Acentra HEALTH


## Criteria Guide
## for the

# Texas Prior Authorization Program

# PDL Criteria

## July 28, 2025

# 1 Contents

# 2 Document Overview

## Purpose

The Texas HHSC Prior Authorization Program Criteria Guide explains the criteria used by the Gainwell Technologies system to evaluate the prior authorization (PA) requests submitted by Texas Medicaid prescribers. This guide, *PDL Criteria*, describes the criteria logic that is based on the Texas Prior Authorization Program's Preferred Drug List (PDL).

## Organization

Each section in this guide describes the criteria used for a particular drug class. The sections include the following information:

- **Prior authorization criteria logic** – a description of how the Gainwell Technologies PA system evaluates the prior authorization request against the PDL criteria rules
- **Logic diagram** – a visual depiction of the criteria logic
- **Alternate therapy list** – the list of preferred drugs within the drug class

A section may also include the following information:

- **Stable therapy list** – the list of non-preferred drugs within the drug class
- **Diagnosis codes** – diagnosis (ICD-10) codes relevant to specific steps in the evaluation
- **Procedure codes** – procedure (CPT; J-) codes relevant to specific steps in the evaluation

## PDL Criteria Exceptions

Each section in this guide contains the following criteria used for a particular drug class. The sections include the following criteria information:

Table 1:

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

HB 3286, Section 2, 88th Legislature, Regular Session, 2023, requires the Health and Human Services Commission (HHSC) to allow the additional exceptions on the Preferred Drug List.

Table 2:

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

These specific PDL exceptions referencing contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exceptions listed in Table 1 and will be notated with "†" on each prior authorization criteria question and logic diagram of each section.

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

Table 3:

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

These specific PDL exceptions will be included in the prior authorization criteria questions and logic diagram of the antipsychotic and antidepressant drug class sections.

# 3 Acne Agents, Oral

# Acne Agents, Oral
# Prior Authorization Criteria

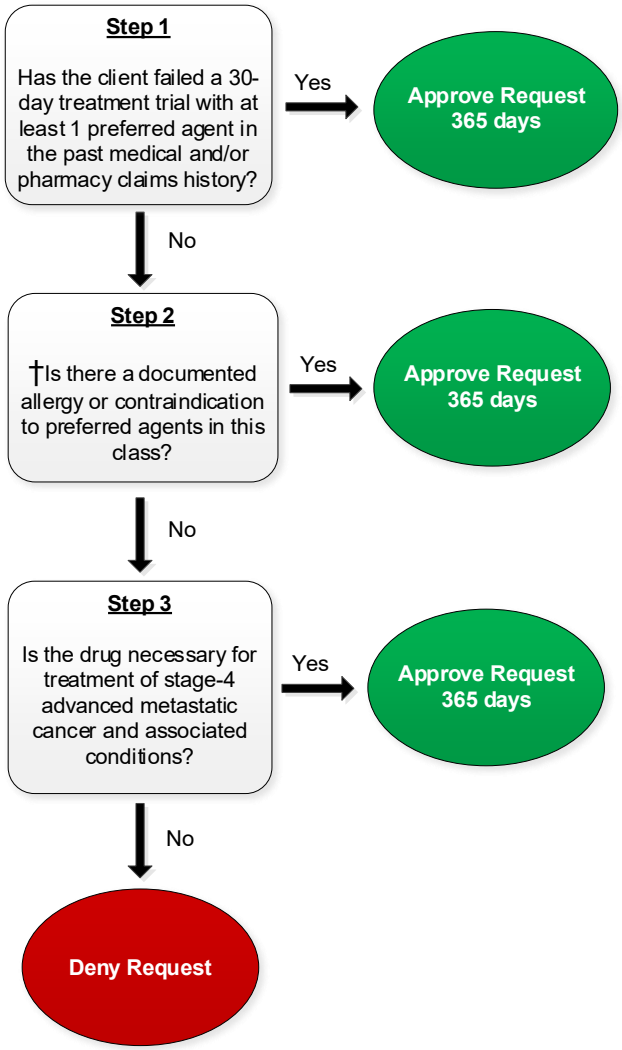
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Acne Agents, Oral
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are on page 1 of the PDL Criteria Guide in the Document Overview section.

# Acne Agents, Oral
# Alternate Therapies

## Preferred Oral Acne Agents

| GCN | Drug Name |
|---|---|
| 59841 | AMNESTEEM 10 MG CAPSULE |
| 59842 | AMNESTEEM 20 MG CAPSULE |
| 59843 | AMNESTEEM 40 MG CAPSULE |
| 59841 | CLARAVIS 10 MG CAPSULE |
| 59842 | CLARAVIS 20 MG CAPSULE |
| 20383 | CLARAVIS 30 MG CAPSULE |
| 59843 | CLARAVIS 40 MG CAPSULE |
| 59841 | ISOTRETINOIN 10 MG CAPSULE |
| 59842 | ISOTRETINOIN 20 MG CAPSULE |
| 37016 | ISOTRETINOIN 25 MG CAPSULE |
| 20383 | ISOTRETINOIN 30 MG CAPSULE |
| 37017 | ISOTRETINOIN 35 MG CAPSULE |
| 59843 | ISOTRETINOIN 40 MG CAPSULE |
| 59841 | ZENATANE 10 MG CAPSULE |
| 59842 | ZENATANE 20 MG CAPSULE |
| 20383 | ZENATANE 30 MG CAPSULE |
| 59843 | ZENATANE 40 MG CAPSULE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 4 Acne Agents, Topical

# Acne Agents, Topical
# Prior Authorization Criteria

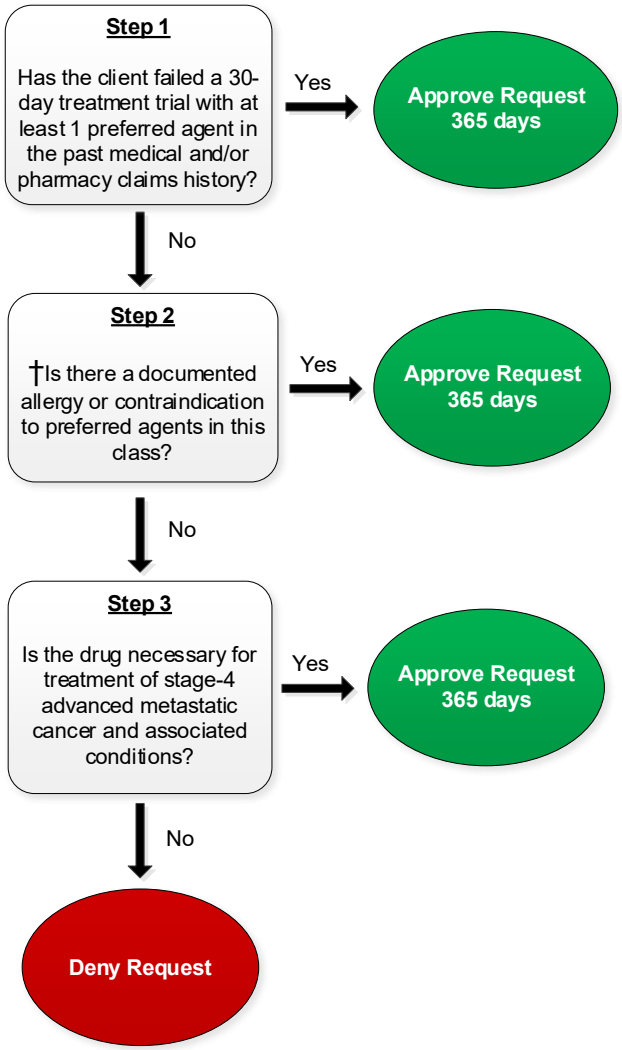
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Acne Agents, Topical
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Acne Agents, Topical
# Alternate Therapies

## Preferred Topical Acne Agents

| GCN | Drug Name |
|---|---|
| 29418 | ACANYA GEL PUMP |
| 24673 | ACNE FOAMING 10% WASH |
| 22930 | ACNE MEDICATION 10% GEL |
| 28610 | ACNE MEDICATION 10% LOTION |
| 22931 | ACNE MEDICATION 5% GEL |
| 28611 | ACNE MEDICATION 5% LOTION |
| 22930 | ACNE TREATMENT 10% GEL |
| 22930 | ACNECLEAR GEL |
| 29300 | ADAPALENE 0.1% GEL |
| 22872 | ATRALIN 0.05% GEL |
| 22930 | BENZOYL PEROXIDE 10% GEL |
| 22984 | BENZOYL PEROXIDE 10% WASH |
| 24673 | BENZOYL PEROXIDE 10% WASH |
| 22932 | BENZOYL PEROXIDE 2.5% GEL |
| 22931 | BENZOYL PEROXIDE 5% GEL |
| 99676 | BENZOYL PEROXIDE 5% WASH |
| 22982 | BENZOYL PEROXIDE 5% WASH |
| 24673 | BP WASH 10% LIQUID |
| 99676 | BP WASH 5% LIQUID |
| 31770 | CLEOCIN T 1% LOTION |
| 98232 | CLIND PH-BENZOYL PEROX 1.2-5% |

| GCN | Drug Name |
|---|---|
| 45411 | CLINDACIN ETZ 1% PLEDGET |
| 45411 | CLINDACIN P 1% PLEDGETS |
| 20176 | CLINDAGEL 1% GEL |
| 45410 | CLINDAMYCIN PH 1% GEL |
| 31720 | CLINDAMYCIN PH 1% SOLUTION |
| 45411 | CLINDAMYCIN PHOS 1% PLEDGET |
| 24673 | CVS ACNE CONTROL 10 % CLEANSER |
| 22930 | CVS ACNE TREATMENT 10% GEL |
| 29300 | CVS ADAPALENE 0.1% GEL |
| 99676 | CVS ADV EXFOLIATING 5% CLEANSR |
| 24673 | CVS FOAMING ACNE FACE 10% WASH |
| 24673 | DAYLOGIC ACNE FOAMING 10% WASH |
| 22930 | DAYLOGIC ACNE TREATMNT 10% GEL |
| 29300 | EFFACLAR ADAPALENE 0.1% GEL |
| 31710 | ERYGEL 2% GEL |
| 31710 | ERYTHROMYCIN 2% GEL |
| 77562 | ERYTHROMYCIN 2% SOLUTION |
| 85400 | ERYTHROMYCIN-BENZOYL GEL |
| 29300 | GNP ADAPALENE 0.1% GEL |
| 94446 | KLARON 10% LOTION |
| 36745 | NEUAC 1.2-5% KIT |
| 37564 | ONEXTON GEL PUMP |
| 24673 | PANOXYL 10% ACNE FOAMING WASH |
| 22930 | PERSA-GEL 10% |
| 17443 | RETIN-A MICRO 0.04% GEL |

| GCN | Drug Name |
|---|---|
| 22874 | RETIN-A MICRO 0.1% GEL |
| 22870 | TRETINOIN 0.01% GEL |
| 22882 | TRETINOIN 0.025% CREAM |
| 22871 | TRETINOIN 0.025% GEL |
| 22880 | TRETINOIN 0.05% CREAM |
| 22881 | TRETINOIN 0.1% CREAM |
| 97560 | ZIANA GEL |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 5 Alzheimer's Agents

# Alzheimer's Agents
# Prior Authorization Criteria

1. Has the client been stable on a non-preferred agent for 30 days in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

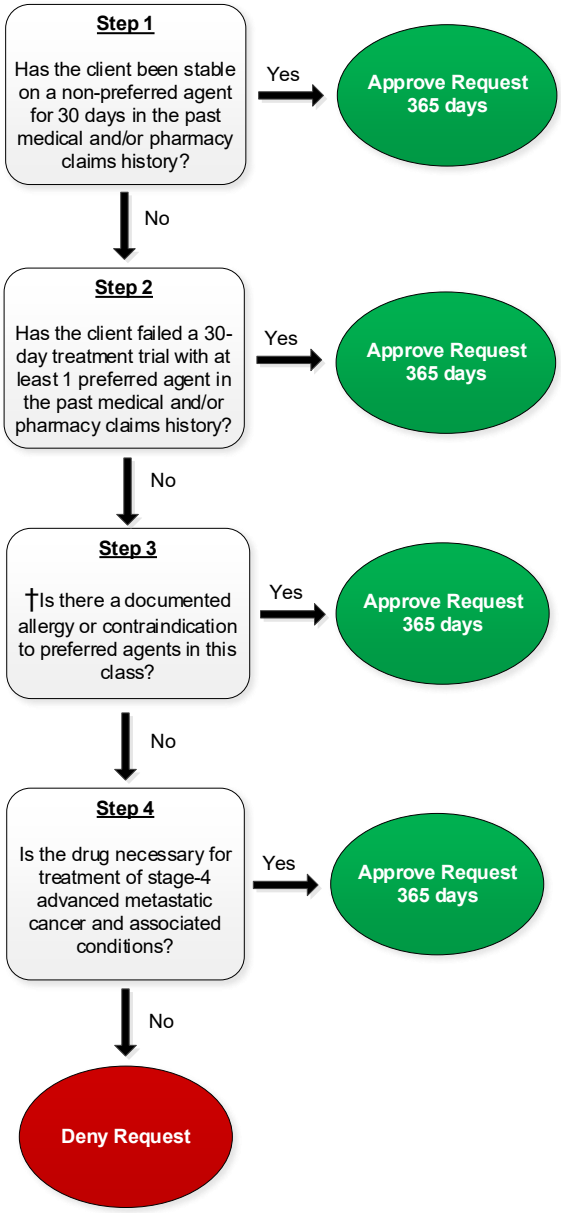
2. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #4)

4. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

†Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Alzheimer's Agents
# Prior Authorization Criteria

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# Alzheimer's Agents
# Alternate Therapies

## Preferred Alzheimer's Agents

| GCN | Drug Name |
|---|---|
| 04300 | DONEPEZIL HCL 10 MG TABLET |
| 04302 | DONEPEZIL HCL 5 MG TABLET |
| 24595 | DONEPEZIL HCL ODT 10 MG TABLET |
| 24594 | DONEPEZIL HCL ODT 5 MG TABLET |
| 33208 | EXELON 13.3 MG/24HR PATCH |
| 98640 | EXELON 4.6 MG/24HR PATCH |
| 98641 | EXELON 9.5 MG/24HR PATCH |
| 20773 | MEMANTINE HCL 5 MG TABLET |
| 03253 | MEMANTINE HCL 10 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 6 Analgesics, Narcotic – Long Acting

# Analgesics, Narcotic – Long Acting Prior Authorization Criteria

1. Has the client failed a 6-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

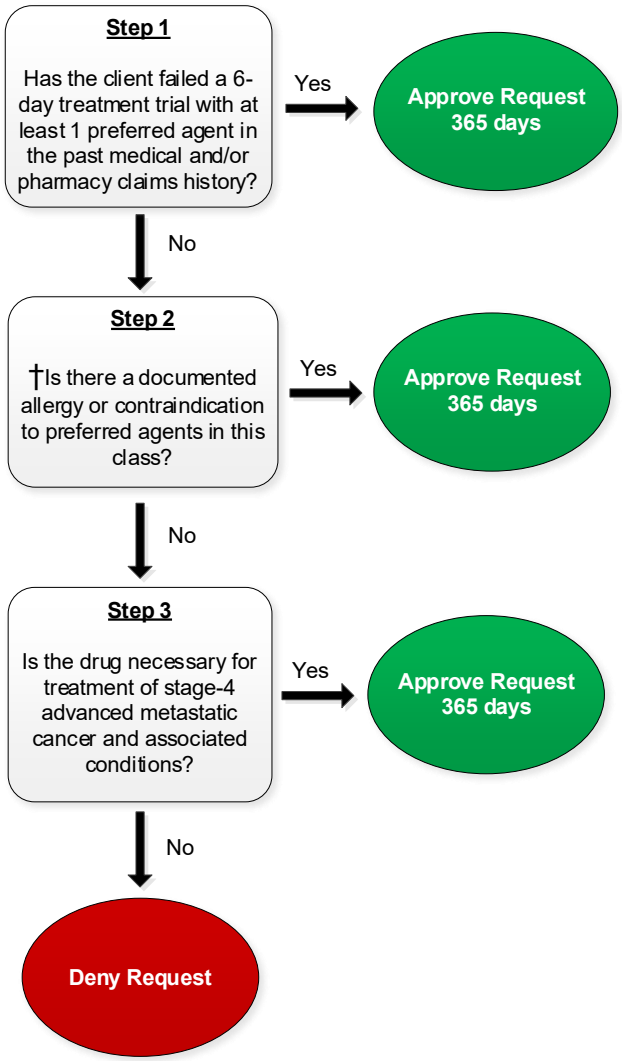
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

*Note: Methadone Oral Solution will be authorized for patients less than 24 months of age.*

†Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Analgesics, Narcotic – Long Acting Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Analgesics, Narcotic – Long Acting Alternate Therapies

## Preferred Long Acting Narcotics

| GCN | Drug Name |
|---|---|
| 25309 | BUTRANS 10 MCG/HR PATCH |
| 35214 | BUTRANS 15 MCG/HR PATCH |
| 25312 | BUTRANS 20 MCG/HR PATCH |
| 25308 | BUTRANS 5 MCG/HR PATCH |
| 36946 | BUTRANS 7.5 MCG/HR PATCH |
| 19203 | FENTANYL 100 MCG/HR PATCH |
| 24635 | FENTANYL 12 MCG/HR PATCH |
| 19200 | FENTANYL 25 MCG/HR PATCH |
| 19201 | FENTANYL 50 MCG/HR PATCH |
| 19202 | FENTANYL 75 MCG/HR PATCH |
| 16642 | MORPHINE SULF ER 100 MG TABLET |
| 16643 | MORPHINE SULF ER 15 MG TABLET |
| 16078 | MORPHINE SULF ER 200 MG TABLET |
| 16640 | MORPHINE SULF ER 30 MG TABLET |
| 16641 | MORPHINE SULF ER 60 MG TABLET |
| 37158 | OXYCONTIN ER 10 MG TABLET |
| 37159 | OXYCONTIN ER 15 MG TABLET |
| 37161 | OXYCONTIN ER 20 MG TABLET |
| 37162 | OXYCONTIN ER 30 MG TABLET |
| 37163 | OXYCONTIN ER 40 MG TABLET |
| 37164 | OXYCONTIN ER 60 MG TABLET |
| 37165 | OXYCONTIN ER 80 MG TABLET |

| GCN | Drug Name |
|---|---|
| 26387 | TRAMADOL HCL ER 100 MG TABLET |
| 50417 | TRAMADOL HCL ER 200 MG TABLET |
| 50427 | TRAMADOL HCL ER 300 MG TABLET |
| 41273 | XTAMPZA ER 13.5 MG CAPSULE |
| 41274 | XTAMPZA ER 18 MG CAPSULE |
| 41275 | XTAMPZA ER 27 MG CAPSULE |
| 41276 | XTAMPZA ER 36 MG CAPSULE |
| 41272 | XTAMPZA ER 9 MG CAPSULE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 7 Analgesics, Narcotic – Short Acting

# Analgesics, Narcotic – Short Acting Prior Authorization Criteria

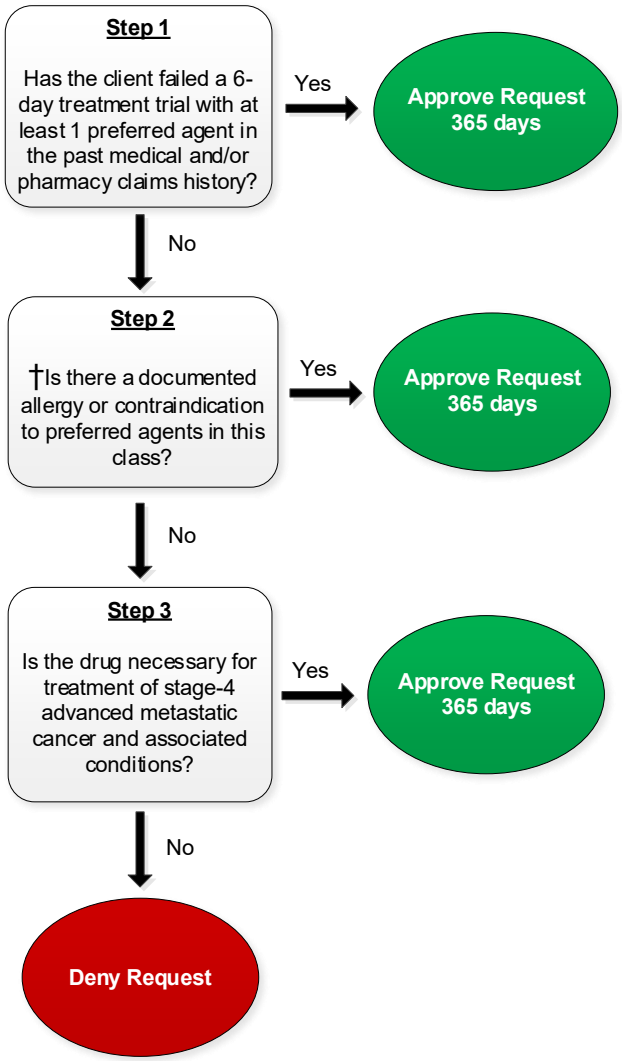
1. Has the client failed a 6-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Analgesics, Narcotic – Short Acting Prior Authorization Criteria

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# Analgesics, Narcotic – Short Acting Alternate Therapies

## Preferred Short Acting Narcotics

| GCN | Drug Name |
|---|---|
| 33606 | ACETAMIN-CODEIN 300-30 MG/12.5 |
| 33604 | ACETAMINOP-CODEIN 240-24 MG/10 |
| 33589 | ACETAMINOP-CODEINE 120-12 MG/5 |
| 55402 | ACETAMINOP-CODEINE 120-12 MG/5 |
| 70131 | ACETAMINOPHEN-COD #2 TABLET |
| 70134 | ACETAMINOPHEN-COD #3 TABLET |
| 70136 | ACETAMINOPHEN-COD #4 TABLET |
| 14966 | ENDOCET 10-325 MG TABLET |
| 70491 | ENDOCET 5-325 MG TABLET |
| 14965 | ENDOCET 7.5-325 MG TABLET |
| 22929 | HYDROCODONE-ACETAMIN 10-300 MG |
| 70330 | HYDROCODONE-ACETAMIN 10-325 MG |
| 16227 | HYDROCODONE-ACETAMIN 10-325/15 |
| 35153 | HYDROCODONE-ACETAMIN 2.5-108/5 |
| 70337 | HYDROCODONE-ACETAMIN 2.5-325 |
| 35154 | HYDROCODONE-ACETAMIN 5-217/10 |
| 26470 | HYDROCODONE-ACETAMIN 5-300 MG |
| 12486 | HYDROCODONE-ACETAMIN 5-325 MG |
| 26709 | HYDROCODONE-ACETAMIN 7.5-300 |
| 12488 | HYDROCODONE-ACETAMIN 7.5-325 |
| 21146 | HYDROCODONE-ACETAMN 7.5-325/15 |

| GCN | Drug Name |
|---|---|
| 31419 | HYDROCODONE-ACETAMN 7.5-325/15 |
| 16141 | HYDROMORPHONE 2 MG TABLET |
| 16143 | HYDROMORPHONE 4 MG TABLET |
| 16144 | HYDROMORPHONE 8 MG TABLET |
| 12486 | LORCET 5-325MG TABLET |
| 70330 | LORCET HD 10-325MG TABLET |
| 12488 | LORCET PLUS 7.5-325MG TABLET |
| 16060 | MORPHINE SULF 10 MG/5 ML CUP |
| 16062 | MORPHINE SULF 20 MG/5 ML SOLN |
| 16070 | MORPHINE SULFATE IR 15 MG TAB |
| 16071 | MORPHINE SULFATE IR 30 MG TAB |
| 16291 | OXYCODONE HCL (IR) 10 MG TAB |
| 20091 | OXYCODONE HCL (IR) 15 MG TAB |
| 21194 | OXYCODONE HCL (IR) 20 MG TAB |
| 20092 | OXYCODONE HCL (IR) 30 MG TAB |
| 16290 | OXYCODONE HCL (IR) 5 MG TABLET |
| 16280 | OXYCODONE HCL 5 MG/5 ML CUP |
| 14966 | OXYCODONE HCL/ACETAMINOPHEN 10-325MG TABLET |
| 14965 | OXYCODONE HCL/ACETAMINOPHEN 7.5-325MG TABLET |
| 70491 | OXYCODONE/ACETAMINOPHEN 5-325MG TABLET |
| 70492 | OXYCODONE-ACETAMINOPHN 2.5-325 |
| 7221 | TRAMADOL HCL 50 MG TABLET |
| 13909 | TRAMADOL-ACETAMINOPHN 37.5-325 |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 8 Androgenic Agents, Topical

# Androgenic Agents, Topical
# Prior Authorization Criteria

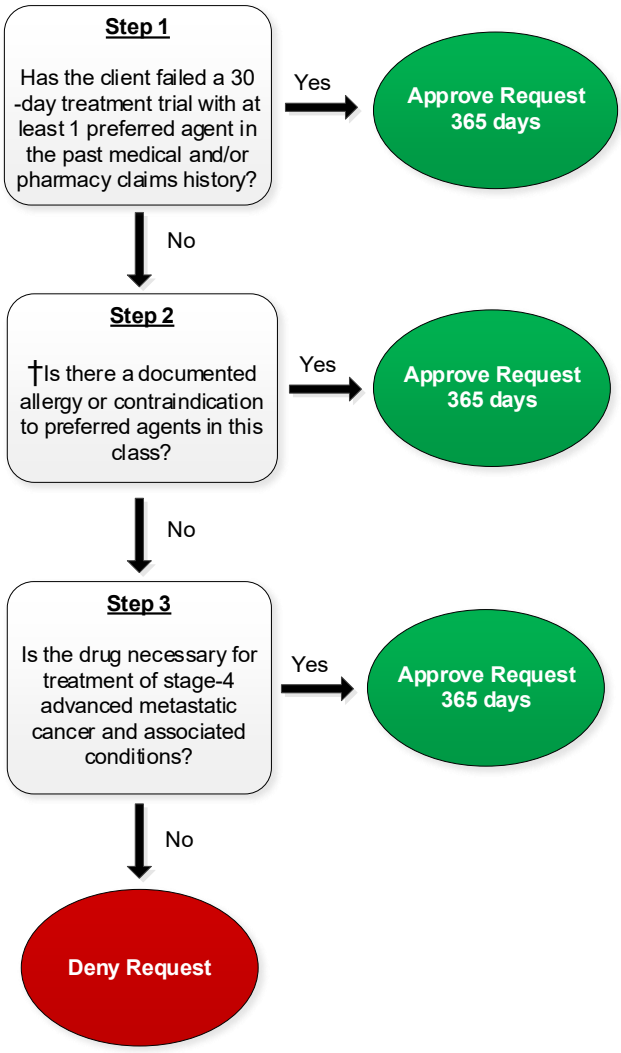
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

†Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Androgenic Agents, Topical
# Prior Authorization Criteria

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# Androgenic Agents, Topical
# Alternate Therapies

## Preferred Androgenic Agents, Topical

| GCN | Drug Name |
|---|---|
| 97089 | TESTIM 1% (50 MG) GEL |
| 47851 | TESTOSTERONE 1% (25 MG/2.5 G) PK |
| 47852 | TESTOSTERONE 1% (50 MG/5 G) PK |
| 29905 | TESTOSTERONE 1.62% GEL PUMP |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 9 Angiotensin Modulators

# Angiotensin Modulators
# Prior Authorization Criteria

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

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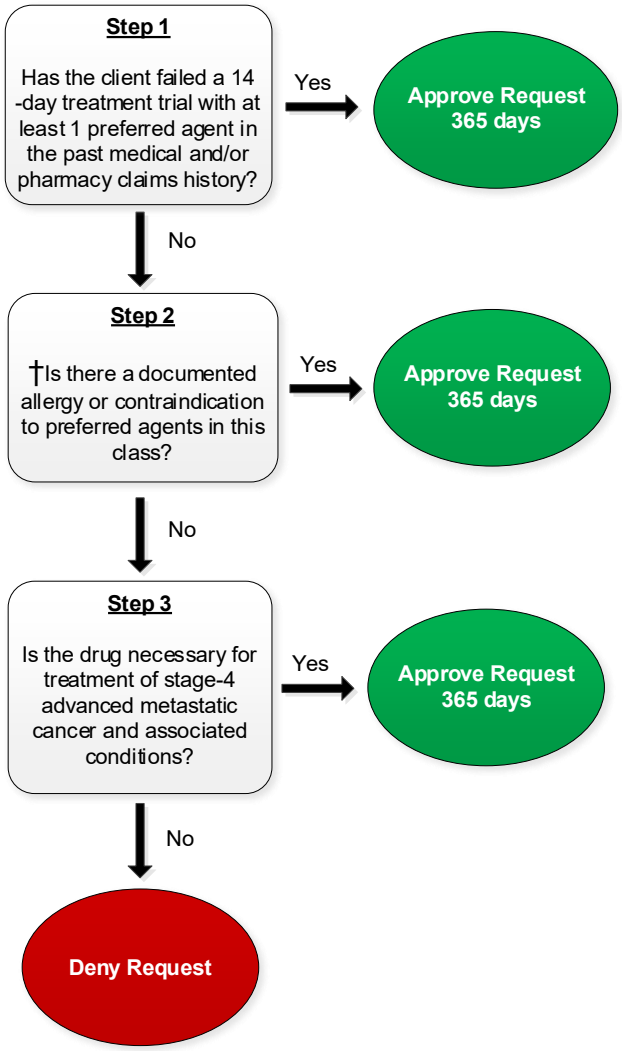
# Angiotensin Modulators Prior Authorization Criteria

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# Angiotensin Modulators
# Prior Authorization Criteria

