapy <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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NSAIDS <i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
COX-II Selective		
meloxicam tablets*	CELEBREX (celecoxib) celecoxib meloxicam capsules MOBIC (meloxicam)* QMIIZ ODT (meloxicam)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ Duplicate Therapy ■ Cox II Inhibitors <p>Dose Optimization applies to some strengths where a "*" is noted</p> <p>"Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria"</p>

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TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

NSAIDs <i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Topical NSAIDs		
<u>diclofenac gel 1%</u> <u>VOLTAREN gel (diclofenac)</u>	<u>diclofenac solution</u> <u>diclofenac patch</u> <u>DICLOFEX DC (diclofenac/capsicum)</u> <u>FLECTOR (diclofenac)</u> <u>INDOCIN (indomethacin) suppositories</u> <u>ketorolac nasal spray</u> <u>LICART PATCH (diclofenac epolamine)</u> <u>PENNSAID (diclofenac)</u> <u>SPRIX NASAL SPRAY (ketorolac nasal spray)</u>	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Duplicate Therapy</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ONCOLOGY, ORAL - BREAST		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
anastrozole ARIMIDEX (anastrozole) AROMASIN (exemestane) capecitabine cyclophosphamide exemestane FARESTON (toremifene) FEMARA (letrozole) IBRANCE (palbociclib) KISQALI (ribociclib) KISQALI/FEMARA KIT (ribociclib/letrozole) lapatinib letrozole NERLYNX (neratinib) PIQRAY (alpelisib) SOLTAMOX (tamoxifen) TALZENNA (talazoparib) tamoxifen toremifene TUKYSA (tucatinib) TYKERB (lapatinib) VERZENIO (abemaciclib) XELODA (capecitabine)		All of the agents in the Oncology, Oral - Breast class are preferred

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HEALTH AND HUMAN SERVICES COMMISSION
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Effective January 27, 2022

ONCOLOGY, ORAL - HEMATOLOGIC		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
ALKERAN (melphalan) BOSULIF (bosutinib) BRUKINSA (zanubrutinib) CALQUENCE (acalabrutinib) COPIKTRA (duvelisib) DAURISMO (glasdegib) FARYDAK (panobinostat) GLEEVEC (imatinib) HYDREA (hydroxyurea) ICLUSIG (ponatinib) IDHIFA (enasidenib) imatinib IMBRUVICA (ibrutinib) INQOVI (decitabine/cedazuridine) INREBIC (fedratinib) JAKAFI (ruxolitinib) LEUKERAN (chlorambucil) MATULANE (procarbazine) melphalan	mercaptapurine MYLERAN (busulfan) NINLARO (ixazomib) ONUREG (azacytidine) POMALYST (pomalidomide) PURIXAN (mercaptapurine) REVLIMID (lenalidomide) RYDAPT (midostaurin) SCEMBLIX (asciminib) SPRYCEL (dasatinib) TABLOID (thioguanine) TASIGNA (nilotinib) THALOMID (thalidomide) TIBSOVO (ivosidenib) tretinoin UKONIQ (umbralisib) VENCLEXTA (venetoclax) XOSPATA (gilteritinib) XPOVIO (selinexor) ZOLINZA (vorinostat) ZYDELIG (idelalisib)	All of the agents in the Oncology, Oral - Hematologic class are preferred

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ONCOLOGY, ORAL - LUNG		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
ALECENSA (alectinib) ALUNBRIG (brigatinib) erlotinib EXKIVITY (mobocertinib) GAVRETO (pralsetinib) GILOTRIF (afatinib) HYCAMTIN (topotecan) IRESSA (gefitinib) LORBRENA (lorlatinib) LUMAKRAS (sotorasib) RETEVMO (selpercatinib) ROZLYTREK (entrectinib) TABRECTA (capmatinib) TAGRISSO (osimertinib) TARCEVA (erlotinib) TEPMETKO (tepotinib) VIZIMPRO (dacomitinib) XALKORI (crizotinib) ZYKADIA (ceritinib)		All of the agents in the Oncology, Oral - Lung class are preferred

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ONCOLOGY, ORAL - OTHER		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
AYVAKIT (avapritinib) BALVERSA (erdafitinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) KOSELUGO (selumetinib) LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) PEMAZYRE (pemigatinib) QINLOCK (ripretinib) RUBRACA (rucaparib) STIVARGA (regorafenib) TAZVERIK (tazemetostat) TEMODAR (temozolomide) temozolomide TRUSELTIQ (infigratinib) TURALIO (pexidartinib) VITRAKVI (larotrectinib) ZEJULA (niraparib)		All of the agents in the Oncology, Oral - Other class are preferred

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TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ONCOLOGY, ORAL - PROSTATE		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
abiraterone bicalutamide EMCYT (estramustine) ERLEADA (apalutamide) flutamide nilutamide NUBEQA (darolutamide) XTANDI (enzalutamide) YONSA (abiraterone) ZYTIGA (abiraterone)		All of the agents in the Oncology, Oral - Prostate class are preferred

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TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ONCOLOGY, ORAL – RENAL CELL		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
AFINITOR (everolimus) CABOMETYX (cabozantinib) everolimus INLYTA (axitinib) LENVIMA (Lenvatinib) NAXAVAR (sorafenib) SUTENT (sunitinib) sunitinib VOTRIENT (pazopanib) WELIREG (belzutifan)		All of the agents in the Oncology, Oral – Renal Cell class are preferred

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ONCOLOGY, ORAL – SKIN		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
BRAFTOVI (encorafenib) COTELLIC (cobimetinib) ERIVEDGE (vismodegib) MEKINIST (trametinib) MEKTOVI (binimetinib) ODOMZO (sonidegib) TAFINLAR (dabrafenib) <u>ZELBORAF</u> (vemurafenib)		All of the agents in the Oncology, Oral – Skin class are preferred “Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

OPHTHALMICS, ANTIBIOTIC – STEROID COMBINATIONS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX (tobramycin/dexamethasone) ointment	BLEPHAMIDE (sulfacetamide/prednisolone) BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone) MAXITROL (neomycin/polymyxin/ dexamethasone) neomycin/bacitracin/polymyxin/hydrocortisone neomycin/polymyxin/hydrocortisone PRED-G (gentamicin/prednisolone) TOBRADEX (tobramycin/dexamethasone) suspension TOBRADEX ST (tobramycin/dexamethasone) tobramycin/dexamethasone ZYLET (tobramycin/loteprednol)	<ul style="list-style-type: none"> ■ 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

OPHTHALMIC ANTIBIOTICS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Aminoglycosides		
GENTAK (gentamicin) gentamicin tobramycin TOBREX (tobramycin) ointment	TOBREX (tobramycin) solution	<ul style="list-style-type: none"> ■ 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

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

OPHTHALMIC ANTIBIOTICS		
continued		
Preferred Agents	Non-Preferred Agents	PA Criteria
		Client must meet at least one of the listed PA criteria
Quinolones		<ul style="list-style-type: none">■ 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
ciprofloxacin ofloxacin	BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) gatifloxacin levofloxacin MOXEZA (moxifloxacin) moxifloxacin OCUFLOX (ofloxacin) VIGAMOX (moxifloxacin) ZYMAXID (gatifloxacin)	
Macrolides		
erythromycin	AZASITE (azithromycin)	

