HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective July 29, 2021

PREFERRED DRUG LIST PUBLICATION LOG	
The PDL is published biannually (January, July). Recent changes to the PDL status are highlighted:	
July 29, 2021:	Published

ACNE AGENTS, ORAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
AMNESTEEM (isotretinoin) CLARAVIS (isotretinoin) isotretinoin MYORISAN (isotretinoin) ZENATANE (isotretinoin)	*ABSORICA (isotretinoin)* *ABSORICA LD (isotretinoin)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

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

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ACNE AGENTS, TOPICAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antibiotics		
clindamycin gel clindamycin pledgets clindamycin solution erythromycin gel, solution	*AMZEEQ (minocycline)* *CLEOCIN-T (clindamycin) clindamycin foam* *clindamycin gel AG (Clindagel)* *clindamycin lotion* *erythromycin medicated swab*	▪ Treatment failure with 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: ▪ Topical Acne Agents

ACNE AGENTS, TOPICAL *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Benzoyl Peroxide		
benzoyl peroxide gel (Rx) benzoyl peroxide lotion (OTC) benzoyl peroxide wash	*BENZEFOAM FOAM OTC (topical)* *benzoyl peroxide cleanser* *benzoyl peroxide cream* *benzoyl peroxide foam* *benzoyl peroxide gel* *benzoyl peroxide kit* *benzoyl peroxide towelette*	▪ Treatment failure with 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: ▪ Topical Acne Agents

ACNE AGENTS, TOPICAL *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Retinoids		
tretinoin cream (Avita, Retin-A) tretinoin gel	*AKLIEF (trifarotene)* *adapalene* *ALTRENO (tretinoin)* *ARAZLO (tazarotene)* *ATRALIN (tretinoin)* *AVITA (tretinoin)* *DIFFERIN (adapalene)* *FABIOR (tazarotene)* *tazarotene* *TAZORAC (tazarotene)* *tretinoin gel (Atralin)* *tretinoin microspheres*	▪ Treatment failure with 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: ▪ Topical Retinoids

ACNE AGENTS, TOPICAL *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Combination and Other Agents		
benzoyl peroxide/clindamycin (Duac) erythromycin/benzoyl peroxide	*ACZONE 7.5% (dapsone)* *AZELEX (azelaic acid)* *BENZACLIN GEL (benzoyl peroxide/clindamycin)* *benzoyl peroxide (Epiduo)* *clindamycin/benzoyl peroxide* *clindamycin/tretinoin* *dapsone* *DUAC (benzoyl peroxide/clindamycin)* *EPIDUO (benzoyl peroxide/adapalene)* *EPIDUO FORTE (benzoyl peroxide/adapalene)* *sulfacetamide* *sulfacetamide sodium* *sulfacetamide sodium/sulfur* *sulfacetamide/sulfur* *sulfacetamide/sulfur/urea* *ZIANA (clindamycin/tretinoin)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Retinoids ▪ Topical Acne Agents

ALZHEIMER'S AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Cholinesterase Inhibitors		▪ Treatment failure with 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 Dose Optimization applies to some strengths where a "*" is noted
donepezil 5, 10 mg tablet* donepezil ODT* EXELON (rivastigmine) transdermal	*ARICEPT (donepezil)** *donepezil 23 mg tablet** *galantamine** *galantamine ER* *RAZADYNE (galantamine) tablet** *RAZADYNE ER (galantamine ER)* *rivastigmine capsules* *rivastigmine transdermal*	
NMDA Receptor Antagonist		
memantine tablets	*memantine solution* *memantine tablet dose pack* *NAMENDA (memantine) tablets* *NAMENDA XR (memantine)*	
Cholinesterase Inhibitor/NMDA Receptor Antagonist Combinations		
	NAMZARIC (donepezil/memantine)	

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

ANALGESICS, NARCOTIC – LONG ACTING			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
BUTRANS (buprenorphine) EMBEDA (morphine/naloxone) fentanyl patch (12.5, 25, 50, 75, 100 mcg) morphine ER (generic MS Contin) tramadol ER (Ultram ER) XTAMPZA ER (oxycodone)	*BELBUCA (buprenorphine)* *buprenorphine patch* *DURAGESIC (fentanyl)* *EXALGO (hydromorphone)* *fentanyl patch (37.5, 62.5, 87.5 mcg)* *hydromorphone ER* *HYSINGLA ER (hydrocodone)* *KADIAN* (morphine) *methadone* *MORPHABOND ER (morphine)* *morphine ER (generic Avinza, Kadian)*	*MS CONTIN (morphine)* *NUCYNTA ER (tapentadol)* *OPANA ER (oxymorphone)* *oxycodone ER* *OXYCONTIN (oxycodone)* *oxymorphone ER* *tramadol ER (generic Conzip, Ryzolt)*	▪ Treatment failure with 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: ▪ Morphine Milligram Equivalent ▪ Opiate Overutilization ▪ Opiate/Benzodiazepine/Muscle Relaxant A drug specific prior authorization applies to drugs with a hyperlink

ANALGESICS, NARCOTIC – SHORT ACTING (NON-PARENTERAL)			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
APAP/codeine hydrocodone/APAP hydrocodone/ibuprofen hydromorphone tablet morphine tablets morphine solution oxycodone solution oxycodone tablet oxycodone/APAP tramadol tramadol/APAP	*ACTIQ (fentanyl)* *APADAZ (benzhydrocodone/APAP)* *butalbital/ASA/caffeine/codeine* *butalbital/APAP/caffeine/codeine* *butorphanol* *carisoprodol/aspirin/codeine* *codeine* *dihydrocodeine/ASA/caffeine* *DILAUDID (hydromorphone)* *DSUVIA (sufentanil citrate)* *fentanyl buccal* *FENTORA (fentanyl)* *FIORINAL W/CODEINE (butalbital/ASA/caffeine/codeine)* *hydromorphone liquid* *hydromorphone suppositories* *IBUDONE (hydrocodone/ibuprofen)* *LAZANDA (fentanyl)* *levorphanol* *meperidine* *morphine concentrated solution*	*NALOCET (oxycodone/APAP)* *NORCO (hydrocodone/APAP)* *NUCYNTA (tapentadol)* *OPANA (oxymorphone)* *oxycodone/APAP (generic Prolate)* *oxycodone/ASA* *oxycodone/ibuprofen* *oxycodone capsule* *oxycodone concentrate solution* *oxymorphone* *pentazocine/naloxone* *PERCOCET (oxycodone/APAP)* *ROXICODONE (oxycodone)* *SUBSYS (fentanyl)* *TYLENOL-CODEINE (codeine/APAP)* *ULTRACET (tramadol/APAP)* *ULTRAM (tramadol)*	▪ Treatment failure with 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: ▪ Morphine Milligram Equivalent ▪ Opiate Overutilization ▪ Opiate/Benzodiazepine/Muscle Relaxant A drug specific prior authorization applies to drugs with a hyperlink

ANDROGENIC AGENTS, TOPICAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ANDROGEL (testosterone) pump	*ANDRODERM (testosterone)* *ANDROGEL (testosterone) packet* *FORTESTA (testosterone)* *TESTIM (testosterone)* *testosterone gel* *VOGELXO (testosterone)*	▪ Treatment failure with 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

ANGIOTENSIN MODULATORS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Ace Inhibitors		
benazepril EPANED (enalapril) enalapril fosinopril* lisinopril quinapril ramipril*	*ACCUPRIL (quinapril)* *ALTACE (ramipril)** *captopril* *moexepril* *perindopril** *PRINIVIL (lisinopril)* *QBRELIS (lisinopril) solution* *trandolapril** *VASOTEC (enalapril)*	▪ Treatment failure with 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 Dose Optimization applies to some strengths where a "*" is noted

ANGIOTENSIN MODULATORS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ACE Inhibitor/Diuretic Combinations		
enalapril/HCTZ lisinopril/HCTZ	*ACCURETIC* *(quinapril/HCTZ)* *benazepril/HCTZ* *captopril/HCTZ* *fosinopril/HCTZ* *moexipril/HCTZ* *quinapril/HCTZ* *VASERETIC* *(enalapril/HCTZ)* *ZESTORETIC* *(lisinopril/HCTZ)*	▪ Treatment failure with 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

ANGIOTENSIN MODULATORS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
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**	▪ Treatment failure with 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 Dose Optimization applies to some strengths where a "*" is noted

ANGIOTENSIN MODULATORS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ARB/Diuretic Combinations		■ Treatment failure with 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 Dose Optimization applies to some strengths where a "*" is noted A drug specific prior authorization applies to drugs with a hyperlink
irbesartan/HCTZ losartan/HCTZ*	*ATACAND-HCT (candesartan/HCTZ)* *AVALIDE (irbesartan/HCTZ)* *BENICAR-HCT (olmesartan/HCTZ)* *candesartan/HCTZ* *DIOVAN-HCT (valsartan/HCTZ)* *EDARBYCLOR (azilsartan/chlorthalidone)* *HYZAAR (losartan/HCTZ)** *MICARDIS-HCT (telmisartan/HCTZ)* *olmesartan/HCTZ* *telmisartan /HCTZ* *valsartan/HCTZ*	
Direct Renin Inhibitors		
	TEKTURNA (aliskerin)	
Direct Renin Inhibitor/Diuretic Combinations		
	TEKTURNA HCT (aliskerin/HCTZ)	

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

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANGIOTENSIN MODULATORS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ARB/Neprilysin Inhibitor Combinations		
ENTRESTO (valsartan/sacubitril)		▪ Treatment failure with 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

ANGIOTENSIN MODULATOR COMBINATIONS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
benazepril /amlodipine valsartan/amlodipine	*AZOR (olmesartan/amlodipine)* *BYVALSON (valsartan/nebivolol)* *EXFORGE (valsartan/amlodipine)* *LOTREL (benazepril/amlodipine)* *olmesartan/amlodipine* *olmesartan/amlodipine/HCTZ* *telmisartan/amlodipine* *trandolapril/verapamil* *valsartan/amlodipine/HCTZ*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

ANTI-ALLERGENS, ORAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
	ORALAIR (Sweet Vernal, Orchard, Perennial Rye, Timothy, & Kentucky Blue Grass mixed pollens allergen extract) *PALFORZIA MAINTENANCE SACHET (peanut allergen powder)* *PALFORZIA TITRATION CAPSULE (peanut allergen powder)*	▪ Treatment failure with 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 A drug specific prior authorization applies to drugs with a hyperlink

ANTIBIOTICS, GASTROINTESTINAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
FIRVANQ(vancomycin) metronidazole tablet neomycin tinidazole	*DIFICID (fidaxomicin)* *FLAGYL (metronidazole)* *metronidazole capsule* *paromomycin* *TINDAMAX (tinidazole)* *VANCOCIN (vancomycin)* *vancomycin* *XIFAXAN (rifaximin)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

ANTIBIOTICS, INHALED		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
BETHKIS (tobramycin) CAYSTON (aztreonam) KITABIS PAK (tobramycin) TOBI PODHALER (tobramycin)	*ARIKAYCE (amikacin)* *TOBI (tobramycin) solution* *tobramycin solution*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Antibiotics, Inhaled

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

ANTIBIOTICS, VAGINAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
CLEOCIN (clindamycin) ovules CLINDESSE (clindamycin) NUVESSA (metronidazole)	*CLEOCIN (clindamycin) cream* *clindamycin* *metronidazole* *SOLOSEC (secnidazole)* *VANDAZOLE (metronidazole)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

ANTICOAGULANTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ELIQUIS (apixaban) enoxaparin PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban)	*ARIXTRA (fondaparinux)* *BEVYXXA (betrixaban)* *COUMADIN (warfarin)* *fondaparinux* *FRAGMIN (dalteparin)* *LOVENOX (enoxaparin)* *SAVAYSA (edoxaban)*	▪ Treatment failure with 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

ANTICONVULSANTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
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 EPIDIOLEX (cannabidiol) EQUETRO (carbamazepine) ethosuximide felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) FYCOMPA (perampanel) GABITRIL (tiagabine) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) KLONOPIN (clonazepam) LAMICTAL (lamotrigine) tablet, ODT LAMICTAL XR (lamotrigine) lamotrigine tablet, ODT levetiracetam levetiracetam XR		▪ All of the agents in the Anticonvulsants class are preferred A drug specific prior authorization applies to drugs with a hyperlink