## Preferred Angiotensin Modulators

| GCN | Drug Name |
|---|---|
| 48612 | BENAZEPRIL HCL 10 MG TABLET |
| 48613 | BENAZEPRIL HCL 20 MG TABLET |
| 48614 | BENAZEPRIL HCL 40 MG TABLET |
| 48611 | BENAZEPRIL HCL 5 MG TABLET |
| 13844 | DIOVAN 160 MG TABLET |
| 13838 | DIOVAN 320 MG TABLET |
| 18092 | DIOVAN 40 MG TABLET |
| 13846 | DIOVAN 80 MG TABLET |
| 09760 | DIOVAN HCT 160-12.5 MG TAB |
| 17245 | DIOVAN HCT 160-25 MG TABLET |
| 27015 | DIOVAN HCT 320-12.5 MG TAB |
| 27014 | DIOVAN HCT 320-25 MG TABLET |
| 07833 | DIOVAN HCT 80-12.5 MG TABLET |
| 29595 | EDARBI 40 MG TABLET |
| 29597 | EDARBI 80 MG TABLET |
| 31163 | EDARBYCLOR 40-12.5 MG TABLET |
| 31164 | EDARBYCLOR 40-25 MG TABLET |
| 42337 | ENALAPRIL 1 MG/ML ORAL SOLN |
| 00961 | ENALAPRIL MALEATE 10 MG TAB |
| 00963 | ENALAPRIL MALEATE 2.5 MG TAB |
| 00962 | ENALAPRIL MALEATE 20 MG TAB |

| GCN | Drug Name |
|---|---|
| 00960 | ENALAPRIL MALEATE 5 MG TABLET |
| 54860 | ENALAPRIL-HCTZ 10-25 MG TABLET |
| 54862 | ENALAPRIL-HCTZ 5-12.5 MG TAB |
| 39046 | ENTRESTO 24 MG-26 MG TABLET |
| 39047 | ENTRESTO 49 MG-51 MG TABLET |
| 39048 | ENTRESTO 97 MG-103 MG TABLET |
| 48581 | FOSINOPRIL SODIUM 10 MG TAB |
| 48582 | FOSINOPRIL SODIUM 20 MG TAB |
| 48580 | FOSINOPRIL SODIUM 40 MG TAB |
| 04749 | IRBESARTAN 150 MG TABLET |
| 04750 | IRBESARTAN 300 MG TABLET |
| 04752 | IRBESARTAN 75 MG TABLET |
| 11042 | IRBESARTAN-HCTZ 150-12.5 MG TB |
| 11295 | IRBESARTAN-HCTZ 300-12.5 MG TB |
| 47261 | LISINOPRIL 10 MG TABLET |
| 47264 | LISINOPRIL 2.5 MG TABLET |
| 47262 | LISINOPRIL 20 MG TABLET |
| 47265 | LISINOPRIL 30 MG TABLET |
| 47263 | LISINOPRIL 40 MG TABLET |
| 47260 | LISINOPRIL 5 MG TABLET |
| 88002 | LISINOPRIL-HCTZ 10-12.5 MG TAB |
| 88000 | LISINOPRIL-HCTZ 20-12.5 MG TAB |
| 88001 | LISINOPRIL-HCTZ 20-25 MG TAB |
| 14853 | LOSARTAN POTASSIUM 100 MG TAB |
| 14850 | LOSARTAN POTASSIUM 25 MG TAB |

| GCN | Drug Name |
|---|---|
| 14851 | LOSARTAN POTASSIUM 50 MG TAB |
| 25851 | LOSARTAN-HCTZ 100-12.5 MG TAB |
| 14854 | LOSARTAN-HCTZ 100-25 MG TAB |
| 14852 | LOSARTAN-HCTZ 50-12.5 MG TAB |
| 27570 | QUINAPRIL 10 MG TABLET |
| 27571 | QUINAPRIL 20 MG TABLET |
| 27573 | QUINAPRIL 40 MG TABLET |
| 27572 | QUINAPRIL 5 MG TABLET |
| 48541 | RAMIPRIL 1.25 MG CAPSULE |
| 48544 | RAMIPRIL 10 MG CAPSULE |
| 48542 | RAMIPRIL 2.5 MG CAPSULE |
| 48543 | RAMIPRIL 5 MG CAPSULE |
| 98077 | TEKTURNA 150 MG TABLET |
| 98076 | TEKTURNA 300 MG TABLET |
| 32191 | TRANDOLAPRIL 1 MG TABLET |
| 32192 | TRANDOLAPRIL 2 MG TABLET |
| 32193 | TRANDOLAPRIL 4 MG TABLET |
| 54860 | VASERETIC 10-25 MG TABLET |
| 00961 | VASOTEC 10 MG TABLET |
| 00963 | VASOTEC 2.5 MG TABLET |
| 00962 | VASOTEC 20 MG TABLET |
| 00960 | VASOTEC 5 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 10 Angiotensin Modulator Combinations

# Angiotensin Modulator Combinations
# Prior Authorization Criteria

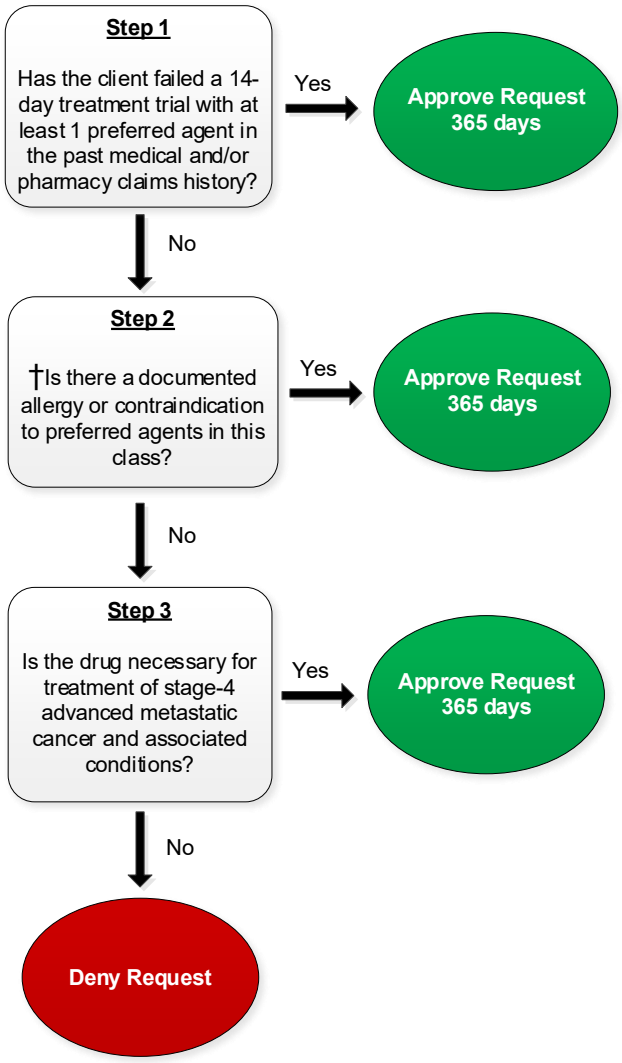
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Angiotensin Modulator Combinations Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Angiotensin Modulator Combinations Alternate Therapies

## Preferred Angiotensin Modulator Combinations

| GCN | Drug Name |
|---|---|
| 17604 | AMLODIPINE-BENAZEPRIL 10-20 MG |
| 26950 | AMLODIPINE-BENAZEPRIL 10-40 MG |
| 33093 | AMLODIPINE-BENAZEPRIL 2.5-10 |
| 33092 | AMLODIPINE-BENAZEPRIL 5-10 MG |
| 33090 | AMLODIPINE-BENAZEPRIL 5-20 MG |
| 26949 | AMLODIPINE-BENAZEPRIL 5-40 MG |
| 97963 | AMLODIPINE-VALSARTAN 10-160 MG |
| 98580 | AMLODIPINE-VALSARTAN 10-320 MG |
| 97962 | AMLODIPINE-VALSARTAN 5-160 MG |
| 98579 | AMLODIPINE-VALSARTAN 5-320 MG |
| 22631 | AMLOD-VALSA-HCTZ 10-160-12.5MG |
| 22649 | AMLOD-VALSA-HCTZ 10-160-25 MG |
| 22705 | AMLOD-VALSA-HCTZ 10-320-25 MG |
| 22625 | AMLOD-VALSA-HCTZ 5-160-12.5 MG |
| 22648 | AMLOD-VALSA-HCTZ 5-160-25 MG |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 11 Anti-Allergens, Oral

# Anti-Allergens, Oral
# Prior Authorization Criteria

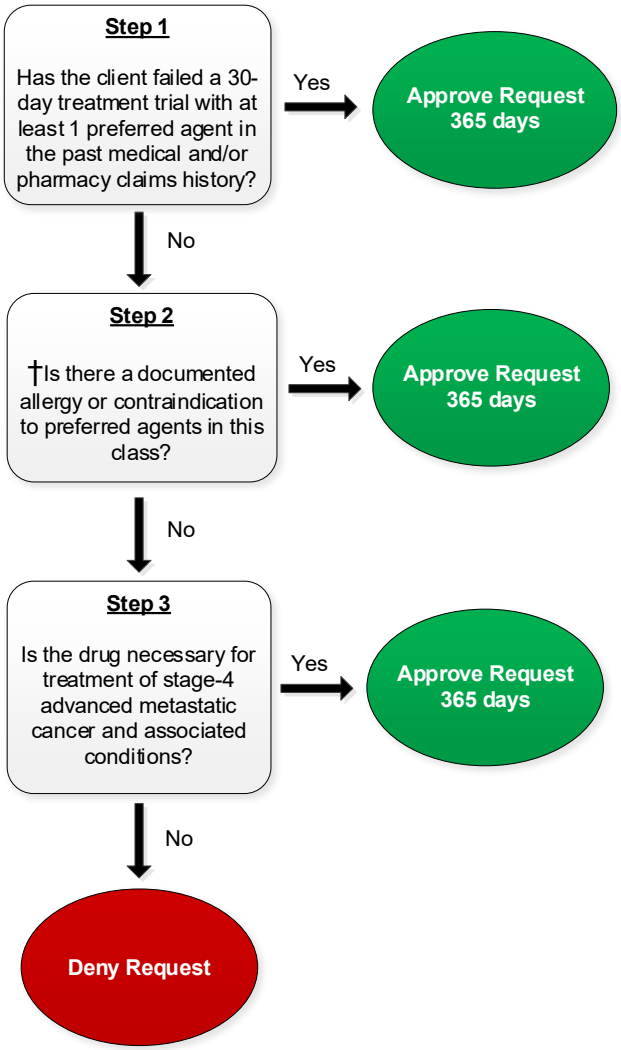
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Anti-Allergens, Oral
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Anti-Allergens, Oral
# Alternate Therapies

## Preferred Anti-Allergens, Oral

| GCN | Drug Name |
|---|---|
| 35777 | GRASTEK 2,800 BAU SL TABLET |
| 42527 | ODACTRA 12 SQ-HDM SL TABLET |
| 33969 | ORALAIR 100 IR STARTER PACK |
| 41118 | ORALAIR 100-300 IR CHILD SAMPL |
| 33970 | ORALAIR 300 IR ADULT SAMPLE KT |
| 33970 | ORALAIR 300 IR STARTER PACK |
| 33970 | ORALAIR 300 IR SUBLINGUAL TAB |
| 36402 | RAGWITEK SUBLINGUAL TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 12 Antibiotics, GI

# Antibiotics, GI
# Prior Authorization Criteria

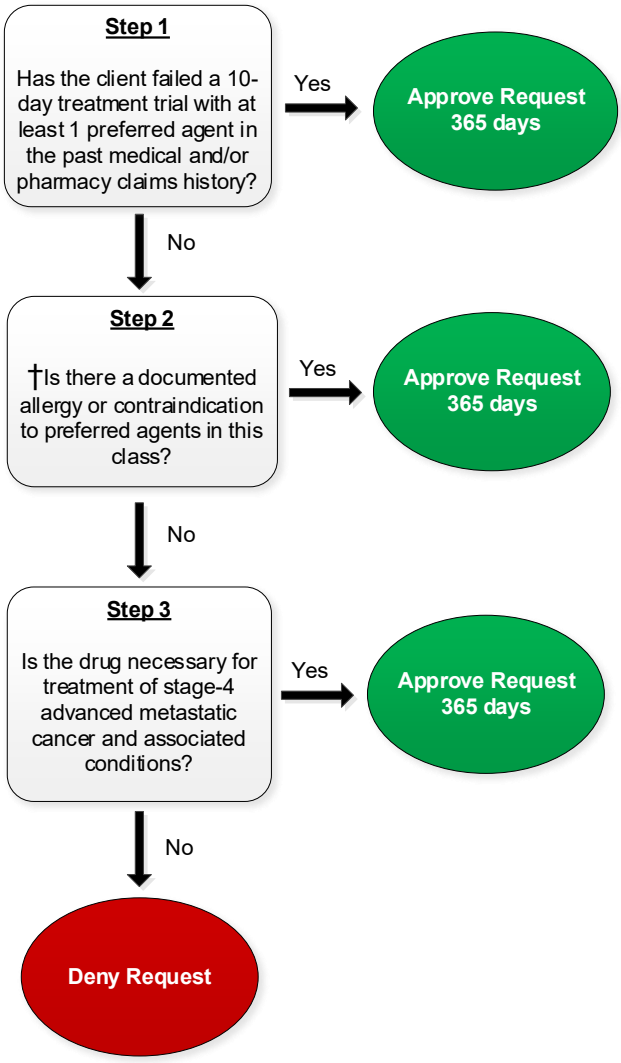
1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antibiotics, GI
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antibiotics, GI
# Alternate Therapies

## Preferred Gastrointestinal Antibiotics

| GCN | Drug Name |
|---|---|
| 44411 | FIRVANQ 25 MG/ML SOLUTION |
| 41291 | FIRVANQ 50 MG/ML SOLUTION |
| 43031 | METRONIDAZOLE 250 MG TABLET |
| 43032 | METRONIDAZOLE 500 MG TABLET |
| 41072 | NEOMYCIN 500 MG TABLET |
| 22867 | TINIDAZOLE 250 MG TABLET |
| 52220 | TINIDAZOLE 500 MG TABLET |
| 41370 | VANCOCIN HCL 125 MG CAPSULE |
| 41371 | VANCOCIN HCL 250 MG CAPSULE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 13 Antibiotics, Inhaled

# Antibiotics, Inhaled
# Prior Authorization Criteria

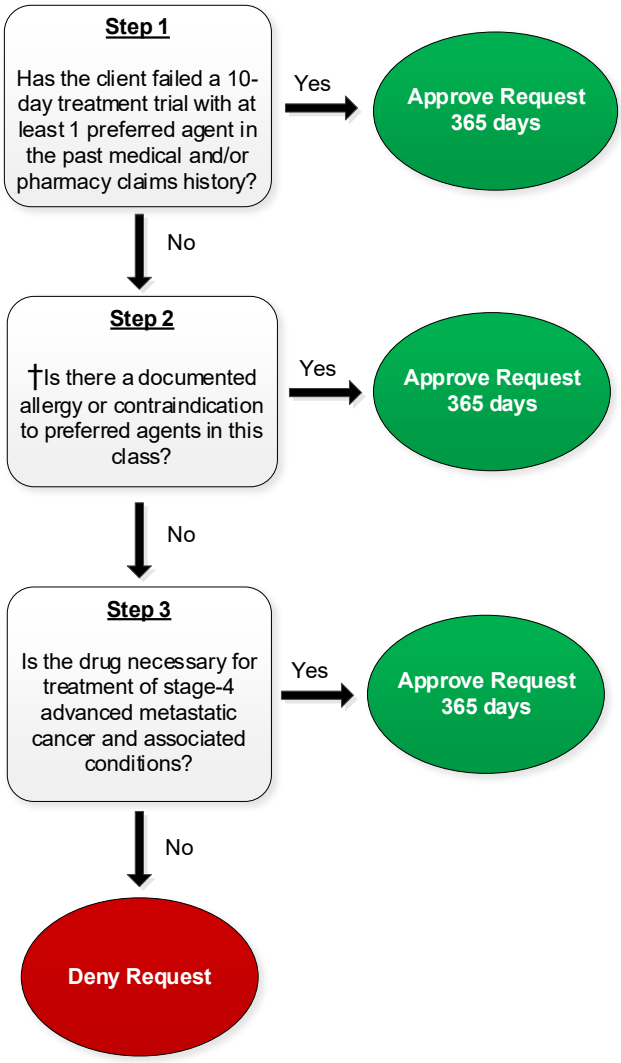
1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section

# Antibiotics, Inhaled
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antibiotics, Inhaled
# Alternate Therapies

## Preferred Inhaled Antibiotics

| GCN | Drug Name |
|---|---|
| 16122 | BETHKIS 300 MG/4 ML AMPULE |
| 28039 | CAYSTON 75 MG INHAL SOLUTION |
| 37569 | KITABIS PAK 300 MG/5 ML |
| 30025 | TOBI PODHALER 28 MG INHALE CAP |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 14 Antibiotics, Topical

# Antibiotics, Topical
# Prior Authorization Criteria

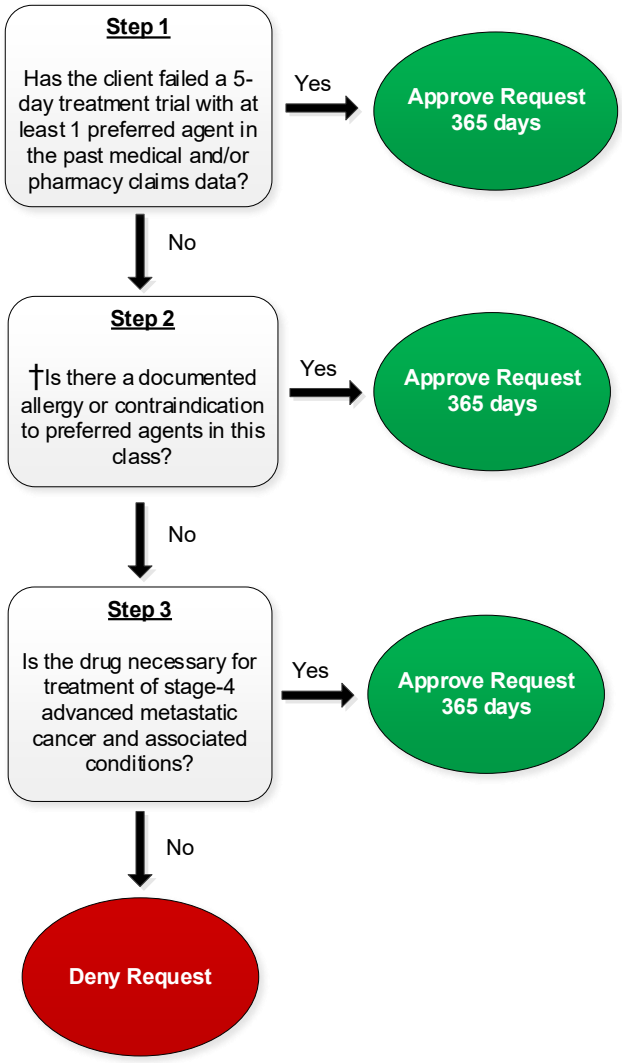
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims data?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antibiotics, Topical
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antibiotics, Topical
# Prior Authorization Criteria

## Preferred Topical Antibiotics

| GCN | Drug Name |
|---|---|
| 31812 | BACITRACIN 500 UNIT/GM OINTMNT |
| 31810 | BACITRACIN ZN 500 UNIT/GM OINT |
| 62427 | BACITRACIN/POLYMYXIN B OINTMENT OTC (TOPICAL) |
| 47450 | MUPIROCIN 2% OINTMENT |
| 98748 | NEOMYCIN/BACITRACIN/POLYMYXIN B OINTMENT |
| 97206 | TRIPLE ANTIBIOTIC OINT PKT |
| 85459 | TRIPLE ANTIBIOTIC OINTMENT |
| 12623 | TRIPLE ANTIBIOTIC PLUS OINTMENT |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 15 Antibiotics, Vaginal

# Antibiotics, Vaginal
# Prior Authorization Criteria

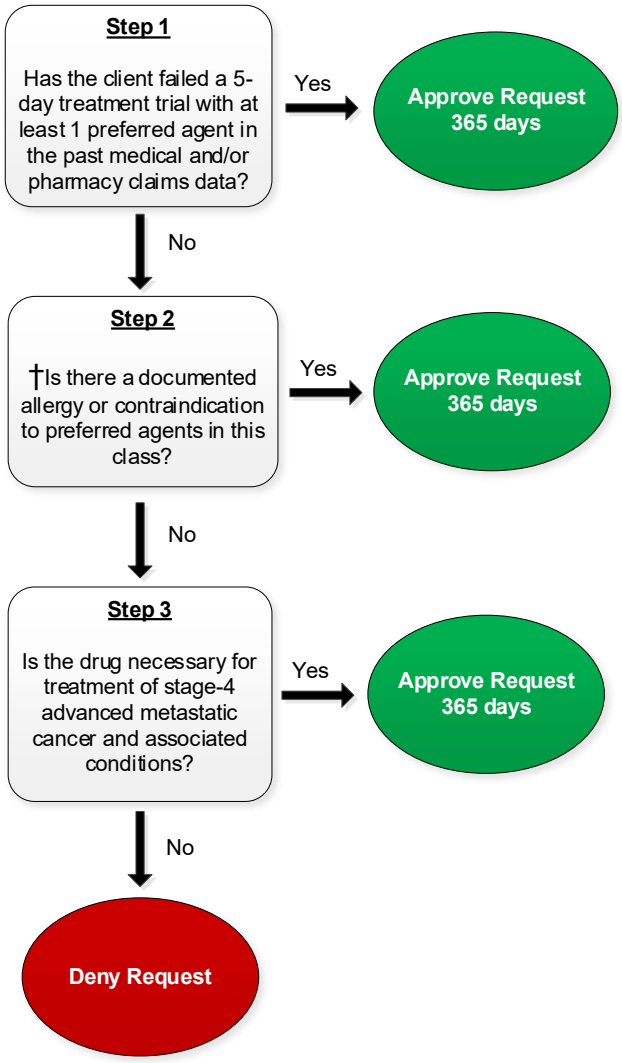
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antibiotics, Vaginal
# Prior Authorization Criteria




†Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antibiotics, Vaginal
# Alternate Therapies

## Preferred Vaginal Antibiotics

| GCN | Drug Name |
|---|---|
| 91969 | CLEOCIN 100 MG VAGINAL OVULE |
| 28581 | CLEOCIN 2% VAGINAL CREAM |
| 49261 | METRONIDAZOLE VAGINAL 0.75% GL |
| 36303 | NUVESSA VAGINAL 1.3% GEL |
| 52753 | XACIATO 2% VAGINAL GEL |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 16 Anticoagulants

# Anticoagulants
# Prior Authorization Criteria

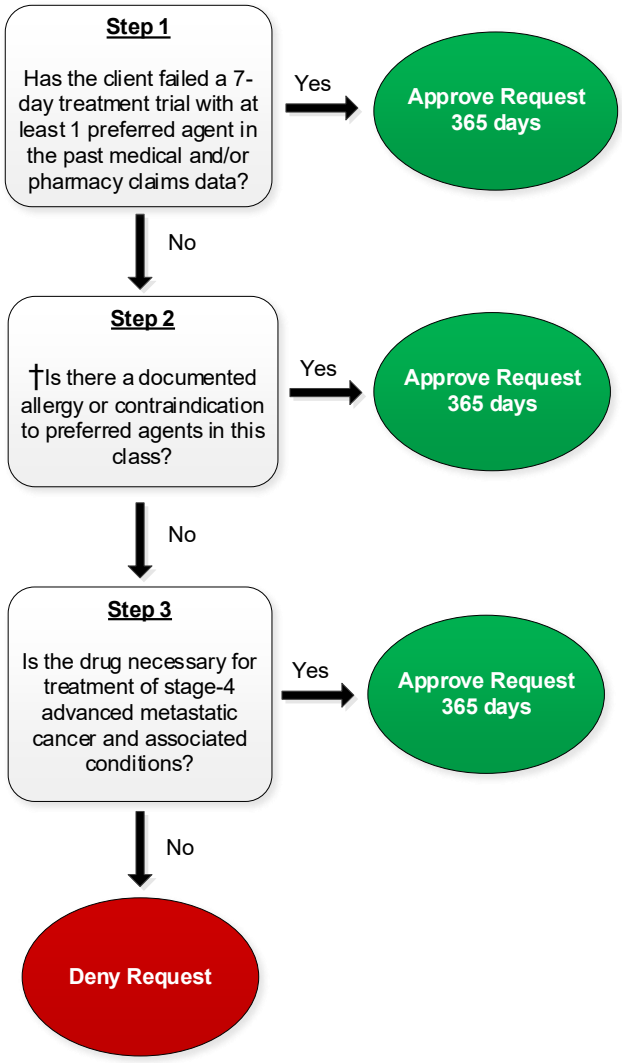
1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Anticoagulants
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Anticoagulants
# Alternate Therapies

## Preferred Anticoagulants

| GCN | Drug Name |
|---|---|
| 30239 | ELIQUIS 2.5 MG TABLET |
| 33935 | ELIQUIS 5 MG TABLET |
| 44357 | ELIQUIS DVT-PE TREAT START 5MG |
| 62773 | ENOXAPARIN 100 MG/ML SYRINGE |
| 42091 | ENOXAPARIN 120 MG/0.8 ML SYR |
| 42071 | ENOXAPARIN 150 MG/ML SYRINGE |
| 00420 | ENOXAPARIN 30 MG/0.3 ML SYR |
| 96334 | ENOXAPARIN 300 MG/3 ML VIAL |
| 70022 | ENOXAPARIN 40 MG/0.4 ML SYR |
| 62771 | ENOXAPARIN 60 MG/0.6 ML SYR |
| 62772 | ENOXAPARIN 80 MG/0.8 ML SYR |
| 25792 | JANTOVEN 1 MG TABLET |
| 25790 | JANTOVEN 10 MG TABLET |
| 25791 | JANTOVEN 2 MG TABLET |
| 25794 | JANTOVEN 2.5 MG TABLET |
| 25796 | JANTOVEN 3 MG TABLET |
| 25797 | JANTOVEN 4 MG TABLET |
| 25793 | JANTOVEN 5 MG TABLET |
| 25798 | JANTOVEN 6 MG TABLET |
| 25795 | JANTOVEN 7.5 MG TABLET |
| 99709 | PRADAXA 110 MG CAPSULE |
| 29166 | PRADAXA 150 MG CAPSULE |

| GCN | Drug Name |
|---|---|
| 99708 | PRADAXA 75 MG CAPSULE |
| 25792 | WARFARIN SODIUM 1 MG TABLET |
| 25790 | WARFARIN SODIUM 10 MG TABLET |
| 25791 | WARFARIN SODIUM 2 MG TABLET |
| 25794 | WARFARIN SODIUM 2.5 MG TABLET |
| 25796 | WARFARIN SODIUM 3 MG TABLET |
| 25797 | WARFARIN SODIUM 4 MG TABLET |
| 25793 | WARFARIN SODIUM 5 MG TABLET |
| 25798 | WARFARIN SODIUM 6 MG TABLET |
| 25795 | WARFARIN SODIUM 7.5 MG TABLET |
| 50027 | XARELTO 1 MG/ML SUSPENSION |
| 14427 | XARELTO 10 MG TABLET |
| 30818 | XARELTO 15 MG TABLET |
| 36934 | XARELTO 2.5 MG TABLET |
| 30819 | XARELTO 20 MG TABLET |
| 37212 | XARELTO DVT-PE TREAT START 30D |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 17 Anticonvulsants

# Anticonvulsants
# Alternate Therapies

All products in this class are preferred and have no PDL prior authorization criteria.
To verify formulary coverage for any drugs listed on PDL, search the Medicaid formulary.