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

OPHTHALMIC ANTIBIOTICS		
<i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Other		
bacitracin/polymyxin POLYCIN (bacitracin/polymyxin B sulfate) polymyxin/trimethoprim	<i>bacitracin</i> <i>BLEPH-10 (sulfacetamide)</i> <i>NATACYN (natamycin)</i> <i>neomycin/bacitracin/polymyxin</i> <i>neomycin/polymyxin/gramicidin</i> <i>POLYTRIM (polymyxin/trimethoprim)</i> <i>sulfacetamide ointment, solution</i>	<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
cromolyn PATADAY XS ONCE DAILY OTC (olopatadine)	<div> <div>ALOCRIL (<i>nedocromil</i>)</div> <div>ALOMIDE (<i>Iodoxamide</i>)</div> <div>ALREX (<i>loteprednol</i>)</div> <div>azelastine</div> <div>bepotastine</div> <div>BEPREVE (<i>bepotastine</i>)</div> <div>epinastine</div> </div> <div> <div>ketotifen</div> <div>LASTACFT (<i>alcaftadine</i>)</div> <div>olopatadine</div> <div>PATADAY (<i>olopatadine</i>)</div> <div>PATADAY OTC (<i>olopatadine</i>)</div> <div>PATANOL (<i>olopatadine</i>)</div> <div>ZADITOR OTC (<i>ketotifen</i>)</div> <div>ZERVIAE (<i>cetirizine</i>)</div> </div>	<ul style="list-style-type: none"> ■ 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

OPHTHALMICS, ANTI-INFLAMMATORIES		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
NSAIDS		
diclofenac ketorolac	<div> <div>ACULAR (<i>ketorolac</i>)</div> <div>ACULAR LS (<i>ketorolac</i>)</div> <div>ACUVAIL (<i>ketorolac</i>)</div> <div>bromfenac</div> <div>BROMSITE (<i>bromfenac</i>)</div> <div>flurbiprofen</div> <div>ILEVRO (<i>nepafenac</i>)</div> <div>ketorolac LS</div> <div>NEVANAC (<i>nepafenac</i>)</div> <div>PROLENSA (<i>bromfenac</i>)</div> </div>	<ul style="list-style-type: none"> ■ 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

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

OPHTHALMICS, ANTI-INFLAMMATORIES		
<i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Steroids		
DUREZOL (difluprednate) Lotemax (loteprednol) drops, ointment prednisolone acetate	dexamethasone difluprednate FLAREX (fluorometholone) fluorometholone FML (fluorometholone) FML FORTE (fluorometholone) ML S.O.P. (fluorometholone) INVELTYS (loteprednol) LOTEMAX (loteprednol) gel loteprednol MAXIDEX (dexamethasone) PRED FORTE (prednisolone) PRED MILD (prednisolone) prednisolone sodium phosphate	<ul style="list-style-type: none"> ■ 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

OPHTHALMICS, ANTI-INFLAMMATORY IMMUNOMODULATORS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
RESTASIS (cyclosporine) XIIDRA (lifitegrast)	<u>RESTASIS MULTIDOSE (cyclosporine)</u> <u>CEQUA (cyclosporine)</u> <u>EYSUVIS (loteprednol etabonate)</u>	<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

OPHTHALMICS, GLAUCOMA AGENTS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Sympathomimetics		<ul style="list-style-type: none">■ 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
brimonidine pilocarpine	ALPHAGAN P (brimonidine) apraclonidine brimonidine P IOPIDINE (apraclonidine)	
Beta Blockers		
carteolol levobunolol timolol	betaxolol BETIMOL (timolol) BETOPTIC S (betaxolol) ISTALOL (timolol) timolol (Istalol) timolol PF (Timoptic Ocudose) TIMOPTIC (timolol) TIMOPTIC XE (timolol)	

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

OPHTHALMICS, GLAUCOMA AGENTS		
<i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria
<i>Client must meet at least one of the listed PA criteria</i>		
Carbonic Anhydrase Inhibitors		
AZOPT (brinzolamide) dorzolamide	brinzolamide TRUSOPT (dorzolamide)	<ul style="list-style-type: none"> ■ 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

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Publication date: January 27, 2022

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

OPHTHALMICS, GLAUCOMA AGENTS		
continued		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Rho Kinase Inhibitor		<ul style="list-style-type: none">■ 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
RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost)		
Prostaglandin Analogs		
latanoprost TRAVATAN-Z (travoprost)	bimatoprost LUMIGAN (bimatoprost) travoprost VYZULTA (latanoprostene bunod) XALATAN (latanoprost) XELPROS (latanoprost) ZIOPTAN (tafluprost)	
Combination Agents		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol) dorzolamide/timolol	
Miscellaneous		
	phospholine iodide	
OPIATE DEPENDENCE TREATMENTS		

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
<p>BUNAVAIL (buprenorphine/naloxone)* buprenorphine* buprenorphine/naloxone* KLOXXADO (naloxone) nasal LUCEMYRA (lofexidine) naloxone syringe, vial naltrexone NARCAN (naloxone) nasal SUBOXONE (buprenorphine/naloxone) film* VIVITROL (naltrexone) ZUBSOLV (buprenorphine/naloxone)*</p>		<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to drugs with an "*" in the class:</p> <ul style="list-style-type: none"> ■ Duplicate Therapy ■ Opiate/Benzodiazepine/Muscle Relaxant <p>"Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria"</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

OTIC ANTIBIOTICS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
CIPRODEX (ciprofloxacin/dexamethasone) neomycin/polymyxin/hydrocortisone ofloxacin	CIPRO HC (ciprofloxacin/hydrocortisone) ciprofloxacin ciprofloxacin/dexamethasone ciprofloxacin HCl/fluocinolone CORTISPORIN-TC (neomyc/colist/hydrocort/thonzn OTIPRIO (ciprofloxacin) OTOVEL (ciprofloxacin/fluocinolone)	<ul style="list-style-type: none"> ■ 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

OTIC ANTI-INFECTIVES/ANESTHETICS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
acetic acid	acetic acid/hydrocortisone	<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

PAH AGENTS (ORAL, INHALATION)		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
<u>ADCIRCA</u> (tadalafil) ambrisentan <u>REVATIO</u> (sildenafil) suspension <u>sildenafil tablet</u> (generic Revatio) TRACLEER (bosentan) tablet	ADEMPAS (<i>riociguat</i>) ALYQ (<i>tadalafil</i>) <i>bosentan</i> LETAIRIS (<i>ambrisentan</i>) OPSUMIT (<i>macitentan</i>) ORENITRAM ER (<i>treprostinil</i>) <u>REVATIO</u> (<i>sildenafil</i>) <u>sildenafil suspension</u> (<i>generic Revatio</i>) <i>tadalafil</i> (<i>generic Adcirca</i>) TRACLEER (<i>bosentan</i>) suspension TYVASO Inhalation (<i>treprostinil</i>) UPTRAVI (<i>selexipag</i>) VENTAVIS Inhalation (<i>iloprost</i>)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Pulmonary HTN Agents</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

PANCREATIC ENZYMES		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
CREON (pancrelipase) ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) PERTZYE (pancrelipase) VIOKACE (pancrelipase)	<ul style="list-style-type: none"> ■ 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

PEDIATRIC VITAMIN PREPARATIONS		
See Separate Listing Of Preferred Pediatric Vitamin Preparations.		<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

PENICILLINS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
amoxicillin ampicillin dicloxacillin penicillin VK		<ul style="list-style-type: none"> ■ 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

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

PHOSPHATE BINDERS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
calcium acetate RENAGEL (sevelamer HCl)	AURYXIA (ferric citrate) FOSRENOL (lanthanum) lanthanum PHOSLYRA (calcium acetate) RENVELA (sevelamer carbonate) sevelamer sevelamer carbonate VELPHORO (sucroferric oxyhydroxide)	<ul style="list-style-type: none"> ■ Treatment failure with preferred drug ■ Allergic reaction to preferred drugs ■ Treatment of stage-four advanced, metastatic cancer and associated conditions ■ Diagnosis of ESRD, hyperphosphatemia AND at least one of the following: <ul style="list-style-type: none"> ➢ Hypercalcemia (corrected serum calcium >10.2mg/dL) ➢ Plasma PTH levels <150 pg/mL on two consecutive measurements ➢ Dialysis patients with severe vascular and/or soft tissue calcifications <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

PLATELET AGGREGATION INHIBITORS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
aspirin/dipyridamole BRILINTA (ticagrelor) clopidogrel prasugrel	dipyridamole EFFIENT (prasugrel) PLAVIX (clopidogrel) ZONTIVITY (vorapaxar)	<ul style="list-style-type: none"> ■ Treatment failure with preferred drug ■ Contraindication to preferred drug ■ Allergic reaction to preferred drug ■ Treatment of stage-four advanced, metastatic cancer and associated conditions <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>
PRENATAL VITAMINS		
See Separate Preferred Prenatal Vitamin Listing.		<ul style="list-style-type: none"> ■ 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.

