Texas Health and Human Services

Preferred Drug List

Texas Medicaid

Effective January 30, 2025

TEXAS
Health and Human Services

General Information

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

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

CHIP drugs are not subject to PDL requirements.

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

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

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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 DUR 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 the MCO Search for each MCO's prior authorization call center number and other contact information.

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Traditional Medicaid

The Texas Prior Authorization Call Center accepts prior authorization requests by phone at 877 PA TEXAS (877-728-3927), by fax at 1-866-469-8590, or online through the VDP Provider Portal.

For more information, refer to these resources:

- VDP Provider Portal Registration User Manual
- VDP Provider Portal User Guide
- VDP Prior Authorization Manual

Texas Drug Utilization Review Board

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

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

Education

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

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PDL CRITERIA EXCEPTIONS

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

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

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

HB 3286, Section 2, 88th Legislature Regular Session, 2023, required the HHSC to allow the following exceptions on the PDL within the antipsychotic and antidepressant drug classes. For the antipsychotic and antidepressant drug classes, if the member was prescribed and is taking a non-preferred drug, the following PDL exception criteria will apply:

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

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REVISION HISTORY

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

DATE	ISSUES/UPDATES
01/30/2025	Published with updates

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ACNE AGENTS, ORAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ACCUTANE (isotretinoin) AMNESTEEM (isotretinoin) CLARAVIS (isotretinoin) isotretinoin isotretinoin (Absorica) MYORISAN (isotretinoin) ZENATANE (isotretinoin)	ABSORICA (isotretinoin) ABSORICA LD (isotretinoin)

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ACNE AGENTS, TOPICAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization may apply to drugs in the class: • Retinoids • Topical Acne Agents Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ANTIBITOICS	
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
BENZOYL PEROXIDE	
benzoyl peroxide gel (OTC) 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
RETINOIDS	
adapalene gel OTC tretinoin cream (Avita, Retin-A) tretinoin gel (Avita, Retin-A)	AKLIEF (trifarotene) adapalene cream, gel RX ALTRENO (tretinoin) ARAZLO (tazarotene) ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene) FABIOR (tazarotene) tazarotene tretinoin gel (Atralin) tretinoin microspheres
COMBINATION AND OTHER AGENTS	
benzoyl peroxide/clindamycin (Duac) EPIDUO FORTE (benzoyl peroxide/adapalene) erythromycin/benzoyl peroxide	adapalene/benzoyl peroxide (Epiduo/Epiduo Forte) CABTREO (adapalene/benzoyl peroxide/clindamycin) clindamycin/benzoyl peroxide (Acanya) clindamycin/tretinoin dapsone DERMACINRX ATRIX CLEANSER OTC (TOPICAL) DERMACINRX ATRIX CREAM OTC (TOPICAL) DERMACINRX ATRIX SOLUTION OTC (TOPICAL) sulfacetamide sulfacetamide sodium sulfacetamide sodium/sulfur sulfacetamide/sulfur sulfacetamide/sulfur/urea TWYNEO (tretinoin/benzoyl peroxide) WINLEVI (clascoterone) ZIANA (clindamycin/tretinoin) ZMA CLEAR CLEANSER (sulfacetamide sodium/sulfur)

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ALZHEIMER'S AGENTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
CHOLINESTERASE INHIBITORS	
donepezil 5, 10 mg tablets donepezil ODT EXELON (rivastigmine) transdermal	ADLARITY (donepezil) transdermal ARICEPT (donepezil) donepezil 23 mg tablets galantamine galantamine ER rivastigmine capsules rivastigmine transdermal
NMDA RECEPTOR ANTAGONIST	
memantine tablets	memantine ER memantine solution memantine tablet dose pack NAMENDA (memantine) tablets/titration pack NAMENDA XR (memantine)
CHOLINESTERASE INHIBITOR/NMADA RECEPTOR ANTAGONIST COMBINATIONS	
	NAMZARIC (donepezil/memantine)

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ANALGESICS, NARCOTICS – LONG ACTING	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • Methadone oral solution will be authorized for patients less than 24 months of age.	The following Clinical Prior Authorization applies **to all drugs** in the class: • Opioid Policy Criteria • Opiate Overutilization • Opiate/Benzodiazepine/Muscle Relaxant Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
BUTRANS (buprenorphine) fentanyl patch (12, 25, 50, 75, 100 mcg) morphine ER (generic MS Contin) tramadol ER (generic Ultram ER) XTAMPZA ER (oxycodone)	BELBUCA (buprenorphine) buprenorphine buccal/film buprenorphine patch CONZIP (tramadol) fentanyl patch (37.5, 62.5, 87.5 mcg) hydrocodone ER hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone methadone brand sol tablets morphine ER (generic Avinza, Kadian) MS CONTIN (morphine) NUCYNTA ER (tapentadol) oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER tramadol ER (generic Conzip) tramadol ER (generic Ryzolt) ZOHYDRO ER (hydrocodone ER)

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ANALGESICS, NARCOTICS – SHORT ACTING	(NON-PARENTERAL)
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Opioid Policy Criteria • Opiate Overutilization • Opiate/Benzodiazepine/Muscle Relaxant Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
APAP/codeine hydrocodone/APAP hydromorphone tablets morphine tablets morphine solution oxycodone solution oxycodone tablets oxycodone/APAP tablets tramadol 50 mg tramadol/APAP	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 citrate oral transmucosal (Actiq) FENTORA (fentanyl) FIORICET W/CODEINE (butalbital/APAP/caffeine/codeine) hydrocodone/ibuprofen hydromorphone liquid hydromorphone suppositories levorphanol LORTAB (hydrocodone/APAP) meperidine morphine concentrated solution morphine disp syringe, oral morphine suppositories NALOCET (oxycodone/APAP) NUCYNTA (tapentadol) oxycodone/APAP solution oxycodone capsules oxycodone concentrate solution oxymorphone pentazocine/naloxone PERCOCET (oxycodone/APAP) PROLATE (oxycodone/APAP) ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol) tramadol 100 mg tramadol solution

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ANDROGENIC AGENTS, TOPICAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Androgenic Agents • Hormonal Therapy Agents Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ANDRODERM (testosterone) ANDROGEL (testosterone) pump TESTIM (testosterone) testosterone gel packet (Androgel 1% pkt, Vogelxo) testosterone gel pump (Androgel) testosterone gel tube (Testim, Vogelxo)	ANDROGEL (testosterone) packets FORTESTA (testosterone) NATESTO (testosterone) testosterone gel (Axiron, Fortesta, Androgel 1.62% pkt) VOGELXO (testosterone)

ANGIOTENSIN MODULATORS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • Epaned will be authorized for patients six years of age and under	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ACE INHIBITORS	
benazepril enalapril solution enalapril tablets fosinopril lisinopril quinapril ramipril	ACCUPRIL (quinapril) ALTACE (ramipril) captopril EPANED (enalapril) LOTENSIN (benazepril) moexipril perindopril QBRELIS (lisinopril) solution trandolapril VASOTEC (enalapril) ZESTRIL (lisinopril)

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ANGIOTENSIN MODULATORS cont.	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	The following Clinical Prior Authorization applies **to all drugs** in the class: • Duplicate Therapy Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ACE INHIBITOR/DIURETIC COMBINATIONS	
enalapril/HCTZ lisinopril/HCTZ	ACCURETIC (quinapril/HCTZ) benazepril/HCTZ captopril/HCTZ fosinopril/HCTZ LOTENSIN HCT (benazepril/HCTZ) quinapril/HCTZ VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBS)	
DIOVAN (valsartan) irbesartan losartan	ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) candesartan COZAAR (losartan) EDARBI (azilsartan) eprosartan MICARDIS (telmisartan) olmesartan telmisartan valsartan
ARB/DIURETIC COMBINATIONS	
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 INIBITORS	
	aliskiren TEKTURNA (aliskerin)
DIRECT RENIN INHIBITOR/DIURETIC COMBINATIONS	
	TEKTURNA HCT (aliskerin/HCTZ)
ARB/NEPRILYSIN INHIBITOR COMBINATIONS	
ENTRESTO (valsartan/sacubitril) tablet	ENTRESTO SPRINKLE (valsartan/sacubitril) pellet valsartan/sacubitril

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ANGIOTENSIN MODULATOR COMBINATIONS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
benazepril /amlodipine valsartan/amlodipine valsartan/amlodipine/HCTZ	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)

ANTI-ALLERGENS, ORAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ODACTRA (house dust mite allergen extract) ORALAIR (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass mixed pollens allergen extract) PALFORZIA TITRATION CAPSULES (peanut allergen powder)	GRASTEK (grass pollen-timothy, standard) PALFORZIA MAINTENANCE SACHET (peanut allergen powder) RAGWITEK (weed pollen-short ragweed)

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ANTIBIOTICS, GASTROINTESTINAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
FIRVANQ (vancomycin) metronidazole tablets neomycin tinidazole VANCOCIN (vancomycin)	AEMCOLO (rifamycin) DIFICID (fidaxomicin) FLAGYL (metronidazole) LIKMEZ (metronidazole) suspension metronidazole capsules nitazoxanide paromomycin vancomycin VOWST (fecal microbio spore, live-brpk) XIFAXAN (rifaximin)

ANTIBIOTICS, INHALED	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies to drugs with an "*" in the class: • Antibiotics, Inhaled Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
BETHKIS (tobramycin)* CAYSTON (aztreonam)* KITABIS PAK (tobramycin)* TOBI PODHALER (tobramycin)*	ARIKAYCE (amikacin) TOBI (tobramycin) solution* tobramycin solution*

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ANTIBIOTICS, TOPICAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
bacitracin ointment bacitracin/polymyxin ointment mupirocin ointment neomycin/bacitracin/polymyxin/pramoxine ointment triple antibiotic ointment	bacitracin packets CENTANY (mupirocin) gentamicin mupirocin cream neomycin/polymyxin/pramoxine XEPI (ozenoxacin)

ANTIBIOTICS, VAGINAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
CLEOCIN (clindamycin) cream, ovules metronidazole 0.75% (generic Metrogel-Vaginal, Vandazole) NUVESSA (metronidazole) XACIATO (clindamycin)	clindamycin CLINDESSE (clindamycin) cream METROGEL-VAGINAL (metronidazole) metronidazole 1.3% (generic Nuvessa) SOLOSEC (secnidazole) VANDAZOLE (metronidazole)

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ANTICOAGULANTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Duplicate Therapy Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ELIQUIS (apixaban) enoxaparin JANTOVEN (warfarin) PRADAXA (dabigatran) capsules warfarin XARELTO (rivaroxaban) tablets, dosepak, suspension	ARIXTRA (fondaparinux) dabigatran fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin) PRADAXA (dabigatran) pellet pack SAVAYSA (edoxaban)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTICONVULSANTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • All of the agents in the Anticonvulsants class are preferred	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
APTIOM (eslicarbazine) BANZEL (rufinamide) BRIVIACT (brivaracetam) carbamazepine carbamazepine ER, XR CARBATROL (carbamazepine) CELONTIN (methsuximide) clobazam clonazepam DEPAKOTE (divalproex sodium) DEPAKOTE ER (divalproex sodium) DIACOMIT (stiripentol) DIASTAT (diazepam) DIASTAT ACUDIAL (diazepam) diazepam DILANTIN (phenytoin) DILANTIN INFATAB (phenytoin) divalproex divalproex ER ELEPSIA XR (levetiracetam) EPIDIOLEX (cannabidiol) EPITOL (carbamazepine) EPRONTIA (topiramate) EQUETRO (carbamazepine) ethosuximide felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) FYCOMPA (perampanel) GABITRIL (tiagabine) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) KLONOPIN (clonazepam) lacosamide LAMICTAL (lamotrigine) tablets, ODT LAMICTAL XR (lamotrigine) lamotrigine tablets, ER, ODT levetiracetam levetiracetam XR LIBERVANT (diazepam) methsuximide MOTPOLY XR (lacosamide) MYSOLINE (primidone) NAYZILAM (midazolam) ONFI (clobazam) oxcarbazepine oxcarbazepine ER OXTELLAR XR (oxcarbazepine) phenobarbital	

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTICONVULSANTS cont.	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • All of the agents in the Anticonvulsants class are preferred	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
PHENYTEK (phenytoin) phenytoin primidone QUDEXY XR (topiramate) ROWEEPRA (levetiracetam) rufinamide suspension rufinamide tablets SABRIL (vigabatrin) SPRITAM (levetiracetam) SUBVENITE (lamotrigine) SYMPAZAN (clobazam) TEGRETOL (carbamazepine) TEGRETOL XR (carbamazepine) tiagabine TOPAMAX (topiramate) topiramate topiramate ER TRILEPTAL (oxcarbazepine) TROKENDI XR (topiramate) valproic acid VALTOCO (diazepam) vigabatrin VIGADRONE (vigabatrin) VIMPAT (lacosamide) XCOPRI (cenobamate) ZARONTIN (ethosuximide) ZONISADE (zonisamide) zonisamide ZTALMY (ganaxolone)	

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTIDEPRESSANTS, OTHER	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Non-preferred drug usage prior to inpatient facility discharge • Stability with non-preferred drug usage • Complication risk with switch from non-preferred drug • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
bupropion bupropion SR (Wellbutrin SR) bupropion XL (Wellbutrin XL) FORFIVO XL (bupropion) mirtazapine phenelzine PRISTIQ (desvenlafaxine) trazodone venlafaxine ER capsules venlafaxine IR VIIBRYD (vilazodone)	APLENZIN (bupropion) AUVELITY (dextromethorphan HBr/bupropion) bupropion XL (Forfivo XL) desvenlafaxine ER EFFEXOR XR (venlafaxine) EMSAM (selegiline) FETZIMA (levomilnacipran) MARPLAN (isocarboxazid) NARDIL (phenelzine) nefazodone REMERON (mirtazapine) tranylcypromine TRINTELLIX (vortioxetine) venlafaxine besylate ER venlafaxine ER tablets vilazodone WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion)
PPD AGENTS	
	ZURZUVAE (zuranolone)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTIDEPRESSANTS, SSRIs	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Non-preferred drug usage prior to inpatient facility discharge • Stability with non-preferred drug usage • Complication risk with switch from non-preferred drug • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
citalopram tablets, solution escitalopram tablets fluoxetine capsules, solution fluvoxamine paroxetine (Paxil) sertraline concentration, tablets	CELEXA (citalopram) citalopram 30mg capsules escitalopram solution fluoxetine capsules DR fluoxetine tablets fluvoxamine ER LEXAPRO (escitalopram) paroxetine (Brisdelle) paroxetine CR PAXIL (paroxetine) PAXIL CR (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) sertraline capsules ZOLOFT (sertraline)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTIDEPRESSANTS, TRICYCLIC	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Non-preferred drug usage prior to inpatient facility discharge • Stability with non-preferred drug usage • Complication risk with switch from non-preferred drug • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
amitriptyline doxepin imipramine nortriptyline capsules	amoxapine ANAFRANIL (clomipramine) clomipramine desipramine imipramine pamoate NORPRAMIN (desipramine) nortriptyline solution PAMELOR (nortriptyline) protriptyline trimipramine