# 18 Antidepressants, Other

# Antidepressants, Other
# Prior Authorization Criteria

1. Has the client been stable on a non-preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Has the client been prescribed and is taking a non-preferred agent before being discharged from an inpatient facility?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #4)

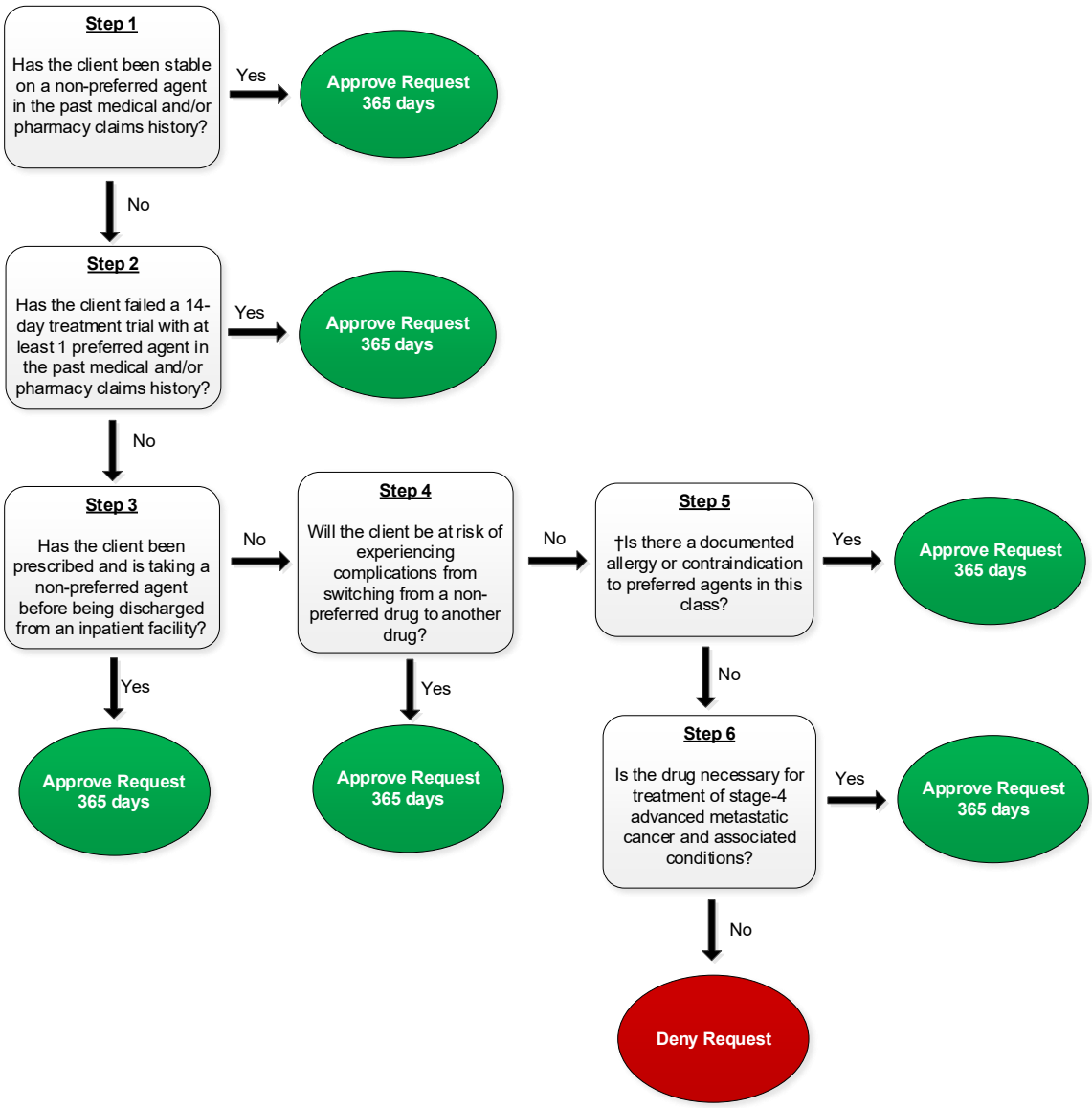
4. Will the client be at risk of experiencing complications from switching from a non-preferred drug to another drug?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #5)

5. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #6)

6. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antidepressants, Other
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antidepressants, Other
# Alternate Therapies

## Preferred Other Antidepressants

| GCN | Drug Name |
|---|---|
| 26198 | APLENZIN ER 174 MG TABLET |
| 16996 | APLENZIN ER 348 MG TABLET |
| 17050 | APLENZIN ER 522 MG TABLET |
| 16385 | BUPROPION HCL 100 MG TABLET |
| 16384 | BUPROPION HCL 75 MG TABLET |
| 16387 | BUPROPION HCL SR 100 MG TABLET |
| 16386 | BUPROPION HCL SR 150 MG TABLET |
| 17573 | BUPROPION HCL SR 200 MG TABLET |
| 20317 | BUPROPION HCL XL 150 MG TABLET |
| 20318 | BUPROPION HCL XL 300 MG TABLET |
| 16818 | EFFEXOR XR 150 MG CAPSULE |
| 16816 | EFFEXOR XR 37.5 MG CAPSULE |
| 16817 | EFFEXOR XR 75 MG CAPSULE |
| 33081 | FORFIVO XL 450 MG TABLET |
| 12529 | MIRTAZAPINE 15 MG ODT |
| 16732 | MIRTAZAPINE 15 MG TABLET |
| 12531 | MIRTAZAPINE 30 MG ODT |
| 16733 | MIRTAZAPINE 30 MG TABLET |
| 13041 | MIRTAZAPINE 45 MG ODT |
| 16734 | MIRTAZAPINE 45 MG TABLET |
| 21817 | MIRTAZAPINE 7.5 MG TABLET |
| 16417 | PHENELZINE SULFATE 15 MG TAB |

| GCN | Drug Name |
|---|---|
| 99452 | PRISTIQ ER 100 MG TABLET |
| 38222 | PRISTIQ ER 25 MG TABLET |
| 99451 | PRISTIQ ER 50 MG TABLET |
| 16392 | TRAZODONE 100 MG TABLET |
| 16393 | TRAZODONE 150 MG TABLET |
| 16394 | TRAZODONE 300 MG TABLET |
| 16391 | TRAZODONE 50 MG TABLET |
| 16815 | VENLAFAXINE HCL 100 MG TABLET |
| 16811 | VENLAFAXINE HCL 25 MG TABLET |
| 16812 | VENLAFAXINE HCL 37.5 MG TABLET |
| 16813 | VENLAFAXINE HCL 50 MG TABLET |
| 16814 | VENLAFAXINE HCL 75 MG TABLET |
| 16818 | VENLAFAXINE HCL ER 150 MG CAP |
| 16816 | VENLAFAXINE HCL ER 37.5 MG CAP |
| 16817 | VENLAFAXINE HCL ER 75 MG CAP |
| 29916 | VIIBRYD 10 MG TABLET |
| 29917 | VIIBRYD 20 MG TABLET |
| 29918 | VIIBRYD 40 MG TABLET |
| 43601 | ZURZUVAE 20 MG CAPSULE |
| 45723 | ZURZUVAE 25 MG CAPSULE |
| 48261 | ZURZUVAE 30 MG CAPSULE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 19 Antidepressants, SSRI

# Antidepressants, SSRI
# Prior Authorization Criteria

1. Has the client been stable on a non-preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Has the client been prescribed and is taking a non-preferred agent before being discharged from an inpatient facility?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #4)

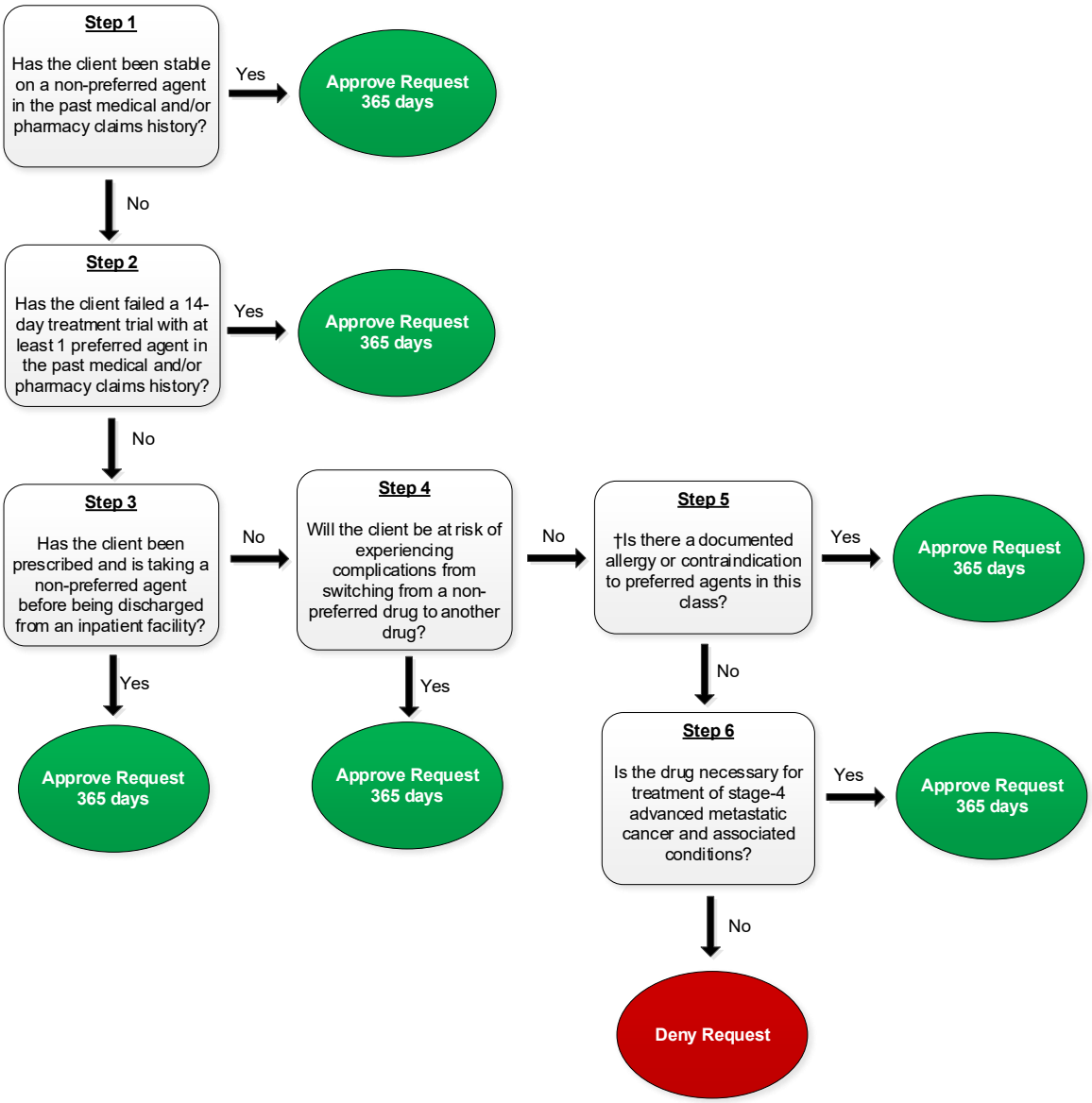
4. Will the client be at risk of experiencing complications from switching from a non-preferred drug to another drug?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #5)

5. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #6)

6. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antidepressants, SSRI Prior Authorization Diagram




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antidepressants, SSRI Alternate Therapies

## Preferred SSRI Antidepressants

| GCN | Drug Name |
|---|---|
| 16345 | CITALOPRAM HBR 10 MG TABLET |
| 16344 | CITALOPRAM HBR 10 MG/5 ML SOLN |
| 16342 | CITALOPRAM HBR 20 MG TABLET |
| 34671 | CITALOPRAM HBR 20 MG/10 ML CUP |
| 16343 | CITALOPRAM HBR 40 MG TABLET |
| 17851 | ESCITALOPRAM 10 MG TABLET |
| 17987 | ESCITALOPRAM 20 MG TABLET |
| 18975 | ESCITALOPRAM 5 MG TABLET |
| 16357 | FLUOXETINE 20 MG/5 ML SOLN CUP |
| 16357 | FLUOXETINE 20 MG/5 ML SOLUTION |
| 16353 | FLUOXETINE HCL 10 MG CAPSULE |
| 16354 | FLUOXETINE HCL 20 MG CAPSULE |
| 16355 | FLUOXETINE HCL 40 MG CAPSULE |
| 16349 | FLUVOXAMINE MALEATE 100 MG TAB |
| 16347 | FLUVOXAMINE MALEATE 25 MG TAB |
| 16348 | FLUVOXAMINE MALEATE 50 MG TAB |
| 16364 | PAROXETINE HCL 10 MG TABLET |
| 16366 | PAROXETINE HCL 20 MG TABLET |
| 16367 | PAROXETINE HCL 30 MG TABLET |
| 16368 | PAROXETINE HCL 40 MG TABLET |

| GCN | Drug Name |
|---|---|
| 16376 | SERTRALINE 20 MG/ML ORAL CONC |
| 16375 | SERTRALINE HCL 100 MG TABLET |
| 16373 | SERTRALINE HCL 25 MG TABLET |
| 16374 | SERTRALINE HCL 50 MG TABLET |
| 16375 | ZOLOFT 100 MG TABLET |
| 16376 | ZOLOFT 20 MG/ML ORAL CONC |
| 16373 | ZOLOFT 25 MG TABLET |
| 16374 | ZOLOFT 50 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 20 Antidepressants, Tricyclic

# Antidepressants, Tricyclic
# Prior Authorization Criteria

1. Has the client been stable on a non-preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Has the client been prescribed and is taking a non-preferred agent before being discharged from an inpatient facility?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #4)

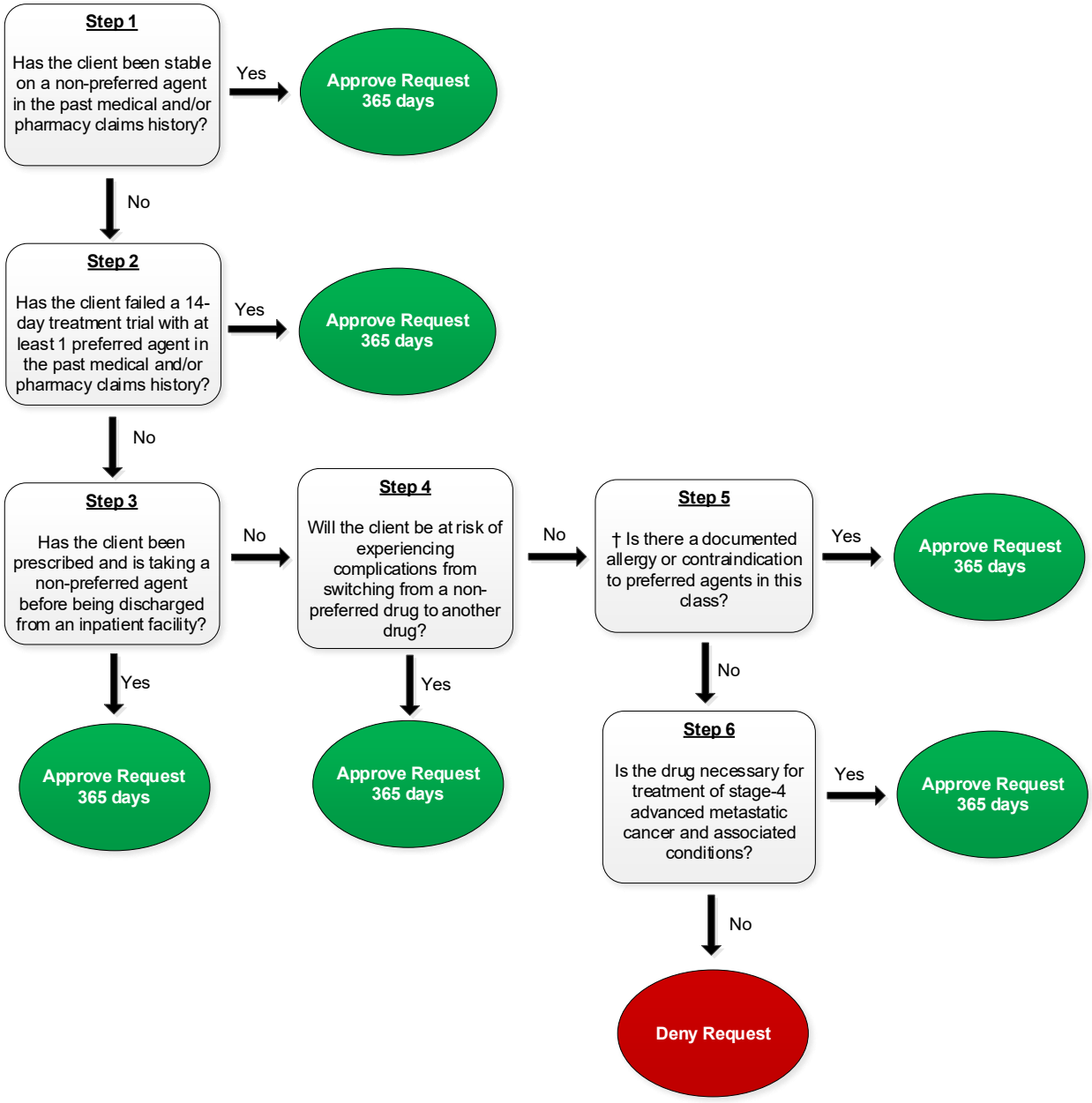
4. Will the client be at risk of experiencing complications from switching from a non-preferred drug to another drug?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #5)

5. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #6)

6. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antidepressants, Tricyclic Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antidepressants, Tricyclic
# Alternate Therapies

## Preferred Tricyclic Antidepressants

| GCN | Drug Name |
|---|---|
| 16512 | AMITRIPTYLINE HCL 10 MG TAB |
| 16513 | AMITRIPTYLINE HCL 100 MG TAB |
| 16514 | AMITRIPTYLINE HCL 150 MG TAB |
| 16515 | AMITRIPTYLINE HCL 25 MG TAB |
| 16516 | AMITRIPTYLINE HCL 50 MG TAB |
| 16517 | AMITRIPTYLINE HCL 75 MG TAB |
| 16563 | DOXEPIN 10 MG CAPSULE |
| 16571 | DOXEPIN 10 MG/ML ORAL CONC |
| 16564 | DOXEPIN 100 MG CAPSULE |
| 16565 | DOXEPIN 150 MG CAPSULE |
| 16566 | DOXEPIN 25 MG CAPSULE |
| 16567 | DOXEPIN 50 MG CAPSULE |
| 16568 | DOXEPIN 75 MG CAPSULE |
| 16541 | IMIPRAMINE HCL 10 MG TABLET |
| 16542 | IMIPRAMINE HCL 25 MG TABLET |
| 16543 | IMIPRAMINE HCL 50 MG TABLET |
| 16529 | NORTRIPTYLINE HCL 10 MG CAP |
| 16532 | NORTRIPTYLINE HCL 25 MG CAP |
| 16533 | NORTRIPTYLINE HCL 50 MG CAP |
| 16534 | NORTRIPTYLINE HCL 75 MG CAP |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 21 Antiemetic-Antivertigo Agents, Oral

# Antiemetic-Antivertigo Agents, Oral Prior Authorization Criteria

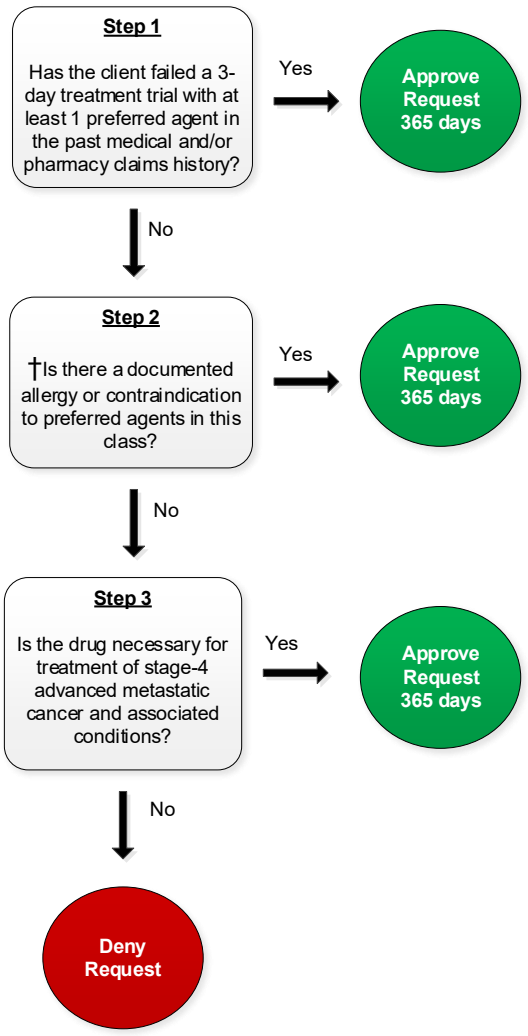
1. Has the client failed a 3-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antiemetic-Antivertigo Agents, Oral Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antiemetic-Antivertigo Agents, Oral Alternate Therapies

## Preferred Antiemetic-Antivertigo Agents

| GCN | Label Name |
|---|---|
| 73710 | ANTI-NAUSEA LIQUID |
| 18303 | ANTIVERT 50 MG TABLET |
| 42645 | BONJESTA ER 20-20 MG TABLET |
| 73860 | DICLEGIS DR 10-10 MG TABLET |
| 18231 | DIMENHYDRINATE 50 MG TABLET |
| 27992 | MARINOL 10 MG CAPSULE |
| 27990 | MARINOL 2.5 MG CAPSULE |
| 27991 | MARINOL 5 MG CAPSULE |
| 18301 | MECLIZINE 12.5 MG CAPLET |
| 18302 | MECLIZINE 25 MG TABLET |
| 18312 | MECLIZINE 25 MG TABLET CHEW |
| 18303 | MECLIZINE 50 MG TABLET |
| 21020 | METOCLOPRAMIDE 10 MG TABLET |
| 34798 | METOCLOPRAMIDE 10 MG/10 ML CUP |
| 21021 | METOCLOPRAMIDE 5 MG TABLET |
| 34797 | METOCLOPRAMIDE 5 MG/5 ML CUP |
| 03610 | METOCLOPRAMIDE 5 MG/5 ML SOLN |
| 20040 | ONDANSETRON 4 MG/5 ML SOLUTION |
| 20041 | ONDANSETRON HCL 4 MG TABLET |
| 20042 | ONDANSETRON HCL 8 MG TABLET |
| 20045 | ONDANSETRON ODT 4 MG TABLET |

| GCN | Label Name |
|---|---|
| 20046 | ONDANSETRON ODT 8 MG TABLET |
| 14771 | PROCHLORPERAZINE 10 MG TAB |
| 14773 | PROCHLORPERAZINE 5 MG TABLET |
| 15042 | PROMETHAZINE 12.5 MG TABLET |
| 15043 | PROMETHAZINE 25 MG TABLET |
| 15044 | PROMETHAZINE 50 MG TABLET |
| 15035 | PROMETHAZINE 6.25 MG/5 ML CUP |
| 18160 | TRANSDERM-SCOP 1 MG/3 DAY PTCH |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 22 Antifungals, Oral

# Antifungals, Oral
# Prior Authorization Criteria

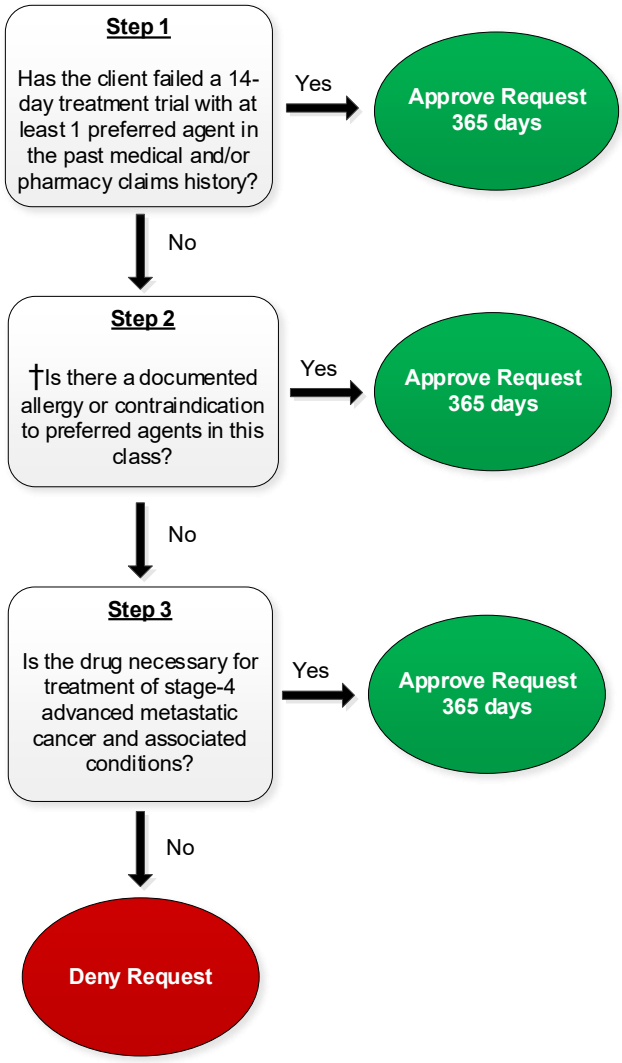
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antifungals, Oral
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antifungals, Oral
# Alternate Therapies

## Preferred Oral Antifungals

| GCN | Label Name |
|---|---|
| 07590 | CLOTRIMAZOLE 10MG TROCHE |
| 42190 | FLUCONAZOLE 100MG TABLET |
| 60822 | FLUCONAZOLE 10MG/ML SUSPENSION |
| 42193 | FLUCONAZOLE 150MG TABLET |
| 42191 | FLUCONAZOLE 200MG TABLET |
| 60821 | FLUCONAZOLE 40MG/ML SUSPENSION |
| 42192 | FLUCONAZOLE 50MG TABLET |
| 42390 | GRISEOFULVIN 125MG/5ML SUSPENSION |
| 42590 | KETOCONAZOLE 200MG TABLET |
| 42440 | NYSTATIN 100,000UNITS/ML SUSPENSION |
| 42452 | NYSTATIN 500,000 UNIT ORAL TAB |
| 26502 | POSACONAZOLE 200MG/5ML SUSP |
| 35649 | POSACONAZOLE DR 100MG TABLET |
| 49101 | SPORANOX 100 MG CAPSULE |
| 60823 | TERBINAFINE HCL 250MG TABLET |
| 21513 | VFEND 40 MG/ML SUSPENSION |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 23 Antifungals, Topical

# Antifungals, Topical
# Prior Authorization Criteria

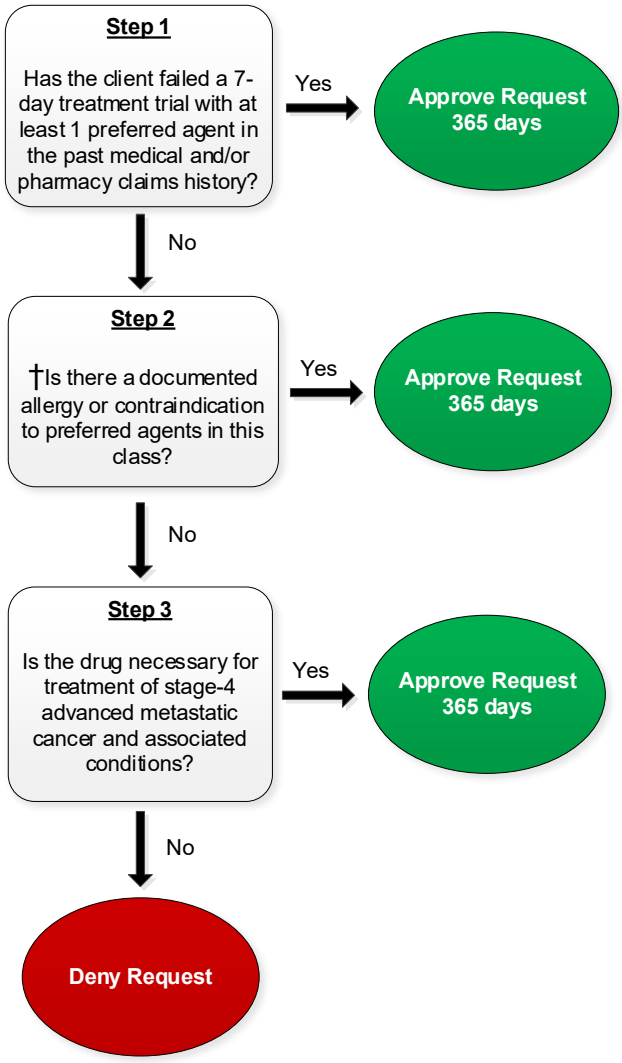
1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antifungals, Topical
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antifungals, Topical Alternate Therapies

## Preferred Topical Antifungals

| GCN | Drug Name |
|---|---|
| 94677 | CICLOPIROX 0.77% CREAM |
| 08040 | CICLOPIROX 8% SOLUTION |
| 30380 | CLOTRIMAZOLE 1% SOLUTION |
| 30370 | CLOTRIMAZOLE 1% TOPICAL CREAM |
| 06919 | CLOTRIMAZOLE-BETAMETHASONE CREAM |
| 36653 | JUBLIA 10% TOPICAL SOLUTION |
| 31850 | KETOCONAZOLE 2% CREAM |
| 31271 | KETOCONAZOLE 2% SHAMPOO |
| 30400 | MICONAZOLE 2% TOPICAL CREAM |
| 30410 | MICONAZOLE NITRATE 2% POWDER |
| 30140 | NYSTATIN 100,000UNIT/GM CREAM |
| 30150 | NYSTATIN 100,000UNIT/GM OINTMENT |
| 30160 | NYSTOP 100,000 UNIT/GM POWDER |
| 62498 | TERBINAFINE 1% CREAM |
| 30300 | TOLNAFTATE 1% CREAM |
| 30310 | TOLNAFTATE 1% POWDER |
| 26571 | VUSION OINTMENT |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 24 Antihistamines, First Generation

# Antihistamines, First Generation
# Prior Authorization Criteria

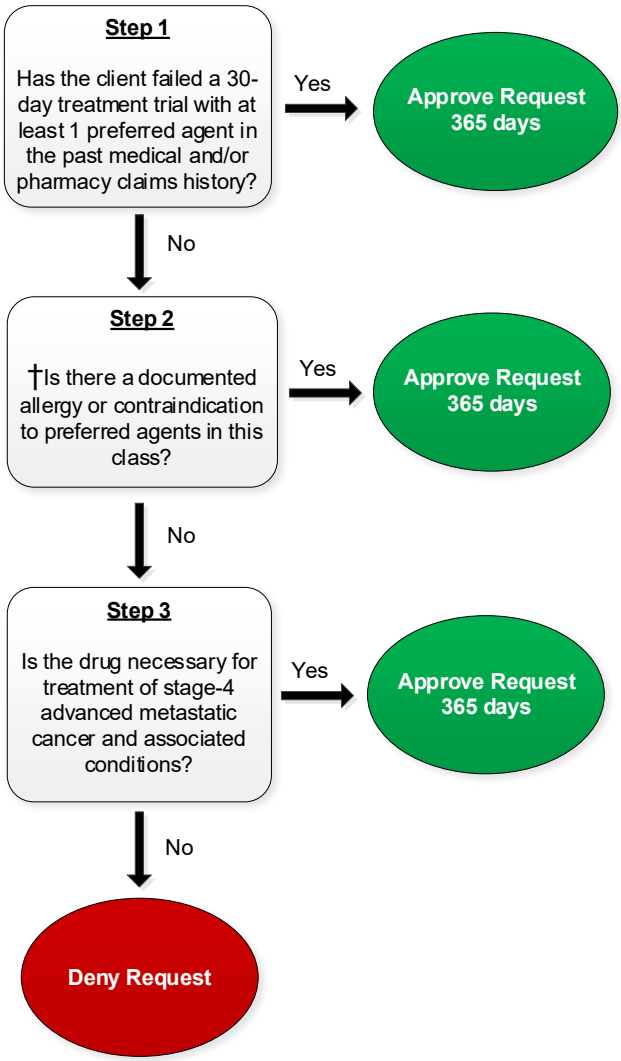
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antihistamines, First Generation
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antihistamines, First Generation
# Alternate Therapies