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

PROGESTATIONAL AGENTS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
MAKENA AUTO INJECTOR (hydroxyprogesterone) MAKENA (hydroxyprogesterone)	hydroxyprogesterone	<ul style="list-style-type: none"> ■ Treatment failure with preferred drug ■ Contraindication to preferred drug ■ Allergic reaction to preferred drug ■ Treatment of stage-four advanced, metastatic cancer and associated conditions <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

PROGESTINS FOR CACHEXIA		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
megestrol suspension, tablets	megestrol ES suspension (generic Megace ES)	<ul style="list-style-type: none"> ■ Treatment failure with preferred drug ■ Contraindication to preferred drug ■ Allergic reaction to preferred drug ■ Treatment of stage-four advanced, metastatic cancer and associated conditions

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

PROTON PUMP INHIBITORS (ORAL)		
Preferred Agents	Non-Preferred Agents	PA Criteria
<p>NEXIUM suspension (esomeprazole)</p> <p>omeprazole Rx*</p> <p>pantoprazole*</p> <p>PROTONIX (pantoprazole) suspension</p>	<p>ACIPHEX (<i>rabeprazole</i>) <i>rabeprazole</i></p> <p>DEXILANT (<i>dexlansoprazole</i>) ZEGERID (<i>omeprazole/sodium bicarbonate</i>)</p> <p><i>esomeprazole*</i></p> <p><i>lansoprazole*</i></p> <p>NEXIUM capsules (<i>esomeprazole</i>)*</p> <p>NEXIUM OTC (<i>esomeprazole</i>)*</p> <p><i>omeprazole OTC*</i></p> <p><i>omeprazole/sodium bicarbonate</i></p> <p><i>pantoprazole suspension</i></p> <p>PREVACID (<i>lansoprazole</i>)*</p> <p>PRILOSEC (<i>omeprazole</i>)suspension</p> <p>PROTONIX tablets (<i>pantoprazole</i>)*</p>	<p>Client must meet at least one of the listed PA criteria</p> <ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Proton Pump Inhibitor</u> <p><u>Dose Optimization</u> applies to some strengths where a "*" is noted</p> <p>"Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria"</p>

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ROSACEA AGENTS, TOPICAL		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
metronidazole cream, gel	azelaic acid FINACEA (azelaic acid) ivermectin METROCREAM (metronidazole) METROGEL (metronidazole) metronidazole lotion MIRVASO (brimonidine) NORITATE (metronidazole) RHOFADÉ (oxymetazoline) ROSADAN KIT (metronidazole) SOOLANTRA (ivermectin) ZILXI (minocycline)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>Rosacea Agents, Topical</u> <p><u>Dose Optimization</u> applies to some strengths where a “*” is noted</p> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

SEDATIVE HYPNOTICS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Benzodiazepines		
flurazepam temazepam 15, 30 mg triazolam	DAYVIGO (lemborexant) estazolam HALCION (triazolam) RESTORIL (temazepam) temazepam 7.5, 22.5 mg	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ Anxiolytics and Sedatives/Hypnotics ■ Opiate/Benzodiazepine/Muscle Relaxant <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

SEDATIVE HYPNOTICS		
<i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria
<i>Client must meet at least one of the listed PA criteria</i>		
Others		
eszopiclone zaleplon zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) doxepin EDLUAR (zolpidem) HETLIOZ (tasimelteon) HETLIOZ LQ (tasimelteon) INTERMEZZO (zolpidem)	LUNESTA (eszopiclone) ramelteon ROZEREM (ramelteon) SILENOR (doxepin) SONATA (zaleplon) zolpidem ER/SL
		<ul style="list-style-type: none"> ■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

SICKLE CELL ANEMIA TREATMENTS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
DROXIA (hydroxyurea) ENDARI (glutamine) hydroxyurea OXBRYTA (voxelotor)* SIKLOS (hydroxyurea)		<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to drugs with an "*" in the class:</p> <ul style="list-style-type: none"> ■ Sickle Cell Anemia Treatments <p>"Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria"</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

SKELETAL MUSCLE RELAXANTS		
Preferred Agents	Non-Preferred Agents	PA Criteria
baclofen carisoprodol (except 250 mg)* cyclobenzaprine * methocarbamol* tizanidine tablets	<div> <div> AMRIX (cyclobenzaprine ER)* carisoprodol 250 mg* carisoprodol compound chlorzoxazone* cyclobenzaprine ER DANTRIUM (dantrolene) dantrolene FEXMID (cyclobenzaprine) * </div> <div> LORZONE (chlorzoxazone)* metaxolone* NORGESIC FORTE (orphenadrine/aspirin/caffeine) orphenadrine* OZOBAX (baclofen) SKELAXIN (metaxolone)* SOMA (carisoprodol)* tizanidine capsules ZANAFLEX (tizanidine) </div> </div>	<p>Client must meet at least one of the listed PA criteria</p> <ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to drugs with an "*" in the class:</p> <ul style="list-style-type: none"> ■ Opiate/Benzodiazepine/Muscle Relaxant <p>"Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria"</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

SMOKING CESSATION		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
bupropion SR CHANTIX (varenicline) nicotine gum nicotine lozenge nicotine patch	NICOTROL (nicotine) NICOTROL NS (nicotine) varenicline tartrate	<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

STEROIDS, TOPICAL		
Preferred Agents	Non-Preferred Agents	
		PA Criteria
		Client must meet at least one of the listed PA criteria
Low Potency		<ul style="list-style-type: none"> ■ 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
DERMA-SMOOTHIE/FS (fluocinolone) hydrocortisone cream, ointment hydrocortisone/aloe cream PROCTOSOL-HC (hydrocortisone)	<i>alclometasone</i> <i>AQUA GLYCOLIC</i> <i>(hydrocortisone/skin cleanser)</i> <i>CAPEX(fluocinolone) shampoo</i> <i>DESONATE (desonide)</i> <i>desonide</i> <i>fluocinolone oil</i> <i>hydrocortisone lotion (Rx)</i>	
Medium Potency		
fluticasone propionate cream, ointment mometasone cream, ointment, solution	<i>beclomethasone valerate foam</i> <i>BESER KIT (fluticasone)</i> <i>clocortolone cream</i> <i>CLODERM (clocortolone)</i> <i>CORDRAN (flurandrenolide)</i> <i>CUTIVATE (fluticasone)</i> <i>DERMATOP (prednicarbate)</i> <i>fluocinolone acetonide</i> <i>flurandrenolide</i>	
	<i>fluticasone propionate lotion</i> <i>hydrocortisone butyrate</i> <i>hydrocortisone valerate</i> <i>LOCOID (hydrocortisone butyrate)</i> <i>LUXIQ (betamethasone)</i> <i>PANDEL (hydrocortisone probutate)</i> <i>prednicarbate</i> <i>SYNALAR (fluocinolone)</i>	