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTIEMETIC-ANTIVERTIGO AGENTS	(EXCLUDES INJECTABLES)
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	The following Clinical Prior Authorization may apply to drugs in the class: • Antiemetic Agents Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ANTICHOLINERGICS, ANTIHISTAMINES, DOPAMINE ANTAGONISTS	
ANTIVERT (meclizine) tablet BONJESTA (doxylamine/pyridoxine) DICLEGIS (doxylamine/pyridoxine) dimenhydrinate meclizine metoclopramide solution, tablets phosphoric acid/dextrose/fructose prochlorperazine tablets promethazine syrup, tablets TRANSDERM-SCOP (scopolamine)	ANTIVERT (meclizine) chewable COMPRO (prochlorperazine) doxylamine/pyridoxine GIMOTI (metoclopramide) prochlorperazine suppositories promethazine suppositories REGLAN (metoclopramide) scopolamine patches trimethobenzamide
CANNABINOIDS	
MARINOL (dronabinol)	dronabinol
5-HT3 RECEPTOR ANTAGONISTS	
ondansetron ODT (4 mg, 8 mg), tablets	ANZEMET (dolasetron) granisetron ondansetron ODT 16 mg SANCUSO (granisetron) SUSTOL (granisetron)
SUBSTANCE P ANTAGONISTS AND COMBINATIONS	
	AKYNZEO (netupitant/palonosetron) aprepitant EMEND (aprepitant)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTIFUNGALS, ORAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
clotrimazole fluconazole griseofulvin suspension ketoconazole posaconazole suspension, tablets, AG nystatin SPORANOX (itraconazole) capsule terbinafine VFEND (voriconazole) suspension	ANCOBON (flucytosine) BREXAFEMME (ibrexafungerp) CRESEMBA (isavuconazonium sulfate) DIFLUCAN (fluconazole) flucytosine griseofulvin tablets /ultramicrosize itraconazole NOXAFIL (posaconazole) suspension, suspdr packet, tablets ORAVIG (miconazole) SPORANOX (itraconazole) solution TOLSURA (itraconazole) VFEND (voriconazole) tablets VIVJOA (oteseconazole) voriconazole

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTIFUNGALS, TOPICAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization may apply to drugs in the class: • Antifungal Agents, Topical Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ANTIFUNGALS	
ciclopirox cream, nail solution clotrimazole JUBLIA (efinaconazole) ketoconazole cream, shampoo miconazole cream, powder NYAMYC (nystatin) powder nystatin NYSTOP (nystatin) powder terbinafine tolnaftate cream, powder VUSION (miconazole/zinc/petrolatum)	ALEVAZOL (clotrimazole) BENSAL HP (benzoic acid/salicylic acid) CICLODAN (ciclopirox) ciclopirox gel, kit, shampoo, susp clotrimazole solution RX DESENEX AERO POWDER OTC (miconazole) econazole ERTACZO (sertaconazole) EXTINA (ketoconazole) FUNGOID (miconazole) ketoconazole foam KETODAN (ketoconazole) KLAYESTA (nystatin) powder LOPROX (ciclopirox) LOTRIMIN AF (clotrimazole) LOTRIMIN ULTRA (butenafine) luliconazole LUZU (luliconazole) miconazole ointment, soln MICOTRIN AC (clotrimazole) cream MICOTRIN AP (miconazole) powder MYCOZYL AC cream OTC (clotrimazole) MYCOZYL AP (miconazole) powder naftifine NAFTIN (naftifine) oxiconazole OXISTAT (oxiconazole) tavaborole tolnaftate solution, spray TRIPENICOL (undecylenic acid) cream, solution VOTRIZA-AL LOTION OTC (clotrimazole)
ANTIFUNGAL/STEROID COMBINATIONS	
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion nystatin/triamcinolone TRIAMAZOLE KIT (econazole/triamcinolone)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTIHISTAMINES, FIRST GENERATION	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure after no less than a 30-day trial of preferred drugs • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Duplicate Therapy Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ANTIHISTAMINES	
BANOPHEN (diphenhydramine) carbinoxamine liquid, tablets chlorpheniramine IR tablets cyproheptadine syrup, tablets diphenhydramine capsules, liquid, tablets HISTEX (triprolidine) liquid, PD DROPS hydroxyzine PEDIACLEAR PD DROPS OTC (triprolidine) PEDIACLEAR-8 LIQUID OTC (pyrilamine maleate) triprolidine drops OTC	carbinoxamine ER suspension clemastine syrup/tablets diphenhydramine chew, elixir ED CHLORPRED (chlorpheniramine/phenylephrine) HISTEX (triprolidine) chew, PDX drop KARBINAL ER (carbinoxamine) suspension PEDIAVENT (dexbrompheniramine) RYCLORA (dexchlorpheniramine) RYVENT (carbinoxamine) triprolidine VISTARIL (hydroxyzine)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTIHISTAMINES, MINIMALLY SEDATING	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure after no less than a 30-day trial of preferred drugs • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	The following Clinical Prior Authorization applies **to all drugs** in the class: • Duplicate Therapy Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ANTIHISTAMINES	
cetirizine solution, tablets loratadine solution, tablets	cetirizine chewable, capsules CLARINEX (desloratadine) CLARITIN LIQUI-GEL (loratadine) desloratadine fexofenadine levocetirizine loratadine capsule, chewable, ODT
ANTIHISTAMINES/DECONGESTANT COMBINATIONS	
	cetirizine/pseudoephedrine CLARINEX-D (desloratadine/pseudoephedrine) fexofenadine/pseudoephedrine loratadine/pseudoephedrine

ANTIHYPERTENSIVES, SYMPATHOLYTICS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
CATAPRES-TTS (clonidine) clonidine transdermal clonidine IR tablets guanfacine IR methyldopa	clonidine ER methyldopa / HCTZ

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTIHYPERURICEMICS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
allopurinol 100mg & 300mg tablets MITIGARE (colchicine) probenecid probenecid/colchicine	allopurinol 200mg colchicine COLCRYS (colchicine) febuxostat GLOPERBA (colchicine) ULORIC (febuxostat) ZYLOPRIM (allopurinol)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTIMIGRAINE AGENTS

PA CRITERIA

Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization may apply to drugs in the class: • Antimigraine Agents, Triptans • Antimigraine Agents, Ergot Derivatives • Calcitonin Gene-Related Peptide Receptor Antagonists, Acute Treatment • Calcitonin Gene-Related Peptide Receptor Antagonists, Prophylaxis Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

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

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTIPARASITICS, TOPICAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
NATROBA (spinosad) permethrin VANALICE GEL OTC (piperonyl butoxide/pyrethrins)	CROTAN (crotamiton) EURAX (crotamiton) ivermectin lindane malathion OVIDE (malathion) piperonyl butoxide/pyrethrins piperonyl butox/pyrethr/permet SKLICE (ivermectin) spinosad

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTIPARKINSON'S AGENTS	(ORAL/TRANSDERMAL)
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ANTICHOLINERGICS	
benztropine trihexyphenidyl	
COMT INHIBITORS	
	COMTAN (entacapone) entacapone ONGENTYS (opicapone) TASMAR (tolcapone) tolcapone
DOPAMINE AGONISTS	
pramipexole ropinirole	APOKYN (apomorphine) apomorphine bromocriptine MIRAPEX ER (pramipexole) NEUPRO transdermal (rotigotine) PARLODEL (bromocriptine) pramipexole ER ropinirole ER
MAO-B INHIBITORS	
	AZILECT (rasagiline) rasagiline selegiline XADAGO (safinamide) ZELAPAR (selegiline)
OTHERS	
amantadine carbidopa/levodopa tablets carbidopa/levodopa ER carbidopa/levodopa/entacapone	carbidopa carbidopa/levodopa ODT DHIVY (carbidopa/levodopa) DUOPA (carbidopa/levodopa) GOCOVRI (amantadine) INBRIJA (levodopa) LODOSYN (carbidopa) NOURIANZ (istradefylline) OSMOLEX ER (amantadine) RYTARY (carbidopa/levodopa) SINEMET (carbidopa/levodopa) STALEVO (levodopa/carbidopa/entacapone)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTIPSYCHOTICS

PA CRITERIA

Client must meet at least one of the listed PA criteria: • Non-preferred drug usage prior to inpatient facility discharge • Stability with non-preferred drug usage • Complication risk with switch from non-preferred drug • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Antipsychotics Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.

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

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTIPSYCHOTICS cont.	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Non-preferred drug usage prior to inpatient facility discharge • Stability with non-preferred drug usage • Complication risk with switch from non-preferred drug • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Antipsychotics Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ANTIPSYCHOTIC/SSRI COMBINATIONS	
amitriptyline/perphenazine	olanzapine/fluoxetine SYMBYAX (olanzapine/fluoxetine)
ANTIPSYCHOTIC/SEROTONIN ANTAGONIST COMBINATIONS	
	LYBALVI (olanzapine/samidorphan)
LONG-ACTING INJECTABLES	
ABILIFY ASIMTUFII (aripiprazole) ABILIFY MAINTENA (aripiprazole) ARISTADA (aripiprazole) ARISTADA INITIO (aripiprazole) INVEGA HAFYERA (paliperidone) INVEGA SUSTENNA (paliperidone) INVEGA TRINZA (paliperidone) PERSERIS (risperidone) RISPERDAL CONSTA (risperidone) UZEDY (risperidone)	risperidone ER vial RYKINDO (risperidone) ZYPREXA RELPREVV (olanzapine)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANTIVIRALS, ORAL/NASAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ANTIHERPETIC	
acyclovir famciclovir valacyclovir	SITAVIG (acyclovir) VALTREX (valacyclovir)
ANTI-INFLUENZA	
oseltamivir	FLUMADINE (rimantadine) RELENZA (zanamivir) rimantadine TAMIFLU (oseltamivir) XOFLUZA (baloxavir)
ANTI-CMV	
VALCYTE (valganciclovir) solution valganciclovir tablets	LIVTENCITY (maribavir) VALCYTE (valganciclovir) tablets valganciclovir solution

ANTIVIRALS, TOPICAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
DENAVIR (penciclovir) docosanol cream OTC XERESE (acyclovir/hydrocortisone) ZOVIRAX (acyclovir) cream, ointment	acyclovir cream, ointment penciclovir

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ANXIOLYTICS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Anxiolytics • Opiate/Benzodiazepine/Muscle Relaxant Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
alprazolam tablets buspirone chlordiazepoxide clorazepate diazepam solution diazepam tablets lorazepam intensol lorazepam tablets	alprazolam ER alprazolam intensol alprazolam ODT ATIVAN (lorazepam) diazepam intensol LOREEV XR (lorazepam) meprobamate oxazepam XANAX XR (alprazolam) XANAX (alprazolam) tablets

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

BETA BLOCKERS (ORAL)	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
BETA BLOCKERS	
acebutolol atenolol bisoprolol HEMANGEOL (propranolol) metoprolol IR metoprolol XL propranolol IR SORINE (sotalol) sotalol	BETAPACE/ AF (sotalol) betaxolol BYSTOLIC (nebivolol) CORGARD (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 bisoprolol/HCTZ	metoprolol/HCTZ propranolol/HCTZ TENORETIC (atenolol/HCTZ) ZIAC (bisoprolol/HCTZ)
BETA- AND ALPHA-BLOCKERS	
carvedilol COREG CR (carvedilol) labetalol	carvedilol ER COREG (carvedilol)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

BILE SALTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drug • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ursodiol tablets	BYLVAY (odevixibat) cap/pellet CHENODAL (chenodiol) CHOLBAM (cholic acid) IQIRVO (elafibranor) LIVMARLI (maralixibat) OCALIVA (obeticholic acid) RELTONE (ursodiol) URSO (ursodiol) URSO FORTE (urosodiol) ursodiol capsules

BLADDER RELAXANT PREPARATIONS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
MYRBETRIQ (mirabegron) tablets/granules oxybutynin IR 5 MG (generic Ditropan) oxybutynin ER solifenacin TOVIAZ (fesoterodine)	darifenacin ER DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN XL (oxybutynin) fesoterodine flavoxate GELNIQUE (oxybutynin) GEMTESA (vibegron) mirabegron oxybutynin IR 2.5 MG OXYTROL (oxybutynin) tolterodine tolterodine ER trospium trospium ER VESICARE (solifenacin) VESICARE LS (solifenacin)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

BONE RESORPTION SUPPRESSION AND RELATED AGENTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
BISPHOSPHONATES	
alendronate tablets	ACTONEL (risedronate) alendronate solution ATELVIA (risedronate) EVENITY (romosozumab-aqqg) FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) ibandronate risedronate
OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS	
EVISTA (raloxifene) FORTEO (teriparatide)	calcitonin nasal PROLIA (denosumab) raloxifene teriparatide TYMLOS (abaloparatide)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

BPH AGENTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ALPHA BLOCKERS	
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 ENTADFI (finasteride/tadalafil) JALYN (dutasteride/tamsulosin)
PHOSPHODIESTERASE 5 INHIBITORS	
	tadalafil