## Preferred First Generation Antihistamines

| GCN | Drug Name |
|---|---|
| 45971 | ALER-CAPS 25 MG CAPSULE |
| 46512 | ALLER-CHLOR 4 MG TABLET |
| 46071 | ALLER-G-TIME 25 MG CAPLET |
| 48831 | ALLERGY 50 MG/20 ML SOLUTION |
| 45971 | ALLERGY RELIEF 25 MG SOFTGEL |
| 45972 | BANOPEHN 50 MG CAPSULE |
| 45971 | BANOPHEN 25 MG CAPSULE |
| 14949 | CARBINOXAMINE 4 MG/5 ML LIQUID |
| 46170 | CARBINOXAMINE MALEATE 4 MG TAB |
| 43082 | CARBINOXAMINE MALEATE 6 MG TAB |
| 48831 | CHILD ALLERGY RLF 12.5 MG/5 ML |
| 48831 | CHILD ALLERGY RLF 12.5 MG/5 ML |
| 15803 | CYPROHEPTADINE 2 MG/5 ML SOLN |
| 15811 | CYPROHEPTADINE 4 MG TABLET |
| 45971 | DIPHENHIST 25 MG CAPSULE |
| 45971 | DIPHENHYDRAMINE 25 MG CAPSULE |
| 45972 | DIPHENHYDRAMINE 50 MG CAPSULE |
| 48831 | DIPHENYDRAMINE 12.5 MG/5 ML |
| 48831 | DIPHENYDRAMINE 12.5 MG/5 ML |
| 36886 | HISTEX 2.5 MG/5 ML SYRUP |
| 36284 | HISTEX PD 0.938 MG/ML DROPS |

| GCN | Drug Name |
|---|---|
| 43586 | HISTEX PD 1.25 MG/ML DROP |
| 13932 | HYDROXYZINE 10 MG/5 ML CUP |
| 13941 | HYDROXYZINE HCL 10 MG TABLET |
| 13943 | HYDROXYZINE HCL 25 MG TABLET |
| 13944 | HYDROXYZINE HCL 50 MG TABLET |
| 13951 | HYDROXYZINE PAM 100 MG CAP |
| 13952 | HYDROXYZINE PAM 25 MG CAP |
| 13953 | HYDROXYZINE PAM 50 MG CAP |
| 46798 | PEDIACLEAR-8 12.5 MG/15 ML LIQ |
| 31501 | PEDIACLEAR PD 0.625 MG/ML DROP |
| 48831 | QC CHILD ALLERGY 12.5 MG/5 ML |
| 45971 | QC COMPLETE ALLERGY 25 MG CAP |
| 48831 | SILADRYL 12.5 MG/5 ML LIQUID |
| 48831 | SM ALLERGY RELIEF 12.5 MG/5 ML |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 25 Antihistamines, Minimally Sedating

# Antihistamines, Minimally Sedating
# Prior Authorization Criteria

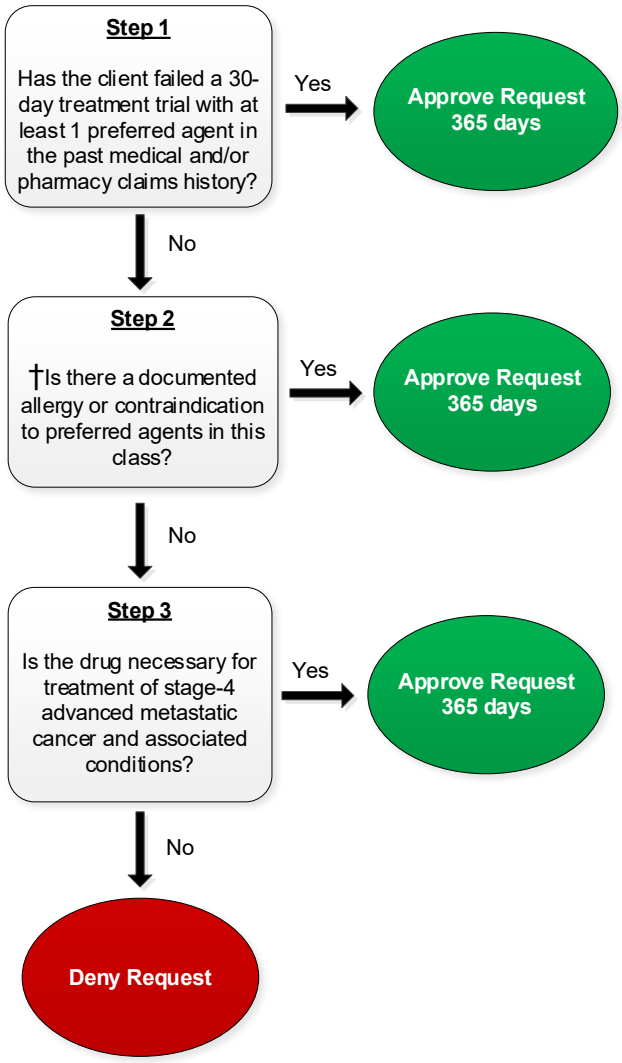
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antihistamines, Minimally Sedating
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antihistamines, Minimally Sedating
# Alternate Therapies

## Preferred Minimally Sedating Antihistamines

| GCN | Drug Name |
|---|---|
| 49290 | CETIRIZINE HCL 1 MG/ML SOLN |
| 49291 | CETIRIZINE HCL 10MG TABLET |
| 49292 | CETIRIZINE HCL 5 MG TABLET |
| 60563 | LORATADINE 10MG TABLET |
| 60562 | LORATADINE 5MG/5ML SYRUP |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 26 Antihypertensives, Sympatholytics

# Antihypertensives, Sympatholytics Prior Authorization Criteria

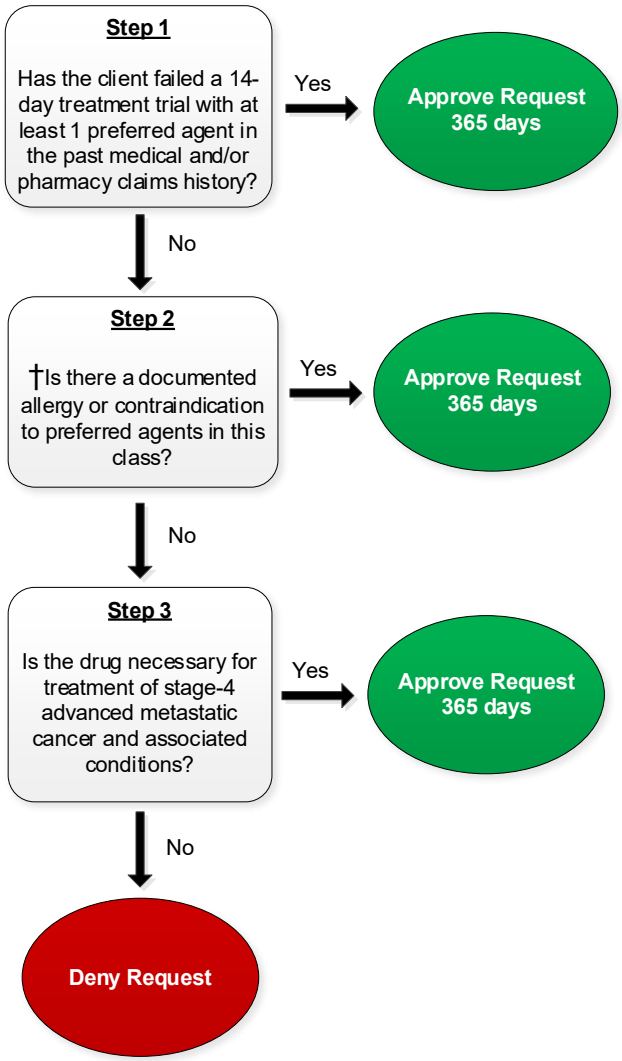
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antihypertensives, Sympatholytics Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antihypertensives, Sympatholytics Alternate Therapies

## Preferred Antihypertensives, Sympatholytics

| GCN | Drug Name |
|---|---|
| 23870 | CLONIDINE 0.1 MG/DAY PATCH |
| 23871 | CLONIDINE 0.2 MG/DAY PATCH |
| 23872 | CLONIDINE 0.3 MG/DAY PATCH |
| 01390 | CLONIDINE HCL 0.1 MG TABLET |
| 01391 | CLONIDINE HCL 0.2 MG TABLET |
| 01392 | CLONIDINE HCL 0.3 MG TABLET |
| 32480 | GUANFACINE 1 MG TABLET |
| 32481 | GUANFACINE 2 MG TABLET |
| 01431 | METHYLDOPA 250 MG TABLET |
| 01432 | METHYLDOPA 500 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 27 Antihyperuricemics

# Antihyperuricemics
# Prior Authorization Criteria

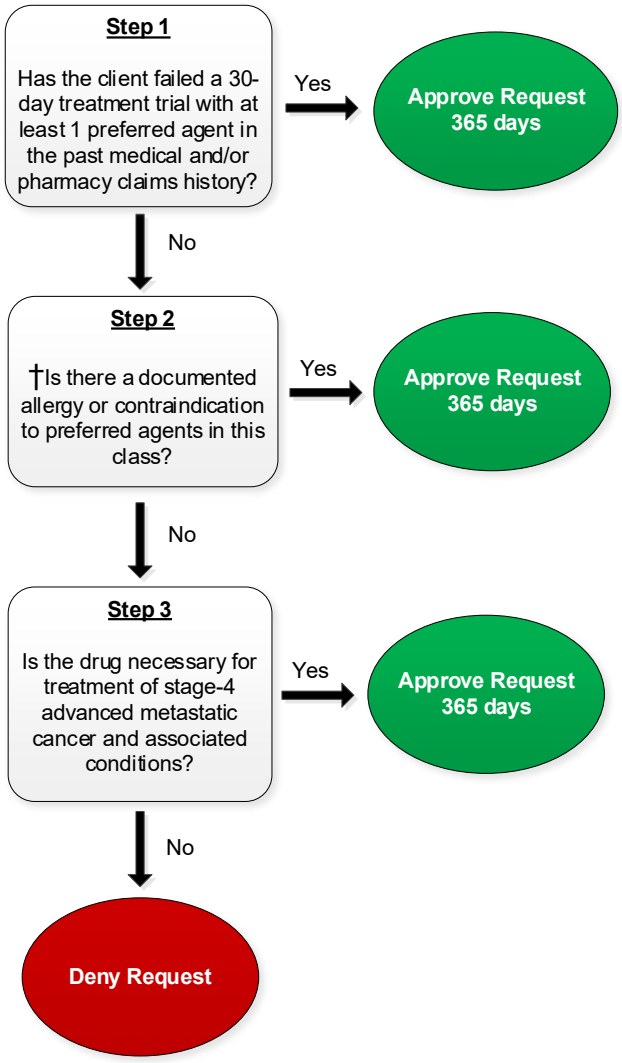
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antihyperuricemics
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antihyperuricemics Alternate Therapies

## Preferred Antihyperuricemics

| GCN | Drug Name |
|---|---|
| 07070 | ALLOPURINOL 100 MG TABLET |
| 07071 | ALLOPURINOL 300 MG TABLET |
| 37202 | MITIGARE 0.6 MG CAPSULE |
| 35072 | PROBENECID 500 MG TABLET |
| 14029 | PROBENECID-COLCHICINE TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 28 Antimigraine Agents, Other

# Antimigraine Agents, Other Prior Authorization Criteria

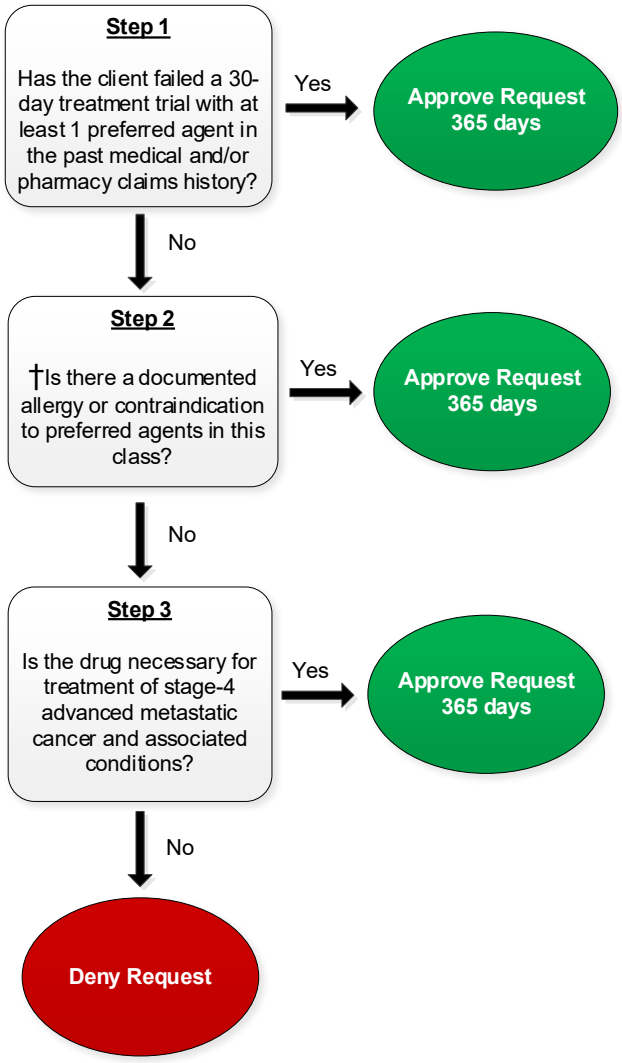
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antimigraine Agents, Other Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antimigraine Agents, Other
# Alternate Therapies

## Preferred Antimigraine Agents, Other

| GCN | Drug Name |
|---|---|
| 46116 | AIMOVIG 140 MG/ML AUTOINJECTOR |
| 44753 | AIMOVIG 70 MG/ML AUTOINJECTOR |
| 47862 | AJOVY 225 MG/1.5 ML AUTOINJECT |
| 45306 | AJOVY 225 MG/1.5 ML SYRINGE |
| 40418 | EMGALITY 120 MG/ML PEN |
| 40419 | EMGALITY 120 MG/ML SYRINGE |
| 47762 | NURTEC ODT 75 MG TABLET |
| 51231 | QULIPTA 10 MG TABLET |
| 51232 | QULIPTA 30 MG TABLET |
| 51236 | QULIPTA 60 MG TABLET |
| 47478 | UBRELVY 100 MG TABLET |
| 47477 | UBRELVY 50 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 29 Antimigraine Agents, Triptans

# Antimigraine Agents, Triptans Prior Authorization Criteria

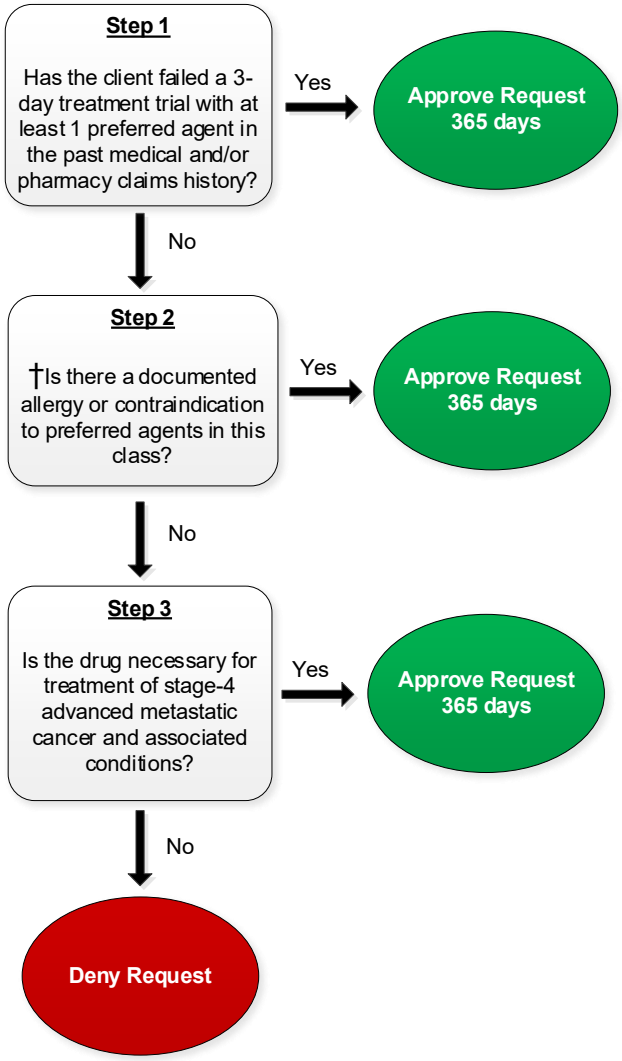
1. Has the client failed a 3-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antimigraine Agents, Triptans
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antimigraine Agents, Triptans Alternate Therapies

## Preferred Antimigraine Agents, Triptans

| GCN | Drug Name |
|---|---|
| 14977 | FROVA 2.5 MG TABLET |
| 26667 | IMITREX 4 MG/0.5 ML CARTRIDGES |
| 26666 | IMITREX 4 MG/0.5 ML PEN INJECT |
| 50740 | IMITREX 5 MG NASAL SPRAY |
| 24708 | IMITREX 6 MG/0.5 ML CARTRIDGES |
| 50741 | IMITREX 6 MG/0.5 ML PEN INJECT |
| 15173 | RELPAX 20 MG TABLET |
| 15174 | RELPAX 40 MG TABLET |
| 19594 | RIZATRIPTAN 10 MG ODT |
| 19592 | RIZATRIPTAN 10 MG TABLET |
| 19593 | RIZATRIPTAN 5 MG ODT |
| 19591 | RIZATRIPTAN 5 MG TABLET |
| 50744 | SUMATRIPTAN 20 MG NASAL SPRAY |
| 50740 | SUMATRIPTAN 5 MG NASAL SPRAY |
| 05701 | SUMATRIPTAN SUCC 100 MG TABLET |
| 05702 | SUMATRIPTAN SUCC 25 MG TABLET |
| 05700 | SUMATRIPTAN SUCC 50 MG TABLET |
| 24217 | ZOMIG 2.5 MG NASAL SPRAY |
| 18972 | ZOMIG 5 MG NASAL SPRAY |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 30 Antiparasitics, Topical

# Antiparasitics, Topical
# Prior Authorization Criteria

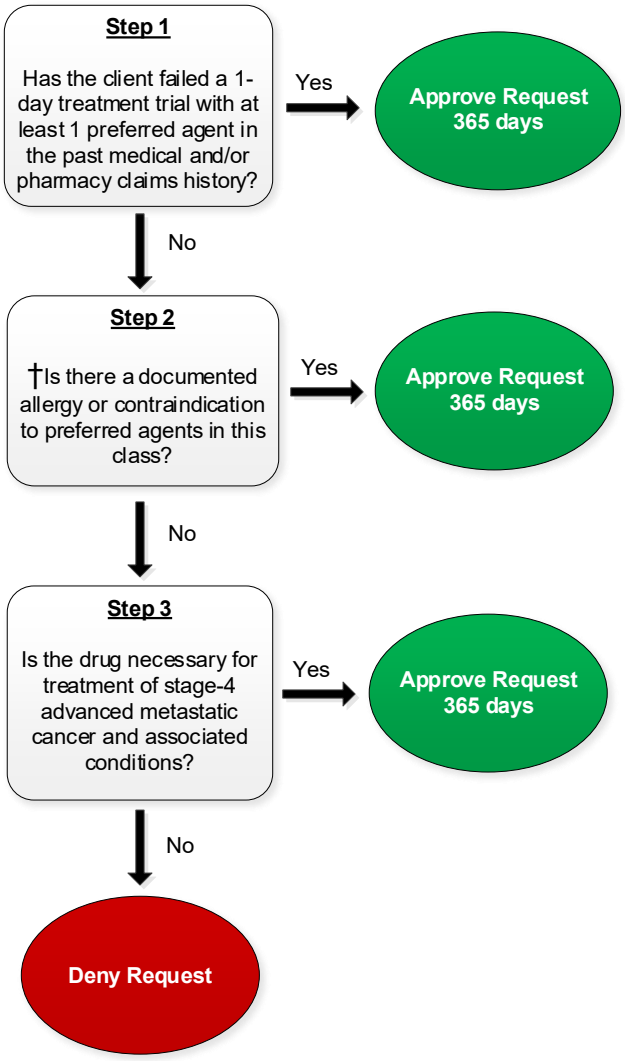
1. Has the client failed a 1-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antiparasitics, Topical
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antiparasitics, Topical
# Alternate Therapies

## Preferred Topical Antiparasitics

| GCN | Drug Name |
|---|---|
| 44520 | CVS LICE TREATMENT 1% CRÈME RINSE |
| 29436 | NATROBA 0.9% TOPICAL SUSPENSION |
| 44370 | PERMETHRIN 5% CREAM |
| 45287 | VANALICE GEL |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 31 Antiparkinson's Agents

# Antiparkinson's Agents
# Prior Authorization Criteria

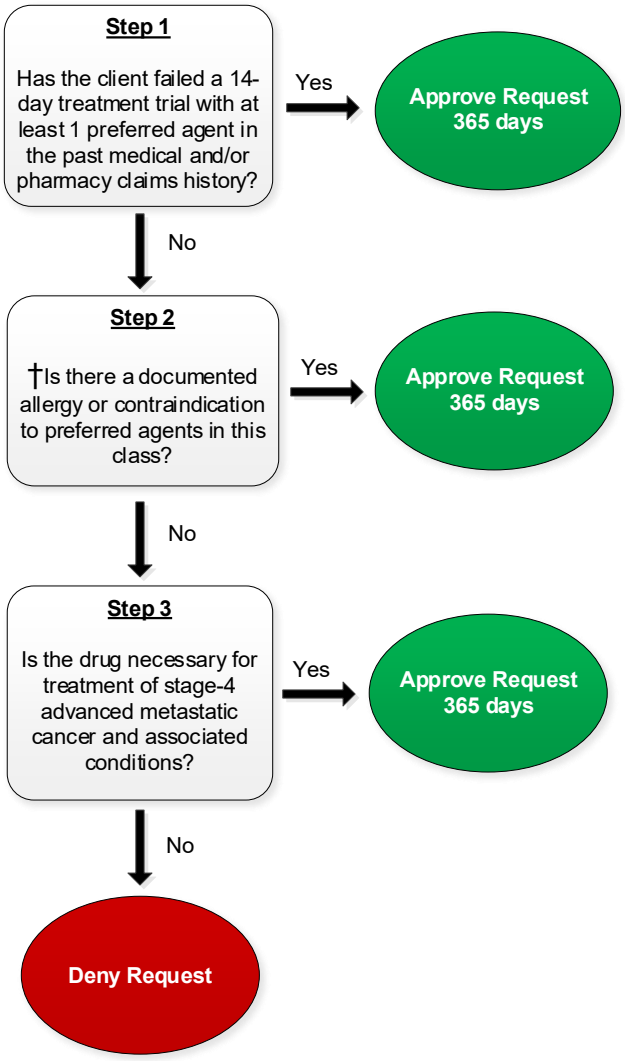
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antiparkinson's Agents
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antiparkinson's Agents
# Alternate Therapies

## Preferred Antiparkinson's Agents

| GCN | Drug Name |
|---|---|
| 17520 | AMANTADINE 100 MG CAPSULE |
| 17521 | AMANTADINE 100 MG TABLET |
| 17530 | AMANTADINE 100 MG/10 ML CUP |
| 17530 | AMANTADINE 50 MG/5 ML SOLN CUP |
| 17530 | AMANTADINE 50 MG/5 ML SOLUTION |
| 42078 | APOKYN 30 MG/3 ML CARTRIDGE |
| 27081 | AZILECT 0.5 MG TABLET |
| 24654 | AZILECT 1 MG TABLET |
| 17620 | BENZTROPINE MES 0.5 MG TAB |
| 17621 | BENZTROPINE MES 1 MG TABLET |
| 17622 | BENZTROPINE MES 2 MG TABLET |
| 62592 | CARBIDOPA-LEVO ER 25-100 TAB |
| 62591 | CARBIDOPA-LEVO ER 50-200 TAB |
| 20146 | CARBIDOPA-LEVODOPA 100 MG-ENTA |
| 62740 | CARBIDOPA-LEVODOPA 10-100 TAB |
| 14474 | CARBIDOPA-LEVODOPA 125 MG-ENTA |
| 20145 | CARBIDOPA-LEVODOPA 150 MG-ENTA |
| 98948 | CARBIDOPA-LEVODOPA 200 MG-ENTA |
| 62741 | CARBIDOPA-LEVODOPA 25-100 TAB |
| 62742 | CARBIDOPA-LEVODOPA 25-250 TAB |
| 20150 | CARBIDOPA-LEVODOPA 50 MG-ENTA |

| GCN | Drug Name |
|---|---|
| 14473 | CARBIDOPA-LEVODOPA 75 MG-ENTA |
| 50692 | LODOSYN 25 MG TABLET |
| 19873 | PRAMIPEXOLE 0.125 MG TABLET |
| 19874 | PRAMIPEXOLE 0.25 MG TABLET |
| 19875 | PRAMIPEXOLE 0.5 MG TABLET |
| 98973 | PRAMIPEXOLE 0.75 MG TABLET |
| 19871 | PRAMIPEXOLE 1 MG TABLET |
| 19872 | PRAMIPEXOLE 1.5 MG TABLET |
| 34100 | ROPINIROLE HCL 0.25 MG TABLET |
| 34104 | ROPINIROLE HCL 0.5 MG TABLET |
| 34101 | ROPINIROLE HCL 1 MG TABLET |
| 34102 | ROPINIROLE HCL 2 MG TABLET |
| 93048 | ROPINIROLE HCL 3 MG TABLET |
| 93038 | ROPINIROLE HCL 4 MG TABLET |
| 34103 | ROPINIROLE HCL 5 MG TABLET |
| 55311 | TASMAR 100 MG TABLET |
| 17561 | TRIHEXYPHENIDYL 2 MG TABLET |
| 17550 | TRIHEXYPHENIDYL 2 MG/5 ML SOLN |
| 17563 | TRIHEXYPHENIDYL 5 MG TABLET |
| 22783 | ZELAPAR 1.25 MG ODT TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 32 Antipsychotics

# Antipsychotics
# Prior Authorization Criteria

1. Has the client been stable on a non-preferred in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Has the client been prescribed and is taking a non-preferred agent before being discharged from an inpatient facility?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #4)

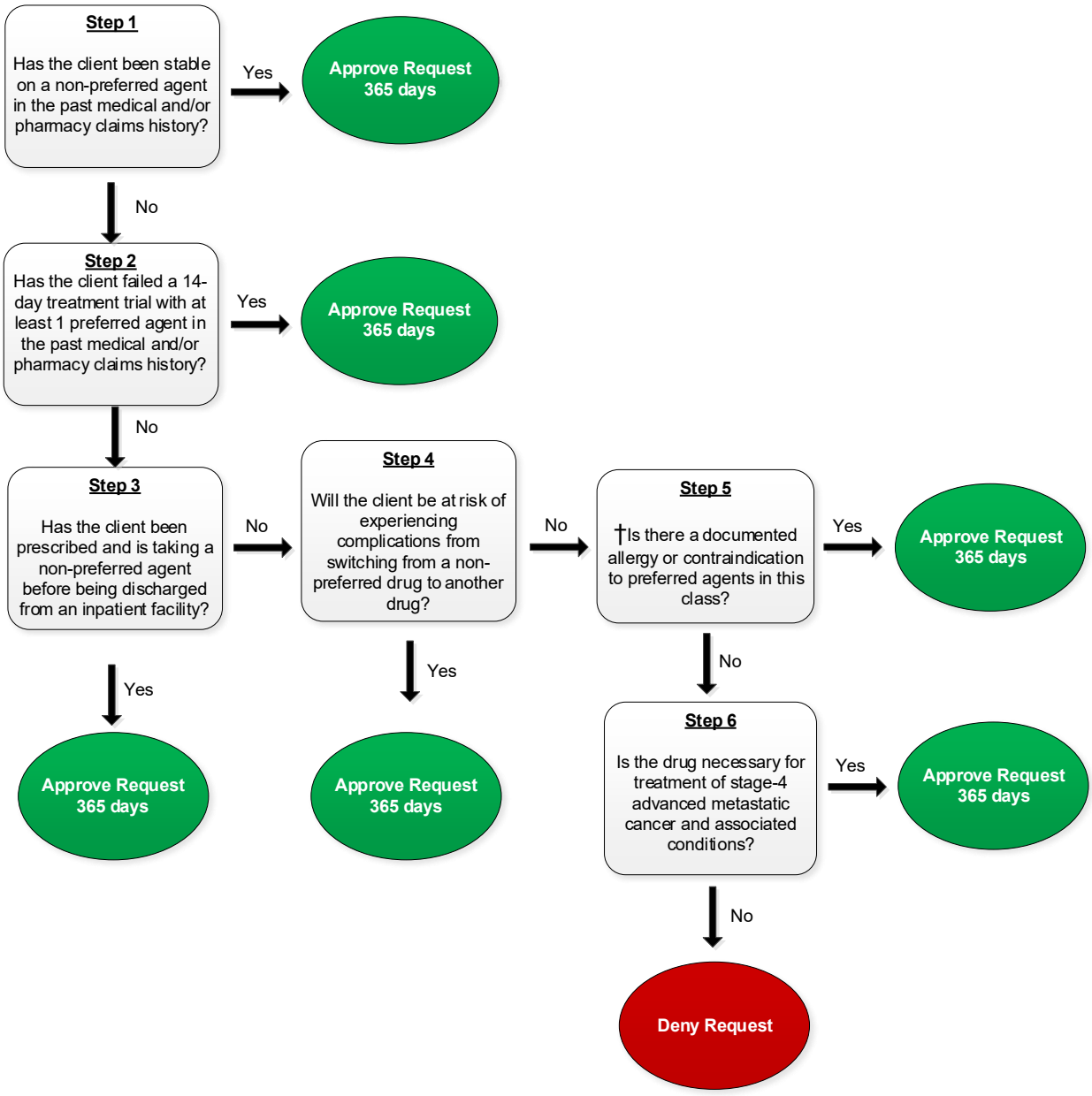
4. Will the client be at risk of experiencing complications from switching from a non-preferred drug to another drug?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #5)

5. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #6)

6. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antipsychotics
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antipsychotics
# Alternate Therapies