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

STERIODS, TOPICAL <i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
High Potency		<ul style="list-style-type: none"> ■ 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
betamethasone dipropionate lotion betamethasone dipropionate/propylene glycol cream betamethasone valerate cream, ointment triamcinolone acetonide cream, lotion, ointment	<i>amcinonide</i> <i>betamethasone dipropionate cream, gel, ointment</i> <i>betamethasone dipropionate/propylene glycol lotion, ointment</i> <i>betamethasone valerate lotion, desoximetasone</i> <i>diflorasone</i> <i>DIPROLENE (betamethasone dipropionate)</i>	
	<i>fluocinonide</i> <i>HALOG (halcinonide)</i> HALOG SOLUTION (halcinonide) <i>KENALOG aerosol (triamcinolone)</i> <i>PSORCON diflorasone</i> <i>SANADERMRX (triamcinolone/dimeth/silicone)</i> <i>TOPICORT (desoximetasone)</i> <i>triamcinolone acetonide aerosol, TRIANEX (triamcinolone)</i> <i>VANOS (fluocinonide)</i>	
Very High Potency		
clobetasol emollient clobetasol propionate cream, gel, ointment, solution halobetasol cream, ointment	<i>APEXICON E (diflorasone)</i> <i>BRYHALI (halobetasol propionate)</i> <i>clobetasol lotion, shampoo</i> <i>clobetasol propionate foam, spray</i> <i>CLOBEX (clobetasol)</i> <i>CLODAN (clobetasol)</i> <i>halobetasol foam</i> <i>IMPEKLO LOTION (clobetasol propionate)</i> <i>LEXETTE (halobetasol propionate)</i> <i>OLUX (clobetasol)</i>	
	<i>TEMOVATE (clobetasol)</i> <i>TOVET (clobetasol)</i> <i>ULTRAVATE (halobetasol propionate)</i>	

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

STIMULANTS AND RELATED AGENTS		
Preferred Agents	Non-Preferred Agents	PA Criteria
Stimulants		
<p><u>ADDERALL XR</u> (amphetamine salt combination)*</p> <p><u>amphetamine salt combination IR</u></p> <p><u>CONCERTA</u> (methylphenidate)*</p> <p><u>DAYTRANA</u> (methylphenidate)*</p> <p><u>dexmethylphenidate IR</u></p> <p><u>dextroamphetamine IR</u></p> <p><u>DYANAVAL XR</u> (amphetamine)</p> <p><u>FOCALIN XR</u> (dexmethylphenidate) *</p> <p><u>JORNAY PM</u> (methylphenidate ER)*</p> <p><u>METHYLIN</u> (methylphenidate) solution</p> <p><u>methylphenidate IR</u></p> <p><u>QUILLICHEW ER</u> (methylphenidate)</p> <p><u>QUILLIVANT XR</u> (methylphenidate)</p> <p><u>VYVANSE</u> (lisdexamfetamine)</p> <p><u>VYVANSE</u> (lisdexamfetamine) chewable tablets</p>	<p><u>ADHANSIA XR</u> (methylphenidate)</p> <p><u>ADZENYS XR ODT</u> (amphetamine)</p> <p><u>ADZENYS ER</u> (amphetamine) suspension</p> <p><u>amphetamine salt combination ER*</u></p> <p><u>amphetamine sulfate</u></p> <p><u>APTENSIO XR</u> (methylphenidate)</p> <p><u>armodafinil</u></p> <p><u>COTEMPLA XR ODT</u> (methylphenidate)</p> <p><u>DESOXYN</u> (methamphetamine)</p> <p><u>DEXEDRINE</u> (dextroamphetamine)</p> <p><u>dexmethylphenidate ER*</u></p> <p><u>dextroamphetamine ER</u></p> <p><u>dextroamphetamine solution</u></p> <p><u>EVEKEO</u> (amphetamine)</p> <p><u>FOCALIN</u> (dexmethylphenidate)</p> <p><u>methamphetamine</u></p> <p><u>methylphenidate CD*</u></p> <p><u>methylphenidate chewable tablets</u></p> <p><u>methylphenidate ER*</u></p> <p><u>methylphenidate solution</u></p> <p><u>modafinil</u></p> <p><u>MYDAYIS</u> (amphetamine salt combination ER)</p> <p><u>NUVIGIL</u> (armodafinil)</p> <p><u>PROCENTRA</u> (dextroamphetamine)</p> <p><u>PROVIGIL</u> (modafinil)</p> <p><u>RITALIN</u> (methylphenidate)</p> <p><u>RITALIN LA</u> (methylphenidate ER)*</p> <p><u>SUNOSI</u> (solriamfetol)</p> <p><u>WAKIX</u> (pitolisant)</p> <p><u>ZENZEDI</u> (dextroamphetamine)</p>	<ul style="list-style-type: none"> ■ 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 <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p> <p><u>Dose Optimization</u> applies to some strengths where a “*” is noted</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

STIMULANTS AND RELATED AGENTS		
<i>continued</i>		
Preferred Agents	Non-Preferred Agents	PA Criteria
<i>Client must meet at least one of the listed PA criteria</i>		
Non-Stimulants		
atomoxetine guanfacine ER <u>QELBREE (viloxazine)</u>	clonidine ER INTUNIV (guanfacine ER) STRATTERA (atomoxetine)	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ <u>ADHD Agents</u> <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

TETRACYCLINES		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
doxycycline hyclate capsule doxycycline monohydrate 50, 100 mg capsules minocycline capsules VIBRAMYCIN (doxycycline) suspension	<div> <i>demeclocycline</i> <i>DORYX (doxycycline hyclate)</i> <i>doxycycline hyclate IR</i> <i>doxycycline hyclate DR</i> <i>doxycycline monohydrate 40, 75, 150 mg capsules</i> <i>doxycycline monohydrate suspension, tablets</i> <i>minocycline tablets</i> <i>minocycline ER</i> </div> <div> <i>MINOLIRA ER (minocycline)</i> <i>NUZYRA tablet (omadacycline)</i> <i>ORACEA (doxycycline)</i> <i>SOLODYN (minocycline)</i> <i>TARGADOX (doxycycline hyclate)</i> <i>tetracycline</i> <i>VIBRAMYCIN (doxycycline) capsule, syrup</i> <i>XIMINO (minocycline)</i> </div>	<ul style="list-style-type: none"> ■ 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

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THROMBOPOIESIS STIMULATING PROTEINS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
PROMACTA (eltrombopag) tablet	DOPTELET (avatrombopag) MULPLETA (lusutrombopag) PROMACTA (eltrombopag) suspension TAVALLISSE (fostamatinib)	<ul style="list-style-type: none"> ■ 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

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

ULCERATIVE COLITIS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
Oral		
DELZICOL (mesalamine) LIALDA (mesalamine) sulfasalazine sulfasalazine DR	<div>APRISO (mesalamine)</div> <div>ASACOL HD (mesalamine)</div> <div>AZULFIDINE (sulfasalazine)</div> <div>balsalazide</div> <div>budesonide DR</div> <div>COLAZAL (balsalazide)</div> <div>DIPENTUM (olsalazine)</div> <div>mesalamine</div> <div>PENTASA (mesalamine)</div> <div>UCERIS (budesonide)</div>	<ul style="list-style-type: none"> ■ Treatment failure with preferred drugs ■ Contraindication to preferred drugs ■ Allergic reaction to preferred drugs ■ Treatment of stage-four advanced, metastatic cancer and associated conditions
Rectal		
mesalamine	<div>CANASA (mesalamine)</div> <div>mesalamine (SFROWASA)</div> <div>mesalamine kit (ROWASA)</div> <div>UCERIS (budesonide)</div>	<ul style="list-style-type: none"> ■ Treatment failure with preferred drugs ■ Contraindication to preferred drugs ■ Allergic reaction to preferred drugs ■ Treatment of stage-four advanced, metastatic cancer and associated conditions