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

BRONCHODILATORS, BETA AGONIST	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	The following Clinical Prior Authorization applies **to all drugs** in the class: • Duplicate Therapy Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
INHALERS, SHORT-ACTING	
PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol)	albuterol HFA levalbuterol PROAIR DIGIHALER (albuterol) PROAIR RESPICLICK (albuterol)
INHALERS, LONG ACTING	
SEREVENT (salmeterol)	STRIVERDI RESPIMAT (olodaterol)
INHALATION SOLUTION	
albuterol XOPENEX (levalbuterol)	arformoterol BROVANA (arformoterol) formoterol levalbuterol PERFOROMIST (formoterol)
ORAL	
albuterol syrup	albuterol tablets albuterol ER terbutaline

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

CALCIUM CHANNEL BLOCKERS (ORAL)	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
SHORT-ACTING	
diltiazem verapamil	CARDIZEM (diltiazem) isradipine nicardipine nifedipine nimodipine NYMALIZE (nimodipine)
LONG-ACTING	
amlodipine CARTIA XT (diltiazem) DILT XR (diltiazem) diltiazem ER felodipine ER KATERZIA (amlodipine) nifedipine ER nifedipine IR NORVASC (amlodipine) TIAZAC (diltiazem) verapamil ER capsules, tablets	CALAN SR (verapamil) CARDIZEM CD (diltiazem) CARDIZEM LA (diltiazem) diltiazem LA levamlodipine MATZIM LA (diltiazem) nisoldipine NORLIQVA (amlodipine oral solution) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TAZTIA XT (diltiazem) TIADYLT ER (diltiazem) verapamil 360 mg capsules verapamil ER PM VERELAN (verapamil) VERELAN PM (verapamil)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)

PA CRITERIA

Client must meet at least one of the listed PA criteria:

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS	
amoxicillin/clavulanate tablets, suspension AUGMENTIN ES 600 susp (amoxicillin/clavulanate)	amoxicillin/clavulanate chewable, XR tablets AUGMENTIN 125 susp (amoxicillin/clavulanate)
CEPHALOSPORINS-FIRST GENERATION	
cefadroxil capsules, suspension cephalexin capsules, suspension	cefadroxil tablets cephalexin tablets
CEPHALOSPORINS-SECOND GENERATION	
cefprozil suspension cefprozil tablets cefuroxime tablets	cefaclor ER cefaclor IR capsules, suspension
CEPHALOSPORINS-THRID GENERATION	
cefdinir cefpodoxime tablets, suspension	cefixime SUPRAX (cefixime)

COLONY STIMULATING FACTORS

PA CRITERIA

Client must meet at least one of the listed PA criteria:

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

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

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

COPD AGENTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	The following Clinical Prior Authorization applies **to all drugs** in the class: • Duplicate Therapy Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ANTICHOLINERGICS	
ATROVENT HFA (ipratropium) ipratropium inhalation solution SPIRIVA HANDIHALER (tiotropium) SPIRIVA RESPIMAT (tiotropium)	INCRUSE ELLIPTA (umeclidinium) LONHALA MAGNAIR (glycopyrrolate) 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	
roflumilast	DALIRESP (roflumilast)

COUGH AND COLD AGENTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization may apply to drugs in the class: • Cough & Cold PA criteria • Dextromethorphan Overutilization Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
See separate **Preferred Cough and Cold Agent** listing.	See separate **Preferred Cough and Cold Agent** listing.

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CYTOKINE AND CAM ANTAGONISTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Cytokine and CAM Antagonists Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ENBREL (etanercept) HUMIRA (adalimumab) OTEZLA (apremilast)	ABRILADA (adalimumab-AFZB) ACTEMRA (tocilizumab) adalimumab-AACF adalimumab-AATY kit, autoinjector adalimumab-ADAZ kit, pen kit adalimumab-ADBM syringe kit, pen kit adalimumab-FKJP kit, pen kit adalimumab-RYVK autoinjector AMJEVITA (adalimumab-atto) ARCALYST (rilonacept) BIMZELX (bimekizumab-BKZX) CIBINQO (abrocitinib) CIMZIA (certolizumab) COSENTYX (secukinumab) CYLTEZO (adalimumab-ADBM) syringe kit, pen kit ENSPRYNG (satralizumab-MWGE) ENTYVIO (vedolizumab) pen HADLIMA (adalimumab-BWWD) kit, pen kit HULIO (adalimumab-FKJP) kit, pen kit HYRIMOZ (adalimumab-ADAZ) kit, pen kit IDACIO (adalimumab-AACF) kit, pen kit ILARIS (canakinumab) ILUMYA (tildrakizumab-ASMN) KEVZARA (sarilumab) KINERET (anakinra) LITFULO (ritlecitinib) OLUMIANT (baricitinib) OMVOH (mirikizumab-MRKZ) pen, syringe ORENCIA (abatacept) RINVOQ ER (upadacitinib) RINVOQ LQ (upadacitinib) solution SILIQ (brodalumab) SIMLANDI (adalimumab-RYVK) autoinjector SIMPONI (golimumab) SKYRIZI (risankizumab-RZAA) SKYRIZI ON-BODY (risankizumab-RZAA) SKYRIZI PEN (risankizumab-RZAA) SOTYKTU (deucravacitinib) SPEVIGO (spesolimab-SBZO) STELARA (ustekinumab) TALTZ (ixekizumab) TREMFYA (guselkumab) TYENNE (tocilizumab-AAZG) autoinjector, PFS

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

CYTOKINE AND CAM ANTAGONISTS cont.	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Cytokine and CAM Antagonists Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
	XELJANZ (tofacitinib) XELJANZ soln (tofacitinib) XELJANZ XR (tofacitinib) YUFLYMA (adalimumab-AATY) autoinjector, syringe YUSIMRY (adalimumab-AQVH) ZYMFENTRA (infliximab-DYYB)

EPINEPHRINE, SELF-INJECTED	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred products • Contraindication to preferred products* • Allergic reaction to preferred products* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
Auvi Q (epinephrine) epinephrine (Mylan authorized generic EPIPEN and EPIPEN JR) EPIPEN (epinephrine) EPIPEN JR (epinephrine)	epinephrine (generic ADRENACLICK) epinephrine (generic EPIPEN and EPIPEN JR) SYMJEPI (epinephrine)

ERYTHROPOIESIS STIMULATING PROTEINS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Erythropoiesis Stimulating Proteins Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ARANESP (darbepoetin) EPOGEN (RhUEPO) RETACRIT (RhUEPO)	JESDUVROQ (daprodustat) MIRCERA (PEG-EPO) PROCRIT (RhUEPO) REBLOZYL (luspatercept-aamt)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

FLUOROQUINOLONES, ORAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ciprofloxacin IR CIPRO (ciprofloxacin) suspension levofloxacin tablets	BAXDELA (delafloxacin) CIPRO (ciprofloxacin) tablets ciprofloxacin suspension levofloxacin solution moxifloxacin ofloxacin

GI MOTILITY, CHRONIC	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass (including OTC products) • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • GI Motility Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
AMITIZA (lubiprostone) LINZESS (linaclotide) LOTRONEX (alosetron) lubiprostone MOVANTIK (naloxegol) TRULANCE (plecanatide)	alosetron IBSRELA (tenapanor HCl) MOTEGRITY (prucalopride) prucalopride RELISTOR (methylnaltrexone) injection RELISTOR (methylnaltrexone) oral SYMPROIC (naldemedine) VIBERZI (eluxadoline)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

GLUCAGON AGENTS

PA CRITERIA

Client must meet at least one of the listed PA criteria:

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

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

GLUCOCORTICOIDS, INHALED

PA CRITERIA

Client must meet at least one of the listed PA criteria:

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

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

- Duplicate Therapy

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

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

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

GLUCORTICOIDS, ORAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
budesonide EC dexamethasone elixir, solution, tablets hydrocortisone methylprednisolone tablet dose pack prednisolone solution prednisone solution, tablets	AGAMREE suspension (vamorolone) ALKINDI SPRINKLE (hydrocortisone) CORTEF (hydrocortisone) cortisone deflazacort dexamethasone intensol / tab ds pk DEXPAK (dexamethasone) EMFLAZA (deflazacort) EOHILIA (budesonide) HEMADY (dexamethasone) MEDROL (methylprednisolone) methylprednisolone tablets MILLIPRED (prednisolone) prednisolone tablets (MILLIPRED) prednisolone sodium phosphate ODT, solution (Millipred, Veripred) prednisone intensol prednisone tablet dose pack RAYOS DR (prednisone) TAPERDEX (dexamethasone) TARPEYO (budesonide)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

GROWTH HORMONE	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Growth Hormone Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
GENOTROPIN (somatropin) NORDITROPIN (somatropin) SKYTROFA (lonapegsomatropin-tcgd) SOGROYA (somapacitan-beco)	HUMATROPE (somatropin) NGENLA (somatrogon-ghla) NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) ZOMACTON (somatropin)

H. PYLORI TREATMENT	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
PYLERA (bismuth subcitrate/ metronidazole/tetracycline)	bismuth/metronidazole/tetracycline lansoprazole/amoxicillin/clarithromycin OMECLAMOX PAK(omeprazole/amoxicillin/clarithromycin) TALICIA (omeprazole/amoxicillin/rifabutin)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

HEMOPHILIA TREATMENT	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • All of the agents in the Hemophilia Treatment class are preferred	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
FACTOR VIII	
ADVATE ADYNOVATE AFSTYLA ALTUVIIIO ELOCTATE ESPEROCT HEMOFIL M HUMATE P JIVI KOATE DVI KOGENATE FS KOVALTRY NOVOEIGHT NUWIQ OBIZUR RECOMBINATE XYNTHA	
FACTOR IX	
ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY PROFILNINE REBINYN RIXUBIS	
OTHER	
ALPHANATE (von Willebrand factor/Factor VIII) COAGADEX (Factor X) CORIFACT (Factor XIII) FEIBA NF (activated prothrombin complex) HEMGENIX (etranacogene dezaparvovec-drlb) HEMLIBRA (emicizumab-kxwh) NOVOSEVEN RT (Factor VIIa) SEVENFACT (Factor VIIa-jncw) TRETTEN (Factor XIII) VOVENDI (von Willebrand factor) WILATE (von Willebrand factor/Factor VIII)	

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

HEPATITIS C AGENTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
PEGYLATED INTERFERONS	
	PEGASYS (pegylated IFN alfa-2a)
POLYMERASE/PROTEASE INHIBITORS	
MAVYRET (glecaprevir/pibrentasvir)	EPCLUSA (sofosbuvir/velpatasvir) HARVONI (ledipasvir/sofosbuvir) tablets, pellet pack ledipasvir/sofosbuvir sofosbuvir/velpatasvir SOVALDI (sofosbuvir) tablets, pellet pack VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir) VOSEVI (sofosbuvir, velpatasvir, voxilaprevir) ZEPATIER (elbasvir/grazoprevir)
RIBAVIRIN	
ribavirin capsules ribavirin tablets	

HEREDITARY ANGIOEDEMA (HAE) TREATMENTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies to **all drugs** in the class: • Hereditary Angioedema Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
BERINERT (C1 esterase inhibitor) CINRYZE (C1 esterase inhibitor) HAEGARDA (C1 esterase inhibitor) icatibant KALBITOR (ecallantide) SAJAZIR (icatibant)	FIRAZYR (icatibant) ORLADEYO (berotralstat) RUCONEST (C1 esterase inhibitor) TAKHZYRO (lanadelumab-FLYO) syringe, vial

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

HIV/AIDS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • All of the agents in the HIV/AIDS class are preferred	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ANTIRETROVIRAL SINGLE AGENT PRODUCTS	
abacavir APTIVUS (tipranavir) atazanavir darunavir didanosine EDURANT (rilpivirine) efavirenz emtricitabine EMTRIVA (emtricitabine) EPIVIR (lamivudine) etravirine fosamprenavir FUZEON (enfuvirtide) INTELENCE (etravirine) ISENTRESS (raltegravir) lamivudine LEXIVA (fosamprenavir) maraviroc nevirapine NORVIR (ritonavir) PIFELTRO (doravirine) PREZCOBIX (darunavir/cobicistat) PREZISTA (darunavir) RETROVIR (zidovudine) REYATAZ (atazanavir) ritonavir RUKOBIA (fostemsavir) SELZENTRY (maraviroc) stavudine SUNLENCA (lenacapavir sodium) tablets tenofovir disoproxil fumarate TIVICAY (dolutegravir) TYBOST (cobicistat) VIRACEPT (nelfinavir) VIRAMUNE XR (nevirapine) VIREAD (tenofovir disoproxil fumurate) ZIAGEN (abacavir) zidovudine	

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

HIV/AIDS cont.	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • All of the agents in the HIV/AIDS class are preferred	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ANTIRETROVIRAL COMBINATIONS	
abacavir/lamivudine abacavir/lamivudine/zidovudine ATRIPLA (efavirenz/emtricitabine/tenofovir) BIKTARVY (bictegravir/emtricitabine/tenofovir) CIMDUO (lamivudine/tenofovir DF) COMBIVIR (lamivudine/zidovudine) COMPLERA (emtricitabine/rilpivirine/tenfovir DF) DELSTRIGO (doravirine/lamivudine/ tenofovir DF) DESCOVY (emtricitabine/tenofovir alafenamide) DOVATO (dolutegravir/lamivudine) efavirenz/emtricitabine/tenofovir disoproxil fumarate efavirenz/lamivudine/tenofovir disoproxil fumarate (SYMFI LO) efavirenz/lamivudine/tenofovir disoproxil fumarate (SYMFI) emtricitabine/tenofovir disoproxil fumarate EPZICOM (abacavir/lamivudine) EVOTAZ (atazanavir/cobicistat) GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide) JULUCA (dolutegravir/rilpivirine) KALETRA (lopinavir/ritonavir) lamivudine/zidovudine lopinavir/ritonavir ODEFSEY (emtricitabine/rilpivirine/tenofovir alafenamide) STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir DF) SYMFI (efavirenz/lamivudine/tenofovir DF) SYMFI LO (efavirenz/lamivudine/tenofovir DF) SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir DF) TRIUMEQ (abacavir/dolutegravir/lamivudine) TRIUMEQ PD (abacavir/dolutegravir/lamivudine) TRIZIVIR (abacavir/lamivudine/zidovudine) TRUVADA (emtricitabine/tenofovir DF)	