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

ANTICONVULSANTS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
MYSOLINE (primidone) NAYZILAM (midazolam) ONFI (clobazam) oxcarbazepine OXTELLAR XR (oxcarbazepine) PEGANONE (ethotoin) phenobarbital PHENYTEK (phenytoin) phenytoin primidone QUDEXY XR (topiramate) SABRIL (vigabatrin) SPRITAM (levetiracetam) SYMPAZAN (clobazam) TEGRETOL (carbamazepine) TEGRETOL XR (carbamazepine) tiagabine TOPAMAX (topiramate) topiramate topiramate ER TRILEPTAL (oxcarbazepine) TROKENDI XR (topiramate) valproic acid VALTOCO (diazepam) zonisamide vigabatran VIMPAT (lacosamide) XCOPRI (cenobamate) ZARONTIN (ethosuximide)		▪ All of the agents in the Anticonvulsants class are preferred

ANTIDEPRESSANTS, OTHER			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
bupropion bupropion SR bupropion XL* mirtazapine* phenelzine trazodone venlafaxine ER capsules* venlafaxine IR	*APLENZIN (bupropion)* *desvenlafaxine ER* *EFFEXOR XR (venlafaxine)** *EMSAM (selegiline)* *FETZIMA (levomilnacipran)* *FORFIVO XL (bupropion)* *KHEDEZLA (desvenlafaxine)* *MARPLAN (isocarboxazid)* *NARDIL (phenelzine)* *nefazodone*	*PRISTIQ (desvenlafaxine)* *REMERON (mirtazapine)** *tranylcypromine* *TRINTELLIX (vortioxetine)* *venlafaxine ER tablets** *VIIBRYD (vilazodone)* *WELLBUTRIN SR (bupropion)* *WELLBUTRIN XL (bupropion)**	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions Dose Optimization applies to some strengths where a "*" is noted

ANTIDEPRESSANTS, SSRIs			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
citalopram* escitalopram tablets* fluoxetine IR fluvoxamine paroxetine* sertraline*	*BRISDELLE (paroxetine)* *CELEXA (citalopram)** *escitalopram solution* *fluoxetine capsule DR* *fluoxetine 60mg tablets* *fluvoxamine ER* *LEXAPRO (escitalopram)**	*paroxetine CR** *PAXIL (paroxetine)** *PAXIL CR (paroxetine)** *PROZAC (fluoxetine)* *ZOLOFT (sertraline)**	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions Dose Optimization applies to some strengths where a "*" is noted

ANTIDEPRESSANTS, TRICYCLIC			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
amitriptyline doxepin imipramine nortriptyline capsule	*amoxapine* *ANAFRANIL (clomipramine)* *clomipramine* *desipramine* *imipramine pamoate* *maprotiline* *nortriptyline solution* *PAMELOR (nortriptyline)* *protriptyline*	*SURMONTIL (trimipramine)* *TOFRANIL (imipramine)* *trimipramine*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

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

ANTIEMETIC-ANTIVERTIGO AGENTS (EXCLUDES INJECTABLES)		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Anticholinergics, Antihistamines, Dopamine Antagonists		▪ Treatment failure with 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: ▪ Antiemetic-Antivertigo Agents
dimenhydrinate meclizine metoclopramide solution, tablets phosphoric acid/dextrose/fructose prochlorperazine tablets promethazine syrup, tablets	*BONJESTA (doxylamine/pyridoxine)* *COMPRO (prochlorperazine)* *DICLEGIS (doxylamine/pyridoxine)* *doxylamine/pyridoxine* *metoclopramide ODT* *prochlorperazine suppositories* *promethazine suppositories* *REGLAN (metoclopramide)* *scopolamine patches* *TRANSDERM-SCOP (scopolamine)* *trimethobenzamide*	
Cannabinoids		
	dronabinol *MARINOL (dronabinol)*	

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

ANTIEMETIC-ANTIVERTIGO AGENTS (EXCLUDES INJECTABLES) *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
5-HT3 Receptor Antagonists		■ Treatment failure with 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 A drug specific prior authorization applies to drugs with a hyperlink The following Clinical Prior Authorization applies **to all drugs** in the class: ■ Antiemetic
ondansetron	*ANZEMET (dolasetron)* *granisetron* *SANCUSO (granisetron)* *ZOFRAN (ondansetron)* *ZUPLENZ (ondansetron)*	
Substance P Antagonists & Combinations		
	aprepitant *AKYNZEO (netupitant/palonosetron)* *EMEND (aprepitant)*	

ANTIFUNGALS, ORAL			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
clotrimazole fluconazole griseofulvin suspension ketoconazole nystatin terbinafine	*ANCOBON (flucytosine)* *CRESEMBA (isavuconazonium sulfate)* *DIFLUCAN (fluconazole)* *flucytosine* *griseofulvin tablets* *itraconazole*	*NOXAFIL (posaconazole)* *nystatin powder* *ORAVIG (miconazole)* *posaconazole* *SPORANOX (itraconazole)* *TOLSURA (itraconazole)* *VFEND (voriconazole)* *voriconazole*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

ANTIFUNGALS, TOPICAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antifungals		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
clotrimazole ketoconazole shampoo miconazole cream, powder nystatin terbinafine tolnaftate cream, powder	*BENSAL HP (benzoic acid/salicylic acid)* *ciclopirox* *clotrimazole solution RX* *DERMACINRX THERAZOLE PAK (betamethasone/clotrimazole/zinc oxide)* *econazole* *EXTINA (ketoconazole)* *FUNGOID (miconazole)* *JUBLIA (efinaconazole)* *KERYDIN (tavaborole)* *ketoconazole cream, foam* *LOPROX (ciclopirox)* *MENTAX (butenafine)* *miconazole ointment, spray* *naftifine* *oxiconazole* *OXISTAT (oxiconazole)* *VUSION (miconazole/ zinc/petrolatum)*	
Antifungal/Steroid Combinations		
clotrimazole/betamethasone cream	*clotrimazole/betamethasone lotion* *LOTRISONE (clotrimazole/betamethasone)* *nystatin/triamcinolone*	

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

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIHISTAMINES, FIRST GENERATION			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antihistamines			
carbinoxamine liquid clemastine tablet OTC clorpheniramine IR tablets cyproheptadine syrup, tablet diphenhydramine capsules, liquid, tablet HISTEX (triprolidine) liquid, PD DROPS Hydroxyzine PEDIACLEAR PD DROPS OTC (triprolidine) PEDIACLEAR-8 LIQUID OTC (pyrilamine maleate)	*carbinoxamine tablets* *chlorpheniramine ER tablets* *clemastine tablets* *diphenhydramine elixir* *ED CHLORPRED (chlorpheniramine/ phenylephrine)* *KARBINAL ER (carbinoxamine) suspension* *M-HIST (triprolidine) PD DROPS* *MICLARA LQ OTC (triprolidine)* *PEDIACLEAR ALLERGY DROPS OTC (triprolidine)* *PEDIACLEAR COUGH OTC (diphenhydramine HCL)* *RYCLORA (dexchlorpheniramine)* *RYVENT (carbinoxamine)* *THERAFLU NIGHTIME (diphenhydramine)* *triprolidine* *VANACLEAR (triprolidine) PD DROPS* *VANAHIST (triprolidine) PD DROPS* *VANAMINE (diphenhydramine) PD DROPS* *VISTARIL (hydroxyzine)*		▪ 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

ANTIHISTAMINES, MINIMALLY SEDATING		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antihistamines		
cetirizine solution, tablets* loratadine solution, tablets	*cetirizine chewable* *CLARINEX (desloratadine)* *desloratadine* *fexofenadine* *levocetirizine* *loratadine ODT*	▪ 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 Dose Optimization applies to some strengths where a "*" is noted

ANTIHISTAMINES, MINIMALLY SEDATING *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antihistamine/Decongestant Combinations		
	cetirizine/pseudoephedrine *loratadine/pseudoephedrine* *SEMPREX-D (acrivastine/pseudoephedrine)*	▪ 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

ANTIHYPERTENSIVES, SYMPATHOLYTICS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
CATAPRES-TTS (clonidine) clonidine IR tablets guanfacine IR methyldopa	*CATAPRES (clonidine)* *clonidine transdermal* *methyldopa / HCTZ*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

ANTIHYPERURICEMICS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
allopurinol MITIGARE (colchicine) probenecid probenecid/colchicine	*colchicine* *COLCRYS (colchicine)* *GLOPERBA (colchicine)* *ULORIC (febuxostat)* *ZYLOPRIM (allopurinol)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

ANTIMIGRAINE AGENTS			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
Triptans			
IMITREX (sumatriptan) nasal rizatriptan sumatriptan injection kit sumatriptan syringe sumatriptan tablets sumatriptan vial ZOMIG (zolmitriptan) nasal	*almotriptan* *AMERGE (naratriptan)* *eletriptan* *FROVA (frovatriptan)* *frovatriptan* *IMITREX (sumatriptan) injection kit* *IMITREX (sumatriptan) tablets* *IMITREX (sumatriptan) vial* *MAXALT (rizatriptan)* *naratriptan*	*ONZETRA XSAIL (sumatriptan)* *RELPAX (eletriptan)* *sumatriptan nasal* *sumatriptan/naproxen* *SUMAVEL DOSEPRO (sumatriptan)* *TOSYMRA (sumatriptan)* *TREXIMET (sumatriptan/naproxen)* *ZEMBRACE SYMTOUCH (sumatriptan)* *zolmitriptan tablets* *ZOMIG (zolmitriptan) tablets*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

ANTIMIGRAINE AGENTS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Non-Triptans		
AIMOVIG (erenumab) EMGALITY (galcanezumab-gnlm) UBRELVY (ubrogepant)	*AJOVY (fremanezumab-vfrm)* *CAMBIA (diclofenac)* *D.H.E. 45 (dihydroergotamine)* *dihydroergotamine mesylate* *EMGALITY 100 mg (cluster headache) (galcanezumab-gnlm)* *MIGRANAL (dihydroergotamine mesylate)* *NURTEC ODT (rimegepant)* *REYVOW (lasmiditan)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

ANTIPARASITICS, TOPICAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
NATROBA (spinosad) permethrin VANALICE GEL OTC (piperonyl butoxide/pyrethrum)	*CROTAN (crotamiton)* *EURAX (crotamiton)* *lindane* *malathion* *OVIDE (malathion)* *SKLICE (ivermectin)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

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

ANTIPARKINSON'S AGENTS (ORAL/TRANSDERMAL)		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Anticholinergics		▪ Treatment failure with 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
benztropine trihexyphenidyl		
COMT Inhibitors		
	COMTAN (entacapone) *entacapone* *ONGENTYS (opicapone)* *TASMAR (tolcapone)* *tolcapone*	
Dopamine Agonists		
pramipexole ropinirole	*APOKYN (apomorphine)* *bromocriptine* *KYNMOBI (apomorphine)* *MIRAPEX (pramipexole)* *MIRAPEX ER (pramipexole)* *NEUPRO transdermal (rotigotine)* *pramipexole ER* *REQUIP (ropinirole) REQUIP XL* *(ropinirole) ropinirole ER*	

ANTIPARKINSON'S AGENTS (ORAL/TRANSDERMAL) *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
MAO-B Inhibitors		▪ Treatment failure with 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 A drug specific prior authorization applies to drugs with a hyperlink
	AZILECT (rasagiline) *rasagiline* *selegiline* *XADAGO (safinamide)* *ZELAPAR (selegiline)*	
Others		
amantadine carbidopa/levodopa tablets carbidopa/levodopa ER carbidopa/levodopa/entacapone	*carbidopa* *carbidopa/levodopa ODT* *DUOPA (carbidopa/levodopa)* *GOCOVRI (amantadine)* *INBRIJA (levodopa)* *LODOSYN (carbidopa)* *NOURIANZ (istradefylline)* *OSMOLEX ER (amantadine)* *RYTARY (carbidopa/levodopa)* *SINEMET (carbidopa/levodopa)* *SINEMET CR (carbidopa/levodopa)* *STALEVO (levodopa/carbidopa/entacapone)*	