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Effective January 27, 2022

UREA CYCLE DISORDERS		
Preferred Agents	Non-Preferred Agents	PA Criteria <i>Client must meet at least one of the listed PA criteria</i>
BUPHENYL (sodium phenylbutyrate) CARBAGLU (carglumic acid)	RAVICTI (glycerol phenylbutyrate) sodium phenylbutyrate powder	<ul style="list-style-type: none"> ■ 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 <p>The following Clinical Prior Authorization applies to all drugs in the class:</p> <ul style="list-style-type: none"> ■ Urea Cycle Disorders <p>“Hyperlinks specifies a Drug Utilization Review Board-approved drug clinical prior authorization criteria”</p>

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HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

PDL Review and Implementation Schedule

2021 Review	CLASS	Date of Most Recent PDL Change	Date of Next PDL Change (Tentative)	2022 Review (Tentative)
JAN	ACNE AGENTS, ORAL	7/1/2021	7/1/2022	JAN
JAN	ACNE AGENTS, TOPICAL	7/1/2021	7/1/2022	JAN
JAN	ANALGESICS, NARCOTICS LONG	7/1/2021	7/1/2022	JAN
JAN	ANALGESICS, NARCOTICS SHORT	7/1/2021	7/1/2022	JAN
JAN	ANGIOTENSIN MODULATOR COMBINATIONS	7/1/2021	7/1/2022	JAN
JAN	ANGIOTENSIN MODULATORS	7/1/2021	7/1/2022	JAN
JAN	ANTIMIGRAINE AGENTS, OTHER	7/1/2021	7/1/2022	JAN
JAN	ANTIMIGRAINE AGENTS, TRIPTANS	7/1/2021	7/1/2022	JAN
JAN	ANTIPARKINSONS AGENTS	7/1/2021	7/1/2022	APR
JAN	BLADDER RELAXANT PREPARATIONS	7/1/2021	7/1/2022	JAN
JAN	GLUCAGON AGENTS	7/1/2021	7/1/2022	JAN
JAN	H. PYLORI TREATMENT	7/1/2021	7/1/2022	JAN
JAN	IMMUNOMODULATORS, ATOPIC DERMATITIS	7/1/2021	7/1/2022	JAN
JAN	INTRANASAL RHINITIS AGENTS	7/1/2021	7/1/2022	JAN
JAN	MOVEMENT DISORDERS	7/1/2021	7/1/2022	JAN
JAN	NEUROPATHIC PAIN	7/1/2021	7/1/2022	JAN
JAN	ONCOLOGY, ORAL - BREAST	7/1/2021	7/1/2022	JAN
JAN	ONCOLOGY, ORAL - HEMATOLOGIC	7/1/2021	7/1/2022	JAN
JAN	ONCOLOGY, ORAL - LUNG	7/1/2021	7/1/2022	JAN
JAN	ONCOLOGY, ORAL - OTHER	7/1/2021	7/1/2022	JAN
JAN	ONCOLOGY, ORAL - PROSTATE	7/1/2021	7/1/2022	JAN
JAN	ONCOLOGY, ORAL - RENAL CELL	7/1/2021	7/1/2022	JAN
JAN	ONCOLOGY, ORAL - SKIN	7/1/2021	7/1/2022	JAN
JAN	PHOSPHATE BINDERS	7/1/2021	7/1/2022	JAN
JAN	PLATELET AGGREGATION INHIBITORS	7/1/2021	7/1/2022	JAN
NA	POTASSIUM BINDERS	NA	7/1/2022	JAN
JAN	PROGESTINS FOR CACHEXIA	7/1/2021	7/1/2022	JAN

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

2021 Review	CLASS	Date of Most Recent PDL Change	Date of Next PDL Change (Tentative)	2022 Review (Tentative)
JAN	PROTON PUMP INHIBITORS	7/1/2021	7/1/2022	JAN
JAN	SMOKING CESSATION	7/1/2021	7/1/2022	JAN
JAN	STIMULANTS AND RELATED AGENTS	7/1/2021	7/1/2022	JAN
APR	ANTI-ALLERGENS, ORAL	7/1/2021	7/1/2022	APR
APR	ANTIBIOTICS, INHALED	7/1/2021	7/1/2022	APR
APR	ANTICOAGULANTS	7/1/2021	7/1/2022	APR
APR	ANTIDEPRESSANTS, OTHER	7/1/2021	7/1/2022	APR
APR	ANTIDEPRESSANTS, SSRIs	7/1/2021	7/1/2022	APR
APR	ANTIDEPRESSANTS, TRICYCLIC	7/2/2021	7/1/2022	APR
APR	ANTIHYPERURICEMICS	7/1/2021	7/1/2022	APR
APR	ANTIVIRALS, ORAL	7/1/2021	7/1/2022	APR
APR	ANXIOLYTICS	7/1/2021	7/1/2022	APR
APR	BETA-BLOCKERS	7/1/2021	7/1/2022	APR
APR	BILE SALTS	7/1/2021	7/1/2022	APR
APR	BPH TREATMENTS	7/1/2021	7/1/2022	APR
APR	BRONCHODILATORS, BETA AGONIST	7/1/2021	7/1/2022	APR
APR	COPD AGENTS	7/1/2021	7/1/2022	APR
APR	COUGH AND COLD	7/1/2021	7/1/2022	APR
APR	ERYTHROPOIESIS STIMULATING PROTEINS	7/1/2021	7/1/2022	APR
APR	GLUCOCORTICOIDs, INHALED	7/1/2021	7/1/2022	APR
APR	HAE TREATMENTS	7/1/2021	7/1/2022	APR
APR	HEMOPHILIA TREATMENT	7/1/2021	7/1/2022	APR
APR	HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS	7/1/2021	1/1/2023	OCT
APR	IMMUNE GLOBULINS, IV	7/1/2021	7/1/2022	APR
APR	IMMUNOMODULATORS, ASTHMA	7/1/2021	7/1/2022	APR
APR	LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS	7/1/2021	7/1/2022	APR
APR	LIPOTROPICS, OTHER	7/1/2021	7/1/2022	APR
APR	LIPOTROPICS, STATINS	7/1/2021	7/1/2022	APR
APR	MULTIPLE SCLEROSIS AGENTS	7/1/2021	7/1/2022	APR