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
AMYLIN ANALOGS	
SYMLIN (pramlintide)	
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS cont.	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • DPP4 Inhibitor Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
INCRETIN ENHANCERS	
JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) JENTADUETO XR (linagliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) ONGLYZA (saxagliptin) TRADJENTA (linagliptin)	alogliptin alogilptin/metformin alogliptin/pioglitazone KAZANO (alogliptin /metformin) NESINA (alogliptin) OSENI (alogliptin /pioglitazone) saxagliptin saxagliptin/metformin ER sitagliptin sitagliptin/metformin ZITUVIO (sitagliptin)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS cont.	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • GLP-1 Receptor Agonists Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
INCRETIN MIMETICS	
BYETTA (exenatide) OZEMPIC (semaglutide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	BYDUREON BCISE (exenatide ER) exenatide liraglutide MOUNJARO (tirzepatide) RYBELSUS (semaglutide)
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS cont.	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • DPP4 Inhibitor The following Clinical Prior Authorization applies **to all drugs** in the class: • GLP-1 Receptor Agonists Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
INCRETIN ENHANCERS/SGLT2 INHIBITOR COMBINATIONS	
GLYXAMBI (empagliflozin/linagliptin) TRIJARDY XR (empagliflozin/linagliptin/metformin)	QTERN (dapagliflozin/saxagliptin) STEGLUJAN (ertugliflozin/sitagliptin)
INCRETIN MIMETIC/INSULIN COMBINATIONS	
	SOLIQUA (lixisenatide/insulin glargine) XULTOPHY (liraglutide/insulin degludec)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

HYPOGLYCEMICS, INSULIN AND RELATED

PA CRITERIA

Client must meet at least one of the listed PA criteria:

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

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

HYPOGLYCEMICS, MEGLITINIDES

PA CRITERIA

Client must meet at least one of the listed PA criteria:

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

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

- Duplicate Therapy

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
nateglinide	
repaglinide	

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

HYPOGLYCEMICS, METFORMIN	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
GLUMETZA (metformin ER) glyburide/metformin metformin IR 500 MG, 850 MG, 1,000 MG (generic Glucophage) metformin ER (GLUCOPHAGE XR)	glipizide/metformin metformin ER (FORTAMET) metformin ER (GLUMETZA) metformin IR 625 MG metformin (solution) RIOMET (metformin) RIOMET ER (metformin)

HYPOGLYCEMICS, SGLT2	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • SGLT2 Inhibitor Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
SUBCLASS	
FARXIGA (dapagliflozin) JARDIANCE (empagliflozin)	dapagliflozin INPEFA (sotagliflozin) INVOKANA (canaglifozin) STEGLATRO (ertugliflozin)
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • SGLT2 Combinations Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
SGLT2 COMBINATIONS	
SYNJARDY (empagliflozin/metformin) SYNJARDY XR (empagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin)	dapagliflozin/metformin ER INVOKAMET (canagliflozin/metformin) INVOKAMET XR (canagliflozin/metformin) SEGLUROMET (ertugliflozin/metformin)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

HYPOGLYCEMICS, TZD	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Thiazolidinediones Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
THIAZOLIDINEDIONES	
pioglitazone	ACTOS (pioglitazone)

HYPOGLYCEMICS, TZD cont.	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Separate prescriptions for the individual components should be used instead of the combination drug. • Treatment of stage-four advanced, metastatic cancer and associated conditions • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs*	The following Clinical Prior Authorization applies **to all drugs** in the class: • Thiazolidinediones Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
THIAZOLIDINEDIONES COMBINATIONS	
DUETACT (pioglitazone/glimepiride)	pioglitazone/metformin pioglitazone/glimepiride

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

IMMUNE GLOBULINS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
GAMMAGARD (immune globulin) GAMMAKED (immune globulin) GAMUNEX-C (immune globulin) HIZENTRA (immune globulin) syringe HIZENTRA (immune globulin) vial	ASCENIV (immune globulin) BIVIGAM (immune globulin) CUTAQUIG (immune globulin) CUVITRU (immune globulin) CYTOGAM (CMV immune globulin) FLEBOGAMMA DIF (immune globulin) GAMASTAN S-D (immune globulin) HEPAGAM B (hepatitis B immune globulin) HYQVIA (immune globulin) OCTAGAM (immune globulin) PANZYGA (immune globulin) PRIVIGEN (immune globulin) VARIZIG (varicella-zoster immune globulin) XEMBIFY (immune globulin)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

IMMUNOMODULATORS, ASTHMA	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • The PA criteria above apply to Dupixent for Asthma	The following Clinical Prior Authorization applies **to all drugs** in the class: • Immunomodulators, Asthma Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
FASENRA PEN (benralizumab) XOLAIR (omalizumab) autoinjector, syringe	NUCALA (mepolizumab) TEZSPIRE PEN (tezepelumab-ekko)

IMMUNOMODULATORS, ATOPIC DERMATITIS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • Dupixent, in this therapeutic PDL class, is for Atopic Dermatitis indication. The clinical prior authorization linked here includes the product's other indications.	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ELIDEL (pimecrolimus) EUCRISA (crisaborole) tacrolimus	ADBRY (tralokinumab) autoinjector, syringe DUPIXENT (dupilumab) OPZELURA (ruxolitinib) pimecrolimus ZORYVE (roflumilast) 0.15% and 0.3% cream, foam

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

IMMUNOSUPPRESSIVES, ORAL/ SQ	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
azathioprine CELLCEPT (mycophenolate mofetil) suspension cyclosporine, modified GENGRAF (cyclosporine modified) capsules, solution mycophenolate mofetil capsules, tablets NEORAL (cyclosporine, modified) capsules RAPAMUNE (sirolimus) solution RAPAMUNE (sirolimus) tablets sirolimus solution sirolimus tablets tacrolimus	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) BENLYSTA AUTOINJECTOR (belimumab.) BENLYSTA SYRINGE (belimumab.) CELLCEPT (mycophenolate mofetil) tablet cyclosporine capsules, softgel ENVARSUS XR (tacrolimus) everolimus tablets IMURAN (azathioprine) LUPKYNIS (voclosporin) mycophenolate mofetil suspension mycophenolic acid MYFORTIC (mycophenolic acid) MYHIBBIN (mycophenolate mofetil) suspension NEORAL (cyclosporine, modified) solution PROGRAF (tacrolimus) REZUROCK (belumosudil) SANDIMMUNE (cyclosporine) tacrolimus XL TAVNEOS (avacopan) ZORTRESS (everolimus)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

INTRANASAL RHINITIS AGENTS

PA CRITERIA

Client must meet at least one of the listed PA criteria:

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

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

IRON, ORAL

PA CRITERIA

Client must meet at least one of the listed PA criteria:

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
See separate **Preferred Oral Iron Drugs** listing.	See separate **Preferred Oral Iron Drugs** listing.

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

LEUKOTRIENE MODIFIERS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Leukotriene Modifiers Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
montelukast tablets and chewable tablets ZYFLO (zileuton)	ACCOLATE (zafirlukast) montelukast granules SINGULAIR (montelukast) zafirlukast zileuton

LINCOSAMIDES/OXAZOLIDINONES/ STREPTOGRAMINS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • 14-day treatment trial with a preferred drug within the past 180 days • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
clindamycin capsules clindamycin solution linezolid tablets, IV linezolid tablets, IV (AG) ZYVOX (linezolid) suspension	CLEOCIN (clindamycin) clindamycin injection LINCOCIN (lincomycin) lincomycin linezolid suspension linezolid suspension AG SIVEXTRO (tedizolid) SYNERCID (quinupristin/dalfopristin) ZYVOX (linezolid) tablets, injection

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

LIPOTROPICS, OTHER	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ADENOSINE TRIPHOSPHATE-CITRATE LYASE INHIBITOR	
	NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe)
BILE ACID SEQUESTRANTS	
cholestyramine COLESTID (colestipol) tablets PREVALITE (cholestyramine/aspartame) packet, powder WELCHOL (colesevalam)	colesevelam COLESTID (colestipol) granules colestipol granules colestipol tablets QUESTRAN (cholestyramine) QUESTRAN LIGHT (cholestyramine)
CHOLESTEROL ABSORPTION INHIBITORS	
ezetimibe	ZETIA (ezetimibe)
FIBRIC ACID DERIVATIVES	
fenofibrate (generic Lofibra, Tricor) gemfibrozil	ANTARA (fenofibrate,micronized) fenofibrate (generic Antara, Fenoglide, Lipofen) fenofibric acid (generic Fibricor, Trilipix) FENOGLIDE (fenofibrate) LIPOFEN (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate) TRILIPIX (fenofibric acid)
HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA TREATMENTS	
	JUXTAPID (lomitapide)
NIACIN	
niacin OTC	niacin ER
OMEGA-3 FATTY ACIDS	
omega-3 fatty acids VASCEPA (icosapent ethyl)	icosapent ethyl LOVAZA (omega-3 fatty acids)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

LIPOTROPICS, OTHER cont.	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Trial of atorvastatin, rosuvastatin, and ezetimibe • Concurrent therapy of atorvastatin or rosuvastatin • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	The following Clinical Prior Authorization applies to all PCSK9 inhibitors: • Hyperlipidemia agents Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
PCSK9 INHIBITORS	
PRALUENT (alirocumab) Pen REPATHA (evolocumab)	

LIPOTROPICS, STATINS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with at least two preferred drugs accounting for no less than 120 days of therapy combined • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	The following Clinical Prior Authorization applies **to all drugs** in the class: • Duplicate Therapy Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
STATINS	
atorvastatin LIPITOR (atorvastatin) lovastatin pravastatin rosuvastatin simvastatin	ALTOPREV (lovastatin) ATORVALIQ suspension (atorvastatin) CRESTOR (rosuvastatin) EZALLOR SPRINKLE (rosuvastatin) fluvastatin fluvastatin ER LESCOL XL (fluvastatin) LIVALO (pitavastatin) pitavastatin ZOCOR (simvastatin) ZYPITAMAG (pitavastatin)
STATIN COMBINATIONS	
	atorvastatin/amlodipine CADUET (atorvastatin/amlodipine) simvastatin/ezetimibe VYTORIN (simvastatin/ezetimibe)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

MACROLIDES (ORAL)	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • A 7-day treatment trial with at least one preferred agent in the last 180 days (Exception may apply when a preferred drug requires less than a 7-day treatment trial) • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For clients with diagnosis of Gastroparesis, Cerebral Palsy Gastroparesis, and GERD associated with Gastrostomy complications, a 90-day PA duration will be approved	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
azithromycin clarithromycin tablets ERYPED 400 (erythromycin) erythromycin base erythromycin ethylsuccinate 200 suspension ZITHROMAX (azithromycin) Z-PAK	clarithromycin suspension clarithromycin ER E.E.S. (erythromycin) tablets E.E.S. (erythromycin) 200 suspension ERYPED 200 (erythromycin) ERY-TAB (erythromycin) ERYTHROCIN (erythromycin) erythromycin base filmtab erythromycin ethylsuccinate 400 suspension ZITHROMAX (azithromycin) powder packet, suspension, tablet, TRI-PAK

MOVEMENT DISORDERS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • VMAT2 Inhibitors Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
AUSTEDO (deutetrabenazine) AUSTEDO XR (deutetrabenazine) AUSTEDO XR (deutetrabenazine) titration pack INGREZZA (valbenazine) capsule, sprinkle capsule tetrabenazine	XENAZINE (tetrabenazine)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

MULTIPLE SCLEROSIS AGENTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • All of the agents in the Multiple Sclerosis class are preferred	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
AMPYRA (dalfampridine) AUBAGIO (teriflunomide) AVONEX (interferon beta-1a) BAFIERTAM (monomethyl fumarate) BETASERON (interferon beta-1b) COPAXONE (glatiramer) dalfampridine dimethyl fumarate EXTAVIA (interferon beta-1b) fingolimod GILENYA (fingolimod) glatiramer GLATOPA (glatiramer) KESIMPTA (ofatumumab) MAVENCLAD (cladribine) MAYZENT (siponimod) PLEGRIDY (peginterferon beta-1a) PONVORY STARTER PACK (ponesimod) PONVORY TABLETS (ponesimod) REBIF (interferon beta-1a) TASCENSO ODT (fingolimod lauryl sulfate) TECFIDERA (dimethyl fumarate) teriflunomide VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod)	

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

NEUROPATHIC PAIN	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ORAL AGENTS	
duloxetine (Cymbalta) gabapentin LYRICA (pregabalin) capsules	CYMBALTA (duloxetine) DRIZALMA SPRINKLE (duloxetine) duloxetine (Irenka) gabapentin ER GRALISE (gabapentin) HORIZANT (gabapentin enacarbil ER) LYRICA CR (pregabalin) LYRICA (pregabalin) solution NEURONTIN (gabapentin) pregabalin capsules pregabalin ER, solution SAVELLA (milnacipran)
TOPICAL AGENTS	
capsaicin OTC lidocaine patch LIDODERM PATCH (lidocaine)	DERMACINRX LIDOCAN PATCH (lidocaine) LIDOCAN II PATCH (lidocaine) QUTENZA (capsaicin/skin cleanser) XYLIDERM (lidocaine/kinesiology tape) ZTLIDO (lidocaine)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

NSAIDs	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	The following Clinical Prior Authorization applies **to all drugs** in the class: • Duplicate Therapy Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
NONSPECIFIC	
diclofenac potassium tablets diclofenac sodium ibuprofen indomethacin capsules ketorolac naproxen EC naproxen sodium OTC naproxen tablets sulindac	DAYPRO (oxaprozin) diclofenac potassium capsules diclofenac SR diflunisal etodolac etodolac SR FELDENE (piroxicam) fenoprofen flurbiprofen indomethacin ER capsules indomethacin suspension ketoprofen ketoprofen ER KIPROFEN (ketoprofen) Lofena (diclofenac) meclofenamate mefenamic acid nabumetone NALFON(fenoprofen) NAPRELAN CR (naproxen sodium) NAPROSYN suspension (naproxen) naproxen CR naproxen sodium (Rx) naproxen suspension oxaprozin piroxicam RELAFEN DS (nabumetone) tolmetin
NSAID/GI PROTECTANT COMBINATIONS	
	ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol DUEXIS (ibuprofen/famotidine) ibuprofen/famotidine naproxen/esomeprazole mag VIMOVO (naproxen/ esomeprazole)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