ANTIPSYCHOTICS				
Preferred Agents		***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antipsychotics				
aripiprazole tablets*	perphenazine	*ABILIFY (aripiprazole) tablets**	*pimozide*	▪ Treatment failure with 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 A drug specific prior authorization applies to drugs with a hyperlink Dose Optimization applies to some strengths where a "*" is noted
chlorpromazine	quetiapine IR	*ABILIFY MYCITE (aripiprazole)*	*quetiapine ER*	
clozapine	risperidone tablets*, solution	*aripiprazole ODT, solution*	*REXULTI (brexpiprazole)*	
fluphenazine	thioridazine	*clozapine ODT*	*RISPERDAL (risperidone)**	
haloperidol	thiothixene	*CAPLYTA (lumateperone)*	*risperidone ODT**	
haloperidol decanoate	trifluoperazine	*CLOZARIL (clozapine)*	*SAPHRIS (asenapine)*	
LATUDA (lurasidone)	ziprasidone	*FANAPT (iloperidone)*	*SECUADO (asenapine)*	
olanzapine*		*FAZACLO (clozapine)*	*SEROQUEL (quetiapine)*	
olanzapine ODT*		*fluphenazine decanoate*	*SEROQUEL XR (quetiapine)*	
		GEODON (ziprasidone) capsule, IM	*VERSACLOZ (clozapine)*	
		HALDOL (haloperidol) decanoate	*VRAYLAR (cariprazine)*	
		haloperidol lactate injection	*ZYPREXA (olanzapine)**	
		INVEGA (paliperidone)	*ZYPREXA ZYDIS (olanzapine)**	
		loxapine		
		NUPLAZID (pimavanserin)		
		olanzapine IM		
		ORAP (pimozide)		
		paliperidone		

ANTIPSYCHOTICS *Continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antipsychotic/SSRI Combinations		
amitriptyline/perphenazine	*olanzapine/fluoxetine* *SYMBYAX (olanzapine/fluoxetine)*	▪ Treatment failure with 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

ANTIPSYCHOTICS *Continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Long-Acting Injectables		
ABILIFY MAINTENA (aripiprazole) ARISTADA (aripiprazole) ARISTADA INITIO (aripiprazole) INVEGA SUSTENNA (paliperidone) INVEGA TRINZA (paliperidone) RISPERDAL CONSTA (risperidone)	*PERSERIS (risperidone)* *ZYPREXA RELPREVV (olanzapine)*	▪ Treatment failure with 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 A drug specific prior authorization applies to drugs with a hyperlink

ANTIVIRALS (ORAL/NASAL)		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antiherpetic		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
acyclovir famciclovir valacyclovir	*VALTREX (valacyclovir)* *ZOVIRAX (acyclovir)*	
Anti-influenza		
oseltamivir	*RELENZA (zanamivir)* *rimantadine* *TAMIFLU (oseltamivir)* *XOFLUZA (baloxavir)*	
Anti-CMV		
VALCYTE (valganciclovir) tablets, solution	*valganciclovir tablets, solution*	

ANTIVIRALS, TOPICAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
acyclovir ointment DENAVIR (penciclovir)	*XERESE (acyclovir/hydrocortisone)* *ZOVIRAX (acyclovir)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

ANXIOLYTICS				
Preferred Agents		***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
alprazolam tablet	diazepam solution	*alprazolam ER*	*TRANXENE T-TAB (clorazepate)*	▪ Treatment failure with 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
buspirone	diazepam tablet	*alprazolam intensol*	*XANAX XR (alprazolam)*	
chlordiazepoxide	lorazepam intensol	*alprazolam ODT*	*XANAX (alprazolam) tablet*	
clorazepate	lorazepam tablet	*diazepam intensol*		
		meprobamate		
		oxazepam		

BETA BLOCKERS (ORAL)		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Beta Blockers		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink
acebutolol atenolol bisoprolol HEMANGEOL (propranolol) metoprolol IR metoprolol XL propranolol IR sotalol	*betaxolol* *BYSTOLIC (nebivolol)* *INDERAL LA (propranolol)* *INNOPRAN XL (propranolol)* *KAPSPARGO (metoprolol succinate)* *nadolol* *pindolol* *propranolol ER* *SOTYLIZE (sotalol)* *TENORMIN (atenolol)* *timolol* *TOPROL XL (metoprolol succinate)*	
Beta Blocker Combinations		
atenolol/chlorthalidone bisoprolol/HCTZ	*CORZIDE (nadolol/bendroflumethiazide)* *DUTOPROL (metoprolol succinate ER/HCTZ)* *metoprolol/HCTZ* *nadolol/bendroflumethiazide* *propranolol/HCTZ* *TENORETIC (atenolol/HCTZ)* *ZIAC (bisoprolol/HCTZ)*	

BETA BLOCKERS (ORAL) *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Beta- and Alpha-Blockers		
carvedilol labetalol	*carvedilol ER** *COREG (carvedilol)* *COREG CR (carvedilol)**	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions Dose Optimization applies to some strengths where a "*" is noted

BILE SALTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ursodiol tablet	*ACTIGALL (ursodiol)* *CHENODAL (chenodiol)* *CHOLBAM (cholic acid)* *OCALIVA (obeticholic acid)* *URSO (ursodiol)* *URSO FORTE (urosodiol)* *ursodiol capsule*	▪ Treatment failure with preferred drug ▪ Contraindication to preferred drug ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

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

BLADDER RELAXANT PREPARATIONS			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
oxybutynin IR oxybutynin ER* TOVIAZ (fesoterodine) VESICARE (solifenacin)*	*darifenacin* *DETROL (tolterodine)* *DETROL LA (tolterodine)** *DITROPAN XL (oxybutynin)** *ENABLEX (darifenacin)* *flavoxate* *GELNIQUE (oxybutynin)* *MYRBETRIQ (mirabegron)*	*OXYTROL (oxybutynin)* *tolterodine* *tolterodine ER** *trospium* *trospium ER*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions Dose Optimization applies to some strengths where a "*" is noted

BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Bisphosphonates		▪ Treatment failure with 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 A drug specific prior authorization applies to drugs with a hyperlink
alendronate tablets	*ACTONEL (risedronate)* *alendronate solution* *ATELVIA (risedronate)* *BINOSTO (alendronate)* *BONIVA (ibandronate) etidronate* *EVENITY (romosozumab-aqqg)* *FOSAMAX (alendronate)* *FOSAMAX PLUS D (alendronate/vitamin D)* *ibandronate risedronate*	
Other Bone Resorption Suppression and Related Agents		
	calcitonin nasal *EVISTA (raloxifene)* *FORTEO (teriparatide)* *raloxifene* *teriparatide* *TYMLOS (abaloparatide)*	

BPH AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Alpha Blockers		▪ Treatment failure with 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 Dose Optimization applies to some strengths where a "*" is noted
alfuzosin doxazosin* tamsulosin terazosin*	*CARDURA (doxazosin)** *FLOMAX (tamsulosin)** *RAPAFLO (silodosin)*	
5-Alpha-Reductase (5AR) Inhibitors		
finasteride	*AVODART (dutasteride)* *dutasteride* *PROSCAR (finasteride)*	
Alpha Blocker/5AR Inhibitor Combinations		
	dutasteride/tamsulosin *JALYN (dutasteride/tamsulosin)*	
Phosphodiesterase 5 Inhibitors		
	tadalafil	

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

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

BRONCHODILATORS, BETA AGONIST		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Inhalers, Short-Acting		▪ Treatment failure with 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
PROAIR HFA (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	*levalbuterol* *PROAIR DIGIHALER (albuterol)* *PROAIR RESPICLICK (albuterol)* *XOPENEX HFA (levalbuterol)*	
Inhalers, Long-Acting		
	ARCAPTA (indacaterol) *SEREVENT (salmeterol)* *STRIVERDI RESPIMAT (olodaterol)*	

BRONCHODILATORS, BETA AGONIST *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Inhalation Solution		▪ Treatment failure with 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
albuterol	*BROVANA (arformoterol)* *levalbuterol* *PERFOROMIST (formoterol)* *XOPENEX (levalbuterol)*	
Oral		
albuterol syrup	*albuterol tablet* *albuterol ER* *metaproterenol* *terbutaline*	

CALCIUM CHANNEL BLOCKERS (ORAL)		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Short-Acting		
diltiazem verapamil	*CALAN (verapamil)* *CARDIZEM (diltiazem)* *Isradipine* *nicardipine* *nifedipine* *nimodipine* *NYMALIZE (nimodipine)* *PROCARDIA (nifedipine)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions Dose Optimization applies to some strengths where a "*" is noted
Long-Acting		
amlodipine* CARTIA XT (diltiazem) diltiazem ER felodipine ER nifedipine ER* TAZTIA XT (diltiazem) verapamil ER capsules, tablets*	*ADALAT CC (nifedipine)** *CALAN SR (verapamil)* *CARDIZEM CD (diltiazem)* *CARDIZEM LA (diltiazem)* *diltiazem LA* *KATERZIA (amlodipine)* *MATZIM LA (diltiazem)* *nisoldipine** *NORVASC (amlodipine)** *PROCARDIA XL (nifedipine)** *TIAZAC (diltiazem)* *verapamil 360 mg capsules* *verapamil ER PM** *VERELAN (verapamil)* *VERELAN PM (verapamil)*	

CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Beta Lactam/Beta-Lactamase Inhibitor Combinations		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
amoxicillin/clavulanate tablets, suspension	*amoxicillin/clavulanate chewable,* XR tablets *AUGMENTIN suspension (amoxicillin/clavulanate)* *AUGMENTIN XR (amoxicillin/clavulanate)*	
Cephalosporins – First Generation		
cefadroxil capsules, suspension cephalexin capsules, suspension	*cefadroxil tablets cephalexin tablets*	

CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL) *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Cephalosporins – Second Generation		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
cefprozil suspension cefprozil tablets cefuroxime tablets	cefaclor ER cefaclor IR capsules, suspension	
Cephalosporins – Third Generation		
cefdinir	*cefixime* *cefpodoxime* *ceftibuten* *SUPRAX (cefixime)*	

COLONY STIMULATING FACTORS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
NEUPOGEN (filgrastim) vial, syringe UDENYCA (pegfilgrastim-cbqv)	FULPHILA (pegfilgrastim - jmdb) GRANIX (tbo-filgrastim) *LEUKINE (sargramostim)* *NEULASTA (pegfilgrastim)* *NIVESTYM (filgrastim-aafi)* *NYVEPRIA (pegfilgrastim-apgf)* *ZARXIO (filgrastim-sndz)* *ZIEXTENZO SYRINGE (pegfilgrastim-bmez)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

COPD AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Anticholinergics		▪ Treatment failure with 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
ATROVENT HFA (ipratropium) ipratropium inhalation solution SPIRIVA HANDIHALER (tiotropium)	*INCRUSE ELLIPTA (umeclidinium)* *LONHALA MAGNAIR (glycopyrrolate)* *SEEBRI NEOHALER (glycopyrrolate)* *SPIRIVA RESPIMAT (tiotropium)* *TUDORZA (aclidinium)*	
Anticholinergic-Beta Agonist Combinations		
albuterol/ipratropium ANORO ELLIPITA (umeclidinium/vilanterol) COMBIVENT RESPIMAT (albuterol/ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	*BEVESPI AEROSPHERE (glycopyrrolate/formoterol)* *DUAKLIR PRESSAIR (aclidinium/formoterol)* *UTIBRON NEOHALER (glycopyrrolate/indacaterol)* *YUPELRI (revefenacin)*	
Phosphodiesterase Inhibitors		
	DALIRESP (roflumilast)	

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

COUGH AND COLD AGENTS	
See Separate Preferred Cough and Cold Agent Listing.	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Cough & cold PA criteria

CYTOKINE AND CAM ANTAGONISTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ENBREL (etanercept) HUMIRA (adalimumab) OTEZLA (apremilast)	*ACTEMRA (tocilizumab)* *CIMZIA (certolizumab)* *COSENTYX (secukinumab)* *ENSPRYNG (satralizumab-mwge)* *ILARIS (canakinumab)* *ILUMYA (tildrakizumab-asmn)* *KEVZARA (sarilumab)* *KINERET (anakinra)* *OLUMIANT (baricitinib)* *ORENCIA (abatacept)* *RINVOQ ER (upadacitinib)* *SILIQ (brodalumab)* *SIMPONI (golimumab)* *SKYRIZI (risankizumab-rzaa)* *STELARA (ustekinumab)* *TALTZ (ixekizumab)* *TREMFYA (guselkumab)* *XELJANZ (tofacitinib)* *XELJANZ XR (tofacitinib)*	▪ Treatment failure with 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

EPINEPHRINE, SELF-INJECTED		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
epinephrine (Mylan authorized generic EPIPEN and EPIPEN JR)	*epinephrine (generic ADRENACLICK)* epinephrine (generic EPIPEN and EPIPEN JR) *EPIPEN (epinephrine)* *EPIPEN JR (epinephrine)* *SYMJEPI (epinephrine)*	▪ Treatment failure with preferred products ▪ Contraindication to preferred products ▪ Allergic reaction to preferred products ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

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

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ERYTHROPOIESIS STIMULATING PROTEINS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ARANESP (darbepoetin) RETACRIT (RhUEPO)	*EPOGEN (RhUEPO)* *MIRCERA (PEG-EPO)* *PROCRIT (RhUEPO)* *REBLOZYL* *(luspatercept-aamt)*	▪ Treatment failure with 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 alldrugs** in the class: ▪ Erythropoiesis-Stimulating Agents