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

2021 Review	CLASS	Date of Most Recent PDL Change	Date of Next PDL Change (Tentative)	2022 Review (Tentative)
APR	PAH AGENTS, ORAL AND INHALED	7/1/2021	7/1/2022	APR
APR	PANCREATIC ENZYMES	7/1/2021	7/1/2022	APR
APR	PEDIATRIC VITAMIN PREPARATIONS	7/1/2021	7/1/2022	APR
APR	PRENATAL VITAMINS	7/1/2021	7/1/2022	APR
APR	SEDATIVE HYPNOTICS	7/1/2021	7/1/2022	APR
APR	SICKLE CELL ANEMIA TREATMENTS	7/1/2021	7/1/2022	APR
APR	THROMBOPOIESIS STIMULATING PROTEINS	7/1/2021	7/1/2022	APR
APR	UREA CYCLE DISORDER, ORAL	7/1/2021	7/1/2022	APR
JUL	ALZHEIMERS AGENTS	1/1/2022	1/1/2023	JUL
JUL	ANTIHISTAMINES, MINIMALLY SEDATING	1/1/2022	1/1/2023	JUL
JUL	ANTIHYPERTENSIVES, SYMPATHOLYTIC	1/1/2022	1/1/2023	JUL
JUL	CALCIUM CHANNEL BLOCKERS	1/1/2022	1/1/2023	JUL
JUL	CEPHALOSPORINS AND RELATED ANTIBIOTICS	1/1/2022	1/1/2023	JUL
JUL	CYTOKINE AND CAM ANTAGONISTS	1/1/2022	1/1/2023	OCT
JUL	FLUOROQUINOLONES, ORAL	1/1/2022	1/1/2023	JUL
JUL	GLUCOCORTICOIDS, ORAL	1/1/2022	1/1/2023	JUL
JUL	IMMUNOSUPPRESSIVES, ORAL	1/1/2022	1/1/2023	JUL
JUL	IRON, ORAL	1/1/2022	1/1/2023	JUL
JUL	LEUKOTRIENE MODIFIERS	1/1/2022	1/1/2023	JUL
JUL	NSAIDS	1/1/2022	1/1/2023	JUL
JUL	OPHTHALMIC ANTIBIOTICS	1/1/2022	1/1/2023	JUL
JUL	OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	1/1/2022	1/1/2023	JUL
JUL	OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	1/1/2022	1/1/2023	JUL
JUL	OPHTHALMICS, ANTI-INFLAMMATORY	1/1/2022	1/1/2023	JUL
JUL	OPHTHALMIC ANTI-INFLAMMATORY/IMMUNOMODULATORS	1/1/2022	1/1/2023	JAN
JUL	OPHTHALMICS, GLAUCOMA AGENTS	1/1/2022	1/1/2023	JUL
JUL	OTIC ANTIBIOTICS	1/1/2022	1/1/2023	JUL
JUL	OTIC ANTI-INFECTIVES & ANESTHETICS	1/1/2022	1/1/2023	JUL
JUL	PENICILLINS	1/1/2022	1/1/2023	JUL

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

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JUL	PROGESTATIONAL AGENTS	1/1/2022	1/1/2023	JUL
JUL	ROSACEA AGENTS, TOPICAL	1/1/2022	1/1/2023	JUL
JUL	SKELETAL MUSCLE RELAXANTS	1/1/2022	1/1/2023	JUL
JUL	STEROIDS, TOPICAL	1/1/2022	1/1/2023	JUL
JUL	ULCERATIVE COLITIS	1/1/2022	1/1/2023	JUL
OCT	ANDROGENIC AGENTS	1/1/2022	1/1/2023	OCT
OCT	ANTIBIOTICS, GI	1/1/2022	1/1/2023	OCT
OCT	ANTIBIOTICS, TOPICAL	1/1/2022	1/1/2023	OCT
OCT	ANTIBIOTICS, VAGINAL	1/1/2022	1/1/2023	OCT
OCT	ANTICONVULSANTS	1/1/2022	1/1/2023	OCT
OCT	ANTIEMETICS/ANTIVERTIGO AGENTS	1/1/2022	1/1/2023	OCT
OCT	ANTIFUNGALS, ORAL	1/1/2022	1/1/2023	OCT
OCT	ANTIFUNGALS, TOPICAL	1/1/2022	1/1/2023	OCT
OCT	ANTIHISTAMINES, FIRST GENERATION	1/1/2022	1/1/2023	OCT
OCT	ANTIPARASITICS, TOPICAL	1/1/2022	1/1/2023	OCT
OCT	ANTIPSYCHOTICS	1/1/2022	1/1/2023	OCT
OCT	ANTIVIRALS, TOPICAL	1/1/2022	1/1/2023	OCT
OCT	BONE RESORPTION SUPPRESSION AND RELATED	1/1/2022	1/1/2023	OCT
OCT	COLONY STIMULATING FACTORS	1/1/2022	1/1/2023	OCT
OCT	EPINEPHRINE, SELF-INJECTED	1/1/2022	1/1/2023	OCT
OCT	GI MOTILITY, CHRONIC	1/1/2022	1/1/2023	OCT
OCT	GROWTH HORMONE	1/1/2022	1/1/2023	OCT
OCT	HEPATITIS C AGENTS	1/1/2022	1/1/2023	OCT
OCT	HIV / AIDS	1/1/2022	1/1/2023	OCT
OCT	HYPOGLYCEMICS, INSULIN AND RELATED	1/1/2022	1/1/2023	OCT
OCT	HYPOGLYCEMICS, MEGLITINIDES	1/1/2022	1/1/2023	OCT
OCT	HYPOGLYCEMICS, METFORMIN	1/1/2022	1/1/2023	OCT
OCT	HYPOGLYCEMICS, SGLT2	1/1/2022	1/1/2023	OCT
OCT	HYPOGLYCEMICS, TZD	1/1/2022	1/1/2023	OCT

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 27, 2022

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OCT	MACROLIDES-KETOLIDES	1/1/2022	1/1/2023	OCT
OCT	OPIATE DEPENDENCE TREATMENTS	1/1/2022	1/1/2023	OCT
OCT	TETRACYCLINES	1/1/2022	1/1/2023	OCT

For all classes listed below the standard PA criteria apply:			
<ul style="list-style-type: none"> ■ 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	CHILDREN'S MUCINEX LIQUID OTC (C) (ORAL)	diphenhyd/phenyleph/acetaminop
ALA-HIST PE TABLET OTC (ORAL)	dexbrompheniramine/phenylephrin	DEXBROMPHENIRAMINE/PHENYLEPHRINE OTC (ORAL)	dexbrompheniramin/phenylephrin
DECONEX IR TABLET OTC (ORAL)	guaifenesin/phenylephrine HCl	DIPHENHYDRAMINE/PHENYLEPHRINE/APAP POWDER PACK OTC (ORAL)	diphenhyd/phenyleph/acetaminop
ED A-HIST TABLET OTC (ORAL)	chlorpheniramine/phenylephrine	DOXYLAMINE/PHENYLEPHRINE OTC (ORAL)	doxylamine/phenylephrine HCl
ED BRON GP LIQUID OTC (ORAL)	guaifenesin/phenylephrine HCl	ED A-HIST LIQUID OTC (ORAL)	chlorpheniramine/phenylephrine
GUAIFENESIN 400 MG TABLET OTC (ORAL)	guaifenesin	GUAIFENESIN/PHENYLEPHRINE TABLET OTC (ORAL)	guaifenesin/phenylephrine HCl
GUAIFENESIN LIQUID OTC (ORAL)	guaifenesin	GUAIFENESIN/PHENYLEPHRINE TABLET OTC (ORAL)	guaifenesin/pseudoephedrine HCl
GUAIFENESIN TABLET ER OTC (ORAL)	guaifenesin	GUAIFENESIN/PHENYLEPHRINE/APAP TABLET OTC (ORAL)	guaifenesin/pseudoephedrine HCl
GUAIFENESIN/PSE TABLET ER OTC (ORAL)	guaifenesin/pseudoephedrine HCl	GUAIFENESIN/PSEUDOEPHEDRINE TABLET OTC (ORAL)	guaifenesin/pseudoephedrine HCl
MUCINEX D TABLET ER 12H OTC (ORAL)	guaifenesin/pseudoephedrine HCl	HISTEX-PE LIQUID OTC (ORAL)	phenylephrine HCl/triprolidine
MUCINEX ER TABLET OTC (ORAL)	guaifenesin	LOHIST-D LIQUID OTC (ORAL)	chlorpheniramine/pseudoephed
MUCINEX FAST-MAX COLD-SINUS TABLET OTC (ORAL)	guaifen/phenyleph/acetaminophn	MUCINEX FAST-MAX NITE COLD-FLU LIQUID OTC (ORAL)	diphenhyd/phenyleph/acetaminop
MUCINEX GRAN PACK OTC (ORAL)	guaifenesin	NOHIST-LQ LIQUID OTC (ORAL)	chlorpheniramine/phenylephrine
MUCUS-CHEST CONGESTION LIQUID OTC (ORAL)	guaifenesin	PHENYLEPHRINE/APAP TABLET OTC (ORAL)	phenylephrine HCl/acetaminophn
NASOPEN PE LIQUID OTC (ORAL)	thonzylamine/phenylephrine	PHENYLEPHRINE/APAP/CHLORPHENIRAMINE TABLET OTC (ORAL)	phenylephrine/acetaminophn/cpm
POLY HIST FORTE TABLET OTC (ORAL)	doxylamine/phenylephrine HCl	PHENYLEPHRINE/BROMPHENIRAMINE TABLET OTC (ORAL)	brompheniramine/phenylephrine
PSE/CHLORPHENIRAMINE TABLET OTC (ORAL)	chlorpheniramine/pseudoephed	POLY-VENT IR TABLET OTC (ORAL)	guaifenesin/pseudoephedrine HCl
PSE/TRIPROLDINE TABLET OTC (ORAL)	triprolidine/pseudoephedrine	RESCON TABLET OTC (ORAL)	dexchlorpheniramin/pseudoephed
RYNEX PE SOLUTION OTC (ORAL)	brompheniramine/phenylephrine	RESCON-GG LIQUID OTC (ORAL)	guaifenesin/phenylephrine HCl
		RYMED TABLET OTC (ORAL)	dexchlorpheniramin/phenylephrine
		RYNEX PSE LIQUID OTC (ORAL)	brompheniramin/pseudoephedrine
		STAHIST AD TABLET OTC (ORAL)	chlorcyclizine/pseudoephedrine