NSAIDs cont.	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	The following Clinical Prior Authorization applies **to all drugs** in the class: • Duplicate Therapy Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
TOPICAL NSAIDs	
diclofenac gel 1%	diclofenac patch diclofenac sodium pump diclofenac solution FLECTOR (diclofenac) ketorolac nasal spray LICART PATCH (diclofenac epolamine) PENNSAID (diclofenac)

NSAIDs cont.	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Duplicate Therapy • Cox II Inhibitors Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
COX-II SELECTIVE	
CELEBREX (celecoxib) celecoxib capsules, AG meloxicam tablets	meloxicam capsules

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ONCOLOGY, ORAL - BREAST	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • All of the agents in the Oncology, Oral – Breast class are preferred	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
anastrozole ARIMIDEX (anastrozole) AROMASIN (exemestane) capecitabine cyclophosphamide exemestane FARESTON (toremifene) FEMARA (letrozole) IBRANCE (palbociclib) KISQALI (ribociclib) KISQALI/FEMARA KIT (ribociclib/letrozole) lapatinib letrozole NERLYNX (neratinib) ORSERDU (elacestrant HCl) PIQRAY (alpelisib) SOLTAMOX (tamoxifen) TALZENNA (talazoparib) tamoxifen toremifene TORPENZ (everolimus) TRUQAP (capivasertib) TUKYSA (tucatinib) TYKERB (lapatinib) VERZENIO (abemaciclib) XELODA (capecitabine)	

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ONCOLOGY, ORAL - HEMATOLOGIC	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • All of the agents in the Oncology, Oral – Hematologic class are preferred	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ALKERAN (melphalan) BOSULIF (bosutinib) BRUKINSA (zanubrutinib) CALQUENCE (acalabrutinib) capsules/tablets COPIKTRA (duvelisib) dasatinib DAURISMO (glasdegib) GLEEVEC (imatinib) HYDREA (hydroxyurea) hydroxyurea ICLUSIG (ponatinib) IDHIFA (enasidenib) imatinib IMBRUVICA (ibrutinib) capsules/suspension/tablets INQOVI (decitabine/cedazuridine) INREBIC (fedratinib) JAKAFI (ruxolitinib) lenalidomide LEUKERAN (chlorambucil) MATULANE (procarbazine) melphalan mercaptopurine MYLERAN (busulfan) NINLARO (ixazomib) OJJAARA (momelotinib) ONUREG (azacytidine) POMALYST (pomalidomide) PURIXAN (mercaptopurine) REVLIMID (lenalidomide) REZLIDHIA (olutasidenib) RYDAPT (midostaurin) SCEMBLIX (asciminib) SPRYCEL (dasatinib) TABLOID (thioguanine) TASIGNA (nilotinib) THALOMID (thalidomide) TIBSOVO (ivosidenib) tretinoin VANFLYTA (quizartinib dihydrochloride) VENCLEXTA (venetoclax) VONJO (pacritinib) XOSPATA (gilteritinib) XPOVIO (selinexor) ZOLINZA (vorinostat) ZYDELIG (idelalisib)	

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ONCOLOGY, ORAL - LUNG	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • All of the agents in the Oncology, Oral – Lung class are preferred	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ALECENSA (alectinib) ALUNBRIG (brigatinib) AUGTYRO (repotrectinib) erlotinib EXKIVITY (mobocertinib) GAVRETO (pralsetinib) gefitinib GILOTRIF (afatinib) HYCAMTIN (topotecan) IRESSA (gefitinib) KRAZATI (adafrasib) LORBRENA (lorlatinib) LUMAKRAS (sotorasib) RETEVMO (selpercatinib) ROZLYTREK (entrectinib) ROZLYTREK PELLET PACK (entrectinib) TABRECTA (capmatinib) TAGRISSO (osimertinib) TARCEVA (erlotinib) TEPMETKO (tepotinib) VIZIMPRO (dacomitinib) XALKORI (crizotinib) XALKORI PELLET (crizotinib) ZYKADIA (ceritinib)	

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ONCOLOGY, ORAL - OTHER	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • All of the agents in the Oncology, Oral – Other class are preferred	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
AYVAKIT (avapritinib) BALVERSA (erdafitinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) FRUZAQLA (fruquintinib) IWILFIN (eflornithine) JAYPIRCA (pirtbrutinib) KOSELUGO (selumetinib) LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) LYTGOBI (futibatinib) OGSIVEO (nirogacestat) OJEMDA (tovorafenib) PEMAZYRE (pemigatinib) QINLOCK (ripretinib) RUBRACA (rucaparib) STIVARGA (regorafenib) TAZVERIK (tazemetostat) temozolomide TURALIO (pexidartinib) VITRAKVI (larotrectinib) ZEJULA (niraparib)	

ONCOLOGY, ORAL - PROSTATE	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • All of the agents in the Oncology, Oral – Prostate class are preferred	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
abiraterone AKEEGA (niraparib/abiraterone) bicalutamide CASODEX (bicalutamide) EMCYT (estramustine) ERLEADA (apalutamide) flutamide nilutamide NUBEQA (darolutamide) ORGOVYX (relugolix) XTANDI (enzalutamide) YONSA (abiraterone) ZYTIGA (abiraterone)	

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

ONCOLOGY, ORAL – RENAL CELL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • All of the agents in the Oncology, Oral – Renal Cell class are preferred	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
AFINITOR (everolimus) CABOMETYX (cabozantinib) everolimus FOTIVDA (tivozanib HCl) INLYTA (axitinib) LENVIMA (Lenvatinib) NEXAVAR (sorafenib) pazopanib sorafenib sunitinib SUTENT (sunitinib) VOTRIENT (pazopanib) WELIREG (belzutifan)	

ONCOLOGY, ORAL - SKIN	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • All of the agents in the Oncology, Oral – Skin class are preferred	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
BRAFTOVI (encorafenib) COTELLIC (cobimetinib) ERIVEDGE (vismodegib) MEKINIST (trametinib) MEKTOVI (binimetinib) ODOMZO (sonidegib) TAFINLAR (dabrafenib) ZELBORAF (vemurafenib)	

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

OPHTHALMICS, ANTIBIOTIC – STEROID COMBINATIONS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX (tobramycin/dexamethasone) ointment TOBRADEX (tobramycin/dexamethasone) suspension tobramycin/dexamethasone suspension, AG ZYLET (tobramycin/loteprednol)	MAXITROL (neomycin/polymyxin/ dexamethasone) neomycin/bacitracin/polymyxin/hydrocortisone neomycin/polymyxin/hydrocortisone TOBRADEX ST (tobramycin/dexamethasone)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

OPHTHALMIC ANTIBIOTICS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
AMINOGLYCOSIDES	
GENTAK (gentamicin) gentamicin tobramycin TOBREX (tobramycin) ointment	
QUINOLONES	
BESIVANCE (besifloxacin) CILOXAN ointment (ciprofloxacin) ciprofloxacin moxifloxacin (**Vigamox**) ophthalmic, AG ofloxacin	CILOXAN solution (ciprofloxacin) gatifloxacin moxifloxacin (**Moxeza**) OCUFLOX (ofloxacin) VIGAMOX (moxifloxacin) ZYMAXID (gatifloxacin)
MACROLIDES	
AZASITE (azithromycin) erythromycin	
OTHER, ANTIFUNGAL	
	NATACYN (natamycin)
OTHER, MISC	
bacitracin/polymyxin POLYCIN (bacitracin/polymyxin B sulfate) polymyxin/trimethoprim	bacitracin neomycin/bacitracin/polymyxin neomycin/polymyxin/gramicidin POLYTRIM (polymyxin/trimethoprim) sulfacetamide ointment, solution

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
BEPREVE (bepotastine) cromolyn ketotifen olopatadine OTC (Pataday Once Daily) olopatadine OTC (Pataday Twice a Day) PATADAY XS ONCE DAILY OTC (olopatadine)	alcaftadine ALOCRIL (nedocromil) ALOMIDE (lodoxamide) ALREX (loteprednol) azelastine bepotastine epinastine LASTACAFT (alcaftadine) LASTACAFT (alcaftadine) OTC loteprednol (generic Alrex) olopatadine PATADAY OTC (olopatadine) ZADITOR OTC (ketotifen) ZERVIATE (cetirizine)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

OPHTHALMICS, ANTI-INFLAMMATORIES	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
NSAIDs	
diclofenac ketorolac	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac) bromfenac BROMSITE (bromfenac) flurbiprofen ILEVRO (nepafenac) ketorolac LS NEVANAC (nepafenac) PROLENSA (bromfenac)
STEROIDS	
DUREZOL (difluprednate) LOTEMAX (loteprednol) drops, gel, ointment prednisolone acetate	dexamethasone difluprednate FLAREX (fluorometholone) fluorometholone FML (fluorometholone) FML FORTE (fluorometholone) INVELTYS (loteprednol) LOTEMAX SM (loteprednol) gel loteprednol (generic Lotemax) MAXIDEX (dexamethasone) PRED FORTE (prednisolone) PRED MILD (prednisolone) prednisolone sodium phosphate

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

OPHTHALMICS, ANTI-INFLAMMATORY IMMUNOMODULATORS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
RESTASIS (cyclosporine) vial XIIDRA (lifitegrast)	CEQUA (cyclosporine) cyclosporine EYSUVIS (loteprednol etabonate) MIEBO (perfluorohexyloctane/PF) RESTASIS MULTIDOSE (cyclosporine) TYRVAYA (varenicline) VERKAZIA (cyclosporine) VEVYE (cyclosporine)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

OPHTHALMICS, GLAUCOMA AGENTS

PA CRITERIA

Client must meet at least one of the listed PA criteria:

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

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

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

OPIATE DEPENDENCE TREATMENTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies to drugs with an "*" in the class: • Opiate/Benzodiazepine/Muscle Relaxant Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
buprenorphine* buprenorphine/naloxone KLOXXADO (naloxone) nasal lofexidine LUCEMYRA (lofexidine) naloxone syringe, vial, nasal spray naltrexone NARCAN (naloxone) nasal NARCAN OTC (naloxone) nasal OPVEE SPRAY (nalmefene HCl nasal) REXTOVY (naloxone) nasal SUBOXONE (buprenorphine/naloxone) film VIVITROL (naltrexone) ZIMHI (naloxone) ZUBSOLV (buprenorphine/naloxone)	

OTIC ANTIBIOTICS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
CIPRODEX (ciprofloxacin/dexamethasone) ciprofloxacin/dexamethasone otic, AG neomycin/polymyxin/hydrocortisone ofloxacin	CIPRO HC (ciprofloxacin/hydrocortisone) ciprofloxacin ciprofloxacin HCl/fluocinolone CORTISPORIN-TC (colistin sulfate - neomycin sulfate - thonzonium bromide - hydrocortisone acetate otic suspension) OTOVEL (ciprofloxacin/fluocinolone)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

OTIC ANTI-INFECTIVES/ANESTHETICS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
acetic acid	acetic acid/hydrocortisone

PAH AGENTS (ORAL, INHALATION)	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Clinical Prior Authorization applies **to all drugs** in the class: • Pulmonary Hypertension Agents; OR • PDE5-Inhibitors Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ADCIRCA (tadalafil) LETAIRIS (ambrisentan) REVATIO (sildenafil) TRACLEER (bosentan) tablets	ADEMPAS (riociguat) ALYQ (tadalafil) ambrisentan bosentan LIQREV (sildenafil) suspension OPSUMIT (macitentan) OPSYNVI (macitentan/tadalafil) ORENITRAM ER (treprostinil) tablets, titration kit sildenafil suspension (generic Revatio) sildenafil tablets (generic Revatio) tadalafil (generic Adcirca) TADLIQ (tadalafil) suspension TRACLEER (bosentan) suspension TYVASO Inhalation (treprostinil) TYVASO DPI (treprostinil) UPTRAVI (selexipag) VENTAVIS Inhalation (iloprost)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

PANCREATIC ENZYMES	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
CREON (pancrelipase) ZENPEP (pancrelipase)	PERTZYE (pancrelipase) VIOKACE (pancrelipase)

PEDIATIRC VITAMIN PREPARATIONS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
See separate **Preferred Pediatric Vitamin Preparations** listing.	See separate **Preferred Pediatric Vitamin Preparations** listing.

PENICILLINS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
amoxicillin ampicillin dicloxacillin penicillin VK	

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

PHOSPHATE BINDERS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria): • Treatment failure with preferred drug • Contraindication to preferred drug* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • Diagnosis of ESRD, hyperphosphatemia AND at least one of the following: – Hypercalcemia (corrected serum calcium > 10.2 mg/dL) – Plasma PTH levels < 150 pg/mL on two consecutive measurements – Dialysis patients with severe vascular and/or soft tissue calcifications	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
calcium acetate RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate)	AURYXIA (ferric citrate) FOSRENOL (lanthanum) lanthanum PHOSLYRA (calcium acetate) sevelamer sevelamer carbonate VELPHORO (sucroferric oxyhydroxide) XPHOZAH (tenapanor)

PLATELET AGGREGATION INHIBITORS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drug • Contraindication to preferred drug* • Allergic reaction to preferred drug* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
aspirin/dipyridamole BRILINTA (ticagrelor) clopidogrel prasugrel	dipyridamole EFFIENT (prasugrel) PLAVIX (clopidogrel)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

POTASSIUM BINDERS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drug • Contraindication to preferred drug* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
LOKELMA (sodium zirconium cyclosilicate) sodium polystyrene sulfonate VELTASSA (patiromer calcium sorbitex)	

PRENATAL VITAMINS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
See separate **Preferred Prenatal Vitamins** listing.	See separate **Preferred Prenatal Vitamins** listing.