FLUOROQUINOLONES, ORAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ciprofloxacin IR ciprofloxacin suspension levofloxacin tablets	*AVELOX (moxifloxacin)* *BAXDELA (delafloxacin)* *CIPRO (ciprofloxacin) tablets* *CIPRO (ciprofloxacin) suspension* *ciprofloxacin ER* *LEVAQUIN (levofloxacin)* *levofloxacin solution* *moxifloxacin* *ofloxacin*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

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

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

GI MOTILITY, CHRONIC		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
AMITIZA (lubiprostone) LINZESS (linaclotide) MOVANTIK (naloxegol)	*alosetron* *LOTRONEX (alosetron)* *MOTEGRITY (prucalopride)* *RELISTOR (methylnaltrexone) injection* *RELISTOR (methylnaltrexone) oral* *SYMPROIC (naldemedine)* *TRULANCE (plecanatide)* *VIBERZI (eluxadoline)*	▪ 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

GLUCAGON AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
BAQSIMI (glucagon) glucagon injection glucagon emergency kit (Lilly) PROGLYCEM (diazoxide)	*diazoxide suspension* *glucagon emergency kit (Fresenius)* *GVOKE (glucagon)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

GLUCOCORTICOIDS, INHALED		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Glucocorticoids		
ASMANEX (mometasone) budesonide respules FLOVENT HFA (fluticasone)	*ALVESCO (ciclesonide)* *ARMONAIR DIGIHALER ((fluticasone)* *ARMONAIR RESPICLICK (fluticasone)* *ARNUITY ELLIPTA (fluticasone)* *ASMANEX HFA (mometasone)* *FLOVENT DISKUS (fluticasone)* *PULMICORT FLEXHALER (budesonide)* *PULMICORT respules (budesonide)* *QVAR (beclomethasone)*	▪ Treatment failure with 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

GLUCOCORTICOIDS, INHALED *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Glucocorticoid/Bronchodilator Combinations		
ADVAIR (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT (budesonide/formoterol)	*AIRDUO DIGIHALER (fluticasone/salmeterol)* *BREO ELLIPTA (fluticasone/vilanterol)* *BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol)* *fluticasone/salmeterol (Air Duo)* *TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)*	▪ Treatment failure with 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

GLUCOCORTICOIDS, ORAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
budesonide EC dexamethasone elixir, solution, tablets hydrocortisone methylprednisolone tablet dose pack prednisolone sodium phosphate prednisolone prednisone solution, tablets	*CORTEF (hydrocortisone)* *dexamethasone intensol* *DEXPAK (dexamethasone)* *DXEVO (dexamethasone)* *EMFLAZA (deflazacort)* *ENTOCORT EC (budesonide)* *HEMADY (dexamethasone)* *MEDROL (methylprednisolone)* *methylprednisolone tablets* *MILLIPRED (prednisolone)* *prednisolone sodium phosphate ODT, solution* *prednisone intensol prednisone tablet dose pack* *TAPERDEX (dexamethasone)*	▪ Treatment failure with 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 A drug specific prior authorization applies to drugs with a hyperlink

GROWTH HORMONE		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
GENOTROPIN NORDITROPIN	*HUMATROPE* *NUTROPIN AQ* *OMNITROPE* *SAIZEN* *SEROSTIM* *ZORBTIVE*	▪ Treatment failure with 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

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

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

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

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

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

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

HEPATITIS C AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Pegylated Interferons		▪ Treatment failure with 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: ▪ Manual Prior Authorization
	PEGASYS (pegylated IFN alfa-2a)	
Polymerase/Protease Inhibitors		
EPCLUSA (sofosbuvir/velpatasvir) MAVYRET (glecaprevir/pibrentasvir) VOSEVI (sofosbuvir, velpatasvir, voxilaprevir)	*DAKLINZA (daclatasvir)* *HARVONI (ledipasvir/sofosbuvir) tablets, pellet pack* *ledipasvir/sofosbuvir* *sofosbuvir/velpatasvir* *SOVALDI (sofosbuvir) tablets, pellet pack* *TECHNIVIE (ombitasvir/paritaprevir/ritonavir)* *VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)* *VIEKIRA XR (dasabuvir/ombitasvir/paritaprevir/ritonavir)* *ZEPATIER (elbasvir/grazoprevir)*	

HEPATITIS C AGENTS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Ribavirin		
ribavirin capsule ribavirin tablet	*REBETOL solution* *RIBASPHERE 400, 600 mg* *ribavirin dose pack*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

HEREDITARY ANGIOEDEMA (HAE) TREATMENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
BERINERT (C1 esterase inhibitor) CINRYZE (C1 esterase inhibitor) HAEGARDA (C1 esterase inhibitor) icatibant KALBITOR (ecallantide)	*FIRAZYR (icatibant)* *ORLADEYO (berotralstat)* *RUCONEST (C1 esterase inhibitor)* *TAKHZYRO (lanadelumab-flyo)*	▪ Treatment failure with 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

HIV/AIDS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antiretroviral Single Agent Products		▪ All of the agents in the HIV/AIDS class are preferred
abacavir APTIVUS (tipranavir) atazanavir CRIXIVAN (indinavir) didanosine EDURANT (rilpivirine) efavirenz EMTRIVA (emtricitabine) EPIVIR (lamivudine) fosamprenavir FUZEON (enfuvirtide) INTELENCE (etravirine) INVIRASE (saquinavir) ISENTRESS (raltegravir) lamivudine LEXIVA (fosamprenavir) Nevirapine NORVIR (ritonavir) PIFELTRO (doravirine) PREZCOBIX (darunavir/cobicistat) PREZISTA (darunavir) RETROVIR (zidovudine) REYATAZ (atazanavir) ritonavir RUKOBIA (fostemsavir) SELZENTRY (maraviroc) stavudine SUSTIVA (efavirenz) tenofovir disoproxil fumarate TIVICAY (dolutegravir) TROGARZO (ibalizumab-uiyk) TYBOST (cobicistat) VIDEX (didanosine) VIRACEPT (nelfinavir) VIRAMUNE (nevirapine) VIRAMUNE XR (nevirapine) VIREAD (tenofovir disoproxil fumurate) ZIAGEN (abacavir) zidovudine		

HIV/AIDS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antiretroviral Combinations		▪ All of the agents in the HIV/AIDS class are preferred
abacavir/lamivudine abacavir/lamivudine/zidovudine ATRIPLA (efavirenz/emtricitabine/tenofovir) BIKTARVY (bictegravir/emtricitabine/tenofovir) CIMDUO (lamivudine/tenofovir DF) COMBIVIR (lamivudine/zidovudine) COMPLERA (emtricitabine/rilpivirine/tenfovir DF) DELSTRIGO (doravirine/lamivudine/ tenofovir DF) DESCOVY (emtricitabine/tenofovir alafenamide) DOVATO (dolutegravir/lamivudine) EPZICOM (abacavir/lamivudine) EVOTAZ (atazanavir/cobicistat) GENVOYA (elvitegravir/cobicistat/ emtricitabine/tenofovir alafenamide) JULUCA (dolutegravir/rilpivirine) KALETRA (lopinavir/ritonavir) lamivudine/zidovudine lopinavir/ritonavir ODEFSEY (emtricitabine/rilpivirine/ tenofovir alafenamide) STRIBILD (elvitegravir/cobicistat/ emtricitabine/tenofovir DF) SYMFI (efavirenz/lamivudine/ tenofovir DF) SYMFI LO (efavirenz/lamivudine/ tenofovir DF) SYMTUZA (darunavir/cobicistat/ emtricitabine/tenofovir DF) TEMIXYS (lamivudine/tenofovir DF) TRIUMEQ (abacavir/dolutegravir/ lamivudine) TRIZIVIR (abacavir/lamivudine/ zidovudine) TRUVADA (emtricitabine/ tenofovir DF)		

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Amylin Analogs		
SYMLIN (pramlintide)		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Incretin Enhancers		
JANUMET (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) ONGLYZA (saxagliptin) TRADJENTA (linagliptin)	*alogliptin* *alogilptin/metformin* *alogliptin/pioglitazone* *JANUMET XR (sitagliptin/metformin)* *JENTADUETO XR (linagliptin/metformin)* *KAZANO (alogliptin /metformin)* *NESINA (alogliptin)* *OSENI (alogliptin /pioglitazone)*	▪ Treatment failure with 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 A drug specific prior authorization applies to drugs with a hyperlink

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

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Incretin Mimetics		
BYDUREON (exenatide ER) pens, vials BYETTA (exenatide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	*ADLYXIN (lixisenatide)* *BYDUREON BCISE (exenatide ER)* *OZEMPIC (semaglutide)* *RYBELSUS (semaglutide)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ GLP-1 Receptor Antagonists

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Incretin Enhancers/SGLT2 Inhibitor Combinations		■ Treatment failure with preferred drugs within any subclass ■ Contraindication to preferred drugs ■ Allergic reaction to preferred drugs ■ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ■ DPP4 Inhibitor The following Clinical Prior Authorization applies **to all drugs** in the class: ■ GLP-1 Receptor Antagonists
GLYXAMBI (empagliflozin/linagliptin)	*QTERN (dapagliflozin/saxagliptin)* *STEGLUJAN (ertugliflozin/sitagliptin)* *TRIJARDY XR (empagliflozin/linagliptin/metformin)*	
Incretin Mimetic/Insulin Combinations		
	SOLIQUA (lixisenatide/insulin glargine) *XULTOPHY (liraglutide/insulin degludec)*	

HYPOGLYCEMICS, INSULIN		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
HUMALOG (insulin lispro) pens, vials HUMALOG JUNIOR KWIKPEN (insulin lispro) HUMALOG MIX (insulin lispro/lispro protamine) pens, vials HUMULIN N (insulin) vials HUMULIN R (insulin) vials HUMULIN R 500 UNITS/ML (insulin) pens, vials HUMULIN R 70/30 (insulin) pens, vials LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLIN (insulin) vials NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	*ADMELOG (insulin lispro) AFREZZA (insulin)* *APIDRA (insulin glulisine)* *BASAGLAR (insulin glargine) FIASP (insulin aspart) HUMALOG 200 UNITS/ML* *HUMULIN N (insulin) pen* *insulin lispro* *LYUMJEV (insulin lispro)* *NOVOLIN (insulin) pens* *NOVOLIN 70/30 (insulin)* *SEMGLEE (insulin glargine) pen, vial* *TOUJEO (insulin glargine) TRESIBA (insulin degludec)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

HYPOGLYCEMICS, MEGLITINIDES		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
nateglinide repaglinide	*repaglinide/metformin* *STARLIX (nateglinide)*	▪ Treatment failure with 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

HYPOGLYCEMICS, METFORMIN		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
glyburide/metformin metformin metformin ER (GLUCOPHAGE XR)	FORTAMET (metformin ER) glipizide/metformin GLUCOPHAGE (metformin) GLUCOPHAGE XR (metformin ER) GLUMETZA (metformin ER) metformin ER (FORTAMET) metformin ER (GLUMETZA) RIOMET (metformin) RIOMET ER (metformin)	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

HYPOGLYCEMICS, SGLT2		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
FARXIGA (dapagliflozin) INVOKANA (canaglifozin) JARDIANCE (empagliflozin)	*STEGLATRO (ertugliflozin)*	▪ Treatment failure with 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

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

HYPOGLYCEMICS, SGLT2 *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
SGLT2 Combinations		
SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin)	*INVOKAMET (canagliflozin/metformin)* *INVOKAMET XR (canagliflozin/metformin)* *SEGLUROMET (ertugliflozin/metformin)* *SYNJARDY XR (empagliflozin/metformin)*	▪ Treatment failure with 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

HYPOGLYCEMICS, TZD		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Thiazolidinediones		
pioglitazone	*AVANDIA (rosiglitazone)*	▪ Treatment failure with 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

HYPOGLYCEMICS, TZD *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
TZD Combinations		
	ACTOPLUS MET XR (pioglitazone/metformin) *DUETACT (pioglitazone/glimepiride)* *pioglitazone/metformin* *pioglitazone/glimepiride*	▪ Separate prescriptions for the individual components should be used instead of the combination drug. ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ For drugs in a therapeutic class and/or subclass with no preferred option, the provider must obtain a PDL prior authorization The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Thiazolidinediones