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

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

COUGH AND COLD, NON-NARCOTIC			
Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
ALA-HIST DM LIQUID OTC (ORAL)	d-methorphan/pe/dexbromphenir	CHLO TUSS LIQUID OTC (ORAL)	dexbromphen/pseudoeph/chlophed
ALAHIST CF TABLET OTC (ORAL)	d-methorphan/pe/dexbromphenir	DM/APAP/CHLORPHENIRAMINE TABLET OTC (ORAL)	dextromethorphan/acetaminoph/cp
BENZONATATE CAPSULE (ORAL)	benzonatate	DM/APAP/DOXYLAMINE CAPSULE OTC (ORAL)	DM/acetaminophen/doxylamine
BROM-PSE-DM SYRUP (ORAL)	brompheniramine/pseudoephed/DM	DM/APAP/DOXYLAMINE LIQUID OTC (ORAL)	DM/acetaminophen/doxylamine
BROMPHENIRAMINE/PHENYLEPHRINE/DM SOLUTION OTC (ORAL)	brompheniram/phenylephrine/DM	DM/CHLORPHENIRAMINE TABLET OTC (ORAL)	chlorpheniramine/dextromethorp
BROTAPP DM ELUXIR OTC (ORAL)	brompheniramine/pseudoephed/DM	DM/PHENYLEPHRINE/APAP CAPSULE OTC (ORAL)	d-methorphan/PE/acetaminophen
CHILD MUCINEX M-S COLD DAY-NTE LIQUID SEQUELES OTC (ORAL)	diphenhydram/PE/DM/acetamin/GG	DM/PHENYLEPHRINE/APAP LIQUID OTC (ORAL)	d-methorphan/PE/acetaminophen
CHILDREN'S MUCINEX LIQUID OTC (NN) (ORAL)	guaifen/dextromethorphan/PE	DM/PHENYLEPHRINE/APAP TABLET OTC (ORAL)	d-methorphan/PE/acetaminophen
CHILDREN'S MUCINEX LIQUID OTC (NN) (ORAL)	phenylephrine/DM/acetaminop/GG	DM/PHENYLEPHRINE/APAP/DOXYLAMINE LIQUID OTC (ORAL)	DM/PE/acetaminophen/doxylamine
DECONEX DMX TABLET OTC (ORAL)	guaifen/dextromethorphan/PE	DM/PSE/CHLORPHENIRAMINE LIQUID OTC (ORAL)	chlorpheniramin/pseudoephed/DM
DELTYM SUSPENSION ER 12H OTC (ORAL)	dextromethorphan polistirex	DURAFU TABLET OTC (ORAL)	pseudoeph/DM/guaifen/acetamin
DEXTROMETHORPHAN CAPSULE OTC (ORAL)	dextromethorphan HBr	ED A-HIST DM TABLET OTC (ORAL)	chlorpheniramine/phenyleph/DM
DEXTROMETHORPHAN SUSPENSION ER 12H OTC (ORAL)	dextromethorphan polistirex	GUAIFENESIN/DM TABLET OTC (ORAL)	guaifenesin/dextromethorphan
ED-A-HIST DM LIQUID OTC (ORAL)	chlorpheniramine/phenyleph/DM	M-END DMX LIQUID OTC (ORAL)	dexbromphen/pseudoephedrine/DM
GUAIFEN/DEXTROMETHORPHAN/PE OTC (ORAL)	guaifen/dextromethorphan/PE	MUCINEX FAST-MAX DAY-NITE COLD LIQUID SEQ OTC (ORAL)	diphenhydram/PE/DM/acetamin/GG
GUAIFENESIN/DM LIQUID OTC (ORAL)	guaifenesin/dextromethorphan	MUCINEX FAST-MAX DAY-NITE CONG TABLET OTC (ORAL)	diphenhydram/PE/DM/acetamin/GG
GUAIFENESIN/DM TABLET ER 12H OTC (ORAL)	guaifenesin/dextromethorphan	MUCINEX FAST-MAX SEVERE COLD LIQUID OTC (ORAL)	phenylephrine/DM/acetaminop/GG
GUAIFENESIN/DM/PHENYLEPHRINE LIQUID OTC (ORAL)	guaifen/dextromethorphan/PE	MUCUS DM MAX TABLET ER 12H OTC (ORAL)	guaifenesin/dextromethorphan
GUAIFENESIN/DM/PHENYLEPHRINE SYRUP OTC (ORAL)	guaifen/dextromethorphan/PE	NINJACOF LIQUID OTC (ORAL)	pyrilamine/chlophedianol
HISTEX-DM SYRUP OTC (ORAL)	triprolidine/phenylephrine/DM	PHENYLEPHRINE/DM/APAP/GUAIFENESIN CAPLET OTC (ORAL)	phenylephrine/DM/acetaminop/GG
LOHIST-DM LIQUID OTC (ORAL)	brompheniram/phenylephrine/DM	POLY-HIST PD DROPS OTC (ORAL)	thonzylamine/chlophedianol
MUCINEX COLD-FLU & SORE THROAT LIQUID OTC (ORAL)	phenylephrine/DM/acetaminop/GG	POLYTUSSIN DM OTC (ORAL)	dexchlorphen/phenylephrine/DM
MUCINEX COUGH GRAN PACK OTC (ORAL)	guaifenesin/dextromethorphan	RESCON-DM LIQUID OTC (ORAL)	chlorpheniramin/pseudoephed/DM
MUCINEX DM TABLET ER 12H OTC (ORAL)	guaifenesin/dextromethorphan		
MUCINEX FAST-MAX CONGEST-COUGH TABLET OTC (ORAL)	guaifen/dextromethorphan/PE		
MUCINEX FAST-MAX DM MAX LIQUID OTC (ORAL)	guaifenesin/dextromethorphan		
NOHIST-DM LIQUID OTC (ORAL)	chlorpheniramine/phenyleph/DM		
POLY-HIST DM LIQUID OTC (ORAL)	thonzylamine/phenylephrine/DM		
POLY-VENT DM TABLET OTC (ORAL)	guaifenesin/DM/pseudoephedrine		
PROMETHAZINE/DM SYRUP (ORAL)	promethazine/dextromethorphan		
RYNEX DM SOLUTION OTC (ORAL)	brompheniram/phenylephrine/DM		
VANACOF DM LIQUID OTC (ORAL)	guaifen/dextromethorphan/PE		
VANACOF 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	CORVITE 150 TABLET (ORAL)	iron,carb/fofolate6/mv,min no.41
FERROUS FUMARATE/FA/MULTIVITAMIN & MINERALS CAPSULE (ORAL)	iron fum/fofic acid/mv,min 15	CORVITE FE TABLET (ORAL)	iron/fofolate no.6/mv,min no.40
FERROUS FUMARATE/IRON POLYSACCHARIDES/FA/MULTIVITAMIN CAPSULE (ORAL)	iron fm,ps no.1/fofic/mv no.18	FEOSOL TABLET OTC (ORAL)	iron polysacch/iron heme poly
FERROUS GLUCONATE TABLET OTC (ORAL)	ferrous gluconate	FER-IN-SOL DROPS OTC (ORAL)	ferrous sulfate
FERROUS SULFATE DROPS OTC (ORAL)	ferrous sulfate	FERGON TABLET OTC (ORAL)	ferrous gluconate
FERROUS SULFATE SOLUTION OTC (ORAL)	ferrous sulfate	FERIVA 21-7 (ORAL)	iron/C/fofolate/B12/zinc/succin
FERROUS SULFATE TABLET OTC (ORAL)	ferrous sulfate	FERIVA FA CAPSULE (ORAL)	iron/C/fofolate/B12/biot/cupric
FERROUS SULFATE, DRIED TABLET ER OTC (ORAL)	ferrous sulfate, dried	FERRIMIN 150 TABLET OTC (ORAL)	ferrous fumarate
IRON CARBONYL/ASCORBIC ACID TABLET OTC (ORAL)	iron,carbonyl/ascorbic acid	FERROUS SULFATE/ASCORBIC ACID/FA TABLET ER OTC (ORAL)	ferrous sulfate/vit C/fofic ac
IRON POLYSACCHARIDES CAPSULE OTC (ORAL)	iron polysaccharide complex	IROSPAN TABLET (ORAL)	iron bg,ps/fofic/B,C no.12/suc
IRON POLYSACCHARIDES/B12/FA CAPSULE (ORAL)	iron ps complex/B12/fofic acid	NEPHRON FA TABLET (ORAL)	vit B comp C no.24/iron/fofic
		TARON FORTE CAPSULE (ORAL)	iron bg,ps/vitC/B12/FA/calcium