PROGESTINS FOR CACHEXIA	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drug • Contraindication to preferred drug* • Allergic reaction to preferred drug* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
megestrol suspension, tablets	megestrol ES suspension (generic Megace ES)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

PROTON PUMP INHIBITORS (ORAL)	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure after no less than a 30-day trial of each preferred drug • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions • Prevacid Solutabs will be approved for children 10 years of age and under	The following Clinical Prior Authorization applies **to all drugs** in the class: • Proton Pump Inhibitor Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
DEXILANT (dexlansoprazole) NEXIUM suspension packet (esomeprazole) omeprazole RX pantoprazole PROTONIX (pantoprazole) suspension	ACIPHEX (rabeprazole) dexlansoprazole DR esomeprazole KONVOMEP (omeprazole/sodium bicarbonate) lansoprazole NEXIUM capsules (esomeprazole) NEXIUM OTC (esomeprazole) omeprazole OTC omeprazole/sodium bicarbonate pantoprazole suspension PREVACID (lansoprazole) PRILOSEC (omeprazole)suspension PROTONIX tablets (pantoprazole) rabeprazole ZEGERID (omeprazole/sodium bicarbonate)

ROSACEA AGENTS, TOPICAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure after no less than a 30-day trial of every preferred drug • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization may apply to drugs in the class: • Rosacea Agents, Topical Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
FINACEA (azelaic acid) foam metronidazole cream, gel NORITATE (metronidazole)	azelaic acid brimonidine gel FINACEA (azelaic acid) gel ivermectin metronidazole lotion RHOFADE (oxymetazoline) ROSADAN KIT (metronidazole)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

SEDATIVE HYPNOTICS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Anxiolytics and Sedatives/Hypnotics • Opiate/Benzodiazepine/Muscle Relaxant Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
BENZODIAZEPINES	
temazepam 15, 30 mg triazolam	estazolam HALCION (triazolam) RESTORIL (temazepam) temazepam 7.5, 22.5 mg
SEDATIVE HYPNOTICS cont.	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
OTHERS	
eszopiclone zaleplon zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) DAYVIGO (lemborexant) doxepin EDLUAR (zolpidem) flurazepam HETLIOZ (tasimelteon) HETLIOZ LQ (tasimelteon) LUNESTA (eszopiclone) ramelteon quazepam QUVIVIQ (daridorexant) ramelteon ROZEREM (ramelteon) SILENOR (doxepin) tasimelteon zolpidem ER/SL/capsules

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

SICKLE CELL ANEMIA TREATMENTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
DROXIA (hydroxyurea) ENDARI (glutamine) hydroxyurea glutamine SIKLOS (hydroxyurea)	

SKELETAL MUSCLE RELAXANTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies to drugs with an "*" in the class: • Opiate/Benzodiazepine/Muscle Relaxant Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
baclofen tablets carisoprodol (except 250 mg)* cyclobenzaprine* methocarbamol* tizanidine tablets	AMRIX (cyclobenzaprine ER)* baclofen solution, suspension carisoprodol 250 mg* carisoprodol compound chlorzoxazone* cyclobenzaprine ER DANTRIUM (dantrolene) dantrolene FEXMID (cyclobenzaprine)* FLEQSUVY (baclofen suspension) LORZONE (chlorzoxazone)* LYVISPAH (baclofen) metaxalone* NORGESIC FORTE (orphenadrine/aspirin/caffeine) orphenadrine* SOMA (carisoprodol)* tizanidine capsules ZANAFLEX (tizanidine)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

SMOKING CESSATION	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
bupropion SR (discontinued brand Zyban) CHANTIX (varenicline) nicotine gum nicotine lozenge nicotine patch varenicline tartrate dose pack, tablets	NICOTROL (nicotine) NICOTROL NS (nicotine)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

STEROIDS, TOPICAL	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
LOW POTENCY	
DERMA-SMOOTHE/FS (fluocinolone) hydrocortisone cream, ointment hydrocortisone/aloe cream PROCTOSOL-HC (hydrocortisone)	alclometasone AQUA GLYCOLIC (hydrocortisone/skin cleanser) desonide fluocinolone oil hydrocortisone lotion (Rx), solution TEXACORT (hydrocortisone) solution
MEDIUM POTENCY	
fluticasone propionate cream, ointment mometasone cream, ointment, solution	BESER KIT (fluticasone) betamethasone valerate foam clocortolone cream CLODERM (clocortolone) fluocinolone acetonide flurandrenolide fluticasone propionate lotion hydrocortisone butyrate hydrocortisone valerate LOCOID (hydrocortisone butyrate) LUXIQ (betamethasone) PANDEL (hydrocortisone probutate) prednicarbate SYNALAR (fluocinolone)
HIGH POTENCY	
betamethasone dipropionate lotion betamethasone dipropionate/propylene glycol cream betamethasone valerate cream, ointment DIPROLENE (betamethasone dipropionate) ointment triamcinolone acetonide cream, lotion, ointment	amcinonide betamethasone dipropionate cream, gel, ointment betamethasone dipropionate/ propylene glycol lotion, ointment betamethasone valerate lotion desoximetasone diflorasone fluocinonide halcinonide HALOG (halcinonide) HALOG SOLUTION (halcinonide) KENALOG aerosol (triamcinolone) TOPICORT (desoximetasone) triamcinolone acetonide aerosol VANOS (fluocinonide)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

STEROIDS, TOPICAL cont.	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
VERY HIGH POTENCY	
clobetasol emollient clobetasol propionate cream, gel, ointment, solution halobetasol cream, ointment	APEXICON E (diflorasone) BRYHALI (halobetasol propionate) clobetasol lotion, shampoo clobetasol propionate foam, spray CLOBEX (clobetasol) CLODAN (clobetasol) halobetasol foam IMPEKLO LOTION (clobetasol propionate) LEXETTE (halobetasol propionate) OLUX (clobetasol) TEMOVATE (clobetasol) TOVET (clobetasol) ULTRAVATE (halobetasol propionate)

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STIMULANTS AND RELATED AGENTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies to drugs with an "*" in the class: • Binge Eating Disorder Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
STIMULANTS	
ADDERALL (amphetamine salt combination) ADDERALL XR (amphetamine salt combination) amphetamine salt combination IR CONCERTA (methylphenidate) DAYTRANA (methylphenidate) dexmethylphenidate IR dextroamphetamine IR DYANAVEL XR (amphetamine) suspension FOCALIN XR (dexmethylphenidate) JORNAY PM (methylphenidate ER) METHYLIN (methylphenidate) solution methylphenidate IR QUILLIVANT XR (methylphenidate) VYVANSE (lisdexamfetamine)* VYVANSE (lisdexamfetamine) chewable tablets*	ADHANSIA XR (methylphenidate) ADZENYS XR ODT (amphetamine) ADZENYS ER (amphetamine) suspension amphetamine salt combination ER amphetamine sulfate APTENSIO XR (methylphenidate) armodafinil AZSTARYS (serdexmethylphenidate/dexmethyl) COTEMPLA XR ODT (methylphenidate) DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) dexmethylphenidate ER dextroamphetamine ER dextroamphetamine solution DYANAVEL XR (amphetamine) tablets EVEKEO (amphetamine) FOCALIN (dexmethylphenidate) lisdexamfetamine* methamphetamine methylphenidate CD methylphenidate chewable tablets methylphenidate ER methylphenidate LA methylphenidate patch methylphenidate solution modafinil MYDAYIS (amphetamine salt combination ER) NUVIGIL (armodafinil) PROCENTRA (dextroamphetamine) PROVIGIL (modafinil) QUILLICHEW ER (methylphenidate) RELEXXII (methylphenidate) RITALIN (methylphenidate) RITALIN LA (methylphenidate ER) SUNOSI (solriamfetol) WAKIX (pitolisant) XELSTRYM (dextroamphetamine) transdermal ZENZEDI (dextroamphetamine)

*To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: https://www.txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions section and are located on page 9 of the PDL Document after the Table of Contents.

STIMULANTS AND RELATED AGENTS cont.	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • ADHD Agents Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
NON-STIMULANTS	
atomoxetine guanfacine ER QELBREE (viloxazine)	clonidine ER INTUNIV (guanfacine ER) STRATTERA (atomoxetine)

TETRACYCLINES	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
doxycycline hyclate capsules doxycycline monohydrate 50, 100 mg capsules, suspension doxycycline monohydrate 50, 100 mg capsules (AG) minocycline capsules	demeclocycline DORYX (doxycycline hyclate) doxycycline hyclate IR doxycycline hyclate DR doxycycline monohydrate 40, 75, 150 mg capsules doxycycline monohydrate tablets minocycline tablets minocycline ER MINOLIRA ER (minocycline) MORGIDOX KIT (doxycycline/skin cleanser no19) NUZYRA tablets (omadacycline) ORACEA (doxycycline) SOLODYN (minocycline) TARGADOX (doxycycline hyclate) tetracycline VIBRAMYCIN (doxycycline) capsules, syrup XIMINO (minocycline)

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THROMBOPOIESIS STIMULATING PROTEINS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
PROMACTA (eltrombopag) tablets	ALVAIZ (eltrombopag) DOPTELET (avatrombopag) MULPLETA (lusutrombopag) PROMACTA (eltrombopag) suspension TAVALISSE (fostamatinib)

ULCERATIVE COLITIS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
ORAL	
APRISO (mesalamine) DELZICOL (mesalamine) DIPENTUM (olsalazine) mesalamine DR tablet (Lialda) PENTASA (mesalamine) sulfasalazine sulfasalazine DR UCERIS (budesonide)	ASACOL HD (mesalamine) AZULFIDINE (sulfasalazine) balsalazide budesonide DR COLAZAL (balsalazide) LIALDA (mesalamine) mesalamine mesalamine DR capsule (Delzicol) mesalamine DR tablet (Asacol HD) mesalamine ER capsule (Apriso, Pentasa) VELSIPITY (etrasimod arginine)
RECTAL	
CANASA (mesalamine) SFROWASA (mesalamine)	mesalamine (Canasa) mesalamine (SFROWASA) mesalamine kit (ROWASA) ROWASA (mesalamine) UCERIS (budesonide)

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UREA CYCLE DISORDERS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria: • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	The following Clinical Prior Authorization applies **to all drugs** in the class: • Urea Cycle Disorders Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
BUPHENYL (sodium phenylbutyrate) CARBAGLU (carglumic acid) PHEBURANE (sodium phenylbutyrate)	carglumic acid OLPRUVA (sodium phenylbutyrate) RAVICTI (glycerol phenylbutyrate) sodium phenylbutyrate powder/ tablets

UTERINE DISORDER TREATMENTS	
PA CRITERIA	
Client must meet at least one of the listed PA criteria): • Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs* • Allergic reaction to preferred drugs* • Treatment of stage-four advanced, metastatic cancer and associated conditions	Hyperlinks specify Drug Utilization Review board-approved drug clinical prior authorization criteria.
PREFERRED AGENTS	**NON-PREFERRED AGENTS**
MYFEMBREE (relugolix /estradiol/norethindrn) ORIAHNN (elagolix/estradiol/norethindrn) ORILISSA (elagolix)	

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APPENDICES

- Treatment failure with 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	PREFERRED INGREDIENTS	NON-PREFERRED AGENTS	NON-PREFERRED INGREDIENTS
ALA-HIST IR TABLET OTC (ORAL)	dexbrompheniramine maleate	ALAHIST D TABLET OTC (ORAL)	phenylephrine hcl/pheniramine maleate
ALAHIST PE TABLET OTC (ORAL)	dexbrompheniramine maleate/phenylephrine hcl	ALL DAY SINUS-COLD-D TABLET OTC (ORAL)	naproxen sodium/pseudoephedrine hcl
ALLERGY MULTI-SYMPTOM CAPLET OTC (ORAL)	phenylephrine hcl/acetaminophen/ chlorpheniramine	COLD-SINUS TABLET OTC (ORAL)	ibuprofen/pseudoephedrine hcl
APRODINE TABLET OTC (ORAL)	triprolidine hcl/pseudoephedrine hcl	CONEX SOLUTION OTC (ORAL)	dexbrompheniramine maleate/pseudoephedrine hcl
COLD-SINUS RLF LIQCAP CAPSULE OTC (ORAL)	ibuprofen/pseudoephedrine hcl	CONEX TABLET OTC (ORAL)	dexbrompheniramine maleate/pseudoephedrine hcl
DECONEX IR TABLET OTC (ORAL)	guaifenesin/phenylephrine hcl	DEXBROMPHENIR-PHENYLEPH TABLET OTC (ORAL)	dexbrompheniramine maleate/phenylephrine hcl
ED-A-HIST TABLET OTC (ORAL)	chlorpheniramine maleate/phenylephrine hcl	DOXYLAMINE-PHENYLEPH TABLET OTC (ORAL)	doxylamine succinate/phenylephrine hcl
ED-BRON GP LIQUID OTC (ORAL)	guaifenesin/phenylephrine hcl	ED A-HIST LIQUID OTC (ORAL) NOHIST-LQ LIQUID OTC (ORAL)	chlorpheniramine maleate/phenylephrine hcl
GUAIFENESIN ER TABLET OTC (ORAL)	guaifenesin	GUAIFENESIN-PSE TABLET OTC (ORAL) POLY-VENT IR TABLET OTC (ORAL)	guaifenesin/pseudoephedrine hcl
GUAIFENESIN SOLUTION OTC (ORAL)	guaifenesin	HISTEX-PE SYRUP OTC (ORAL)	phenylephrine hcl/triprolidine hcl
GUAIFENESIN TABLET OTC (ORAL)	guaifenesin	LOHIST-D LIQUID OTC (ORAL)	chlorpheniramine maleate/pseudoephedrine hcl
GUAIFENESIN-PSE ER TABLET OTC (ORAL)	guaifenesin/pseudoephedrine hcl	MUCINEX D (ORAL) TAB ER 12H	guaifenesin/pseudoephedrine hcl
MUCINEX INSTASOOTHE SPRAY OTC (ORAL)	benzocaine/menthol	MUCUS RELIEF PE TABLET OTC (ORAL)	guaifenesin/phenylephrine hcl
MUCUS-CHEST CONG LIQUID OTC (ORAL)	guaifenesin		
NIGHT SEVERE COLD-COUGH POWDER PACKET OTC (ORAL)	diphenhydramine hcl/phenylephrine hcl/acetaminophen	NASOPEN PE LIQUID OTC (ORAL)	thonzylamine hcl/phenylephrine hcl
PHENYLEPHRINE/BROMPHENIRAMINE SOLN OTC (ORAL) RYNEX PE LIQUID OTC (ORAL)	brompheniramine maleate/phenylephrine hcl	PROMETHAZINE VC SYRUP (ORAL)	phenylephrine hcl/promethazine hcl
POLY HIST FORTE TABLET OTC (ORAL)	doxylamine succinate/phenylephrine hcl	RU-HIST D TABLET OTC (ORAL)	brompheniramine maleate/phenylephrine hcl
SINUS CONGESTION-PAIN CAPLET OTC (ORAL)	phenylephrine hcl/acetaminophen	RYMED TABLET OTC (ORAL)	dexchlorpheniramine maleate/phenylephrine hcl
SINUS CONGST-PAIN TABLET OTC (ORAL)	guaifenesin/phenylephrine hcl/acetaminophen	RYNEX PSE LIQUID OTC (ORAL)	brompheniramine maleate/phenylephrine hcl
SUDOGEST COLD AND ALLERGY TAB OTC (ORAL)	chlorpheniramine maleate/pseudoephedrine hcl	TUNSEL PEDI DROP OTC (ORAL)	guaifenesin/phenylephrine hcl