IMMUNE GLOBULINS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
CYTOGAM (CMV immune globulin) GAMMAGARD (immune globulin) GAMMAKED (immune globulin) GAMUNEX-C (immune globulin) HIZENTRA (immune globulin) vial	*ASCENIV (immune globulin)* *BIVIGAM (immune globulin)* *CARIMUNE NF (immune globulin)* *CUTAQUIG (immune globulin)* *CUVITRU (immune globulin)* *FLEBOGAMMA DIF (immune globulin)* *HYQVIA (immune globulin)* *HIZENTRA (immune globulin) syringe* *OCTAGAM (immune globulin)* *PANZYGA (immune globulin)* *PRIVIGEN (immune globulin)* *XEMBIFY (immune globulin)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

IMMUNOMODULATORS, ASTHMA		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
FASENRA PEN (benralizumab)	*NUCALA (mepolizumab)*	▪ Treatment failure with 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

IMMUNOMODULATORS, ATOPIC DERMATITIS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
EUCRISA (crisaborole)	*DUPIXENT (dupilumab)* *ELIDEL (pimecrolimus)* *tacrolimus*	▪ Treatment failure with 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. A drug specific prior authorization applies to drugs with a hyperlink

IMMUNOSUPPRESSIVES, ORAL			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
azathioprine cyclosporine, modified mycophenolate mofetil capsules, tablets NEORAL (cyclosporine, modified) capsules RAPAMUNE (sirolimus) solution sirolimus tablets tacrolimus	*ASTAGRAF XL (tacrolimus)* *CELLCEPT (mycophenolate mofetil)* *cyclosporine* *ENVARSUS XR (tacrolimus)* *mycophenolate mofetil suspension* *mycophenolic acid* *MYFORTIC (mycophenolic acid)* *NEORAL (cyclosporine, modified) solution*	*PROGRAF (tacrolimus)* *RAPAMUNE (sirolimus) tablets* *SANDIMMUNE (cyclosporine)* *sirolimus solution* *ZORTRESS (everolimus)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

INTRANASAL RHINITIS AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Glucocorticoids		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ The PA criteria above apply to Dupixent for Chronic Rhinosinusitis ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization
fluticasone	*BECONASE AQ (beclomethasone)* *budesonide* *fluticasone OTC* *flunisolide* *mometasone* *NASONEX (mometasone)* *OMNARIS (ciclesonide)* *QNASL (beclomethasone dipropionate)* *triamcinolone* *XHANCE (fluticasone)*	
Others		
azelastine (generic ASTELIN)	*ASTEPRO (azelastine)* *azelastine (generic ASTEPRO)* *ipratropium nasal spray* *olopatadine* *PATANASE (olopatadine)*	
Combinations		
	DYMISTA (azelastine/fluticasone)	

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

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

IRON, ORAL	
See Separate Listing of Preferred Oral Iron Drugs.	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

LEUKOTRIENE MODIFIERS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
montelukast chewable tablets, tablets	montelukast granules *SINGULAIR (montelukast)* *zafirlukast* *zileuton* *ZYFLO CR (zileuton)*	▪ Treatment failure with 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

LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
clindamycin capsules clindamycin solution linezolid	*CLEOCIN (clindamycin)* *LINCOCIN (lincomycin)* *SIVEXTRO (tedizolid)* *ZYVOX (linezolid)*	▪ 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

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

LIPOTROPICS, OTHER		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Adenosine Triphosphate-Citrate Lyase Inhibitor		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization
	NEXLETOL (bempedoic acid) *NEXLIZET (bempedoic acid/ezetimibe)*	
Bile Acid Sequestrants		
cholestyramine colestipol tablets	*colesevalam* *COLESTID (colestipol)* *colestipol granules* *QUESTRAN (cholestyramine)* *QUESTRAN LIGHT (cholestyramine)* *WELCHOL (colesevalam)*	
Cholesterol Absorption Inhibitors		
ZETIA (ezetimibe)	*ezetimibe*	
Fibric Acid Derivatives		
fenofibrate (generic Lofibra, Tricor) gemfibrozil	*fenofibrate (generic Antara, Fenoglide, Lipofen)* *fenofibric acid (generic Fibricor, Trilipix)* *FENOGLIDE (fenofibrate)* *LIPOFEN (fenofibrate)* *LOPID (gemfibrozil)* *TRICOR (fenofibrate)* *TRIGLIDE (fenofibrate)* *TRILIPIX (fenofibric acid)*	

LIPOTROPICS, OTHER *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Homozygous Familial Hypercholesterolemia Treatments		▪ Treatment failure with 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 A drug specific prior authorization applies to drugs with a hyperlink
	JUXTAPID (lomitapide) *KYNAMRO (mipomersen)*	
Niacin		
niacin OTC	*niacin ER* *NIASPAN (niacin)*	
Omega-3 Fatty Acids		
omega-3 fatty acids	*LOVAZA (omega-3 fatty acids)* *VASCEPA (icosapent ethyl)*	

LIPOTROPICS, OTHER *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
PCSK9 Inhibitors		
	PRALUENT (alirocumab) *REPATHA (evolocumab)*	▪ Trial of atorvastatin, rosuvastatin, and ezetimibe ▪ Concurrent therapy of atorvastatin or rosuvastatin ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization Clinical prior authorizations applies to all PCSK9 inhibitors: ▪ PCSK9 Inhibitors

<table>
<tr><th colspan="3">LIPOTROPICS, STATINS</th></tr>
<tr><th>Preferred Agents</th><th>Non-Preferred Agents</th><th>PA Criteria
Client must meet at least one of the listed PA criteria</th></tr>
<tr><td colspan="2">Statins</td><td rowspan="4">■ 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

Dose Optimization applies to some strengths where a “*” is noted</td></tr>
<tr><td>atorvastatin*
lovastatin*
pravastatin*
rosuvastatin*
simvastatin*</td><td>CRESTOR (rosuvastatin)*
EZALLOR SPRINKLE (rosuvastatin)
fluvastatin*
fluvastatin ER
LESCOL XL (fluvastatin)
LIPITOR (atorvastatin)*
LIVALO (pitavastatin)
PRAVACHOL (pravastatin)*
ZOCOR (simvastatin)*
ZYPITAMAG (pitavastatin)</td></tr>
<tr><td colspan="2">Statin Combinations</td></tr>
<tr><td></td><td>atorvastatin/amlodipine
CADUET (atorvastatin/amlodipine)
simvastatin/ezetimibe
VYTORIN (simvastatin/ezetimibe)</td></tr>
</table>

MACROLIDES (ORAL)			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
azithromycin clarithromycin tablets ERYPED (erythromycin) erythromycin base	*clarithromycin suspension* *clarithromycin ER* *E.E.S. (erythromycin)* *ERY-TAB (erythromycin)* *ERYTHROCIN (erythromycin)*	*erythromycin base filmtab* *erythromycin ethylsuccinate suspension* *ZITHROMAX (azithromycin)*	▪ 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

MOVEMENT DISORDERS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
AUSTEDO (deutetrabenazine) INGREZZA (valbenazine) tetrabenazine	*XENAZINE (tetrabenazine)*	▪ Treatment failure with 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

MULTIPLE SCLEROSIS AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
AMPYRA (dalfampridine) AUBAGIO (teriflunomide) AVONEX (interferon beta-1a) BAFIERTAM (monomethyl fumarate) BETASERON (interferon beta-1b) COPAXONE (glatiramer) dalfampridine dimethyl fumarate EXTAVIA (interferon beta-1b) GILENYA (fingolimod) glatiramer KESIMPTA (ofatumumab) MAVENCLAD (cladribine) MAYZENT (siponimod) PLEGRIDY (peginterferon beta-1a) REBIF (interferon beta-1a) TECFIDERA (dimethyl fumarate) TYSABRI (natalizumab) VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod)		▪ All of the agents in the Multiple Sclerosis class are preferred A drug specific prior authorization applies to drugs with a hyperlink

NEUROPATHIC PAIN		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Oral Agents		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink
duloxetine (Cymbalta) gabapentin pregabalin capsule	*CYMBALTA (duloxetine)* *RIZALMA SPRINKLE (duloxetine)* *duloxetine (Irenka)* *GABACAINE KIT (gabapentin/lidocaine)* *GRALISE (gabapentin)* *HORIZANT (gabapentin enacarbil ER)* *LYRICA (pregabalin)* *LYRICA CR (pregabalin)* *NEURONTIN (gabapentin)* *SAVELLA (milnacipran)*	
Topical Agents		
capsaicin OTC	*lidocaine patch* *LIDODERM (lidocaine)* *LIDOPURE (lidocaine)* *ZILACAINEPATCH (lidocaine)* *ZTLIDO (lidocaine)*	

NSAIDS			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
Nonspecific			
diclofenac potassium ibuprofen indomethacin capsules naproxen EC naproxen sodium OTC naproxen tablets	*ADVIL (ibuprofen)* *ALEVE (naproxen)* *ANAPROX(naproxen)* *CHILDREN'S MOTRIN (ibuprofen)* *DAYPRO (oxaprozin)* *diclofenac sodium* *diclofenac SR* *DICLOTREX KIT (diclofenac/menthol/camphor)* *diflunisal* *etodolac* *etodolac SR* *FELDENE (piroxicam)* *fenoprofen* *flurbiprofen* *IBUPAK KIT (ibuprofen/glycerin)* *INDOCIN (indomethacin) capsules, suspension* *indomethacin ER capsules* *ketoprofen* *ketoprofen ER*	*ketorolac* *meclofenamate* *mefenamic acid* *nabumetone* *NALFON(fenoprofen)* *NAPROSYN (naproxen)* *naproxen CR* *naproxen sodium (Rx)* *naproxen suspension* *oxaprozin* *piroxicam* *RELAFEN DS (nabumetone)* *sulindac* *Tolmetin* *VENNGEL ONE KIT (diclofenac sodium)* *ZORVOLEX (diclofenac)*	▪ Treatment failure with 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 A drug specific prior authorization applies to drugs with a hyperlink

NSAIDS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
NSAID/GI Protectant Combinations		
	ARTHROTEC (diclofenac/misoprostol) *diclofenac/misoprostol* *DUEXIS (ibuprofen/famotidine)* *VIMOVO (naproxen/ esomeprazole)*	▪ Treatment failure with 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

NSAIDS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
COX-II Selective		
meloxicam tablets*	*CELEBREX (celecoxib)* *celecoxib* *MOBIC (meloxicam)** *QMIIZ ODT (meloxicam)*	▪ Treatment failure with 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 Dose Optimization applies to some strengths where a "*" is noted

NSAIDS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Topical NSAIDs		
diclofenac gel 1% *VOLTAREN gel (diclofenac)*	*FLECTOR (diclofenac)* *INDOCIN (indomethacin) suppositories* *PENNSAID (diclofenac)*	▪ Treatment failure with 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 A drug specific prior authorization applies to drugs with a hyperlink

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

u

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

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

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

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

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

ONCOLOGY, ORAL – SKIN		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
BRAFTOVI (encorafenib) COTELLIC (cobimetinib) ERIVEDGE (vismodegib) MEKINIST (trametinib) MEKTOVI (binimetinib) ODOMZO (sonidegib) TAFINLAR (dabrafenib) ZELBORAF (vemurafenib)		All of the agents in the Oncology, Oral – Skin class are preferred A drug specific prior authorization applies to drugs with a hyperlink

OPHTHALMICS, ANTIBIOTIC – STEROID COMBINATIONS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
BLEPHAMIDE (sulfacetamide/prednisolone) neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX (tobramycin/dexamethasone) ointment	*BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone)* *MAXITROL (neomycin/polymyxin/ dexamethasone)* *neomycin/bacitracin/polymyxin/hydrocortisone* *neomycin/polymyxin/hydrocortisone* *PRED-G (gentamicin/prednisolone)* *TOBRADEX (tobramycin/dexamethasone) suspension* *TOBRADEX ST (tobramycin/dexamethasone)* *tobramycin/dexamethasone* *ZYLET (tobramycin/loteprednol)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OPHTHALMIC ANTIBIOTICS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Aminoglycosides		
GENTAK (gentamicin) gentamicin tobramycin TOBREX (tobramycin) ointment	*TOBREX (tobramycin) solution*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OPHTHALMIC ANTIBIOTICS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Quinolones		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
ciprofloxacin ofloxacin	*BESIVANCE (besifloxacin)* *CILOXAN (ciprofloxacin)* *gatifloxacin* *levofloxacin* *MOXEZA (moxifloxacin)* *moxifloxacin* *OCUFLOX (ofloxacin)* *VIGAMOX (moxifloxacin)*	
Macrolides		
erythromycin	*AZASITE (azithromycin)*	