## Preferred Antipsychotics

| GCN | Drug Name |
|---|---|
| 54058 | ABILIFY ASIMTUFII 720 MG/2.4ML |
| 54059 | ABILIFY ASIMTUFII 960 MG/3.2ML |
| 37681 | ABILIFY MAINTENA ER 300 MG SYR |
| 34284 | ABILIFY MAINTENA ER 300 MG VL |
| 37682 | ABILIFY MAINTENA ER 400 MG SYR |
| 34285 | ABILIFY MAINTENA ER 400 MG VL |
| 18537 | ARIPIPRAZOLE 10 MG TABLET |
| 18538 | ARIPIPRAZOLE 15 MG TABLET |
| 26305 | ARIPIPRAZOLE 2 MG TABLET |
| 18539 | ARIPIPRAZOLE 20 MG TABLET |
| 18541 | ARIPIPRAZOLE 30 MG TABLET |
| 20173 | ARIPIPRAZOLE 5 MG TABLET |
| 43488 | ARISTADA ER 1064 MG/3.9 ML SYR |
| 39726 | ARISTADA ER 441 MG/1.6 ML SYRN |
| 39727 | ARISTADA ER 662 MG/2.4 ML SYRN |
| 39728 | ARISTADA ER 882 MG/3.2 ML SYRN |
| 44941 | ARISTADA INITIO ER 675 MG/2.4 |
| 52616 | CAPLYTA 10.5 MG CAPSULE |
| 52617 | CAPLYTA 21 MG CAPSULE |
| 47492 | CAPLYTA 42 MG CAPSULE |
| 14431 | CHLORPROMAZINE 10 MG TABLET |

| GCN | Drug Name |
|---|---|
| 14434 | CHLORPROMAZINE 100 MG TABLET |
| 14390 | CHLORPROMAZINE 100 MG/ML CONC |
| 14435 | CHLORPROMAZINE 200 MG TABLET |
| 14432 | CHLORPROMAZINE 25 MG TABLET |
| 14331 | CHLORPROMAZINE 25 MG/ML AMP |
| 14421 | CHLORPROMAZINE 25 MG/ML VIAL |
| 14391 | CHLORPROMAZINE 30 MG/ML CONC |
| 14433 | CHLORPROMAZINE 50 MG TABLET |
| 14331 | CHLORPROMAZINE 50 MG/2 ML AMP |
| 14421 | CHLORPROMAZINE 50 MG/2 ML VIAL |
| 18142 | CLOZAPINE 100 MG TABLET |
| 31672 | CLOZAPINE 200 MG TABLET |
| 18141 | CLOZAPINE 25 MG TABLET |
| 18143 | CLOZAPINE 50 MG TABLET |
| 27416 | ERZOFRI 117 MG/0.75 ML SYRINGE |
| 27417 | ERZOFRI 156 MG/ML SYRINGE |
| 27418 | ERZOFRI 234 MG/1.5 ML SYRINGE |
| 56074 | ERZOFRI 351 MG/2.25 ML SYRINGE |
| 27414 | ERZOFRI 39 MG/0.25 ML SYRINGE |
| 27415 | ERZOFRI 78 MG/0.5 ML SYRINGE |
| 14602 | FLUPHENAZINE 1 MG TABLET |
| 14603 | FLUPHENAZINE 10 MG TABLET |
| 14604 | FLUPHENAZINE 2.5 MG TABLET |
| 14580 | FLUPHENAZINE 2.5 MG/5 ML ELIX |
| 14571 | FLUPHENAZINE 2.5 MG/ML VIAL |

| GCN | Drug Name |
|---|---|
| 14605 | FLUPHENAZINE 5 MG TABLET |
| 14590 | FLUPHENAZINE 5 MG/ML CONC |
| 15530 | HALOPERIDOL 0.5 MG TABLET |
| 15531 | HALOPERIDOL 1 MG TABLET |
| 15532 | HALOPERIDOL 10 MG TABLET |
| 15533 | HALOPERIDOL 2 MG TABLET |
| 15534 | HALOPERIDOL 20 MG TABLET |
| 15535 | HALOPERIDOL 5 MG TABLET |
| 14801 | HALOPERIDOL DEC 100 MG/ML AMP |
| 14781 | HALOPERIDOL DEC 100 MG/ML VIAL |
| 14780 | HALOPERIDOL DEC 250 MG/5 ML VL |
| 14800 | HALOPERIDOL DEC 50 MG/ML AMPUL |
| 14780 | HALOPERIDOL DEC 50 MG/ML VIAL |
| 14781 | HALOPERIDOL DEC 500 MG/5 ML VL |
| 15520 | HALOPERIDOL LAC 10 MG/5 ML CUP |
| 15520 | HALOPERIDOL LAC 2 MG/ML CONC |
| 50889 | INVEGA HAFYERA 1,092 MG/3.5 ML |
| 50891 | INVEGA HAFYERA 1,560 MG/5 ML |
| 27416 | INVEGA SUSTENNA 117 MG/0.75 ML |
| 27417 | INVEGA SUSTENNA 156 MG/ML SYRG |
| 27418 | INVEGA SUSTENNA 234 MG/1.5 ML |
| 27414 | INVEGA SUSTENNA 39 MG/0.25 ML |
| 27415 | INVEGA SUSTENNA 78 MG/0.5 ML |
| 38697 | INVEGA TRINZA 273 MG/0.88 ML |
| 38698 | INVEGA TRINZA 410 MG/1.32 ML |

| GCN | Drug Name |
|---|---|
| 38699 | INVEGA TRINZA 546 MG/1.75 ML |
| 38702 | INVEGA TRINZA 819 MG/2.63 ML |
| 33147 | LURASIDONE HCL 120 MG TABLET |
| 31226 | LURASIDONE HCL 20 MG TABLET |
| 29366 | LURASIDONE HCL 40 MG TABLET |
| 35192 | LURASIDONE HCL 60 MG TABLET |
| 29367 | LURASIDONE HCL 80 MG TABLET |
| 44963 | NUPLAZID 34 MG CAPSULE |
| 15082 | OLANZAPINE 10 MG TABLET |
| 15085 | OLANZAPINE 15 MG TABLET |
| 15084 | OLANZAPINE 2.5 MG TABLET |
| 15086 | OLANZAPINE 20 MG TABLET |
| 15083 | OLANZAPINE 5 MG TABLET |
| 15081 | OLANZAPINE 7.5 MG TABLET |
| 92008 | OLANZAPINE ODT 10 MG TABLET |
| 34022 | OLANZAPINE ODT 15 MG TABLET |
| 34023 | OLANZAPINE ODT 20 MG TABLET |
| 92007 | OLANZAPINE ODT 5 MG TABLET |
| 16674 | PERPHEN-AMITRIP 2 MG-10 MG TAB |
| 16676 | PERPHEN-AMITRIP 2 MG-25 MG TAB |
| 16675 | PERPHEN-AMITRIP 4 MG-10 MG TAB |
| 16677 | PERPHEN-AMITRIP 4 MG-25 MG TAB |
| 16678 | PERPHEN-AMITRIP 4 MG-50 MG TAB |
| 14650 | PERPHENAZINE 16 MG TABLET |
| 14651 | PERPHENAZINE 2 MG TABLET |

| GCN | Drug Name |
|---|---|
| 14652 | PERPHENAZINE 4 MG TABLET |
| 14653 | PERPHENAZINE 8 MG TABLET |
| 45128 | PERSERIS ER 120 MG SYRINGE KIT |
| 45127 | PERSERIS ER 90 MG POWDER SYRNG |
| 45127 | PERSERIS ER 90 MG SYRINGE KIT |
| 93088 | QUETIAPINE 150 MG TABLET |
| 67662 | QUETIAPINE FUMARATE 100 MG TAB |
| 67663 | QUETIAPINE FUMARATE 200 MG TAB |
| 67661 | QUETIAPINE FUMARATE 25 MG TAB |
| 67665 | QUETIAPINE FUMARATE 300 MG TAB |
| 26411 | QUETIAPINE FUMARATE 400 MG TAB |
| 26409 | QUETIAPINE FUMARATE 50 MG TAB |
| 38278 | REXULTI 0.25 MG TABLET |
| 38476 | REXULTI 0.5 MG TABLET |
| 38589 | REXULTI 1 MG TABLET |
| 38609 | REXULTI 2 MG TABLET |
| 38618 | REXULTI 3 MG TABLET |
| 38619 | REXULTI 4 MG TABLET |
| 98414 | RISPERDAL CONSTA 12.5 MG VIAL |
| 20217 | RISPERDAL CONSTA 25 MG VIAL |
| 20218 | RISPERDAL CONSTA 37.5 MG VIAL |
| 20219 | RISPERDAL CONSTA 50 MG VIAL |
| 92872 | RISPERIDONE 0.25 MG TABLET |
| 92892 | RISPERIDONE 0.5 MG TABLET |
| 16136 | RISPERIDONE 1 MG TABLET |

| GCN | Drug Name |
|---|---|
| 16135 | RISPERIDONE 1 MG/ML SOLUTION |
| 16137 | RISPERIDONE 2 MG TABLET |
| 16138 | RISPERIDONE 3 MG TABLET |
| 16139 | RISPERIDONE 4 MG TABLET |
| 14882 | THIORIDAZINE 10 MG TABLET |
| 14883 | THIORIDAZINE 100 MG TABLET |
| 14880 | THIORIDAZINE 25 MG TABLET |
| 14881 | THIORIDAZINE 50 MG TABLET |
| 15690 | THIOTHIXENE 1 MG CAPSULE |
| 15691 | THIOTHIXENE 10 MG CAPSULE |
| 15692 | THIOTHIXENE 2 MG CAPSULE |
| 15694 | THIOTHIXENE 5 MG CAPSULE |
| 14830 | TRIFLUOPERAZINE 1 MG TABLET |
| 14831 | TRIFLUOPERAZINE 10 MG TABLET |
| 14832 | TRIFLUOPERAZINE 2 MG TABLET |
| 14833 | TRIFLUOPERAZINE 5 MG TABLET |
| 54104 | UZEDY ER 100 MG/0.28 ML SYRING |
| 51479 | UZEDY ER 125 MG/0.35 ML SYRING |
| 54105 | UZEDY ER 150 MG/0.42 ML SYRING |
| 54106 | UZEDY ER 200 MG/0.56 ML SYRING |
| 54107 | UZEDY ER 250 MG/0.7 ML SYRINGE |
| 54098 | UZEDY ER 50 MG/0.14 ML SYRINGE |
| 54099 | UZEDY ER 75 MG/0.21 ML SYRINGE |
| 39579 | VRAYLAR 1.5 MG CAPSULE |
| 39582 | VRAYLAR 3 MG CAPSULE |

| GCN | Drug Name |
|---|---|
| 39583 | VRAYLAR 4.5 MG CAPSULE |
| 39584 | VRAYLAR 6 MG CAPSULE |
| 13331 | ZIPRASIDONE HCL 20 MG CAPSULE |
| 13332 | ZIPRASIDONE HCL 40 MG CAPSULE |
| 13333 | ZIPRASIDONE HCL 60 MG CAPSULE |
| 13334 | ZIPRASIDONE HCL 80 MG CAPSULE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 33 Antipsychotics, Long-Acting Injectables

# Antipsychotics, Long-Acting Injectables Prior Authorization Criteria

1. Has the client been stable on a non-preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Has the client been prescribed and is taking a non-preferred agent before being discharged from an inpatient facility?
   [ ] Yes (Approve – 365 days
   [ ] No (Go to #4)

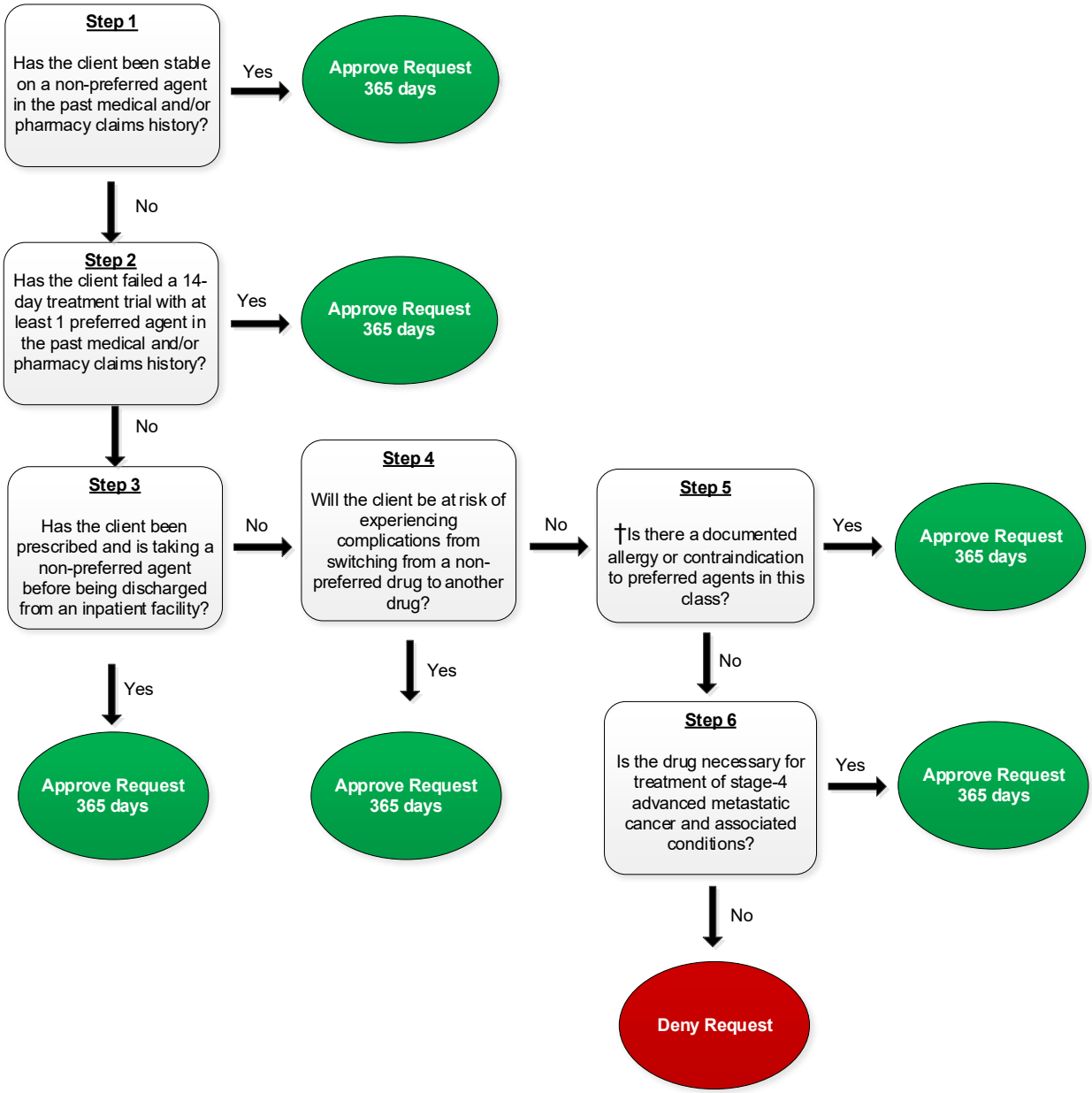
4. Will the client be at risk of experiencing complications from switching from a non-preferred drug to another drug?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #5)

5. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #6)

6. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antipsychotics, Long-Acting Injectables Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antipsychotics, Long-Acting Injectables Alternate Therapies

## Preferred Long-Acting Injectable Antipsychotics

| GCN | Drug Name |
|---|---|
| 54058 | ABILIFY ASIMTUFII 720 MG/2.4ML |
| 54059 | ABILIFY ASIMTUFII 960 MG/3.2ML |
| 37681 | ABILIFY MAINTENA ER 300MG SYRINGE |
| 34284 | ABILIFY MAINTENA ER 300MG VIAL |
| 37682 | ABILIFY MAINTENA ER 400MG SYRINGE |
| 34285 | ABILIFY MAINTENA ER 400MG VIAL |
| 43488 | ARISTADA ER 1064MG/3.9ML SYRN |
| 39726 | ARISTADA ER 441MG/1.6ML SYRN |
| 39727 | ARISTADA ER 662MG/2.4ML SYRN |
| 39728 | ARISTADA ER 882MG/3.2 SYRN |
| 44941 | ARISTADA INITIO ER 675MG/2.4ML |
| 27416 | ERZOFRI 117 MG/0.75 ML SYRINGE |
| 27417 | ERZOFRI 156 MG/ML SYRINGE |
| 27418 | ERZOFRI 234 MG/1.5 ML SYRINGE |
| 56074 | ERZOFRI 351 MG/2.25 ML SYRINGE |
| 27414 | ERZOFRI 39 MG/0.25 ML SYRINGE |
| 27415 | ERZOFRI 78 MG/0.5 ML SYRINGE |
| 14580 | FLUPHENAZINE 2.5 MG/5 ML ELIX |
| 14571 | FLUPHENAZINE 2.5 MG/ML VIAL |
| 14590 | FLUPHENAZINE 5 MG/ML CONC |
| 14801 | HALOPERIDOL DEC 100MG/ML AMP |

| GCN | Drug Name |
|---|---|
| 14781 | HALOPERIDOL DEC 100MG/ML VIAL |
| 14800 | HALOPERIDOL DEC 50MG/ML AMP |
| 14780 | HALOPERIDOL DEC 50MG/ML VIAL |
| 15520 | HALOPERIDOL LAC 10 MG/5 ML CUP |
| 50889 | INVEGA HAFYERA 1,092MG/3.5ML |
| 50891 | INVEGA HAFYERA 1,560MG/5ML |
| 27416 | INVEGA SUSTENNA 117MG PREFILLED SYRINGE |
| 27417 | INVEGA SUSTENNA 156MG PREFILLED SYRINGE |
| 27418 | INVEGA SUSTENNA 234MG PREFILLED SYRINGE |
| 27414 | INVEGA SUSTENNA 39MG PREFILLED SYRINGE |
| 27415 | INVEGA SUSTENNA 78MG PREFILLED SYRINGE |
| 38697 | INVEGA TRINZA 273MG/0.875ML |
| 38698 | INVEGA TRINZA 410MG/1.315ML |
| 38699 | INVEGA TRINZA 546MG/1.75ML |
| 38702 | INVEGA TRINZA 819MG/2.625ML |
| 45128 | PERSERIS ER 120 MG SYRINGE KIT |
| 45127 | PERSERIS ER 90 MG POWDER SYRNG |
| 98414 | RISPERDAL CONSTA 12.5MG SYRINGE |
| 20217 | RISPERDAL CONSTA 25MG SYRINGE |
| 20218 | RISPERDAL CONSTA 37.5MG SYRINGE |
| 20219 | RISPERDAL CONSTA 50MG SYRINGE |
| 16135 | RISPERIDONE 1 MG/ML SOLUTION |
| 54104 | UZEDY ER 100 MG/0.28 ML SYRING |
| 54105 | UZEDY ER 150 MG/0.42 ML SYRING |
| 54106 | UZEDY ER 200 MG/0.56 ML SYRING |

| GCN | Drug Name |
|---|---|
| 54107 | UZEDY ER 250 MG/0.7 ML SYRINGE |
| 54098 | UZEDY ER 50 MG/0.14 ML SYRINGE |
| 54099 | UZEDY ER 75 MG/0.21 ML SYRINGE |
| 51479 | UZEDY ER 125 MG/0.35 ML SYRING |
| 40683 | VRAYLAR 1.5 MG-3 MG PACK |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 34 Antivirals, Oral/Nasal

# Antivirals, Oral/Nasal
# Prior Authorization Criteria

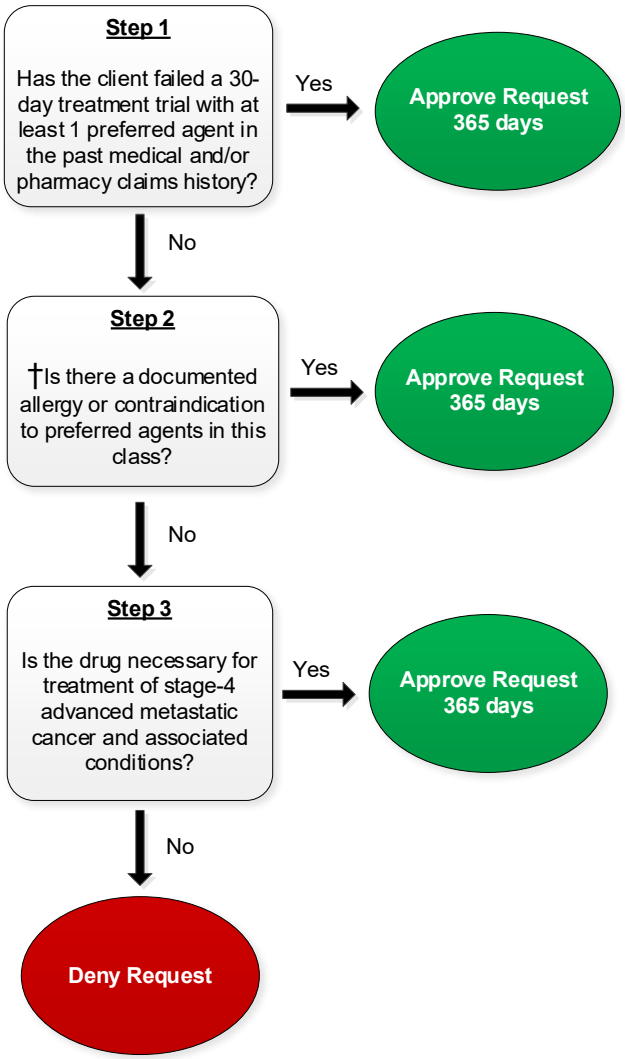
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antivirals, Oral/Nasal
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antivirals, Oral/Nasal
# Alternate Therapies

## Preferred Oral/Nasal Antivirals

| GCN | Drug Name |
|---|---|
| 43790 | ACYCLOVIR 200 MG CAPSULE |
| 43731 | ACYCLOVIR 200 MG/5 ML SUSP |
| 33593 | ACYCLOVIR 200 MG/5 ML SUSP CUP |
| 13724 | ACYCLOVIR 400 MG TABLET |
| 43731 | ACYCLOVIR 400 MG/10ML SUSP CUP |
| 13721 | ACYCLOVIR 800 MG TABLET |
| 14101 | FAMCICLOVIR 125 MG TABLET |
| 14109 | FAMCICLOVIR 250 MG TABLET |
| 14108 | FAMCICLOVIR 500 MG TABLET |
| 29729 | OSELTAMIVIR 6 MG/ML SUSPENSION |
| 98980 | OSELTAMIVIR PHOS 30 MG CAPSULE |
| 98981 | OSELTAMIVIR PHOS 45 MG CAPSULE |
| 73441 | OSELTAMIVIR PHOS 75 MG CAPSULE |
| 52199 | PAXLOVID 150-100 MG (MODERATE) |
| 57553 | PAXLOVID 300/150-100MG(SEVERE) |
| 51742 | PAXLOVID 300-100 MG DOSE PACK |
| 13742 | VALACYCLOVIR HCL 1 GRAM TABLET |
| 13740 | VALACYCLOVIR HCL 500 MG TABLET |
| 13088 | VALGANCICLOVIR 450 MG TABLET |
| 14453 | VALGANCICLOVIR HCL 50 MG/ML |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 35 Antivirals, Topical

# Antivirals, Topical Prior Authorization Criteria

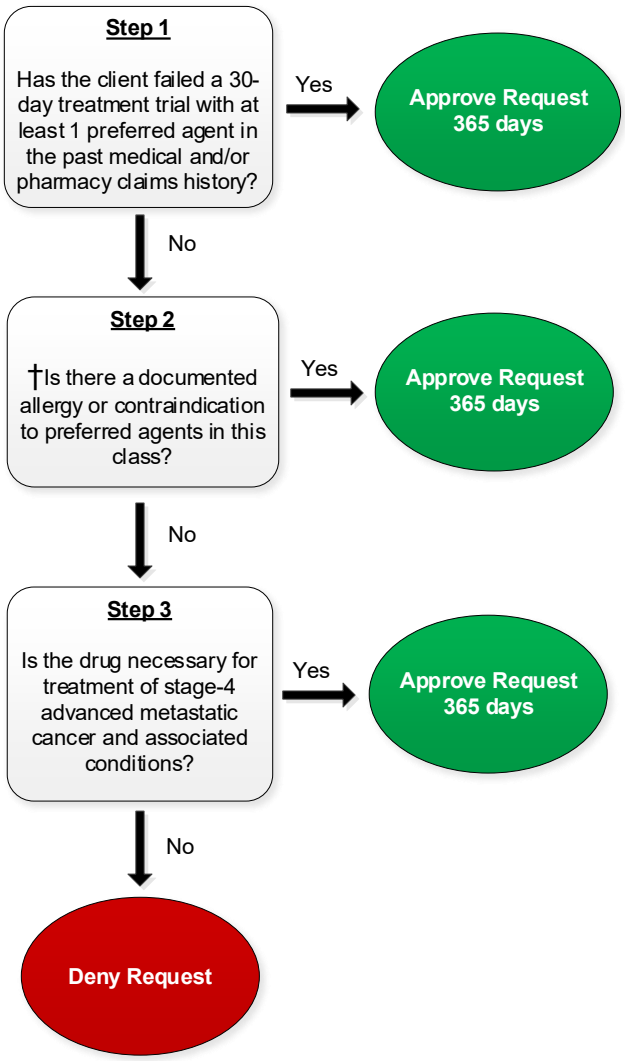
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antivirals, Topical Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Antivirals, Topical
# Alternate Therapies

## Preferred Topical Antivirals

| GCN | Drug Name |
|---|---|
| 37051 | DENAVIR 1% CREAM |
| 12866 | DOCOSANOL 10% CREAM |
| 28857 | XERESE 5%-1% CREAM |
| 62420 | ZOVIRAX 5% CREAM |
| 31640 | ZOVIRAX 5% OINTMENT |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 36 Anxiolytics

# Anxiolytics
# Prior Authorization Criteria

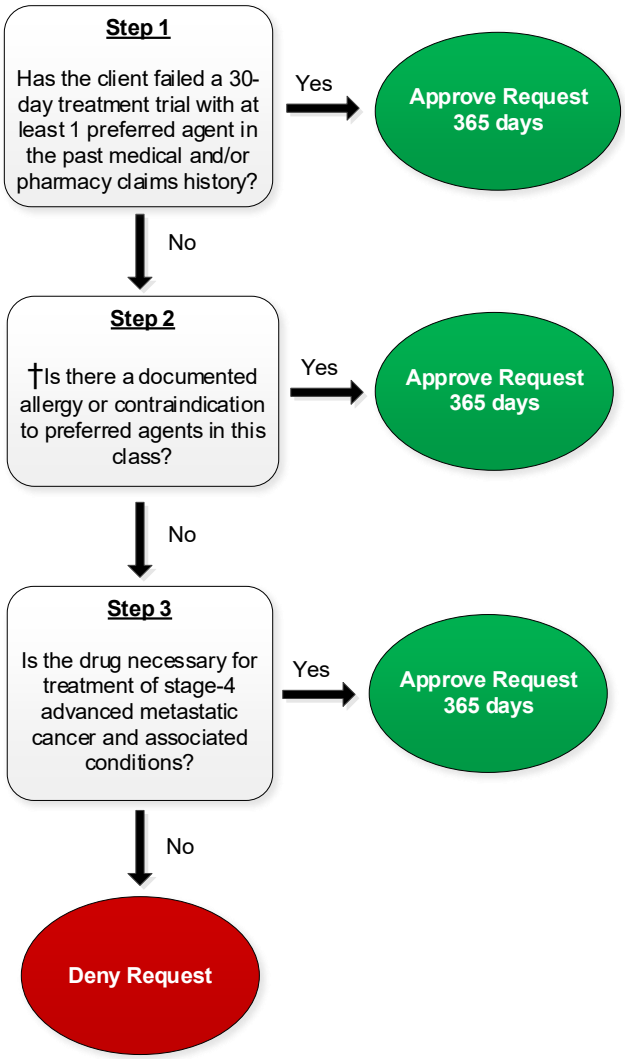
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Anxiolytics
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Anxiolytics
# Alternate Therapies

## Preferred Anxiolytics

| GCN | Drug Name |
|---|---|
| 14260 | ALPRAZOLAM 0.25 MG TABLET |
| 14261 | ALPRAZOLAM 0.5 MG TABLET |
| 14262 | ALPRAZOLAM 1 MG TABLET |
| 14263 | ALPRAZOLAM 2 MG TABLET |
| 14160 | ATIVAN 0.5 MG TABLET |
| 14161 | ATIVAN 1 MG TABLET |
| 14162 | ATIVAN 2 MG TABLET |
| 28891 | BUSPIRONE HCL 10 MG TABLET |
| 28892 | BUSPIRONE HCL 15 MG TABLET |
| 92121 | BUSPIRONE HCL 30 MG TABLET |
| 28890 | BUSPIRONE HCL 5 MG TABLET |
| 13037 | BUSPIRONE HCL 7.5 MG TABLET |
| 14031 | CHLORDIAZEPOXIDE 10 MG CAPSULE |
| 14032 | CHLORDIAZEPOXIDE 25 MG CAPSULE |
| 14033 | CHLORDIAZEPOXIDE 5 MG CAPSULE |
| 14090 | CLORAZEPATE 15 MG TABLET |
| 14092 | CLORAZEPATE 3.75 MG TABLET |
| 14093 | CLORAZEPATE 7.5 MG TABLET |
| 14220 | DIAZEPAM 10 MG TABLET |
| 14221 | DIAZEPAM 2 MG TABLET |
| 14222 | DIAZEPAM 5 MG TABLET |

| GCN | Drug Name |
|---|---|
| 31551 | DIAZEPAM 5 MG/5 ML ORAL CUP |
| 45560 | DIAZEPAM 5 MG/5 ML SOLUTION |
| 14160 | LORAZEPAM 0.5 MG TABLET |
| 14161 | LORAZEPAM 1 MG TABLET |
| 14162 | LORAZEPAM 2 MG TABLET |
| 19601 | LORAZEPAM 2 MG/ML ORAL CONCENT |
| 19601 | LORAZEPAM INTENSOL 2 MG/ML |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 37 Beta Blockers, Oral