COUGH AND COLD NASAL

PREFERRED AGENTS	PREFERRED INGREDIENTS	NON-PREFERRED AGENTS	NON-PREFERRED INGREDIENTS
OXYMETAZOLINE NASAL SPRAY OTC (NASAL)	oxymetazoline hcl spray (non-aerosol)	OXYMETAZOLINE MIST OTC (NASAL)	oxymetazoline hcl mist
SINUS RELIEF NASAL SPRAY OTC (NASAL)	phenylephrine hcl spray (non-aerosol)		

COUGH AND COLD, NARCOTIC

PREFERRED AGENTS	PREFERRED INGREDIENTS	NON-PREFERRED AGENTS	NON-PREFERRED INGREDIENTS
CODEINE-GUAIFEN SOLUTION OTC (ORAL)	codeine phosphate/guaifenesin solution	CAPCOF LIQUID OTC (ORAL) POLY-TUSSIN AC LIQUID OTC (ORAL)	brompheniramine maleate/phenylephrine hcl/codeine phosphate
HYDROCODONE-HOMATROPINE SOLUTION (ORAL)	hydrocodone bitartrate/homatropine methylbromide	HISTEX-AC SYRUP OTC (ORAL)	triprolidine hcl/phenylephrine hcl/codeine phosphate
		HYCODAN SOLUTION (ORAL)	hydrocodone bitartrate/homatropine methylbromide
		HYCODAN TABLET (ORAL) HYDROCODONE-HOMATROPINE TABLET (ORAL)	hydrocodone bitartrate/homatropine methylbromide
		HYDROCODONE-CHLORPHEN ER SUSPENSION (ORAL)	hydrocodone polistirex/chlorpheniramine polistirex
		MAR-COF CG LIQUID (ORAL)	codeine phosphate/guaifenesin solution
		PROMETHAZINE VC-CODEINE SYRUP (ORAL)	promethazine/phenylephrine hcl/codeine
		PROMETHAZINE-CODEINE SOLUTION (ORAL)	promethazine hcl/codeine
		TUXARIN ER TABLET (ORAL)	chlorpheniramine maleate/codeine phosphate

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COUGH AND COLD, NON-NARCOTIC			
PREFERRED AGENTS	**PREFERRED INGREDIENTS**	**NON-PREFERRED AGENTS**	**NON-PREFERRED INGREDIENTS**
ALAHIST CF TABLET OTC (ORAL)	dextromethorphan hbr/phenylephrine hcl/dexbrompheniramine	AQUANAZ TABLET OTC (ORAL)	guaifenesin/dextromethorphan hbr/ phenylephrine
ALAHIST DM LQ OTC (ORAL)	pheniramine maleate/phenylephrine hcl/ dextromethorphan hbr	BRANTUSSIN DM LIQUID OTC (ORAL) WESTUSSIN DM NF LIQUID OTC (ORAL)	dextromethorphan hbr/phenylephrine hcl/dexbrompheniramine
ALA-HIST DM LQ OTC (ORAL) POLYTUSSIN DM LIQUID OTC (ORAL)	dextromethorphan hbr/phenylephrine hcl/dexbrompheniramine	CAPMIST DM TABLET OTC (ORAL)	guaifenesin/dextromethorphan hbr/ pseudoephedrine hcl
BENZONATATE CAPSULE (ORAL)	benzonatate	CAPRON DM LIQUID OTC (ORAL)	pyrilamine maleate/dextromethorphan hbr
BROMPHEN-PSE-DM SYRUP (ORAL)	brompheniramine maleate/pseudoephedrine hcl/ dextromethorphan	CAPRON DM TABLET OTC (ORAL)	pyrilamine maleate/dextromethorphan hbr
CHILD DELSYM COUGH PLUS DY-NT OTC (ORAL) DELSYM COUGH PLUS DAY-NIGHT LQ OTC (ORAL)	diphenhydramine/phenylephrine/dextromethorph/ acetaminophen/gg	CHLO HIST ORAL SOLUTION OTC (ORAL)	dexbrompheniramine maleate/chlophedianol hcl
CHILD MUCINEX FREEFROM DY COLD LIQUID OTC (ORAL)	phenylephrine hcl/dextromethorphan hbr/acetaminophen/guaifen	CHLO TUSS LIQUID OTC (ORAL)	dexbrompheniramine maleate/pseudoephedrine hcl/chlophedianol
CHILDREN'S MUCINEX FREEFROM LQ OTC (ORAL) MUCINEX FAST-MAX CONGEST-COUGH LIQUID OTC (ORAL)	guaifenesin/dextromethorphan hbr/phenylephrine	COLD MAX DAY-NIGHT CAPLET OTC (ORAL)	dextromethorphan/phenylephrine/acetaminophen/ chlorpheniramin
CHILD'S MULTI-SYMPTOM COLD LIQ OTC (ORAL)	guaifenesin/dextromethorphan hbr/ phenylephrine	COUGH DM SYRUP OTC (ORAL)	guaifenesin/dextromethorphan hbr
CHILDREN'S COUGH-COLD LIQUID OTC (ORAL) RYNEX DM LIQUID OTC (ORAL)	brompheniramine maleate/phenylephrine hcl/dextromethorphan	DAYTIME COLD-FLU LIQUID OTC (ORAL)	dextromethorphan hbr/phenylephrine hcl/ acetaminophen
CHLOPHENDIANOL-DEXCHLORP-PSE LQ OTC (ORAL)	dexchlorpheniramine maleate/ pseudoephedrine/chlophedianol	DAYTIME SEVERE COLD-FLU CAPLET OTC (ORAL)	phenylephrine hcl/dextromethorphan hbr/ acetaminophen/guaifen
COLD MAX DAYTIME CAPLET OTC (ORAL) DM/PHENYLEPHRINE/APAP TABLET OTC (ORAL)	dextromethorphan hbr/phenylephrine hcl/acetaminophen	DAYTIME SEVERE COLD-FLU LIQUID OTC (ORAL)	phenylephrine hcl/dextromethorphan hbr/ acetaminophen/guaifen
COUGH-COLD HBP TABLET OTC (ORAL) DM/CHLORPHENIRAMINE TABLET OTC (ORAL)	chlorpheniramine maleate/dextromethorphan hbr	DAYTIME-NIGHTTIME COLD-FLU CAPSULE OTC (ORAL)	dextromethorphan hbr/phenylephrine/ acetaminophen/doxylamine
DAY MULTI-SYMP FLU-SEVERE COLD POWDER PACK OTC (ORAL) FLU-SEV COLD-COUGH DAY PACKET OTC (ORAL)	dextromethorphan hbr/phenylephrine hcl/ acetaminophen	ED A-HIST DM TABLET OTC (ORAL)	chlorpheniramine maleate/phenylephrine hcl/dextromethorphan
DAYTIME COLD-FLU SOFTGEL OTC (ORAL)	dextromethorphan hbr/phenylephrine hcl/ acetaminophen	ENDAL LIQUID OTC (ORAL)	dextromethorphan hbr/triprolidine hcl
DECONEX DMX TAB OTC (ORAL)	guaifenesin/dextromethorphan hbr/ phenylephrine	LOHIST-DM SYRUP OTC (ORAL)	brompheniramine maleate/phenylephrine hcl/dextromethorphan
DELSYM COUGH CAPLET OTC (ORAL)	dextromethorphan hbr	M-END DMX LIQUID OTC (ORAL)	dexbromphen/pseudoephedrine/ dextromethorphan
DELSYM NIGHTTIME COUGH LIQUID OTC (ORAL) MUCINEX NIGHTSHIFT COLD-FLU LQ OTC (ORAL)	triprolidine hcl/dextromethorphan hbr/acetaminophen	MUCINEX DM ER TABLET OTC (ORAL)	guaifenesin/dextromethorphan hbr
DEXTROMETHORPHAN CAPSULE OTC (ORAL)	dextromethorphan hbr	MUCUS RLF DM MAX TABLET OTC (ORAL)	guaifenesin/dextromethorphan hbr
DEXTROMETHORPHAN SUSPENSION ER 12H OTC (ORAL)	dextromethorphan polistirex	NINJACOF LIQUID OTC (ORAL)	pyrilamine maleate/chlophedianol hcl
DM-GUAIF-PE LIQUID OTC (ORAL)	guaifenesin/dextromethorphan hbr/ phenylephrine	NINJACOF-D LIQUID OTC (ORAL)	pyrilamine maleate/pseudoephedrine hcl/ chlophedianol hcl
DM-GUAIF-PE TABLET OTC (ORAL)	guaifenesin/dextromethorphan hbr/ phenylephrine	PYRILAMINE DM LIQUID OTC (ORAL)	pyrilamine maleate/dextromethorphan hbr
DURAFLU TAB OTC (ORAL)	pseudoephedrine/dextromethorphan/guaifenesin/ acetaminophen	SEVERE COLD-FLU NIGHTTIME LQ OTC (ORAL)	dextromethorphan hbr/phenylephrine/ acetaminophen/doxylamine
ED-A-HIST DM LIQUID OTC (ORAL) NOHIST-DM LIQUID OTC (ORAL)	chlorpheniramine maleate/phenylephrine hcl/dextromethorphan	TUSNEL CAPLET OTC (ORAL)	guaifenesin/dextromethorphan hbr/ pseudoephedrine hcl
FLU HBP CAPLET OTC (ORAL)	dextromethorphan hbr/acetaminophen/ chlorpheniramine maleate	TUSNEL DM LIQUID OTC (ORAL)	guaifenesin/dextromethorphan hbr/ phenylephrine
GUAIFENESIN DM LIQUID OTC (ORAL)	guaifenesin/dextromethorphan hbr	TUSNEL DM PEDIATRIC LIQUID OTC (ORAL)	guaifenesin/dextromethorphan hbr/ phenylephrine
GUAIFENESIN DM TAB OTC (ORAL)	guaifenesin/dextromethorphan hbr	TUSNEL LIQUID OTC (ORAL)	guaifenesin/dextromethorphan hbr/ pseudoephedrine hcl
GUAIFENESIN-DM SYRUP OTC (ORAL)	guaifenesin/dextromethorphan hbr	TUSNEL PED LIQ OTC (ORAL)	guaifenesin/dextromethorphan hbr/ pseudoephedrine hcl
HISTEX-DM SYRUP OTC (ORAL)	triprolidine hcl/phenylephrine hcl/ dextromethorphan hbr	VANACOF DMX LIQUID OTC (ORAL)	guaifenesin/dextromethorphan hbr/ phenylephrine
MUCINEX INSTASOOTH COUGH LOZENGE OTC (ORAL)	dextromethorphan hbr/hexylresorcinol	WESTUSSIN DM SYR OTC (ORAL)	dexchlorpheniramine maleate/ phenylephrine/dextromethorphan
MUCINEX NIGHTSHIFT COLD-FLU LQ OTC (ORAL)	triprolidine hcl/dextromethorphan hbr/ acetaminophen		
MUCINEX NIGHTSHIFT CLD-FLU CPT OTC (ORAL)	triprolidine hcl/dextromethorphan hbr/ acetaminophen		
MUCINEX NIGHTSHIFT SEVR CLD-FLU LIQUID OTC (ORAL) MUCINEX NIGHTSHIFT SINUS LIQ OTC (ORAL)	triprolidine hcl/phenylephrine/dextromethorphan/ acetaminophen		
MUCINEX NIGHTSHIFT SEVR CLD-FLU TABLET OTC (ORAL) MUCINEX NIGHTSHIFT SINUS CAPLT OTC (ORAL)	triprolidine hcl/phenylephrine/dextromethorphan/ acetaminophen		
MUCINEX SINUSMAX DAY-NT CAPLET OTC (ORAL)	triprolidine/phenylephrine/dextromethorph/ acetamin/guaifenes		
MUCINEX SINUS-MAX PRESSURE-CGH CAPSULE OTC (ORAL)	phenylephrine hcl/dextromethorphan hbr/acetaminophen/guaifen		
MUCUS RELIEF DM MAX LIQUID OTC (ORAL)	guaifenesin/dextromethorphan hbr		
MUCUS RLF DM ER TAB OTC (ORAL)	guaifenesin/dextromethorphan hbr		
NIGHTTIME COLD-FLU LIQUID OTC (ORAL)	dextromethorphan hbr/acetaminophen/ doxylamine		
NIGHTTIME COLD-FLU RLF SOFTGEL OTC (ORAL)	dextromethorphan hbr/acetaminophen/ doxylamine		
NIGHTTIME COUGH LIQUID OTC (ORAL)	dextromethorphan hbr/doxylamine succinate		
POLY-HIST DM LIQUID OTC (ORAL)	thonzylamine hcl/phenylephrine hcl/ dextromethorphan hbr		
POLYTUSSIN DM LIQUID OTC (ORAL)	pyrilamine maleate/phenylephrine hcl/dextromethorphan hbr		
POLYTUSSIN DM SYR OTC (ORAL)	dexchlorpheniramine maleate/ phenylephrine/dextromethorphan		
POLY-VENT DM TABLET OTC (ORAL)	guaifenesin/dextromethorphan hbr/ pseudoephedrine hcl		
PROMETHAZINE-DM SYRUP (ORAL)	promethazine hcl/dextromethorphan hbr		
SEVERE COLD-FLU CAPLET OTC (ORAL)	phenylephrine hcl/dextromethorphan hbr/acetaminophen/guaifen tablet		
TUSSIN CF LIQUID OTC (ORAL)	guaifenesin/dextromethorphan hbr/ phenylephrine		