OPHTHALMIC ANTIBIOTICS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Other		
bacitracin/polymyxin polymyxin/trimethoprim	*bacitracin* *BLEPH-10 (sulfacetamide)* *NATACYN (natamycin)* *neomycin/bacitracin/polymyxin* *neomycin/polymyxin/gramicidin* *POLYTRIM (polymyxin/trimethoprim)* *sulfacetamide ointment, solution*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
cromolyn PATADAY XS ONCE DAILY OTC (olopatadine) PAZEO (olopatadine)	*ALOCRIL (nedocromil)* *ALOMIDE (lodoxamide)* *ALREX (loteprednol)* *azelastine* *BEPREVE (bepotastine)* *ELESTAT (epinastine)* *EMADINE (emedastine)* *epinastine* *ketotifen* *LASTACAFT (alcaftadine)* *olopatadine* *PATADAY (olopatadine)* *PATADAY OTC (olopatadine)* *PATANOL (olopatadine)* *ZERVIATE (cetirizine)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OPHTHALMICS, ANTI-INFLAMMATORIES		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
NSAIDS		
diclofenac ketorolac	*ACULAR (ketorolac)* *ACULAR LS (ketorolac)* *ACUVAIL (ketorolac)* *bromfenac* *flurbiprofen* *ILEVRO (nepafenac)* *ketorolac LS* *NEVANAC (nepafenac)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OPHTHALMICS, ANTI-INFLAMMATORIES *continued*			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
Steroids			
DUREZOL (difluprednate) (loteprednol) ointment prednisolone acetate	*dexamethasone* *FLAREX (fluorometholone)* *fluorometholone* *FML (fluorometholone)* *FML FORTE (fluorometholone)* *ML S.O.P. (fluorometholone)* *INVELTYS (loteprednol)* *LOTEMAX (loteprednol) gel, suspension* *loteprednol*	*MAXIDEX (dexamethasone)* *OMNIPRED (prednisolone)* *PRED FORTE (prednisolone)* *PRED MILD (prednisolone)* *prednisolone sodium phosphate*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OPHTHALMICS, ANTI-INFLAMMATORY IMMUNOMODULATORS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
RESTASIS (cyclosporine)	*RESTASIS MULTIDOSE (cyclosporine)* *CEQUA (cyclosporine)* *EYSUVIS (loteprednol etabonate)* *XIIDRA (lifitegrast)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OPHTHALMICS, GLAUCOMA AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Sympathomimetics		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
brimonidine pilocarpine	*ALPHAGAN P (brimonidine)* *apraclonidine* *brimonidine P* *IOPIDINE (apraclonidine)*	
Beta Blockers		
carteolol levobunolol timolol	*betaxolol* *BETOPTIC S (betaxolol)* *ISTALOL (timolol)* *timolol (Istalol)* *TIMOPTIC (timolol)* *TIMOPTIC XE (timolol)*	

OPHTHALMICS, GLAUCOMA AGENTS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Carbonic Anhydrase Inhibitors		
AZOPT (brinzolamide) dorzolamide	*TRUSOPT (dorzolamide)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OPHTHALMICS, GLAUCOMA AGENTS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Rho Kinase Inhibitor		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization
RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost)		
Prostaglandin Analogs		
latanoprost TRAVATAN-Z (travoprost)	*bimatoprost* *LUMIGAN (bimatoprost)* *VYZULTA (latanoprostene bunod)* *XALATAN (latanoprost)* *XELPROS (latanoprost)* *ZIOPTAN (tafluprost)*	
Combination Agents		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	*COSOPT (dorzolamide/timolol)* *COSOPT PF (dorzolamide/timolol)* *dorzolamide/timolol*	
Miscellaneous		
	phospholine iodide	

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

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

OPIATE DEPENDENCE TREATMENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
BUNAVAIL (buprenorphine/naloxone)* buprenorphine* buprenorphine/naloxone* LUCEMYRA (lofexidine) naloxone syringe, vial naltrexone NARCAN (naloxone) nasal SUBOXONE (buprenorphine/naloxone) film* VIVITROL (naltrexone) ZUBSOLV (buprenorphine/naloxone)*		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies to drugs with an "*" in the class: ▪ Duplicate Therapy ▪ Opiate/Benzodiazepine/Muscle Relaxant

OTIC ANTIBIOTICS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
CIPRODEX (ciprofloxacin/dexamethasone) neomycin/polymyxin/hydrocortisone ofloxacin	*CIPRO HC (ciprofloxacin/hydrocortisone)* *COLY-MYCIN S (colistin/neomycin/hydrocortisone)* *ciprofloxacin* *OTOVEL (ciprofloxacin/fluocinolone)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OTIC ANTI-INFECTIVES/ANESTHETICS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
acetic acid	*acetic acid/hydrocortisone* *PINNACAINE (benzocaine)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

PAH AGENTS (ORAL, INHALATION)		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ADCIRCA (tadalafil) ambrisentan REVATIO (sildenafil) suspension sildenafil tablet (generic Revatio) TRACLEER (bosentan) tablet	*ADEMPAS (riociguat)* *bosentan* *LETAIRIS (ambrisentan)* *OPSUMIT (macitentan)* *ORENITRAM ER (treprostinil)* *REVATIO (sildenafil)* *sildenafil suspension (generic Revatio)* *tadalafil (generic Adcirca)* *TRACLEER (bosentan) suspension* *TYVASO Inhalation (treprostinil)* *UPTRAVI (selexipag)* *VENTAVIS Inhalation (iloprost)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

PANCREATIC ENZYMES		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
CREON (pancrelipase) ZENPEP (pancrelipase)	*PANCREAZE (pancrelipase)* *PERTZYE (pancrelipase)* *VIOKACE (pancrelipase)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

PEDIATRIC VITAMIN PREPARATIONS	
See Separate Listing Of Preferred Pediatric Vitamin Preparations.	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

PENICILLINS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
amoxicillin ampicillin dicloxacillin penicillin VK		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

PHOSPHATE BINDERS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
calcium acetate RENAGEL (sevelamer HCl)	*AURYXIA (ferric citrate)* *ELIPHOS (calcium acetate)* *FOSRENOL (lanthanum)* *lanthanum* *PHOSLYRA (calcium acetate)* *RENVELA (sevelamer carbonate)* *sevelamer* *VELPHORO (sucroferric oxyhydroxide)*	▪ Treatment failure with preferred drug ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ Diagnosis of ESRD, hyperphosphatemia AND at least one of the following: ➢ Hypercalcemia (corrected serum calcium >10.2 mg/dL) ➢ Plasma PTH levels <150 pg/mL on two consecutive measurements ➢ Dialysis patients with severe vascular and/or soft tissue calcifications A drug specific prior authorization applies to drugs with a hyperlink

PLATELET AGGREGATION INHIBITORS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
AGGRENOX (dipyridamole/aspirin) BRILINTA (ticagrelor) clopidogrel prasugrel	*dipyridamole* *dipyridamole/aspirin* *EFFIENT (prasugrel)* *PLAVIX (clopidogrel)* *ZONTIVITY (vorapaxar)*	▪ Treatment failure with preferred drug ▪ Contraindication to preferred drug ▪ Allergic reaction to preferred drug ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

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

PROGESTATIONAL AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
MAKENA AUTO INJECTOR (hydroxyprogesterone) MAKENA (hydroxyprogesterone)	*hydroxyprogesterone*	▪ Treatment failure with preferred drug ▪ Contraindication to preferred drug ▪ Allergic reaction to preferred drug ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific clinical prior authorization applies to drugs with a hyperlink

PROGESTINS FOR CACHEXIA		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
megestrol suspension, tablets	*megestrol ES suspension (generic Megace ES)*	▪ Treatment failure with preferred drug ▪ Contraindication to preferred drug ▪ Allergic reaction to preferred drug ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

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

PROTON PUMP INHIBITORS (ORAL)		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
omeprazole Rx* pantoprazole* NEXIUM suspension (esomeprazole) PROTONIX (pantoprazole) suspension	*ACIPHEX (rabeprazole)* *DEXILANT (dexlansoprazole)* *esomeprazole** *lansoprazole** *NEXIUM capsules (esomeprazole)** *NEXIUM OTC (esomeprazole)** *omeprazole OTC** *omeprazole/sodium bicarbonate* *PREVACID (lansoprazole)** *PROTONIX tablets (pantoprazole)** *rabeprazole* *ZEGERID (omeprazole/sodium bicarbonate)*	▪ 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 Dose Optimization applies to some strengths where a "*" is noted

ROSACEA AGENTS, TOPICAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
metronidazole cream, gel	*azelaic acid* *FINACEA (azelaic acid)* *ivermectin* *METROCREAM (metronidazole)* *METROGEL (metronidazole)* *metronidazole lotion* *MIRVASO (brimonidine)* *NORITATE (metronidazole)* *RHOFADE (oxymetazoline)* *ROSADAN KIT (metronidazole)* *SOOLANTRA (ivermectin)*	▪ Treatment failure after no less than a 30-day trial of every preferred drug ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Rosacea Agents, Topical Dose Optimization applies to some strengths where a "*" is noted

SEDATIVE HYPNOTICS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Benzodiazepines		
flurazepam temazepam 15, 30 mg triazolam	*DAYVIGO (lemborexant)* *estazolam* *RESTORIL (temazepam)* *temazepam 7.5, 22.5 mg*	▪ Treatment failure with 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

SEDATIVE HYPNOTICS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Others		
eszopiclone zaleplon zolpidem	*AMBIEN (zolpidem)* *AMBIEN CR (zolpidem)* *BELSOMRA (suvorexant)* *EDLUAR (zolpidem)* *HETLIOZ (tasimelteon)* *INTERMEZZO (zolpidem)* *LUNESTA (eszopiclone)* *ROZEREM (ramelteon)* *SILENOR (doxepin)* *SONATA (zaleplon)* *zolpidem ER*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

SICKLE CELL ANEMIA TREATMENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
DROXIA (hydroxyurea) ENDARI (glutamine) hydroxyurea OXBRYTA (voxelotor)* SIKLOS (hydroxyurea)		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies to drugs with an "*" in the class: ▪ Sickle Cell Anemia Treatments

SKELETAL MUSCLE RELAXANTS			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
baclofen carisoprodol (except 250 mg)* cyclobenzaprine* methocarbamol* tizanidine tablets	*AMRIX (cyclobenzaprine ER)** *carisoprodol 250 mg** *carisoprodol compound* *chlorzoxazone** *DANTRIUM (dantrolene)* *dantrolene* *FEXMID (cyclobenzaprine) **	*LORZONE (chlorzoxazone)** *metaxolone** *NORGESIC FORTE (orphenadrine/aspririn/caffeine)* *orphenadrine** *ROBAXIN (methocarbamol)** *SKELAXIN (metaxolone)** *SOMA (carisoprodol)** *tizanidine capsules* *ZANAFLEX (tizanidine)*	▪ Treatment failure with 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

SMOKING CESSATION		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
bupropion SR CHANTIX (varenicline) nicotine gum nicotine lozenge nicotine patch	*NICODERM CQ (nicotine)* *NICORETTE (nicotine) gum* *NICORETTE (nicotine) lozenge* *NICOTROL (nicotine)* *NICOTROL NS (nicotine)* *ZYBAN (bupropion)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

STEROIDS, TOPICAL			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
Low Potency			▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
DERMA-SMOOTHE/FS (fluocinolone) hydrocortisone cream, ointment hydrocortisone/aloe cream PROCTOSOL-HC (hydrocortisone)	*alclometasone* *DESONATE (desonide)* *desonide* *fluocinolone oil* *hydrocortisone lotion (Rx)*	*MICORT-HC (hydrocortisone)* *TEXACORT (hydrocortisone) solution*	
Medium Potency			
fluticasone propionate cream, ointment mometasone cream, ointment, solution	*beclomethasone valerate foam* *BESER KIT (fluticasone)* *clocortolone cream* *CLODERM (clocortolone)* *CORDRAN (flurandrenolide)* *CUTIVATE (fluticasone)* *ELOCON (mometasone)* *fluocinolone acetonide* *flurandrenolide*	*fluticasone propionate lotion* *hydrocortisone butyrate* *hydrocortisone valerate* *LUXIQ (betamethasone)* *PANDEL (hydrocortisone probutate)* *prednicarbate*	