# Beta Blockers, Oral
# Prior Authorization Criteria

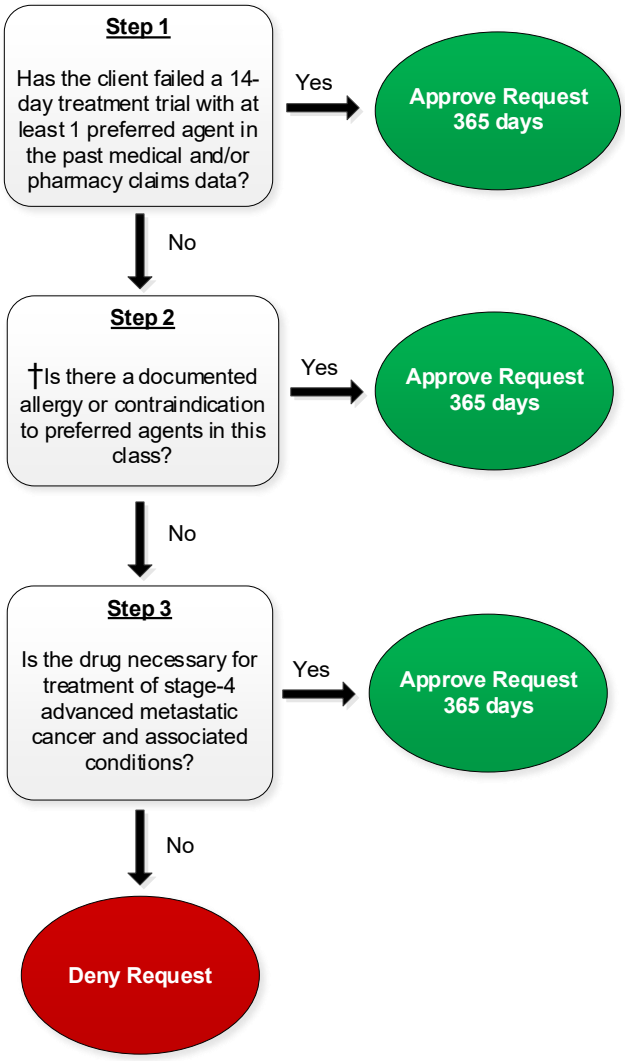
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Beta Blockers, Oral
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Beta Blockers, Oral
# Alternate Therapies

## Preferred Beta Blockers, Oral

| GCN | Drug Name |
|---|---|
| 26460 | ACEBUTOLOL 200 MG CAPSULE |
| 26461 | ACEBUTOLOL 400 MG CAPSULE |
| 20660 | ATENOLOL 100 MG TABLET |
| 20662 | ATENOLOL 25 MG TABLET |
| 20661 | ATENOLOL 50 MG TABLET |
| 66991 | ATENOLOL-CHLORTHALIDONE 100-25 |
| 66990 | ATENOLOL-CHLORTHALIDONE 50-25 |
| 39516 | BETAPACE 120 MG TABLET |
| 39511 | BETAPACE 160 MG TABLET |
| 39513 | BETAPACE 240 MG TABLET |
| 39512 | BETAPACE 80 MG TABLET |
| 63820 | BISOPROLOL FUMARATE 10 MG TAB |
| 92577 | BISOPROLOL FUMARATE 2.5 MG TAB |
| 63821 | BISOPROLOL FUMARATE 5 MG TAB |
| 45063 | BISOPROLOL-HCTZ 10-6.25 MG TAB |
| 45061 | BISOPROLOL-HCTZ 2.5-6.25 MG TB |
| 45062 | BISOPROLOL-HCTZ 5-6.25 MG TAB |
| 01552 | CARVEDILOL 12.5 MG TABLET |
| 01551 | CARVEDILOL 25 MG TABLET |
| 01553 | CARVEDILOL 3.125 MG TABLET |
| 01554 | CARVEDILOL 6.25 MG TABLET |

| GCN | Drug Name |
|---|---|
| 97596 | COREG CR 10 MG CAPSULE |
| 97597 | COREG CR 20 MG CAPSULE |
| 97598 | COREG CR 40 MG CAPSULE |
| 97599 | COREG CR 80 MG CAPSULE |
| 36526 | HEMANGEOL 4.28 MG/ML ORAL SOLN |
| 03231 | INDERAL LA 120 MG CAPSULE |
| 03232 | INDERAL LA 160 MG CAPSULE |
| 03233 | INDERAL LA 60 MG CAPSULE |
| 03230 | INDERAL LA 80 MG CAPSULE |
| 19359 | INDERAL XL 120 MG CAPSULE |
| 20621 | INDERAL XL 80 MG CAPSULE |
| 19359 | INNOPRAN XL 120 MG CAPSULE |
| 20621 | INNOPRAN XL 80 MG CAPSULE |
| 10342 | LABETALOL HCL 100 MG TABLET |
| 10341 | LABETALOL HCL 200 MG TABLET |
| 10340 | LABETALOL HCL 300 MG TABLET |
| 10343 | LABETALOL HCL 400 MG TABLET |
| 20742 | METOPROLOL SUCC ER 100 MG TAB |
| 20743 | METOPROLOL SUCC ER 200 MG TAB |
| 12947 | METOPROLOL SUCC ER 25 MG TAB |
| 20741 | METOPROLOL SUCC ER 50 MG TAB |
| 20641 | METOPROLOL TARTRATE 100 MG TAB |
| 17734 | METOPROLOL TARTRATE 25 MG TAB |
| 37653 | METOPROLOL TARTRATE 37.5 MG TB |
| 20642 | METOPROLOL TARTRATE 50 MG TAB |

| GCN | Drug Name |
|---|---|
| 37656 | METOPROLOL TARTRATE 75 MG TAB |
| 20630 | PROPRANOLOL 10 MG TABLET |
| 20631 | PROPRANOLOL 20 MG TABLET |
| 45260 | PROPRANOLOL 20 MG/5 ML SOLN |
| 45260 | PROPRANOLOL 20 MG/5ML SOLN CUP |
| 20632 | PROPRANOLOL 40 MG TABLET |
| 45261 | PROPRANOLOL 40 MG/5 ML SOLN |
| 20633 | PROPRANOLOL 60 MG TABLET |
| 20634 | PROPRANOLOL 80 MG TABLET |
| 39516 | SOTALOL 120 MG TABLET |
| 39511 | SOTALOL 160 MG TABLET |
| 39513 | SOTALOL 240 MG TABLET |
| 39512 | SOTALOL 80 MG TABLET |
| 39516 | SOTALOL AF 120 MG TABLET |
| 39511 | SOTALOL AF 160 MG TABLET |
| 39512 | SOTALOL AF 80 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 38 Bile Salts

# Bile Salts
# Prior Authorization Criteria

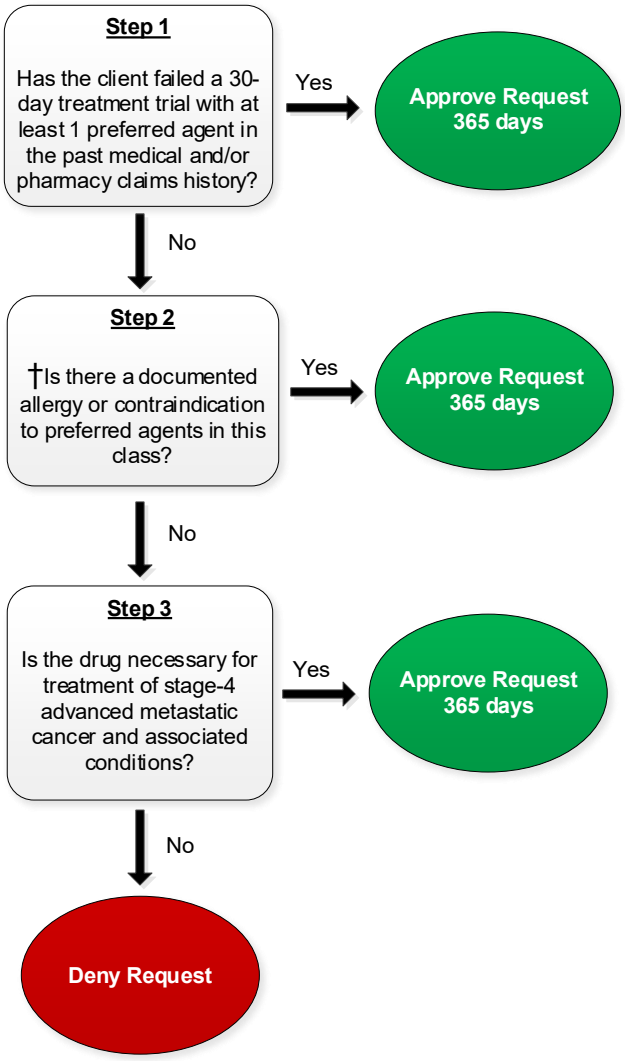
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Bile Salts
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Bile Salts
# Alternate Therapies

## Preferred Bile Salts

| GCN | Drug Name |
|---|---|
| 01072 | URSODIOL 250MG TABLET |
| 17730 | URSODIOL 500 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 39 Bladder Relaxant Preparations

# Bladder Relaxant Preparations Prior Authorization Criteria

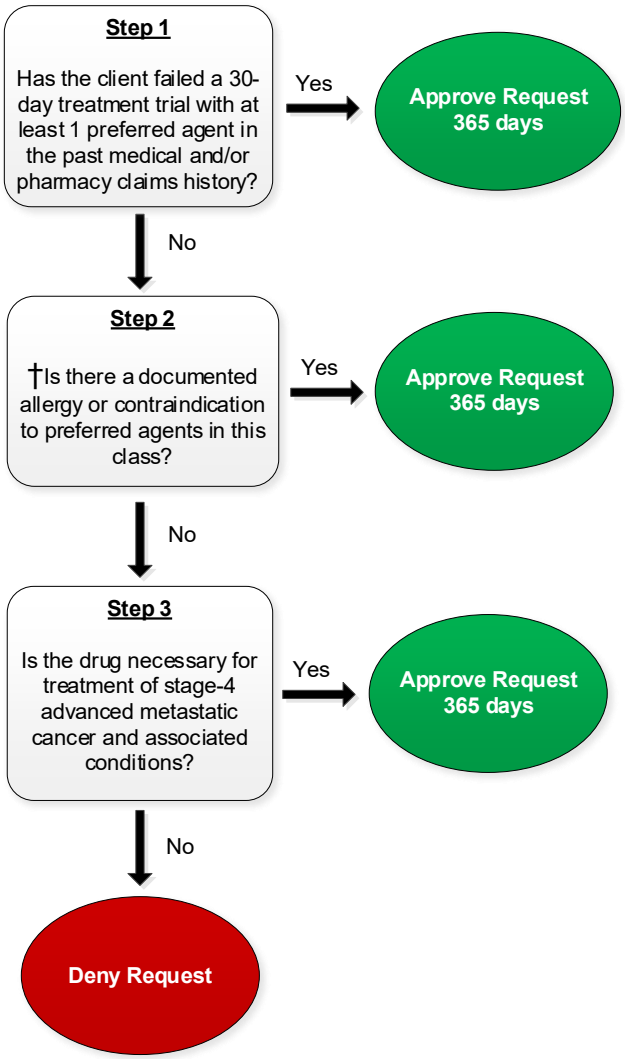
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Bladder Relaxant Preparations Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Bladder Relaxant Preparations Alternate Therapies

## Preferred Bladder Relaxant Preparations

| GCN | Drug Name |
|---|---|
| 32766 | MYRBETRIQ ER 25 MG TABLET |
| 32767 | MYRBETRIQ ER 50 MG TABLET |
| 49454 | MYRBETRIQ ER 8 MG/ML SUSP |
| 19380 | OXYBUTYNIN 5 MG TABLET |
| 19370 | OXYBUTYNIN 5 MG/5 ML SOLN CUP |
| 19370 | OXYBUTYNIN 5 MG/5 ML SOLUTION |
| 19370 | OXYBUTYNIN 5 MG/5 ML SYRUP |
| 19389 | OXYBUTYNIN CL ER 10 MG TABLET |
| 93557 | OXYBUTYNIN CL ER 15 MG TABLET |
| 19388 | OXYBUTYNIN CL ER 5 MG TABLET |
| 19363 | OXYTROL 3.9 MG/24HR PATCH |
| 23277 | SOLIFENACIN 10 MG TABLET |
| 23276 | SOLIFENACIN 5 MG TABLET |
| 99711 | TOVIAZ ER 4 MG TABLET |
| 99712 | TOVIAZ ER 8 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 40 Bone Resorption Suppression and Related Agents

# Bone Resorption Suppression and Related Agents Prior Authorization Criteria

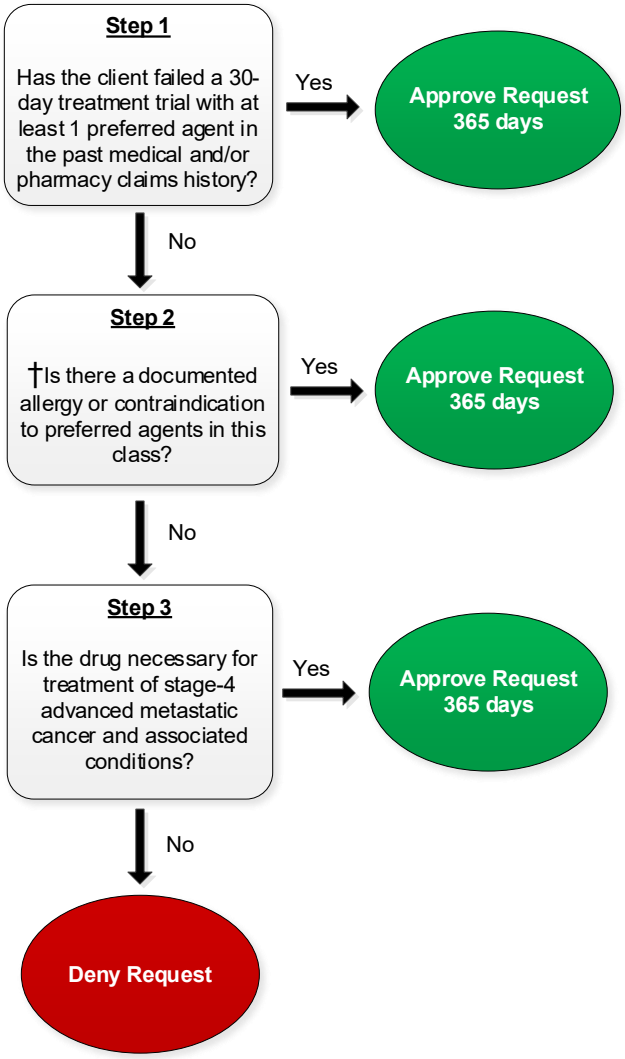
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Bone Resorption Suppression and Related Agents Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Bone Resorption Suppression and Related Agents Alternate Therapies

## Preferred Bone Resorption Suppression and Related Agents

| GCN | Drug Name |
|---|---|
| 21682 | ALENDRONATE SODIUM 5 MG TABLET |
| 21680 | ALENDRONATE SODIUM 10MG TABLET |
| 12389 | ALENDRONATE SODIUM 35MG TABLET |
| 85361 | ALENDRONATE SODIUM 70MG TABLET |
| 59011 | EVISTA 60MG TABLET |
| 14404 | FORTEO 600MCG/2.4ML PEN INJ |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 41 BPH Agents

# BPH Agents
# Prior Authorization Criteria

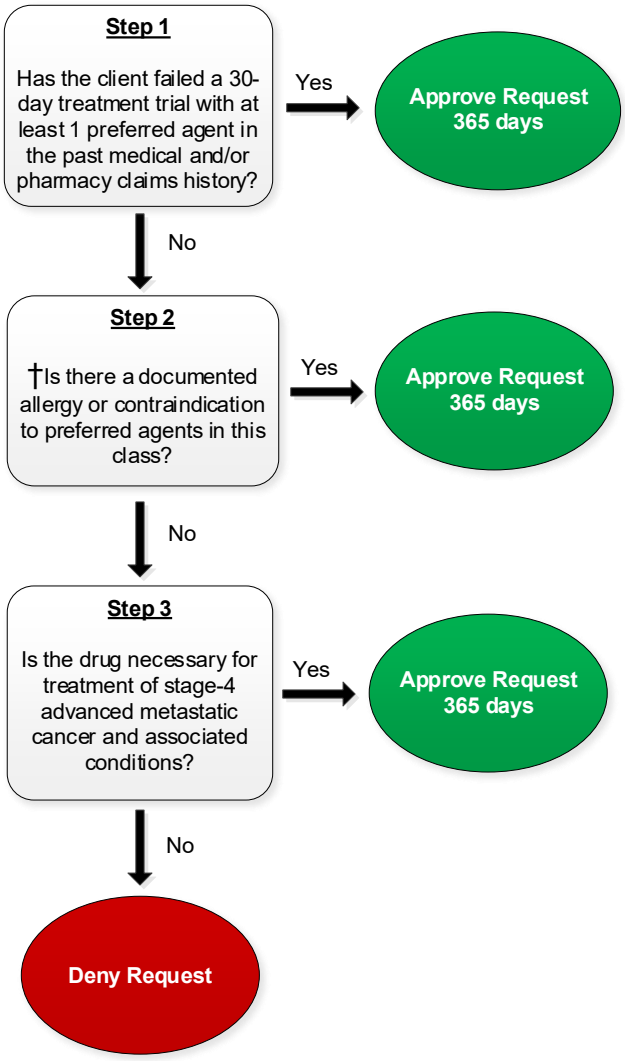
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# BPH Agents
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# BPH Agents
# Alternate Therapies

## Preferred BPH Agents

| GCN | Drug Name |
|---|---|
| 92024 | ALFUZOSIN HCL ER 10 MG TABLET |
| 91985 | CARDURA XL 4 MG TABLET |
| 84848 | CARDURA XL 8 MG TABLET |
| 33431 | DOXAZOSIN MESYLATE 1 MG TAB |
| 33432 | DOXAZOSIN MESYLATE 2 MG TAB |
| 33433 | DOXAZOSIN MESYLATE 4 MG TAB |
| 33434 | DOXAZOSIN MESYLATE 8 MG TAB |
| 30521 | FINASTERIDE 5 MG TABLET |
| 48191 | TAMSULOSIN HCL 0.4 MG CAPSULE |
| 47124 | TERAZOSIN 1 MG CAPSULE |
| 47127 | TERAZOSIN 10 MG CAPSULE |
| 47125 | TERAZOSIN 2 MG CAPSULE |
| 47126 | TERAZOSIN 5 MG CAPSULE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 42 Bronchodilators, Beta Agonist

# Bronchodilators, Beta Agonist
# Prior Authorization Criteria

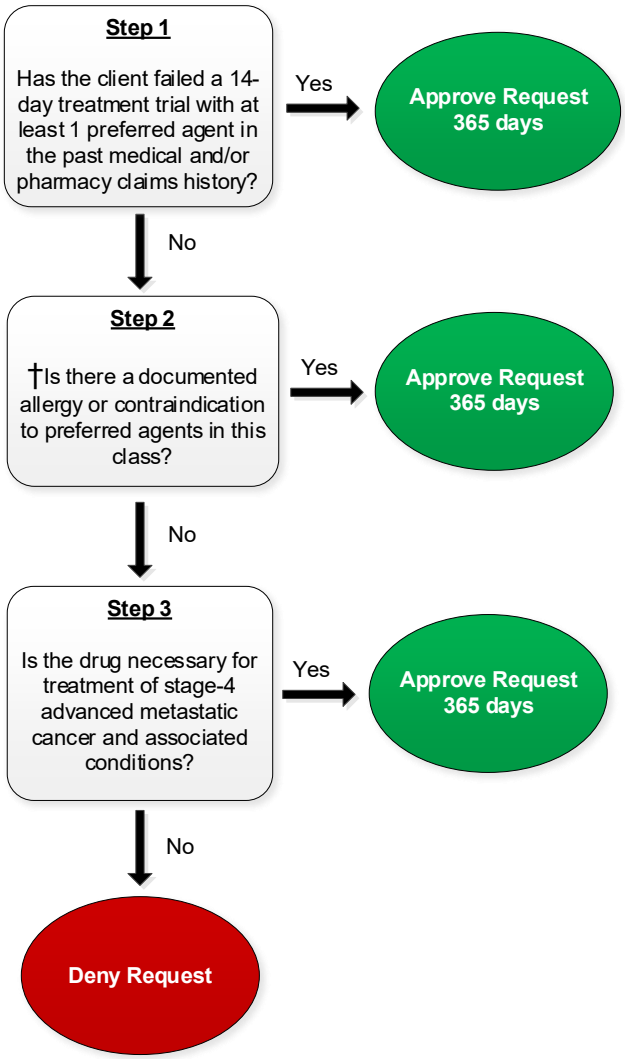
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Bronchodilators, Beta Agonist
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Bronchodilators, Beta Agonist Alternate Therapies

## Preferred Bronchodilators, Beta Agonist

| GCN | Drug Name |
|---|---|
| 41680 | ALBUTEROL 100 MG/20 ML SOLN |
| 22697 | ALBUTEROL 2.5 MG/0.5 ML SOL |
| 14633 | ALBUTEROL SUL 0.63 MG/3 ML SOL |
| 14634 | ALBUTEROL SUL 1.25 MG/3 ML SOL |
| 41681 | ALBUTEROL SUL 2.5 MG/3 ML SOLN |
| 22780 | ALBUTEROL SULF 2 MG/5 ML SYRUP |
| 22913 | PROAIR HFA 90 MCG INHALER |
| 22913 | PROVENTIL HFA 90MCG INHALER |
| 64012 | SEREVENT DISKUS 50 MCG |
| 22913 | VENTOLIN HFA 90 MCG INHALER |
| 15665 | XOPENEX 0.31 MG/3 ML SOLUTION |
| 24540 | XOPENEX 0.63 MG/3 ML SOLUTION |
| 24541 | XOPENEX 1.25 MG/3 ML SOLUTION |
| 23146 | XOPENEX CONC 1.25 MG/0.5 ML |
| 24422 | XOPENEX HFA 45 MCG INHALER |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 43 Calcium Channel Blockers (Oral)

# Calcium Channel Blockers (Oral) Prior Authorization Criteria

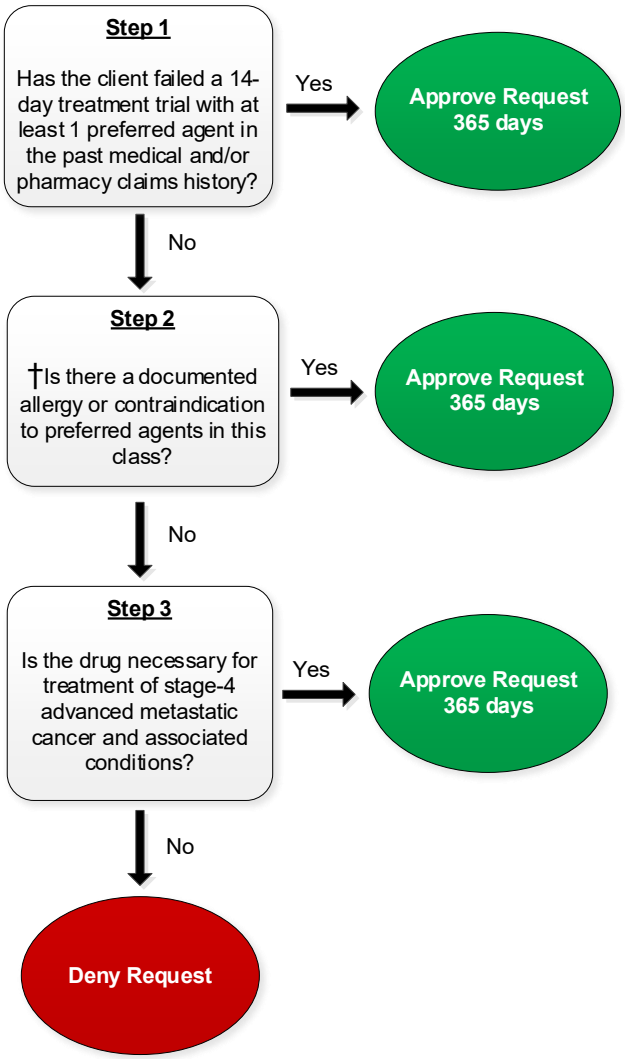
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Calcium Channel Blockers (Oral) Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Calcium Channel Blockers (Oral) Alternate Therapies

## Preferred Calcium Channel Blockers

| GCN | Drug Name |
|---|---|
| 02682 | AMLODIPINE BESYLATE 10 MG TAB |
| 02681 | AMLODIPINE BESYLATE 2.5 MG TAB |
| 02683 | AMLODIPINE BESYLATE 5 MG TAB |
| 02325 | DILTIAZEM 24HR ER 300MG CAPSULE |
| 02363 | DILTIAZEM 120 MG TABLET |
| 02321 | DILTIAZEM 12HR ER 120 MG CAP |
| 02322 | DILTIAZEM 12HR ER 60 MG CAP |
| 02320 | DILTIAZEM 12HR ER 90 MG CAP |
| 02324 | DILTIAZEM 24 HR ER 240MG CAPSULE |
| 07463 | DILTIAZEM 24H ER(XR) 120 MG CP |
| 07461 | DILTIAZEM 24H ER(XR) 180 MG CP |
| 07462 | DILTIAZEM 24H ER(XR) 240 MG CP |
| 07460 | DILTIAZEM 24H ER(XR) 360 MG CP |
| 02330 | DILTIAZEM 24HR ER 120 MG CP |
| 02326 | DILTIAZEM 24HR ER 120MG CAPSULE |
| 02329 | DILTIAZEM 24HR ER 180 MG CAP |
| 02323 | DILTIAZEM 24HR ER 180MG CAPSULE |
| 02332 | DILTIAZEM 24HR ER 240 MG CAP |
| 02333 | DILTIAZEM 24HR ER 300 MG CAP |
| 02328 | DILTIAZEM 24HR ER 360 MG CAP |
| 94691 | DILTIAZEM 24HR ER 420 MG CAP |

| GCN | Drug Name |
|---|---|
| 02360 | DILTIAZEM 30 MG TABLET |
| 02361 | DILTIAZEM 60 MG TABLET |
| 02362 | DILTIAZEM 90 MG TABLET |
| 02622 | FELODIPINE ER 10 MG TABLET |
| 02620 | FELODIPINE ER 2.5 MG TABLET |
| 02621 | FELODIPINE ER 5 MG TABLET |
| 46652 | KATERZIA 1 MG/ML SUSPENSION |
| 02350 | NIFEDIPINE 10 MG CAPSULE |
| 02351 | NIFEDIPINE 20 MG CAPSULE |
| 02221 | NIFEDIPINE ER 30 MG TABLET |
| 02226 | NIFEDIPINE ER 30 MG TABLET |
| 02222 | NIFEDIPINE ER 60 MG TABLET |
| 02227 | NIFEDIPINE ER 60 MG TABLET |
| 02223 | NIFEDIPINE ER 90 MG TABLET |
| 02228 | NIFEDIPINE ER 90 MG TABLET |
| 02681 | NORVASC 2.5 MG TABLET |
| 02683 | NORVASC 5 MG TABLET |
| 02682 | NORVASC 10 MG TABLET |
| 02330 | TIAZAC ER 120 MG CAPSULE |
| 02329 | TIAZAC ER 180 MG CAPSULE |
| 02332 | TIAZAC ER 240 MG CAPSULE |
| 02333 | TIAZAC ER 300 MG CAPSULE |
| 02328 | TIAZAC ER 360 MG CAPSULE |
| 94691 | TIAZAC ER 420 MG CAPSULE |
| 02341 | VERAPAMIL 120 MG TABLET |

| GCN | Drug Name |
|---|---|
| 47110 | VERAPAMIL 40 MG TABLET |
| 02342 | VERAPAMIL 80 MG TABLET |
| 03003 | VERAPAMIL ER 120 MG CAPSULE |
| 32472 | VERAPAMIL ER 120 MG TABLET |
| 03001 | VERAPAMIL ER 180 MG CAPSULE |
| 32471 | VERAPAMIL ER 180 MG TABLET |
| 03002 | VERAPAMIL ER 240 MG CAPSULE |
| 32470 | VERAPAMIL ER 240 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 44 Cephalosporins and Related Antibiotics

# Cephalosporins and Related Antibiotics (Oral) Prior Authorization Criteria

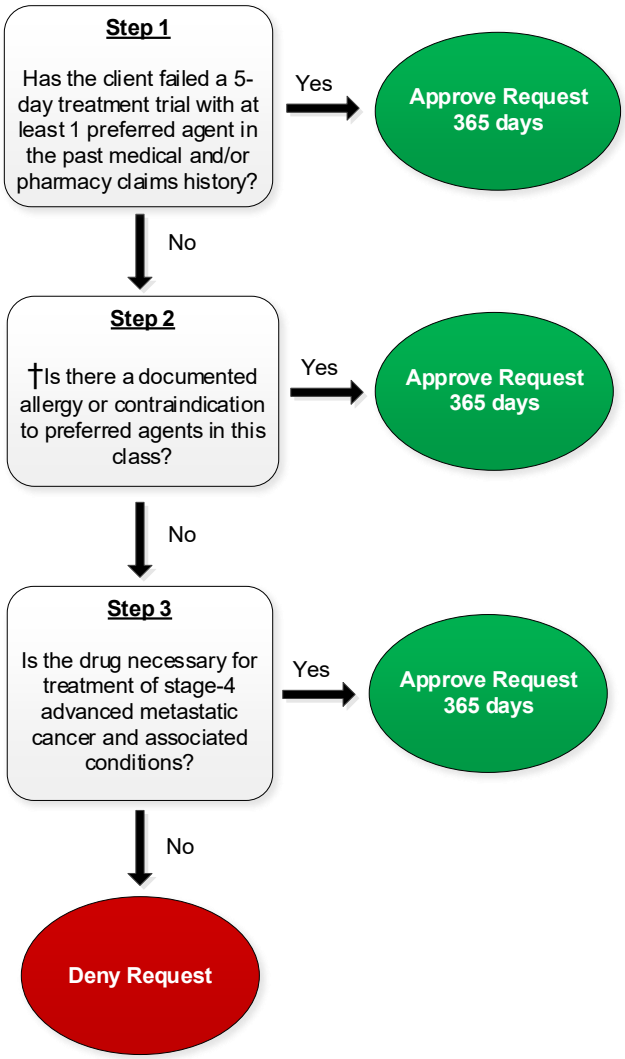
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Cephalosporins and Related Antibiotics (Oral) Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Cephalosporins and Related Antibiotics (Oral) Alternate Therapies