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COUGH AND COLD, NON-NARCOTIC cont.			
PREFERRED AGENTS	**PREFERRED INGREDIENTS**	**NON-PREFERRED AGENTS**	**NON-PREFERRED INGREDIENTS**
VANACOF 2 LIQUID (ORAL)	dexchlorpheniramine maleate/chlophedianol hcl		
VANACOF CP LIQUID (ORAL)	pyrilamine maleate/chlophedianol hcl		
VANACOF DM OTC (ORAL)	guaifenesin/dextromethorphan hbr/ phenylephrine		
VANACOF LIQUID OTC (ORAL)	dexchlorpheniramine maleate/ pseudoephedrine/chlophedianol		
VANACOF XP LIQUID OTC (ORAL)	guaifenesin/dextromethorphan hbr		
VANATAB DM CAPLET OTC (ORAL)	guaifenesin/dextromethorphan hbr/ phenylephrine		

IRON, ORAL			
PREFERRED AGENTS	**PREFERRED INGREDIENTS**	**NON-PREFERRED AGENTS**	**NON-PREFERRED INGREDIENTS**
CENTRATEX CAPSULE (ORAL)	multivitamin-minerals no. 73/ferrous fumarate/folic acid	ACCRUFER CAPSULE (ORAL)	ferric maltol
FERREX CAPSULE OTC (ORAL)	iron polysaccharide complex	ACTIVE FE TABLET(ORAL)	iron, carbonyl/folic acid/multivit with minerals
FERROUS FUMARATE TABLET OTC (ORAL)	ferrous fumarate	BENTIVITE BX TABLET (ORAL)	ferrous sulfate/folic acid
FERROUS GLUCONATE TABLET OTC (ORAL)	ferrous gluconate	CORVITE 150 TABLET (ORAL)	iron,carbonyl/methyltetrahydrofolate,folic acid/mv,min no.41
FERROUS SULFATE DROP OTC (ORAL)	ferrous sulfate (drops)	CORVITE FE TABLET (ORAL)	iron/methyltetrahydrofolate gluc, folate/multivit, mins no.40
FERROUS SULFATE EC TABLET OTC (ORAL)	ferrous sulfate (enteric coated)	FEROSOL BIFERA CAPLET OTC (ORAL)	iron polysaccharide complex/iron heme polypeptide
FERROUS SULFATE ELIXIR OTC (ORAL)	ferrous sulfate (elixir)	FERGON TABLET OTC (ORAL)	ferrous gluconate
FERROUS SULFATE SOLUTION OTC (ORAL)	ferrous sulfate (solution)	FERIVA 21-7 TABLET (ORAL)	iron asp gly/ascorbic acid/folate no.1/vit B12/ zinc/succinic
FERROUS SULFATE TABLET OTC (ORAL)	ferrous sulfate (tablet)	FERIVA FA CAPSULE (ORAL)	iron bisgly, aspart, fumarate/vit C/folate/vit B12/ biotin/cupric
FERROUS SULFATE, DRIED TABLET ER OTC (ORAL)	ferrous sulfate, dried tablet ER	FERRIMIN TAB OTC (ORAL)	ferrous fumarate
PUREVIT DUALFE PLUS CAPSULE (ORAL) SE-TAN PLUS CAPSULE (ORAL)	iron fumarate-iron polysacch cplex/folic acid/multivit no.18	FOLITAB CAPLET OTC (ORAL)	ferrous sulfate/ascorbic acid/folic acid
		FOLIVANE-F CAPSULE (ORAL)	iron fumarate,polysac comp/folic acid/vitamin C/niacinamide
		IRONSPAN TABLET (ORAL)	iron bisgl,ps cmplx/folic acid/vit B, C no.12/succinic acid
		NEPHRON FA TABLET (ORAL)	vit B complex and vit C no.24/ferrous fumarate/folic acid
		TARON FORTE CAPSULE (ORAL)	iron bisgly,pscmplx/ascorbate calc/B12/folic acid/calc-threo

PEDIATRIC VITAMIN PREPARATIONS			
PREFERRED AGENTS	**PREFERRED INGREDIENTS**	**NON-PREFERRED AGENTS**	**NON-PREFERRED INGREDIENTS**
MULTIVIT-FLUOR DROP (ORAL)	pediatric multivitamin no. 2/ sodium fluoride	DAVIMET-FLUORIDE CHW TB (ORAL)	pediatric multivitamin no.247/sodium fluoride
MULTIVIT-FLUOR TAB CHW (ORAL)	pediatric multivitamins no. 17 with sodium fluoride	FLORAFOL PEDI CHEW TAB (ORAL)	pediatric multivitamin no.251 with sodium fluoride
MULTIVIT-FLUOR-IRON DROP (ORAL)	pediatric multivitamin no. 45/sodium fluoride/ ferrous sulfate	FLORIVA CHEWABLE TABLET (ORAL)	pediatric multivitamin no. 85 with sodium fluoride
		FLORIVA PLUS DROP OTC (ORAL)	pediatric multivitamin no. 161/sodium fluoride
		MULTI-VIT-FLOR TAB CHEW OTC (ORAL)	pediatric multivitamin no. 228 with sodium fluoride
		MULTIVIT-FLUOR TAB CHW OTC (ORAL) POLY-VI-FLOR TAB CHEW (ORAL)	pediatric multivitamin no. 219 with sodium fluoride
		MULTIVIT-FLUOR TAB CHW OTC (ORAL)	pediatric multivitamin no. 242 with sodium fluoride
		POLY-VI-FLOR DROP (ORAL)	pediatric multivitamin no. 213 with sodium fluoride
		POLY-VI-FLOR DROP (ORAL)	pediatric multivitamin no. 220 with fluoride
		POLY-VI-FLOR TAB CHEW (ORAL)	pediatric multivitamin no. 175 with fluoride
		POLY-VI-FLOR-IRON CHW (ORAL)	pediatric multivitamin no. 175 with fluoride and iron
		POLY-VI-FLOR-IRON CHWTB (ORAL)	pediatric multivitamin no. 205/sodium fluoride/iron, carbonyl
		POLY-VI-FLOR-IRON DROP (ORAL)	pediatric multivitamin no. 214/sodium fluoride/ferric citrate
		POLY-VI-FLOR-IRON DROP (ORAL)	pediatric multivitamin no. 220/sodium fluoride/iron sulfate
		QUFLORA FE CHEW TABLET (ORAL)	pediatric multivitamin no. 142 / iron carbonyl/ sodium fluoride
		QUFLORA FE PED DROP (ORAL)	pediatric multivitamin no. 151 / ferrous sulfate / sod fluoride
		QUFLORA GUMMIES (ORAL)	pediatric multivitamin no. 157 with sodium fluoride
		QUFLORA PED CHEW TAB (ORAL)	pediatric multivitamin no. 63 with sodium fluoride
		QUFLORA PED DROP (ORAL)	pediatric multivitamin no. 83 with sodium fluoride
		QUFLORA PED DROP (ORAL)	pediatric multivitamin no. 84 with sodium fluoride
		TRI-VI-FLOR DROPS (ORAL)	pediatric multivit A, C, and D3 no.38 with sodium fluoride
		TRI-VITE-FLUORIDE DROPS (ORAL) VIT A, C, D-FLUORIDE (ORAL)	pediatric multivit with A, C, D3 no.21/sodium fluoride

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PRENATAL VITAMINS			
PREFERRED AGENTS	**PREFERRED INGREDIENTS**	**NON-PREFERRED AGENTS**	**NON-PREFERRED INGREDIENTS**
COMPLETE NATAL DHA (ORAL) WESNATAL DHA COMPLETE (ORAL)	prenatal vitamin no.52/iron/folic acid/omega-3/dha	CITRANATAL B-CALM COMBO PACK (ORAL)	prenatal vitamin no.48/iron carbonyl, gluconate/folic acid/b6
FOLIVANE-OB CAPSULE OTC (ORAL)	mv-mins no. 74/ ferrous fumarate/ iron ps cplx/folic acid	C-NATE DHA SOFTGEL (ORAL) WESNATE DHA SOFTGEL (ORAL)	prenatal vitamins no.11/ ferrous fumarate/ folic acid/omega-3
M-NATAL PLUS TABLET (ORAL) PRENATAL VITAMIN PLUS LOW IRON (ORAL) WESTAB PLUS TABLET (ORAL)	prenatal vits with calcium no.72/ferrous fumarate/folic acid	COMPLETENATE TABLET CHEW (ORAL)	prenatal vitamins no.14/ferrous fumarate/folic acid
SELECT-OB + DHA PACK (ORAL)	prenatal vitamins no. 33/iron poly sach complex/folic acid/dha	DERMACINRCX CAPLET OTC (ORAL)	prenatal vitamins no. 170/ferrous fumarate/folic acid
THRIVITE RX TABLET (ORAL)	prenatal vitamin with calcium no.76/iron, carbonyl/folic acid	ELITE-OB CAPLET (ORAL) OB COMPLETE CAPLET (ORAL)	multivitamin with minerals no. 69/iron, carbonyl/folic acid
TRICARE PRENATAL TABLET (ORAL)	prenatal vits with calcium 103/ferrous fumarate/folic acid	ENBRACE HR SOFTGEL (ORAL)	multivit no.41/iron cysteine glycinate/ folate no. 8/ phosph-dha
TRINATAL RX 1 TABLET (ORAL)	prenatal vitamin 27 with calcium/ferrous fumarate/folic acid	NESTABS DHA COMBO PACK (ORAL)	prenatal vits with calcium no.87/iron bisgly/folic acid/dha
VITAFOL GUMMIES (ORAL)	prenatal vit no. 112/iron phosph/folic acid/omega-3s/dha/epa	NESTABS ONE SOFTGEL (ORAL)	multivit 42/iron carbonyl, b-g che/ methyltetrahydrofolate/dha
VITAFOL NANO TABLET (ORAL)	prenatal vitamins no.75/ferrous fumarate/folate comb. no. 1	NESTABS TABLET (ORAL)	prenatal vitamin no.86/iron bis-glycinate/folic acid
VITAFOL ULTRA SOFTGEL (ORAL)	prenatal vit no.67/iron polysaccharides/folate comb. no. 1/dha	NIVA-PLUS TABLET OTC (ORAL)	multivitamin with minerals no. 60/ferrous fumarate/folic acid
VITAFOL-OB CAPLET (ORAL)	prenatal vits with calcium no.10/ferrous fum/folic acid	OB COMPLETE ONE SOFTGEL (ORAL)	prenatal vit no. 85/iron carb, asp. gly/folic acid/dha/fish oil
VITAFOL-OB+DHA COMBO PACK (ORAL)	prenatal vits with calcium no.10/ferrous fum/folic acid/dha	OB COMPLETE PETITE SOFTGEL (ORAL)	prenatal no56/iron carbonyl, asparto glycinate/folic acid/dha
VITAFOL-ONE CAPSULE (ORAL)	prenatal vits no.26/iron polysaccharide cplex/folic acid/dha	OB COMPLETE PREMIER TABLET (ORAL)	prenatal vits no.83/iron, carbonyl,iron aspart.gly/ folic acid
		OB COMPLETE WITH DHA SOFTGEL (ORAL)	prenatal vit no.30/iron carbonyl, asp glyc/folic acid/omega-3
		PNV-DHA SOFTGEL (ORAL) WESCAP-PN DHA CAPSULE (ORAL) ZATEAN-PN DHA CAPSULE (ORAL)	multivitamin combination no. 47/ferrous fum/folate no. 1/dha
		PNV-OMEGA SOFTGEL (ORAL) ZATEAN-PN PLUS SOFTGEL (ORAL)	multivitamin-minerals no. 71/iron fumarate/folic acid no. 1/dha
		PNV-SELECT TABLET (ORAL)	prenatal vit with calcium no.40/iron fumarate/folate no. 1
		PRENATE AM TABLET (ORAL)	multivit no. 38/methyltetrahyrofolate glucose, folic acid/ginger
		PRENATE CHEWABLE TABLET (ORAL)	multivitamin no. 36/methyltetrahyrofolate gluc, folic acid
		PRENATE DHA SOFTGEL (ORAL)	prenatal vitamins no. 78/iron/ asparto glycin/folate no.1/dha
		PRENATE ELITE TABLET (ORAL)	prenatal vits no. 114/ferrous aspart glycinate/folate no. 1
		PRENATE ENHANCE SOFTGEL (ORAL)	prenatal vitamins no.68/iron fumarate/folate no.6/dha
		PRENATE ESSENTIAL SOFTGEL (ORAL)	multivitamin no. 40/iron asparto glycinate/folate no. 1/dha
		PRENATE MINI SOFTGEL (ORAL)	prenatal vits no.87/iron carb-asp.glycinate/folate no.1/dha
		PRENATE PIXIE SOFTGEL (ORAL)	prenatal vitamins no. 85/iron asparto glycin/folate no. 1/dha
		PRENATE RESTORE SOFTGEL (ORAL)	prenatal vitamins no.69/iron fumarate/folate comb no.6/dha
		PRENATE STAR TABLET (ORAL)	prenatal vitamins no. 77/ferrous asparto glycinate/folic acid
		PRIMACARE SOFTGEL (ORAL)	prenatal vits no.118/iron asparto glycinate/folate no.6/dha
		SELECT-OB CHEWABLE CAPLET (ORAL)	prenatal vit no. 128/iron polysaccharide complex/folic acid
		SELECT-OB CHEWABLE CAPLET (ORAL)	prenatal vitamin no.13/iron polysaccharides/folate comb no.1
		SE-NATAL 19 CHEWABLE TABLET (ORAL)	prenatal vits with calcium 118/ferrous fumarate/folic acid
		SE-NATAL-19 TABLET (ORAL)	prenatal vitamins no. 119/iron fumarate/folic acid
		TARON-C DHA CAPSULE (ORAL) WESCAP-C DHA SOFTGEL (ORAL)	mv-min 75/ ferrous fum/iron ps cplx/folic ac/ omega-3/dha/epa
		TRISTART DHA SOFTGEL (ORAL) WESTGEL DHA SOFTGEL (ORAL)	prenatal vitamins no. 93/iron carbonyl/folate comb no.9/dha
		VITAFOL FE PLUS SOFTGEL (ORAL)	prenatal vits no. 102/iron polysacch/folate no.1/dha

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