STEROIDS, TOPICAL *continued*			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
High Potency			▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
betamethasone dipropionate lotion betamethasone dipropionate/propylene glycol cream betamethasone valerate cream, ointment triamcinolone acetonide cream, lotion, ointment	*Amcinonide* *betamethasone dipropionate cream, gel, ointment* *betamethasone dipropionate/ propylene glycol lotion, ointment* *betamethasone valerate lotion, desoximetasone* *diflorasone* *DIPROLENE (betamethasone dipropionate)*	*fluocinonide* *HALOG (halcinonide)* *KENALOG aerosol (triamcinolone)* *SERNIVO (betamethasone dipropionate)* *TOPICORT (desoximetasone)* *triamcinolone acetonide aerosol,* *TRIANEX (triamcinolone)* *VANOS (fluocinonide)*	
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)* *halobetasol foam* *IMPEKLO LOTION (clobetasol propionate)* *LEXETTE (halobetasol propionate)* *OLUX (clobetasol)*	*TEMOVATE (clobetasol)* *ULTRAVATE (halobetasol propionate)* *ULTRAVATE X PAC (halobetasol/lactic acid)*	

STIMULANTS AND RELATED AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Stimulants		
ADDERALL XR (amphetamine salt combination)* amphetamine salt combination IR CONCERTA (methylphenidate)* DAYTRANA (methylphenidate)* dexmethylphenidate IR dextroamphetamine IR DYANAVEL XR (amphetamine) FOCALIN XR (dexmethylphenidate) * JORNAY PM (methylphenidate ER)* METHYLIN (methylphenidate) solution methylphenidate IR QUILLICHEW ER (methylphenidate) 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* *COTEMPLA XR ODT (methylphenidate)* *DESOXYN (methamphetamine)* *DEXEDRINE (dextroamphetamine)* *dexmethylphenidate ER** *dextroamphetamine ER* *dextroamphetamine solution* *EVEKEO (amphetamine)* *FOCALIN (dexmethylphenidate)* *methamphetamine* *methylphenidate CD** *methylphenidate chewable tablets* *methylphenidate ER** *methylphenidate solution* *modafinil* *MYDAYIS (amphetamine salt combination ER)* *NUVIGIL (armodafinil)* *PROCENTRA (dextroamphetamine)* *PROVIGIL (modafinil)* *RITALIN (methylphenidate)* *RITALIN LA (methylphenidate ER)** *SUNOSI (solriamfetol)* *WAKIX (pitolisant)* *ZENZEDI (dextroamphetamineD)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink Dose Optimization applies to some strengths where a "*" is noted

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

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

STIMULANTS AND RELATED AGENTS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Non-Stimulants		
atomoxetine guanfacine ER	*clonidine ER* *INTUNIV (guanfacine ER)* *STRATTERA (atomoxetine)*	▪ Treatment failure with 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

TETRACYCLINES			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
doxycycline hyclate capsule doxycycline monohydrate 50, 100 mg capsules minocycline capsules VIBRAMYCIN (doxycycline) suspension	*demeclocycline* *doxycycline hyclate IR* *doxycycline hyclate DR* *doxycycline monohydrate 40, 75, 150 mg capsules* *doxycycline monohydrate suspension, tablets* *minocycline tablets* *minocycline ER*	*MINOLIRA ER (minocycline)* *NUZYRA tablet (omadacycline)* *ORACEA (doxycycline)* *SOLODYN (minocycline)* *tetracycline* *VIBRAMYCIN (doxycycline) capsule, syrup*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

THROMBOPOIESIS STIMULATING PROTEINS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
PROMACTA (eltrombopag) tablet	*DOPTELET (avatrombopag)* *MULPLETA (lusutrombopag)* *PROMACTA (eltrombopag) suspension* *TAVALISSE (fostamatinib)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

ULCERATIVE COLITIS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Oral		
DELZICOL (mesalamine) LIALDA (mesalamine) sulfasalazine sulfasalazine DR	*APRISO (mesalamine)* *ASACOL HD (mesalamine)* *AZULFIDINE (sulfasalazine)* *balsalazide* *budesonide DR* *COLAZAL (balsalazide)* *DIPENTUM (olsalazine)* *GIAZO (balsalazide)* *mesalamine* *PENTASA (mesalamine)* UCERIS (budesonide)	▪ Treatment failure with preferred drugs ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
Rectal		
mesalamine	*CANASA (mesalamine)* *UCERIS (budesonide)*	▪ Treatment failure with preferred drugs ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

UREA CYCLE DISORDERS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
BUPHENYL (sodium phenylbutyrate) CARBAGLU (carglumic acid)	*RAVICTI (glycerol phenylbutyrate)* *sodium phenylbutyrate powder*	▪ Treatment failure with 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

For all classes listed below the standard PA criteria apply:
■ Treatment failure with preferred drugs within any subclass
■ Contraindication to preferred drugs
■ Allergic reaction to preferred drugs
■ Treatment of stage-four advanced, metastatic cancer and associated conditions

COUGH AND COLD ORAL

Preferred Agents		Non-Preferred Agents		PA CRITERIA
Agent	Ingredients	Agent	Ingredients	
ALA-HIST IR TABLET OTC (ORAL)	dexbrompheniramine maleate	CHILDREN'S MUCINEX LIQUID OTC (C) (ORAL)	diphenhyd/phenyleph/acetaminop, guaifenesin/phenylephrine HCl	
ALA-HIST PE TABLET OTC (ORAL)	dexbrompheniramin/phenylephrin	DEXBROMPHENIRAMINE/PHENYLEPHRINE OTC (ORAL)	dexbrompheniramin/phenylephrin	
DECONEX IR TABLET OTC (ORAL)	guaifenesin/phenylephrine HCl	DIPHENHYDRAMINE/PHENYLEPHRINE/APAP POWDER PACK OTC (ORAL)	diphenhyd/phenyleph/acetaminop	
ED A-HIST TABLET OTC (ORAL)	chlorpheniramine/phenylephrine	DOXYLAMINE/PHENYLEPHRINE OTC (ORAL)	doxylamine/phenylephrine HCl	
ED BRON GP LIQUID OTC (ORAL)	guaifenesin/phenylephrine HCl	ED A-HIST LIQUID OTC (ORAL)	chlorpheniramine/phenylephrine	
GUAIFENESIN 200 MG TABLET OTC (ORAL)	guaifenesin	GUAIFENESIN/PHENYLEPHRINE TABLET OTC (ORAL)	guaifenesin/phenylephrine HCl	
GUAIFENESIN 400 MG TABLET OTC (ORAL)	guaifenesin	GUAIFENESIN/PHENYLEPHRINE TABLET OTC (ORAL)	guaifenesin/pseudoephedrne HCl	
GUAIFENESIN LIQUID OTC (ORAL)	guaifenesin	GUAIFENESIN/PHENYLEPHRINE/APAP TABLET OTC (ORAL)	guaifen/phenyleph/acetaminophn	
GUAIFENESIN TABLET ER OTC (ORAL)	guaifenesin	GUAIFENESIN/PSEUDOEPHEDRNE TABLET OTC (ORAL)	guaifenesin/pseudoephedrne HCl	
GUAIFENESIN/PSE TABLET ER OTC (ORAL)	guaifenesin/pseudoephedrne HCl	HISTEX-PE LIQUID OTC (ORAL)	phenylephrine HCl/triprolidine	
MUCINEX D TABLET ER 12H OTC (ORAL)	guaifenesin/pseudoephedrne HCl	LOHIST-D LIQUID OTC (ORAL)	chlorpheniramine/pseudoephed	
MUCINEX ER TABLET OTC (ORAL)	guaifenesin	MUCINEX FAST-MAX NITE COLD-FLU LIQUID OTC (ORAL)	diphenhyd/phenyleph/acetaminop	
MUCINEX FAST-MAX COLD-SINUS TABLET OTC (ORAL)	guaifen/phenyleph/acetaminophn	NOHIST-LQ LIQUID OTC (ORAL)	chlorpheniramine/phenylephrine	
MUCINEX GRAN PACK OTC (ORAL)	guaifenesin	PHENYLEPHRINE/APAP TABLET OTC (ORAL)	phenylephrine HCl/acetaminophn	
MUCUS-CHEST CONGESTION LIQUID OTC (ORAL)	guaifenesin	PHENYLEPHRINE/APAP/CHLORPHENIRAMINE TABLET OTC (ORAL)	phenylephrine/acetaminophn/cpm	
NASOPEN PE LIQUID OTC (ORAL)	thonzylamine/phenylephrine	PHENYLEPHRINE/BROMPHENIRAMINE TABLET OTC (ORAL)	brompheniramine/phenylephrine	
POLY HIST FORTE TABLET OTC (ORAL)	doxylamine/phenylephrine HCl	POLY-VENT IR TABLET OTC (ORAL)	guaifenesin/pseudoephedrne HCl	
PSE/CHLORPHENIRAMINE TABLET OTC (ORAL)	chlorpheniramine/pseudoephed	RESCON TABLET OTC (ORAL)	dexchlorpheniramin/pseudoephed	
PSE/TRIPROLIDINE TABLET OTC (ORAL)	triprolidine/pseudoephedrine	RESCON-GG LIQUID OTC (ORAL)	guaifenesin/phenylephrine HCl	
RYNEX PE SOLUTION OTC (ORAL)	brompheniramine/phenylephrine	RYMED TABLET OTC (ORAL)	dexchlorpheniram/phenylephrine	
		RYNEX PSE LIQUID OTC (ORAL)	brompheniramin/pseudoephedrine	
		STAHIST AD TABLET OTC (ORAL)	chlorcyclizine/pseudoephedrine	