## Preferred Cephalosporins and Related Antibiotics

| GCN | Drug Name |
|---|---|
| 67154 | AMOX-CLAV 200-28.5 MG/5 ML SUS |
| 67070 | AMOX-CLAV 250-125 MG TABLET |
| 67151 | AMOX-CLAV 250-62.5 MG/5 ML SUS |
| 67153 | AMOX-CLAV 400-57 MG/5 ML SUSP |
| 67071 | AMOX-CLAV 500-125 MG TABLET |
| 28020 | AMOX-CLAV 600-42.9 MG/5 ML SUS |
| 67076 | AMOX-CLAV 875-125 MG TABLET |
| 45343 | CEFADROXIL 250 MG/5 ML SUSP |
| 45341 | CEFADROXIL 500 MG CAPSULE |
| 45344 | CEFADROXIL 500 MG/5 ML SUSP |
| 32232 | CEFDINIR 125 MG/5 ML SUSP |
| 23308 | CEFDINIR 250 MG/5 ML SUSP |
| 32231 | CEFDINIR 300 MG CAPSULE |
| 48821 | CEFPODOXIME 100 MG TABLET |
| 49302 | CEFPODOXIME 100 MG/5 ML SUSP |
| 48822 | CEFPODOXIME 200 MG TABLET |
| 49301 | CEFPODOXIME 50 MG/5 ML SUSP |
| 29291 | CEFPROZIL 125 MG/5 ML SUSP |
| 29271 | CEFPROZIL 250 MG TABLET |
| 29292 | CEFPROZIL 250 MG/5 ML SUSP |
| 29272 | CEFPROZIL 500 MG TABLET |

| GCN | Drug Name |
|---|---|
| 47281 | CEFUROXIME AXETIL 250 MG TAB |
| 47282 | CEFUROXIME AXETIL 500 MG TAB |
| 39811 | CEPHALEXIN 125 MG/5 ML SUSP |
| 39801 | CEPHALEXIN 250 MG CAPSULE |
| 39812 | CEPHALEXIN 250 MG/5 ML SUSP |
| 39802 | CEPHALEXIN 500 MG CAPSULE |
| 27016 | CEPHALEXIN 750 MG CAPSULE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 45 Colony Stimulating Factors

# Colony Stimulating Factors
# Prior Authorization Criteria

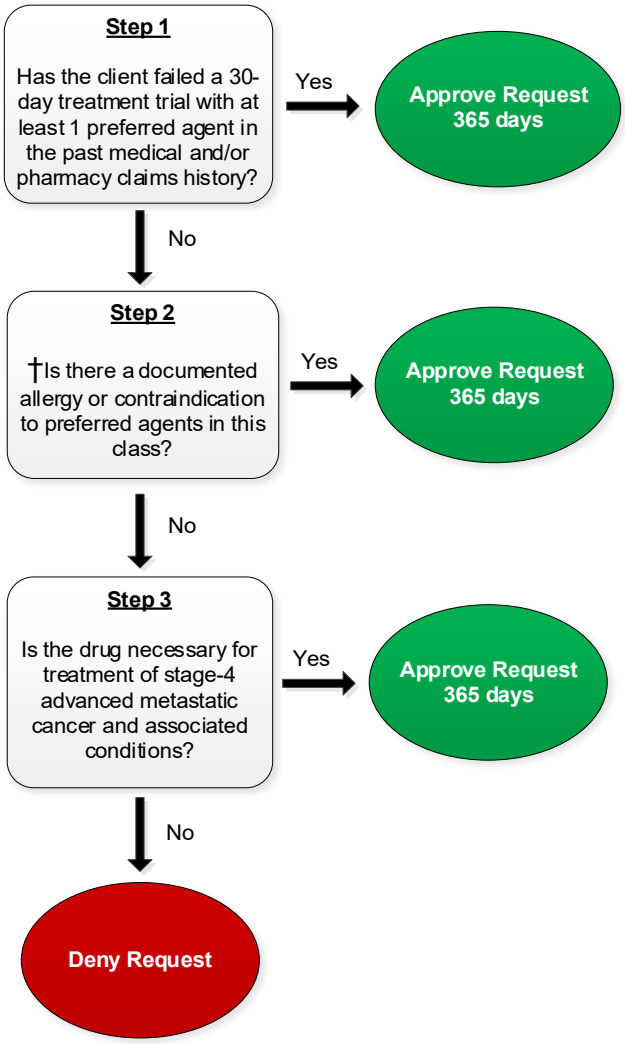
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Colony Stimulating Factors Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Colony Stimulating Factors Alternate Therapies

## Preferred Colony Stimulating Factors

| GCN | Drug Name |
|---|---|
| 45674 | GRANIX 300 MCG/ML VIAL |
| 45673 | GRANIX 480 MCG/1.6 ML VIAL |
| 13309 | NEUPOGEN 300 MCG/0.5 ML SYR |
| 26001 | NEUPOGEN 300 MCG/ML VIAL |
| 13308 | NEUPOGEN 480 MCG/0.8 ML SYR |
| 13206 | NEUPOGEN 480 MCG/1.6 ML VIAL |
| 48222 | NYVEPRIA 6 MG/0.6 ML SYRINGE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 46 COPD Agents

# COPD Agents
# Prior Authorization Criteria

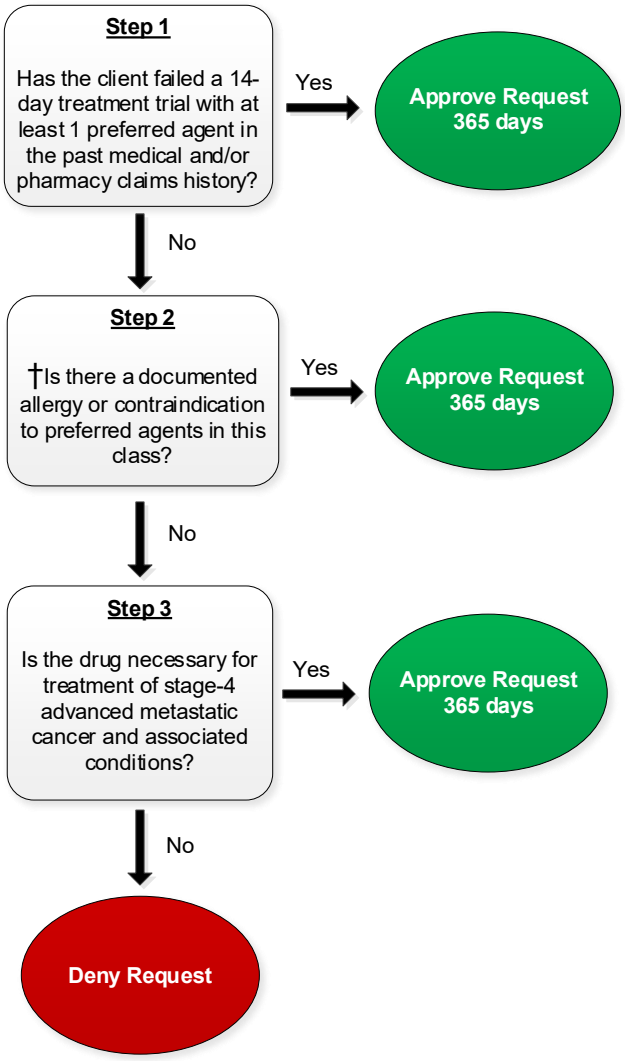
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# COPD Agents
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# COPD Agents
# Alternate Therapies

## Preferred COPD Agents

| GCN | Drug Name |
|---|---|
| 35903 | ANORO ELLIPTA 62.5-25 MCG INH |
| 24621 | ATROVENT 17 MCG HFA INHALER |
| 32395 | COMBIVENT RESPIMAT 20-100 MCG |
| 13456 | IPRAT-ALBUT 0.5-3(2.5) MG/3 ML |
| 42235 | IPRATROPIUM BR 0.02% SOLN |
| 44498 | ROFLUMILAST 250 MCG TABLET |
| 28934 | ROFLUMILAST 500 MCG TABLET |
| 17853 | SPIRIVA HANDIHALER 18 MCG CAP |
| 39587 | SPIRIVA RESPIMAT 1.25 MCG INH |
| 98921 | SPIRIVA RESPIMAT 2.5 MCG INH |
| 38687 | STIOLTO RESPIMAT INHALER (10) |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 47 Cough and Cold Agents

# Cough and Cold Non-Antitussive Prior Authorization Criteria

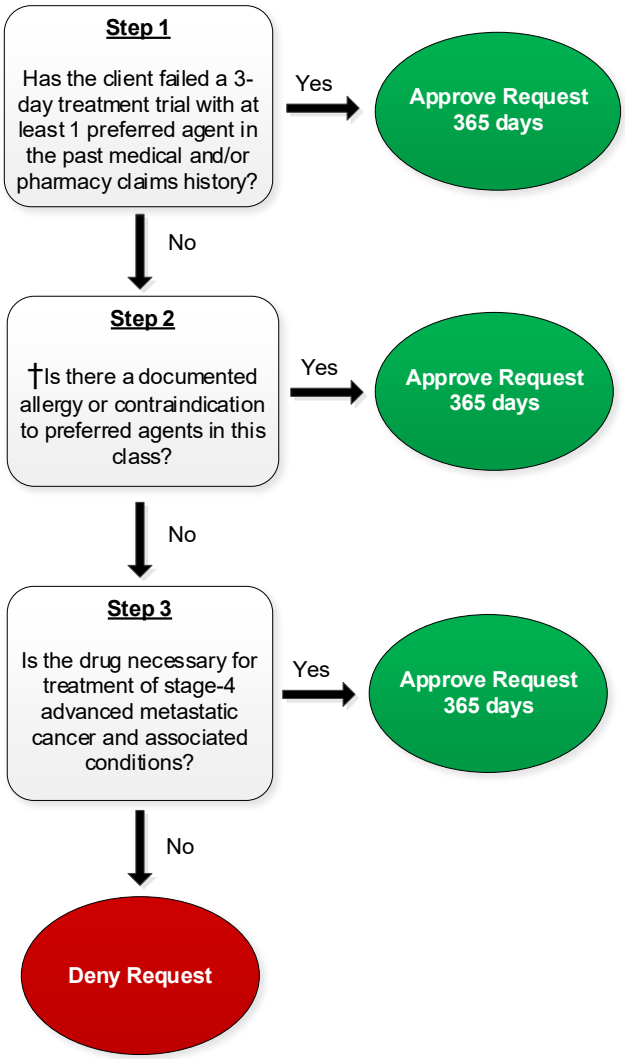
1. Has the client failed a 3-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Cough and Cold Non-Antitussive Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Cough and Cold Non-Antitussive Alternate Therapies

## Preferred Cough and Cold Non-Antitussives

| GCN | Drug Name |
|---|---|
| 34062 | 12 HOUR NASAL RELIEF SPRAY |
| 34124 | 4 WAY 1% NASAL SPRAY |
| 02512 | ADULT WAL-TUSSIN LIQUID |
| 02482 | AIR-POWER 200 MG TABLET |
| 46711 | ALA-HIST IR 2 MG TABLET |
| 48628 | ALAHIST PE 2-7.5 MG TABLET |
| 85915 | ALLERGY MULTI-SYMPTOM CAPLET |
| 34062 | ANEFRIN 0.05% NASAL SPRAY |
| 96445 | APRODINE TABLET |
| 18906 | CHEST CONGEST RLF 400 MG TAB |
| 02512 | CHEST CONGESTION RELIEF SOLN |
| 27207 | CHILD COLD-ALLERGY LIQUID |
| 34062 | CHILD MUCINEX STUFFY NOSE SPRY |
| 27207 | CHILD TRIAMINIC COLD-ALLERGY |
| 27207 | CHILD WAL-TAP COLD-ALLERGY ELX |
| 02512 | CHILDREN'S CHEST CONGEST LIQ |
| 27207 | CHILDREN'S COLD-ALLERGY ELIXIR |
| 02512 | CHILDREN'S MUCUS RELIEF LIQ |
| 21827 | COLD-SINUS RLF 200-30MG LIQCAP |
| 51977 | CONEX 2 MG-60 MG/5 ML SOLN |
| 99509 | CONEX PED 1 MG-30 MG/5 ML SOLN |

| GCN | Drug Name |
|---|---|
| 02512 | COUGH SYRUP 100 MG/5 ML |
| 18906 | CVS CHEST CONGESTION RLF TAB |
| 27207 | CVS CHILD COLD-ALLERGY LIQUID |
| 02512 | CVS CHILD'S CHEST CONGEST LIQ |
| 21827 | CVS COLD-SINUS 200-30MG LIQCAP |
| 89731 | CVS MUCUS D ER 1,200-120 MG TB |
| 54980 | CVS MUCUS D ER 600-60 MG TAB |
| 98863 | CVS MUCUS ER 1,200 MG TABLET |
| 35905 | CVS MUCUS ER 600 MG TABLET |
| 34062 | CVS NASAL SPRAY 0.05% |
| 34124 | CVS NASAL SPRAY 1% |
| 14359 | CVS SEVERE COUGH-COLD POWD PKT |
| 85915 | CVS SINUS CONGESTION PAIN CPLT |
| 25468 | CVS SINUS HEADACHE PE CAPLET |
| 34062 | CVS SINUS NASAL SPRAY 0.05% |
| 25468 | CVS SINUS PAIN-CONGEST CAPLET |
| 25462 | CVS SINUS PE-ALLERGY 4-10MG TB |
| 34124 | CVS SINUS RELIEF 1% NASAL SPRY |
| 26743 | CVS SINUS RLF PRESS-PAIN CPLT |
| 02512 | CVS TUSSIN 100 MG/5 ML LIQUID |
| 42022 | DECONEX IR 385-10 MG TABLET |
| 02512 | DIABETIC TUSSIN EX LIQUID |
| 34062 | DRISTAN 0.05% NASAL SPRAY |
| 14148 | ED A-HIST LIQUID |
| 54250 | ED BRON GP LIQUID |

| GCN | Drug Name |
|---|---|
| 25462 | ED-A-HIST 4 MG-10 MG TABLET |
| 14359 | EQ FLU-SEVERE COLD-COUGH PKT |
| 35905 | EQ MUCUS ER 600 MG TABLET |
| 35905 | EQ MUCUS RELIEF ER 600 MG TAB |
| 85915 | EQ MULTI-SYMPTOM ALLERGY RLF |
| 34124 | EQ NASAL SPRAY 1% |
| 34062 | EQ ORIGINAL NASAL SPRAY 0.05% |
| 26743 | EQ SINUS CONGESTION-PAIN CPLT |
| 25468 | EQ SINUS CONGEST-PAIN GELCAP |
| 25462 | EQ SUPHEDRINE PE SINUS 4-10 MG |
| 18906 | EQL CHEST CONGEST 400 MG CPLT |
| 25468 | EQL DAYTIME SINUS CONGEST-PAIN |
| 14359 | EQL FLU-SEV CLD-COUGH NITE PKT |
| 26743 | EQL HEAD CONGEST-MUCUS PE CPLT |
| 35905 | EQL MUCUS RELIEF ER 600 MG TAB |
| 34124 | EQL NASAL SPRAY 1% |
| 25462 | EQL SINUS-ALLERGY PE TABLET |
| 02512 | EQL TUSSIN MUCUS-CHEST CONGEST |
| 02512 | EXPECTORANT 100 MG/5 ML SYRUP |
| 02482 | EXPECTORANT 200 MG TABLET |
| 18906 | FENESIN IR 400 MG TABLET |
| 85915 | FLONASE HEADACHE 325-2-5MG CPT |
| 02512 | FT ADULT TUSSIN 200 MG/10 ML |
| 18906 | FT CHEST CONGEST 400 MG CAPLET |
| 89731 | FT MUCUS RELIEF D ER 1,200-120 |

| GCN | Drug Name |
|---|---|
| 54980 | FT MUCUS RELIEF D ER 600-60 MG |
| 98863 | FT MUCUS RELIEF ER 1,200 MG TB |
| 35905 | FT MUCUS RELIEF ER 600 MG TAB |
| 34062 | FT NASAL SPRAY 0.05% |
| 26743 | FT SINUS SEVERE 325-200-5 MG |
| 02512 | GERI-TUSSIN 100 MG/5 ML SOLN |
| 02512 | GERI-TUSSIN 200 MG/10 ML LIQ |
| 18906 | G-FENESIN 400 MG CAPLET |
| 26743 | GNP COLD HEAD CONGST SEVR CPLT |
| 35905 | GNP MUCUS ER 600 MG TABLET |
| 18906 | GNP MUCUS RELIEF 400 MG TABLET |
| 26743 | GNP MUCUS RLF SINUS CONG PAIN |
| 98863 | GNP MUCUS-ER MAX 1,200 MG TAB |
| 34124 | GNP NASAL FOUR 1% NASAL SPRAY |
| 34062 | GNP NASAL SPRAY 0.05% |
| 34124 | GNP NASAL SPRAY 1% |
| 34062 | GNP NASAL SPRAY ORIGINAL 0.05% |
| 34062 | GNP NO DRIP 0.05% NASAL SPRAY |
| 25468 | GNP SINUS PRESSURE-PAIN CAPLET |
| 26743 | GNP SINUS SEVERE CAPLET |
| 25468 | GNP SINUS-HEADACHE CAPLET |
| 18906 | GNP TUSSIN 400 MG TABLET |
| 02512 | GNP TUSSIN MUCUS-CON 200 MG/10 |
| 26743 | GS COLD HEAD CONGST SEVR CPLT |
| 35905 | GS MUCUS ER 600 MG CAPLET |

| GCN | Drug Name |
|---|---|
| 34124 | GS NASAL FOUR 1% NASAL SPRAY |
| 34062 | GS NASAL SPRAY 0.05% |
| 34062 | GS NO DRIP 0.05% NASAL SPRAY |
| 26743 | GS PRESSURE-PAIN PE PLUS MUCUS |
| 34062 | GS SINUS NASAL SPRAY 0.05% |
| 26743 | GS SINUS SEVERE 325-200-5 MG |
| 25468 | GS SINUS-HEADACHE CAPLET |
| 02512 | GS TUSSIN MUCUS-CONG 100 MG/5 |
| 02512 | GUAIFENESIN 100 MG/5 ML LIQUID |
| 02512 | GUAIFENESIN 100 MG/5 ML SOLN |
| 02512 | GUAIFENESIN 100MG/5ML SOLN CUP |
| 02482 | GUAIFENESIN 200 MG TABLET |
| 02512 | GUAIFENESIN 200 MG/10 ML CUP |
| 02512 | GUAIFENESIN 200 MG/10 ML LIQ |
| 02512 | GUAIFENESIN 300 MG/15 ML CUP |
| 18906 | GUAIFENESIN 400 MG CAPLET |
| 18906 | GUAIFENESIN 400 MG TABLET |
| 98863 | GUAIFENESIN ER 1,200 MG TABLET |
| 35905 | GUAIFENESIN ER 600 MG TABLET |
| 89731 | GUAIFENESIN-PSE ER 1200-120 MG |
| 54980 | GUAIFENESIN-PSE ER 600-60 MG |
| 26743 | HEAD CONGESTION-MUCUS CAPLET |
| 57325 | HISTEX-DM 20-30-2.5MG/5ML SYRP |
| 18906 | HM CHEST CONGEST RLF 400 MG TB |
| 27207 | HM CHILD'S DIBROMM COLD-ALLGY |

| GCN | Drug Name |
|---|---|
| 35905 | HM MUCUS RELIEF ER 600 MG TAB |
| 34062 | HM ORIGINAL NASAL SPRAY 0.05% |
| 02512 | HV TUSSIN MUCUS-CONG 200 MG/10 |
| 14359 | KRO FLU-SEV CLD-COUGH NITE PKT |
| 26743 | KRO MUCUS RLF COLD-SINUS CPLT |
| 98863 | KRO MUCUS-ER MAX 1,200 MG TAB |
| 34124 | KRO NASAL SPRAY 1% |
| 34062 | KRO NASAL SPRAY ORIGINAL 0.05% |
| 34062 | KRO NO DRIP 0.05% NASAL SPRAY |
| 26743 | KRO SINUS RLF PRESS-PAIN CPLT |
| 44021 | LOHIST-D LIQUID |
| 34062 | LONG ACTING 0.05% NASAL SPRAY |
| 54250 | MAXI-TUSS PE MAX LIQUID |
| 02512 | MAXTUSSIN 200 MG/10 ML LIQUID |
| 85915 | MEDICIDIN-D TABLET |
| 54980 | MUCINEX D ER 600-60 MG TABLET |
| 98863 | MUCINEX ER 1,200 MG TABLET |
| 35905 | MUCINEX ER 600 MG TABLET |
| 50018 | MUCINEX INSTASOOTHE 7%-1% SPRY |
| 26743 | MUCINEX SINUS-MAX SEVERE CPLT |
| 18906 | MUCOSA 400 MG TABLET |
| 54980 | MUCUS D ER 600-60 MG TABLET |
| 35905 | MUCUS ER 600 MG TABLET |
| 18906 | MUCUS RELIEF 400 MG CAPLET |
| 18906 | MUCUS RELIEF 400 MG MINI CPLT |

| GCN | Drug Name |
|---|---|
| 18906 | MUCUS RELIEF 400 MG TABLET |
| 89731 | MUCUS RELIEF D ER 1,200-120 MG |
| 54980 | MUCUS RELIEF D ER 600-60 MG TB |
| 98863 | MUCUS RELIEF ER 1,200 MG TAB |
| 35905 | MUCUS RELIEF ER 600 MG TABLET |
| 26743 | MUCUS RELIEF SINUS PRES-PAIN |
| 26743 | MUCUS RLF SEVERE SINUS CONGEST |
| 02512 | MUCUS-CHEST CONG 200 MG/10 ML |
| 34062 | NASAL DECONGESTANT 0.05% SPRAY |
| 34124 | NASAL FOUR 1% NASAL SPRAY |
| 34062 | NASAL SPRAY 0.05% |
| 34124 | NASAL SPRAY 1% |
| 34062 | NASAL SPRAY ORIGINAL 0.05% |
| 32676 | NASOPEN PE LIQUID |
| 34124 | NEO-SYNEPHRINE 1% SPRAY |
| 14359 | NIGHT SEVERE COLD-COUGH PKT |
| 34062 | NO DRIP 0.05% NASAL SPRAY |
| 14148 | NOHIST-LQ LIQUID |
| 34062 | NOSTRILLA 0.05% NASAL SPRAY |
| 34062 | OXYMETAZOLINE 0.05% SPRAY |
| 46499 | POLY HIST FORTE 10.5-10 MG TAB |
| 25468 | PRESSURE AND PAIN PE CAPLET |
| 85915 | PUB ALLERGY SINUS PE CAPLET |
| 27207 | PUB CHILD'S DIBROMM COLD-ALLGY |
| 34124 | PUB NASAL FOUR 1% NASAL SPRAY |

| GCN | Drug Name |
|---|---|
| 34062 | PUB NO DRIP 0.05% NASAL SPRAY |
| 34062 | PUB ORIGINAL NASAL SPRAY 0.05% |
| 34062 | PUB OXYMETAZOLINE HCL 0.05% |
| 25468 | PUB SINUS RELIEF CAPLET |
| 02512 | PUB TUSSIN 100 MG/5 ML SYRUP |
| 02512 | QC ADULT TUSSIN 200 MG/10 ML |
| 27207 | QC CHILD'S DIBROMM COLD-ALLGY |
| 26743 | QC COLD HEAD CONGST SEVR CPLT |
| 26743 | QC HEAD CONGEST-MUCUS PE CPLT |
| 18906 | QC MUCUS RELIEF 400 MG CAPLET |
| 98863 | QC MUCUS RELIEF ER 1,200 MG TB |
| 35905 | QC MUCUS RELIEF ER 600 MG TAB |
| 26743 | QC MUCUS RLF SINUS CONG PAIN |
| 34124 | QC NASAL SPRAY 1% |
| 14359 | QC NIGHT SEVERE COLD-COUGH PKT |
| 26743 | QC SINUS SEVERE 325-200-5 MG |
| 25468 | QC SINUS-HEADACHE CAPLET |
| 34062 | RA 12HR NASAL SPRAY 0.05% |
| 02512 | RA EXPECTORANT COUGH SYRUP |
| 18906 | RA MUCUS RELIEF 400 MG TABLET |
| 26743 | RA MUCUS RELIEF COLD-SINUS MAX |
| 89731 | RA MUCUS RELIEF D ER 1,200-120 |
| 54980 | RA MUCUS RELIEF D ER 600-60 MG |
| 34062 | RA NASAL SPRAY 0.05% |
| 25468 | RA SINUS CONGEST-PAIN GELCAP |

| GCN | Drug Name |
|---|---|
| 26743 | RA SINUS CONGEST-PAIN RLF CPLT |
| 25462 | RA SUPHEDRINE PE COLD 4-10 MG |
| 25468 | RA SUPHEDRINE PE SINUS 5-325MG |
| 02512 | RA TUSSIN CHEST CONGESTION SYR |
| 18906 | REFENESEN 400 MG TABLET |
| 28476 | RYMED TABLET |
| 27207 | RYNEX PE LIQUID |
| 12933 | RYNEX PSE LIQUID |
| 02512 | SCOT-TUSSIN 100 MG/5 ML LIQ |
| 02512 | SCOT-TUSSIN EXPECTORANT LIQUID |
| 26743 | SEVERE SINUS CONGEST-PAIN CPLT |
| 02512 | SILTUSSIN SA 200 MG/10 ML CUP |
| 02512 | SILTUSSIN SA 300 MG/15 ML CUP |
| 25468 | SINUS CONGESTION-PAIN CAPLET |
| 26743 | SINUS CONGESTION-PAIN CAPLET |
| 85915 | SINUS CONGESTION-PAIN CAPLET |
| 25468 | SINUS CONGESTION-PAIN GELCAP |
| 26743 | SINUS CONGST-PAIN 325-200-5 MG |
| 25468 | SINUS PRESSURE-PAIN CAPLET |
| 34124 | SINUS RELIEF 1% NASAL SPRAY |
| 34062 | SINUS RELIEF NASAL SPRAY 0.05% |
| 25468 | SINUS-HEADACHE 5-325 MG CAPLET |
| 85915 | SINUTROL PE 2-5-325 MG TABLET |
| 18906 | SM CHEST CONGESTION 400MG CPLT |
| 27207 | SM CHILD COLD-ALLERGY LIQUID |

| GCN | Drug Name |
|---|---|
| 35905 | SM MUCUS RELIEF ER 600 MG TAB |
| 98863 | SM MUCUS-ER MAX 1,200 MG TAB |
| 34062 | SM NASAL SPRAY 0.05% |
| 34062 | SM NASAL SPRAY SINUS |
| 26743 | SM SINUS SEVERE CAPLET |
| 02512 | SM TUSSIN MUCUS-CONG 200 MG/10 |
| 44023 | SUDOGEST COLD AND ALLERGY TAB |
| 02512 | TUSNEL-EX 100 MG/5 ML LIQUID |
| 18906 | TUSSIN 400 MG TABLET |
| 02512 | TUSSIN CHEST CONGESTION LIQUID |
| 02512 | TUSSIN MUCUS-CONG 200 MG/10 ML |
| 85915 | VALIHIST 325-2-5 MG TABLET |
| 34062 | VICKS SINEX 12 HOUR SPRAY |
| 96445 | WAL-ACT D COLD & ALLERGY TAB |
| 44023 | WAL-FINATE-D TABLET |
| 14359 | WAL-FLU SEVERE COLD-COUGH PKT |
| 34124 | WAL-FOUR 1% NASAL SPRAY |
| 25468 | WAL-PHED PE SINUS HEADACHE CPT |
| 25462 | WAL-PHED PE SINUS-ALLERGY TAB |
| 26743 | WAL-PHED PE TRIPLE RELIEF CPLT |
| 44023 | WAL-PHED SINUS AND ALLERGY TAB |
| 27207 | WAL-TAP ELIXIR |
| 02512 | WAL-TUSSIN SYRUP |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# Cough and Cold Narcotic Antitussive Prior Authorization Criteria

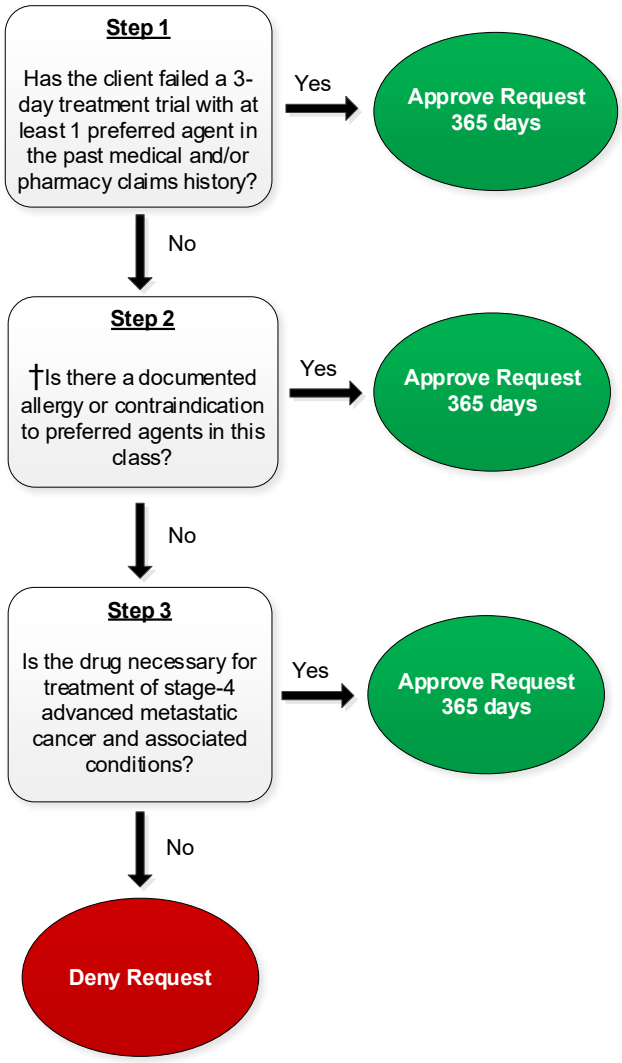
1. Has the client failed a 3-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Cough and Cold Narcotic Antitussive Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Cough and Cold Narcotic Antitussive Alternate Therapies