PEDIATRIC VITAMIN PREPARATIONS			
Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
MULTIVITAMINS WITH FLUORIDE DROPS (ORAL)	pedi multivit no.2 w-fluoride	FLORIVA CHEW (ORAL)	pedi multivit no.85/fluoride
MULTIVITS WITH IRON & FLUORIDE DROPS (ORAL)	pedi multivit 45/fluoride/iron	FLORIVA PLUS DROPS OTC (ORAL)	pedi multivit no.161/fluoride
PEDI MVI NO.16 WITH FLUORIDE TAB CHEW (ORAL)	pedi multivit no.16 w-fluoride	FLUORIDE/VITAMINS A,C,AND D DROPS (ORAL)	ped mvit A,C,D3 no.21/fluoride
		POLY-VI-FLO CHEW (ORAL)	pedi multivit no.33/fluoride
		POLY-VI-FLO DROPS (ORAL)	pedi multivit no.37 w-fluoride
		POLY-VI-FLO WITH IRON CHEW (ORAL)	pedi multivit 33/fluoride/iron
		POLY-VI-FLO WITH IRON DROPS (ORAL)	pedi multivit 37/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-FLO DROPS (ORAL)	ped mvit A,C,D3 no.38/fluoride
		TRI-VITAMIN WITH FLUORIDE (ORAL)	ped mvit A,C,D3 no.21/fluoride

PRENATAL VITAMINS			
Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
PNV2/IRON B-G SUC-P/FA/OMEGA-3 (ORAL)	PNV cmb 52/iron/FA/omega-3/dha	CITRANATAL B-CALM (ORAL)	prenatal 48/iron/fofic acid/B6
SELECT-OB + DHA (ORAL)	prenatal vit 33/iron/fofic/dha	COMPLETENATE CHEW TABLET (ORAL)	prenatal vit 14/iron fum/fofic
TRICARE (ORAL)	prenatal vit103/iron fum/fofic	FE C/FA (ORAL)	multvit-min9/iron/fofic acid
TRINATAL RX 1 (ORAL)	prenatal vit27,calcium/iron/FA	NESTABS (ORAL)	prenatal vit86/iron/fofic acid
VITAFOL NANO (ORAL)	prenatal no.75/iron/fofolate no1	NESTABS DHA (ORAL)	prenatal 87/iron bis/fofic/dha
VITAFOL TAB CHEW (ORAL)	PNV 112/iron/fofic/om3/dha/epa	OB COMPLETE ONE (ORAL)	PNV 85/iron/fofic/dha/fish oil
VITAFOL ULTRA (ORAL)	PNV 67/iron ps/fofolate no.1/dha	OB COMPLETE PETITE (ORAL)	prenatal56/iron/fofic acid/dha
VITAFOL-OB (ORAL)	prenatal vit 10/iron fum/fofic	OB COMPLETE PREMIER (ORAL)	PNV83/iron,carb,asp/fofic acid
VITAFOL-OB-DHA (ORAL)	prenatal vit 10/iron/fofic/dha	OB COMPLETE TABLET (ORAL)	multvit-min9/iron/fofic acid
VITAFOL-ONE (ORAL)	prenatal 26/iron ps/fofic/dha	PNV COMBOR47/IRON/FA #1/DHA (ORAL)	multvit 47/iron/fofolate 1/dha
		PNV NO.118/IRON FUMARATE/FA CHEW TABLET (ORAL)	PNV no.118/iron fumarate/FA
		PNV NO.15/IRON FUM & PS CMP/FA (ORAL)	mvn-min 74/iron fum/iron/FA
		PNV W-CA NO.40/IRON FUM/FA CMB NO.1 (ORAL)	prenatal,calc.40/iron/fofolate 1
		PNV WITH CA NO.68/IRON/FA NO.1/DHA (ORAL)	mv-mins 71/iron/fofic no.1/dha
		PNV WITH CA NO.72/IRON/FA (ORAL)	PNV,calcium 72/iron/fofic acid
		PNV816/IRON FUM & PS/FA/OM-3 (ORAL)	mvn-min75/iron/iron ps/om3/dha
		PRENATAL VIT #76/IRON,CARB/FA (ORAL)	prenatal vit,calc76/iron/fofic
		PRENATE AM (ORAL)	multvit 38/fofolate no.6/ginger
		PRENATE CHEWABLE TABLET (ORAL)	multivitamin no.36/fofolate no.6
		PRENATE DHA (ORAL)	prenatal 78/iron/fofolate 1/dha
		PRENATE ELITE (ORAL)	prenatal 114/iron a-g/fofolate 1
		PRENATE ENHANCE (ORAL)	prenatal vit68/iron/FA no6/dha
		PRENATE ESSENTIAL (ORAL)	multvit no.40/iron/fofolate1/dha
		PRENATE MINI (ORAL)	prenatal vit 87/iron/fofic/dha
		PRENATE PIXIE (ORAL)	prenatal vit 85/iron/FA 1/dha
		PRENATE RESTORE (ORAL)	prenatal vit69/iron/fofolate6/dh
		PRENATE STAR (ORAL)	prenatal no.77/iron asp glyf/FA
		SELECT-OB TAB CHEW (ORAL)	prenatal vit128/iron/fofic acid
		TRISTART DHA (ORAL)	prenatal 93/iron/fofolate 9/dha
		VP-PNV-DHA (ORAL)	prenatal no.52/iron/FA/dha
		WESTGEL DHA (ORAL)	prenatal 93/iron/fofolate 9/dha