COUGH AND COLD NASAL

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

COUGH AND COLD, NARCOTIC

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

COUGH AND COLD, NON-NARCOTIC

Preferred Agents		Non-Preferred Agents		PA CRITERIA
Agent	Ingredients	Agent	Ingredients	
ALAHIST CF TABLET OTC (ORAL)	d-methorphan/pe/dexbromphenir	CHILDREN'S DAYCLEAR ALLERGY CHEWABLE OTC (ORAL)	pyrilamine/chlophedianol	
ALA-HIST DM LIQUID OTC (ORAL)	d-methorphan/pe/dexbromphenir	CHLO TUSS LIQUID OTC (ORAL)	dexbromphen/pseudoeph/chlophed	
BENZONATATE CAPSULE (ORAL)	benzonatate	DM/APAP/CHLORPHENIRAMINE TABLET OTC (ORAL)	dextromethorphn/acetaminoph/cp	
BROMPHENIRAMINE/PHENYLEPHRINE/DM SOLUTION OTC (ORAL)	brompheniram/phenylephrine/DM	DM/APAP/DOXYLAMINE CAPSULE OTC (ORAL)	DM/acetaminophen/doxylamine	
BROM-PSE-DM SYRUP (ORAL)	brompheniramine/pseudoephed/DM	DM/APAP/DOXYLAMINE LIQUID OTC (ORAL)	DM/acetaminophen/doxylamine	
BROTAPP DM ELIXIR OTC (ORAL)	brompheniramine/pseudoephed/DM	DM/CHLORPHENIRAMINE TABLET OTC (ORAL)	chlorpheniramine/dextromethorp	
CHILD MUCINEX M-S COLD DAY-NTE LIQUID SEQUELES OTC (ORAL)	diphenhydram/PE/DM/acetamin/GG	DM/PHENYLEPHRINE/APAP CAPSULE OTC (ORAL)	d-methorphan/PE/acetaminophen	
CHILDREN'S MUCINEX LIQUID OTC (NN) (ORAL)	guaifen/dextromethorphan/PE	DM/PHENYLEPHRINE/APAP LIQUID OTC (ORAL)	d-methorphan/PE/acetaminophen	
CHILDREN'S MUCINEX LIQUID OTC (NN) (ORAL)	phenylephrine/DM/acetaminop/GG	DM/PHENYLEPHRINE/APAP POWDER PACK OTC (ORAL)	d-methorphan/PE/acetaminophen	
DECONEX DMX TABLET OTC (ORAL)	guaifen/dextromethorphan/PE	DM/PHENYLEPHRINE/APAP TABLET OTC (ORAL)	d-methorphan/PE/acetaminophen	
DELSYM SUSPENSION ER 12H OTC (ORAL)	dextromethorphan polistirex	DM/PHENYLEPHRINE/APAP/DOXYLAMINE LIQUID OTC (ORAL)	DM/PE/acetaminophen/doxylamine	
DEXTROMETHORPHAN CAPSULE OTC (ORAL)	dextromethorphan HBr	DM/PSE/CHLORPHENIRAMINE LIQUID OTC (ORAL)	chlorpheniramin/pseudoephed/DM	
DEXTROMETHORPHAN SUSPENSION ER 12H OTC (ORAL)	dextromethorphan polistirex	DURAFLU TABLET OTC (ORAL)	pseudoeph/DM/guaifen/acetamin	
ED-A-HIST DM LIQUID OTC (ORAL)	chlorpheniramine/phenyleph/DM	ED A-HIST DM TABLET OTC (ORAL)	chlorpheniramine/phenyleph/DM	
GUAIFEN/DEXTROMETHORPHAN/PE OTC (ORAL)	guaifen/dextromethorphan/PE	GUAIFENESIN/DM TABLET OTC (ORAL)	guaifenesin/dextromethorphan	
GUAIFENESIN/DM LIQUID OTC (ORAL)	guaifenesin/dextromethorphan	M-END DMX LIQUID OTC (ORAL)	dexbromphen/pseudoephedrine/DM	
GUAIFENESIN/DM TABLET ER 12H OTC (ORAL)	guaifenesin/dextromethorphan	MUCINEX FAST-MAX DAY-NITE COLD LIQUID SEQ OTC (ORAL)	diphenhydram/PE/DM/acetamin/GG	
GUAIFENESIN/DM/PHENYLEPHRINE LIQUID OTC (ORAL)	guaifen/dextromethorphan/PE	MUCINEX FAST-MAX DAY-NITE CONG TABLET OTC (ORAL)	diphenhydram/PE/DM/acetamin/GG	
GUAIFENESIN/DM/PHENYLEPHRINE SYRUP OTC (ORAL)	guaifen/dextromethorphan/PE	MUCINEX FAST-MAX SEVERE COLD LIQUID OTC (ORAL)	phenylephrine/DM/acetaminop/GG	
HISTEX-DM SYRUP OTC (ORAL)	triprolidine/phenylephrine/DM	MUCUS DM MAX TABLET ER 12H OTC (ORAL)	guaifenesin/dextromethorphan	
LOHIST-DM LIQUID OTC (ORAL)	brompheniram/phenylephrine/DM	NINJACOF LIQUID OTC (ORAL)	pyrilamine/chlophedianol	
MUCINEX COLD-FLU & SORE THROAT LIQUID OTC (ORAL)	phenylephrine/DM/acetaminop/GG	PHENYLEPHRINE/DM/APAP/GUAIFENESIN CAPLET OTC (ORAL)	phenylephrine/DM/acetaminop/GG	
MUCINEX COUGH GRAN PACK OTC (ORAL)	guaifenesin/dextromethorphan	POLY-HIST PD DROPS OTC (ORAL)	thonzylamine/chlophedianol	
MUCINEX DM TABLET ER 12H OTC (ORAL)	guaifenesin/dextromethorphan	POLYTUSSIN DM OTC (ORAL)	dexchlorphen/phenylephrine/DM	
MUCINEX FAST-MAX CONGEST-COUGH TABLET OTC (ORAL)	guaifen/dextromethorphan/PE	RESCON-DM LIQUID OTC (ORAL)	chlorpheniramin/pseudoephed/DM	
MUCINEX FAST-MAX DM MAX LIQUID OTC (ORAL)	guaifenesin/dextromethorphan			
NOHIST-DM LIQUID OTC (ORAL)	chlorpheniramine/phenyleph/DM			
POLY-HIST DM LIQUID OTC (ORAL)	thonzylamine/phenylephrine/DM			
POLY-VENT DM TABLET OTC (ORAL)	guaifenesin/DM/pseudoephedrine			
PROMETHAZINE/DM SYRUP (ORAL)	promethazine/dextromethorphan			
RYNEX DM SOLUTION OTC (ORAL)	brompheniram/phenylephrine/DM			
VANACOF DM LIQUID OTC (ORAL)	guaifen/dextromethorphan/PE			
VANACOF DMX LIQUID OTC (ORAL)	guaifen/dextromethorphan/PE			
VANACOF LIQUID OTC (ORAL)	dexchlorphenir/pse/chlophedian			
VANATAB DM TABLET OTC (ORAL)	guaifen/dextromethorphan/PE			

IRON, ORAL

Preferred Agents	
Agent	Ingredients
FERROUS FUMARATE TABLET OTC (ORAL)	ferrous fumarate
FERROUS FUMARATE/FA/MULTIVITAMIN & MINERALS CAPSULE (ORAL)	iron fum/folic acid/mv,min 15
FERROUS FUMARATE/IRON POLYSACCHARIDES/FA/MULTIVITAMIN CAPSULE (ORAL)	iron fm,ps no.1/folic/mv no.18
FERROUS GLUCONATE TABLET OTC (ORAL)	ferrous gluconate
FERROUS SULFATE DROPS OTC (ORAL)	ferrous sulfate
FERROUS SULFATE SOLUTION OTC (ORAL)	ferrous sulfate
FERROUS SULFATE TABLET ER OTC (ORAL)	ferrous sulfate
FERROUS SULFATE TABLET OTC (ORAL)	ferrous sulfate
FERROUS SULFATE, DRIED TABLET ER OTC (ORAL)	ferrous sulfate, dried
IRON CARBONYL/ASCORBIC ACID TABLET OTC (ORAL)	iron,carbonyl/ascorbic acid
IRON POLYSACCHARIDES CAPSULE OTC (ORAL)	iron polysaccharide complex
IRON POLYSACCHARIDES/B12/FA CAPSULE (ORAL)	iron ps complex/B12/folic acid

Non-Preferred Agents		PA CRITERIA
Agent	Ingredients	
CORVITE 150 TABLET (ORAL)	iron,carb/folate6/mv,min no.41	
CORVITE FE TABLET (ORAL)	iron/folate no.6/mv,mins no.40	
FEOSOL TABLET OTC (ORAL)	iron polysacch/iron heme polyp	
FERGON TABLET OTC (ORAL)	ferrous gluconate	
FER-IN-SOL DROPS OTC (ORAL)	ferrous sulfate	
FERIVA 21-7 (ORAL)	iron/C/folate/B12/zinc/succin	
FERIVA FA CAPSULE (ORAL)	iron/C/folate/B12/biot/cupric	
FERRIMIN 150 TABLET OTC (ORAL)	ferrous fumarate	
FERROUS SULFATE/ASCORBIC ACID/FA TABLET ER OTC (ORAL)	ferrous sulfate/vit C/folic ac	
IROSPAN TABLET (ORAL)	iron bg,ps/folic/B,C no.12/suc	
NEPHRON FA TABLET (ORAL)	vit B comp C no.24/iron/folic	
TARON FORTE CAPSULE (ORAL)	iron bg,ps/vitC/B12/FA/calcium	

PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	
Agent	Ingredients
AQUADEKS DROPS OTC (ORAL)	pedi multivit 40/phytonadione
MULTIVITAMINS WITH FLUORIDE DROPS (ORAL)	pedi multivit no.2 w-fluoride
MULTIVITS WITH IRON & FLUORIDE DROPS (ORAL)	pedi multivit 45/fluoride/iron
PEDI MVI NO.16 WITH FLUORIDE TAB CHEW (ORAL)	pedi multivit no.16 w-fluoride
POLY-VI-SOL DROPS OTC (ORAL)	pediatric multivitamin no.192
POLY-VI-SOL WITH IRON DROPS OTC (ORAL)	pedi mv no.189/ferrous sulfate

Non-Preferred Agents		PA CRITERIA
Agent	Ingredients	
CHILDREN'S VITAMINS WITH IRON CHEW OTC (ORAL)	multivitamin with iron	
FLORIVA CHEW (ORAL)	pedi multivit no.85/fluoride	
FLORIVA PLUS DROPS OTC (ORAL)	pedi multivit no.161/fluoride	
FLUORIDE/VITAMINS A,C,AND D DROPS (ORAL)	ped mvit A,C,D3 no.21/fluoride	
POLY-VI-FLOR CHEW (ORAL)	pedi multivit no.33/fluoride	
POLY-VI-FLOR DROPS (ORAL)	pedi multivit no.37 w-fluoride	
POLY-VI-FLOR WITH IRON CHEW (ORAL)	pedi multivit 33/fluoride/iron	
POLY-VI-FLOR WITH IRON DROPS (ORAL)	pedi multivit 37/fluoride/iron	
QUFLORA (ORAL)	pedi multivit 84 with fluoride	
QUFLORA (ORAL)	pedi multivit no.63 w-fluoride	
QUFLORA (ORAL)	pedi multivit no.83 w-fluoride	
QUFLORA FE (ORAL)	ped multivit 142/iron/fluoride	
QUFLORA FE (ORAL)	ped multivit 151/iron/fluoride	
QUFLORA OTC (ORAL)	pedi multivit no.157/fluoride	
TRI-VI-FLORO DROPS (ORAL)	ped mvit A,C,D3 no.38/fluoride	
TRI-VITAMIN WITH FLUORIDE (ORAL)	ped mvit A,C,D3 no.21/fluoride	

PRENATAL VITAMINS

Preferred Agents	
Agent	Ingredients
PNV2/IRON B-G SUC-P/FA/OMEGA-3 (ORAL)	PNV cmb 52/iron/FA/omega-3/dha
SELECT-OB + DHA (ORAL)	prenatal vit 33/iron/folic/dha
TRICARE (ORAL)	prenatal vit103/iron fum/folic
TRINATAL RX 1 (ORAL)	prenatal vit27,calcium/iron/FA
VITAFOL NANO (ORAL)	prenatal no.75/iron/folate no1
VITAFOL TAB CHEW (ORAL)	PNV 112/iron/folic/om3/dha/epa
VITAFOL ULTRA (ORAL)	PNV 67/iron ps/folate no.1/dha
VITAFOL-OB (ORAL)	prenatal vit 10/iron fum/folic
VITAFOL-OB+DHA (ORAL)	prenatal vit 10/iron/folic/dha
VITAFOL-ONE (ORAL)	prenatal 26/iron ps/folic/dha

Non-Preferred Agents		PA CRITERIA
Agent	Ingredients	
CITRANATAL B-CALM (ORAL)	prenatal 48/iron/folic acid/B6	
COMPLETENATE CHEW TABLET (ORAL)	prenatal vit 14/iron fum/folic	
FE C/FA (ORAL)	multivit-min69/iron/folic acid	
NESTABS (ORAL)	prenatal vit86/iron/folic acid	
NESTABS DHA (ORAL)	prenatal 87/iron bis/folic/dha	
OB COMPLETE ONE (ORAL)	PNV 85/iron/folic/dha/fish oil	
OB COMPLETE PETITE (ORAL)	prenatal56/iron/folic acid/dha	
OB COMPLETE PREMIER (ORAL)	PNV83/iron,carb,asp/folic acid	
OB COMPLETE TABLET (ORAL)	multivit-min69/iron/folic acid	
PNV COMBO#47/IRON/FA #1/DHA (ORAL)	multivit 47/iron/folate 1/dha	
PNV NO.118/IRON FUMARATE/FA CHEW TABLET (ORAL)	PNV no.118/iron fumarate/FA	
PNV NO.15/IRON FUM & PS CMP/FA (ORAL)	mvn-min 74/iron fum/iron/FA	
PNV W-CA NO.40/IRON FUM/FA CMB NO.1 (ORAL)	prenatal,calc.40/iron/folate 1	
PNV WITH CA NO.68/IRON/FA NO.1/DHA (ORAL)	mv-mins 71/iron/folic no.1/dha	
PNV WITH CA,NO.72/IRON/FA (ORAL)	PNV,calcium 72/iron/folic acid	
PNV#16/IRON FUM & PS/FA/OM-3 (ORAL)	mvn-min75/iron/iron ps/om3/dha	
PRENATAL VIT #76/IRON,CARB/FA (ORAL)	prenatal vit,calc76/iron/folic	
PRENATE AM (ORAL)	multivit 38/folate no.6/ginger	
PRENATE CHEWABLE TABLET (ORAL)	multivitamin no.36/folate no.6	
PRENATE DHA (ORAL)	prenatal 78/iron/folate 1/dha	
PRENATE ELITE (ORAL)	prenatal 114/iron a-g/folate 1	
PRENATE ENHANCE (ORAL)	prenatal vit68/iron/FA no6/dha	
PRENATE ESSENTIAL (ORAL)	multivit no.40/iron/folat1/dha	
PRENATE MINI (ORAL)	prenatal vit 87/iron/folic/dha	
PRENATE PIXIE (ORAL)	prenatal vit 85/iron/FA 1/dha	
PRENATE RESTORE (ORAL)	prenatal vit69/iron/folate6/dh	
PRENATE STAR (ORAL)	prenatal no.77/iron asp gly/FA	
SELECT-OB TAB CHEW (ORAL)	prenatal vit128/iron/folic acd	
TRISTART DHA (ORAL)	prenatal 93/iron/folate 9/dha	
VP-PNV-DHA (ORAL)	prenatal no.52/iron/FA/dha	
WESTGEL DHA (ORAL)	prenatal 93/iron/folate 9/dha	