**Preferred Cough and Cold Narcotic Antitussives**

| GCN | Drug Name |
|---|---|
| 91713 | CHERATUSSIN AC SYRUP |
| 91713 | CODEINE-GUAIF 10-100MG/5ML |
| 34672 | CODEINE-GUAIFEN 10-100 MG/5 ML |
| 91713 | CODEINE-GUAIFEN 10-100 MG/5 ML |
| 34673 | GUAIFEN-CODEINE 200-20 MG/10ML |
| 91713 | GUAIFENESIN AC COUGH SYRUP |
| 91713 | GUAIFENESIN-CODEINE SYRUP |
| 33377 | HYDROCODONE-HOMATROP 5 ML CUP |
| 13973 | HYDROCODONE-HOMATROPINE SOLN |
| 91713 | VIRTUSSIN AC LIQUID |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# Cough and Cold
# Non-Narcotic Antitussive
# Prior Authorization Criteria

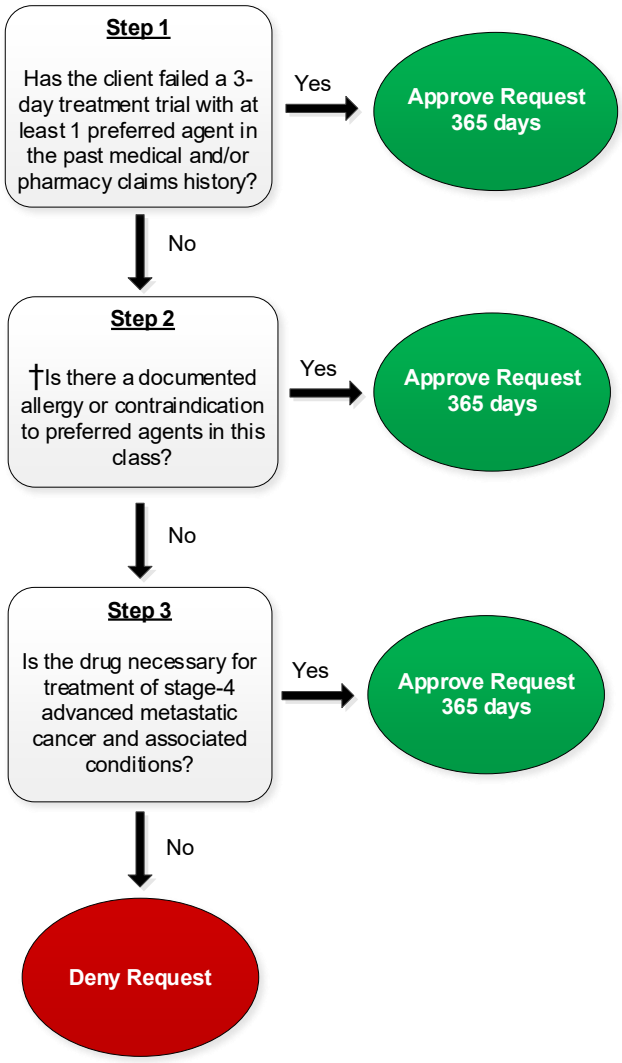
1. Has the client failed a 3-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Cough and Cold Non-Narcotic Antitussive Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Cough and Cold Non-Narcotic Antitussive Alternate Therapies

## Preferred Cough and Cold Non-Narcotic Antitussives

| GCN | Drug Name |
|---|---|
| 17802 | 12-HR COUGH RELIEF 30 MG/5 ML |
| 53090 | ADLT WAL-TUSSIN COUGH-COLD CF |
| 53495 | ADULT WAL-TUSSIN DM SYRUP |
| 43882 | ALAHIST CF TABLET |
| 54425 | ALAHIST DM 10-12.5-5 MG/5ML LQ |
| 42443 | ALAHIST DM 2-15-7.5 MG/5 ML LQ |
| 42443 | ALAHIST DM LIQUID |
| 25093 | ALKA-SELTZER PLUS DAY CAP |
| 30232 | ALL-NITE COLD-FLU RELIEF LIQ |
| 99356 | AP-HIST DM LIQUID |
| 29840 | BENZONATATE 100 MG CAPSULE |
| 28229 | BENZONATATE 150 MG CAPSULE |
| 93007 | BENZONATATE 200 MG CAPSULE |
| 53491 | BIOCOTRON LIQUID |
| 96136 | BROMFED DM 2-30-10 MG/5 ML SYR |
| 23807 | CHEST CONG RLF DM 400-20 MG TB |
| 47921 | CHILD DELSYM COUGH PLUS DY-NT |
| 53497 | CHILD DELSYM COUGH-CHEST DM LQ |
| 30579 | CHILD MUCINEX COLD-FLU LIQUID |
| 28875 | CHILD MUCINEX COUGH-CONGEST LQ |
| 47825 | CHILD MUCINEX FREEFROM NT COLD |

| GCN | Drug Name |
|---|---|
| 37876 | CHILD MUCINEX M-S COLD DAY-NTE |
| 26808 | CHILDREN'S COLD-COUGH ELIXIR |
| 99788 | CHLOPHEDIANOL-DEXCHLORP-PSE LQ |
| 26742 | COLD HEAD CONGESTION CAPLET |
| 27135 | COLD HEAD CONGESTION CAPLET |
| 20556 | COLD-FLU RELIEF LIQUID |
| 17802 | COUGH DM 30MG/5ML SUSP |
| 96140 | COUGH-COLD HBP TABLET |
| 46697 | CVS FLU HBP 325-2-10 MG CAPLET |
| 53550 | CVS MUCUS DM ER 600-30 MG TAB |
| 25094 | CVS NIGHTTIME COLD-FLU SOFTGEL |
| 26684 | CVS NIGHTTIME COUGH LIQUID |
| 17770 | CVS TUSSIN COUGH 15 MG LIQ GEL |
| 44033 | DAY MULTI-SYMP FLU-SEVERE COLD |
| 46479 | DECONEX DMX 17.5-400-10 MG TAB |
| 42056 | DECONEX DMX TABLET |
| 17802 | DELSYM 30MG/5ML SUSPENSION |
| 22004 | DELSYM COUGH 15 MG CAPLET |
| 53497 | DELSYM COUGH+CHEST CNGST DM LQ |
| 47819 | DELSYM NIGHTTIME COUGH LIQUID |
| 17802 | DEXTROMETHORPHAN ER 30MG/5ML |
| 26808 | DIMAPHEN DM ELIXIR |
| 42056 | DM-GUAIF-PE 17.5-385-10 MG TAB |
| 34782 | DM-GUAIF-PE 18-200-10 MG/15 ML |
| 39986 | DURAFLU 325-20-200-60 MG TAB |

| GCN | Drug Name |
|---|---|
| 19347 | ED-A-HIST DM LIQUID |
| 26808 | ENDACOF-DM LIQUID |
| 14355 | GS FLU-SEV COLD-COUGH DAY PKT |
| 36311 | HISTEX-DM SYRUP |
| 30577 | MUCINEX COLD-FLU-SORETHROAT LQ |
| 38895 | MUCINEX FAST-MAX COLD-FLU CAP |
| 36524 | MUCINEX FAST-MAX CONGEST-COUGH |
| 53497 | MUCINEX FAST-MAX DM MAX LIQUID |
| 49896 | MUCINEX FASTMX CLD-NTSHFT CPLT |
| 50004 | MUCINEX INSTASOOTH COUGH 5-2MG |
| 49573 | MUCINEX NIGHTSHFT SEVR CLD-FLU |
| 49596 | MUCINEX NIGHTSHIFT CLD-FLU CPT |
| 23807 | MUCUS RELIEF DM TABLET |
| 30232 | NIGHTTIME COLD-FLU LIQUID |
| 19347 | NO-HIST DM LIQUID |
| 34835 | POLY-HIST DM LIQUID |
| 44218 | POLYTUSSIN DM 1-10-5MG/5ML SYR |
| 42443 | POLYTUSSIN DM 2-15-7.5 MG/5 ML |
| 54479 | POLYTUSSIN DM 7.5-5-12.5MG/5ML |
| 34799 | POLY-VENT DM TABLET |
| 13975 | PROMETHAZINE-DM 6.25-15 MG/5ML |
| 45903 | ROBAFEN DM 200-20 MG/20 ML LIQ |
| 53491 | ROBAFEN DM COUGH LIQUID |
| 26808 | RYNEX DM LIQUID |
| 23807 | SM CHEST CONGEST RLF DM CAPLET |

| GCN | Drug Name |
|---|---|
| 53491 | SM TUSSIN DM LIQUID |
| 33223 | SUPRESS A DROPS |
| 55139 | VANACOF CP 12.5-25 MG/15 ML LQ |
| 34782 | VANACOF DM LIQUID |
| 99788 | VANACOF LIQUID |
| 55095 | VANACOF XP 18-396 MG/15 ML LIQ |
| 55157 | VANACOF-2 12.5-1 MG/5 ML LIQ |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 48 Cytokine and CAM Antagonists

# Cytokine and CAM Antagonists Prior Authorization Criteria

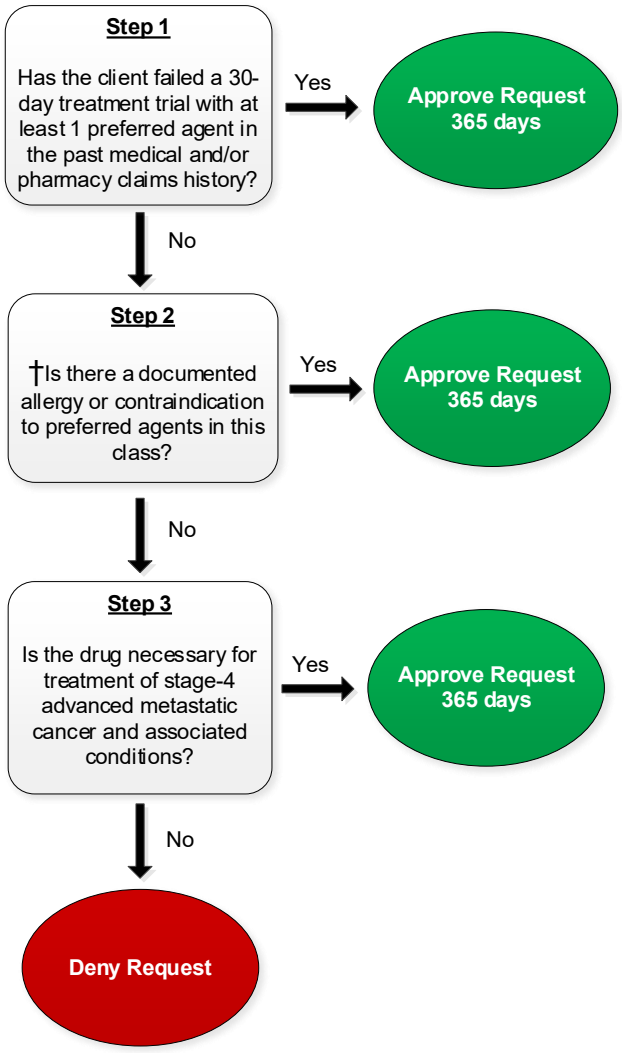
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Cytokine and CAM Antagonists Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Cytokine and CAM Antagonists Alternate Therapies

## Preferred Cytokine and CAM Antagonists

| GCN | Drug Name |
|---|---|
| 53885 | ADALIMUMAB-ADAZ(CF) 10MG/0.1ML |
| 53883 | ADALIMUMAB-ADAZ(CF) 20MG/0.2ML |
| 53884 | ADALIMUMAB-ADAZ(CF) 40 MG SYRG |
| 53875 | ADALIMUMAB-ADAZ(CF) PEN 40 MG |
| 53887 | ADALIMUMAB-ADAZ(CF) PEN 80 MG |
| 48318 | ADALIMUMAB-FKJP(CF) 20 MG SYRG |
| 48336 | ADALIMUMAB-FKJP(CF) 40 MG SYRG |
| 48317 | ADALIMUMAB-FKJP(CF) PEN 40 MG |
| 98398 | ENBREL 25 MG/0.5 ML SYRINGE |
| 48417 | ENBREL 25 MG/0.5 ML VIAL |
| 43924 | ENBREL 50 MG/ML MINI CARTRIDGE |
| 97724 | ENBREL 50 MG/ML SURECLICK |
| 23574 | ENBREL 50 MG/ML SYRINGE |
| 46718 | HADLIMA 40 MG/0.8 ML SYRINGE |
| 46717 | HADLIMA PUSHTOUCH 40 MG/0.8 ML |
| 53846 | HADLIMA(CF) 40 MG/0.4 ML SYRNG |
| 53848 | HADLIMA(CF) PUSHTOUCH 40MG/0.4 |
| 48318 | HULIO(CF) 20 MG/0.4 ML SYRINGE |
| 48336 | HULIO(CF) 40 MG/0.8 ML SYRINGE |
| 48317 | HULIO(CF) PEN 40 MG/0.8 ML |
| 18924 | HUMIRA 40 MG/0.8 ML SYRINGE |

| GCN | Drug Name |
|---|---|
| 97005 | HUMIRA PEN 40 MG/0.8 ML |
| 44659 | HUMIRA(CF) 10 MG/0.1 ML SYRING |
| 44664 | HUMIRA(CF) 20 MG/0.2 ML SYRING |
| 43505 | HUMIRA(CF) 40 MG/0.4 ML SYRING |
| 43506 | HUMIRA(CF) PEN 40 MG/0.4 ML |
| 44014 | HUMIRA(CF) PEN 80 MG/0.8 ML |
| 44014 | HUMIRA(CF) PEN CRHN-UC-HS 80MG |
| 44014 | HUMIRA(CF) PEN PEDI UC 80 MG |
| 44954 | HUMIRA(CF) PEN PS-UV-AHS 80-40 |
| 30289 | ORENCIA 125 MG/ML SYRINGE |
| 43389 | ORENCIA 50 MG/0.4 ML SYRINGE |
| 43397 | ORENCIA 87.5 MG/0.7 ML SYRINGE |
| 41656 | ORENCIA CLICKJECT 125 MG/ML |
| 56084 | OTEZLA 10-20 MG STARTER 28 DAY |
| 36173 | OTEZLA 10-20-30MG START 14 DAY |
| 37765 | OTEZLA 10-20-30MG START 28 DAY |
| 56083 | OTEZLA 20 MG TABLET |
| 36172 | OTEZLA 30 MG TABLET |
| 55956 | PYZCHIVA 45 MG/0.5 ML SYRINGE |
| 55957 | PYZCHIVA 90 MG/ML SYRINGE |
| 46822 | RINVOQ ER 15 MG TABLET |
| 51719 | RINVOQ ER 30 MG TABLET |
| 52085 | RINVOQ ER 45 MG TABLET |
| 55651 | RINVOQ LQ 1 MG/ML SOLUTION |
| 55583 | SELARSDI 45 MG/0.5 ML SYRINGE |

| GCN | Drug Name |
|---|---|
| 55584 | SELARSDI 90 MG/ML SYRINGE |
| 56047 | SIMLANDI(CF) 20 MG/0.2 ML SYRG |
| 56016 | SIMLANDI(CF) 40 MG/0.4 ML SYRG |
| 56048 | SIMLANDI(CF) 80 MG/0.8 ML SYRG |
| 55332 | SIMLANDI(CF) AI 40 MG/0.4 ML |
| 57361 | SIMLANDI(CF) AI 80 MG/0.8 ML |
| 49591 | SKYRIZI 150 MG/ML PEN |
| 49617 | SKYRIZI 150 MG/ML SYRINGE |
| 53397 | SKYRIZI 180 MG/1.2 ML ON-BODY |
| 52475 | SKYRIZI 360 MG/2.4 ML ON-BODY |
| 46024 | TREMFYA 100 MG/ML ONE-PRESS |
| 57417 | TREMFYA 100 MG/ML PEN |
| 43612 | TREMFYA 100 MG/ML SYRINGE |
| 56229 | TREMFYA 200 MG/2 ML PEN |
| 56229 | TREMFYA 200MG/2ML PEN INDCT PK |
| 55583 | USTEKINUMAB-AEKN 45 MG/0.5 ML |
| 55584 | USTEKINUMAB-AEKN 90 MG/ML SYR |
| 44882 | XELJANZ 10 MG TABLET |
| 33617 | XELJANZ 5 MG TABLET |
| 56599 | YESINTEK 45 MG/0.5 ML SYRINGE |
| 56607 | YESINTEK 45 MG/0.5 ML VIAL |
| 56603 | YESINTEK 90 MG/ML SYRINGE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 49 Epinephrine, Self-Injected

# Epinephrine, Self-Injected Prior Authorization Criteria

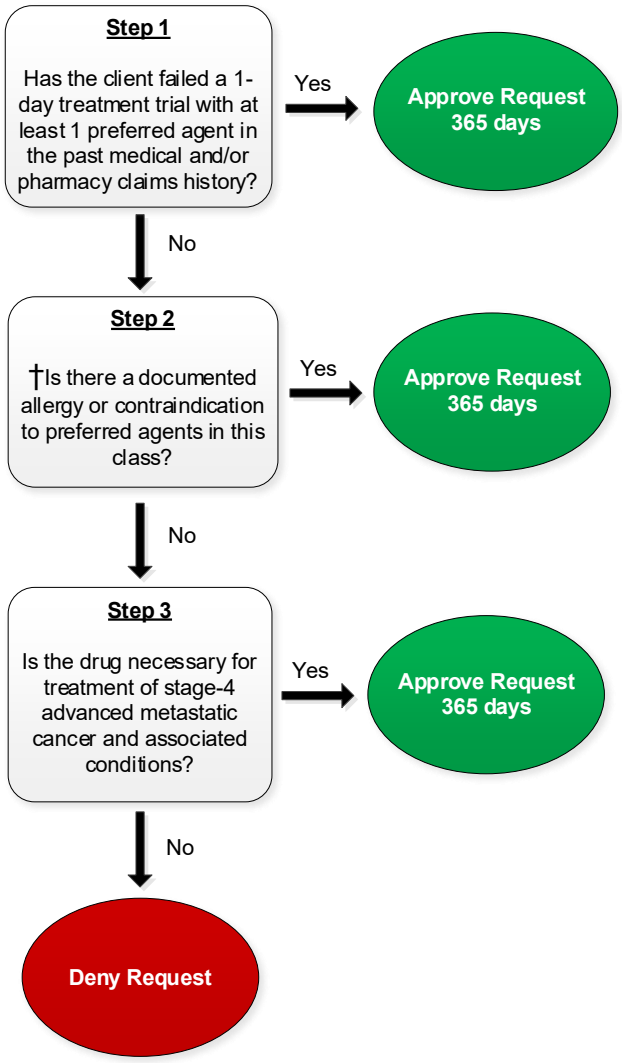
1. Has the client failed a 1-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Epinephrine, Self-Injected Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Epinephrine, Self-Injected Alternate Therapies

## Preferred Self-Injected Epinephrine Agents

| GCN | Drug Name |
|---|---|
| 44487 | AUVI-Q 0.1 MG AUTO-INJECTOR |
| 28038 | AUVI-Q 0.15 MG AUTO-INJECTOR |
| 19862 | AUVI-Q 0.3 MG AUTO-INJECTOR |
| 19861 | EPINEPHRINE 0.15 MG AUTO-INJCT |
| 19861 | EPIPEN JR 2-PAK 0.15 MG INJCTR |
| 19862 | EPINEPHRINE 0.3MG AUTO-INJECT |
| 19862 | EPIPEN 2-PAK 0.3 MG AUTO-INJCT |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 50 Erythropoiesis Stimulating Proteins

# Erythropoiesis Stimulating Proteins
# Prior Authorization Criteria

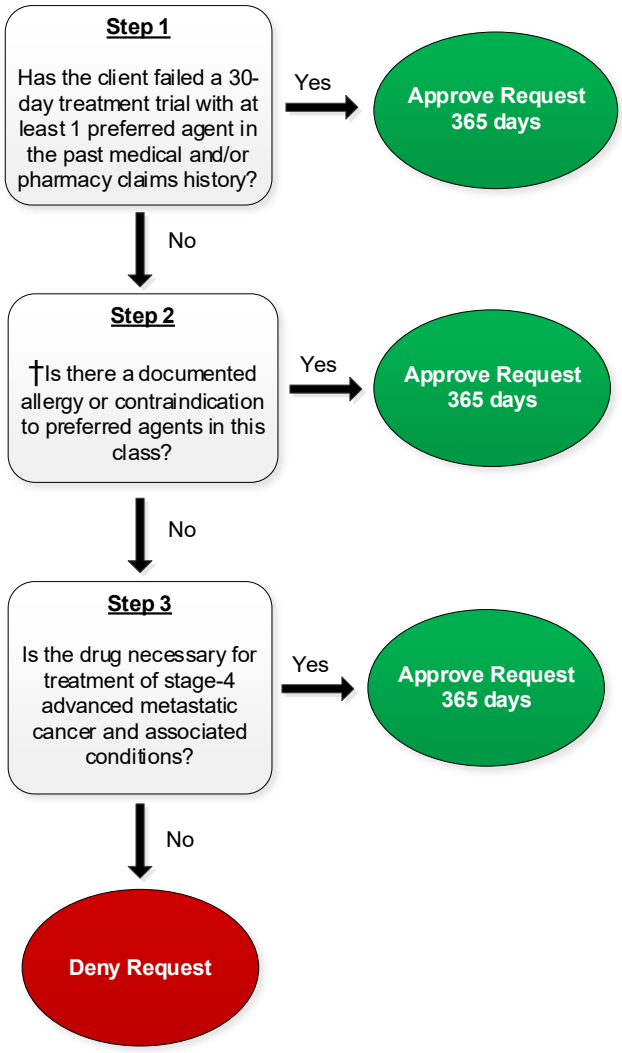
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Erythropoiesis Stimulating Proteins
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Erythropoiesis Stimulating Proteins
# Alternate Therapies

## Preferred Erythropoiesis Stimulating Proteins

| GCN | Drug Name |
|---|---|
| 14877 | ARANESP 10 MCG/0.4 ML SYRINGE |
| 14894 | ARANESP 100 MCG/0.5 ML SYRINGE |
| 14055 | ARANESP 100 MCG/ML VIAL |
| 15202 | ARANESP 150 MCG/0.3 ML SYRINGE |
| 97063 | ARANESP 200 MCG/0.4 ML SYRINGE |
| 14056 | ARANESP 200 MCG/ML VIAL |
| 97064 | ARANESP 25 MCG/0.42 ML SYRING |
| 14049 | ARANESP 25 MCG/ML VIAL |
| 97065 | ARANESP 300 MCG/0.6 ML SYRINGE |
| 14891 | ARANESP 40 MCG/0.4 ML SYRINGE |
| 14053 | ARANESP 40 MCG/ML VIAL |
| 27164 | ARANESP 500 MCG/1 ML SYRINGE |
| 14893 | ARANESP 60 MCG/0.3 ML SYRINGE |
| 14054 | ARANESP 60 MCG/ML VIAL |
| 25112 | EPOGEN 10,000 UNITS/ML VIAL |
| 25110 | EPOGEN 2,000 UNITS/ML VIAL |
| 24059 | EPOGEN 20,000 UNITS/2 ML VIAL |
| 25114 | EPOGEN 20,000 UNITS/ML VIAL |
| 25113 | EPOGEN 3,000 UNITS/ML VIAL |
| 25111 | EPOGEN 4,000 UNITS/ML VIAL |
| 44767 | RETACRIT 10,000 UNIT/ML VIAL |

| GCN | Drug Name |
|---|---|
| 44764 | RETACRIT 2,000 UNIT/ML VIAL |
| 48885 | RETACRIT 20,000 UNIT/2 ML VIAL |
| 48911 | RETACRIT 20,000 UNIT/ML VIAL |
| 44765 | RETACRIT 3,000 UNIT/ML VIAL |
| 44766 | RETACRIT 4,000 UNIT/ML VIAL |
| 44768 | RETACRIT 40,000 UNIT/ML VIAL |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 51 Fluoroquinolones, Oral

# Fluoroquinolones, Oral
# Prior Authorization Criteria

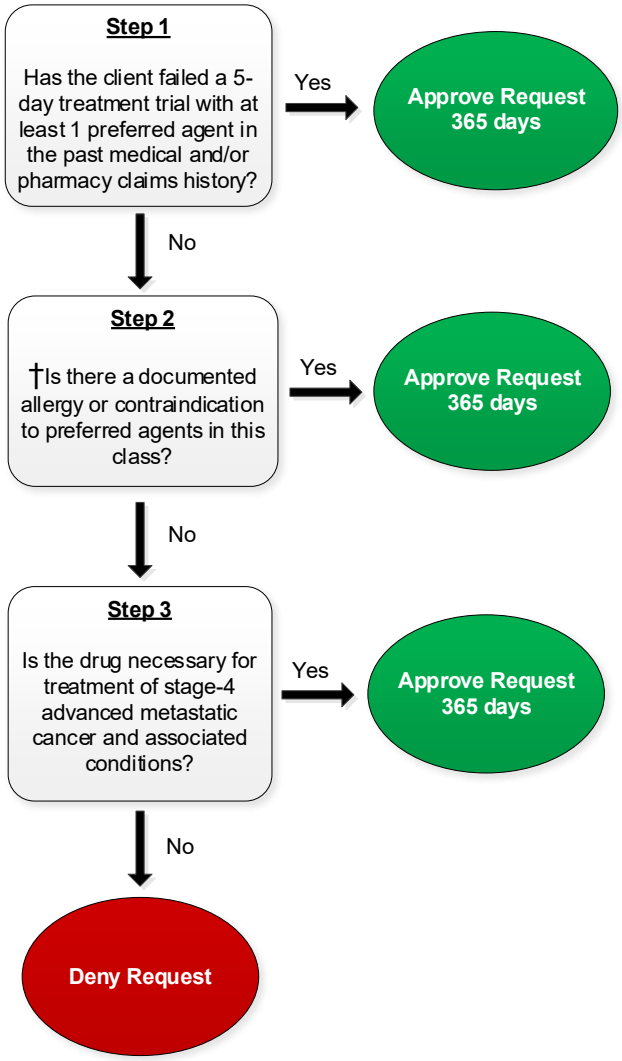
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Fluoroquinolones, Oral
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Fluoroquinolones, Oral
# Alternate Therapies

## Preferred Oral Fluoroquinolones

| GCN | Drug Name |
|---|---|
| 47057 | CIPRO 10% SUSPENSION |
| 47056 | CIPRO 5% SUSPENSION |
| 47053 | CIPROFLOXACIN HCL 100 MG TAB |
| 47050 | CIPROFLOXACIN HCL 250 MG TAB |
| 47051 | CIPROFLOXACIN HCL 500 MG TAB |
| 47052 | CIPROFLOXACIN HCL 750 MG TAB |
| 47073 | LEVOFLOXACIN 250 MG TABLET |
| 47074 | LEVOFLOXACIN 500 MG TABLET |
| 89597 | LEVOFLOXACIN 750 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 52 GI Motility, Chronic

# GI Motility, Chronic
# Prior Authorization Criteria

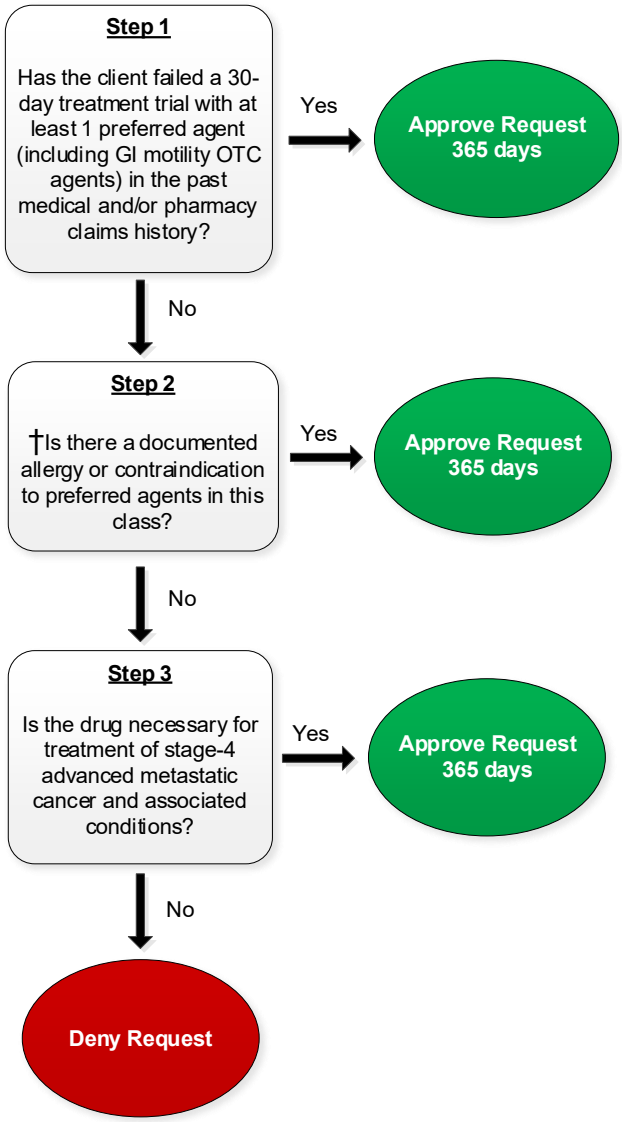
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent (including GI motility OTC agents) in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# GI Motility, Chronic
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# GI Motility, Chronic Alternate Therapies

## Preferred GI Motility, Chronic

| GCN | Drug Name |
|---|---|
| 33187 | LINZESS 145 MCG CAPSULE |
| 33188 | LINZESS 290 MCG CAPSULE |
| 42975 | LINZESS 72 MCG CAPSULE |
| 21422 | LOTRONEX 0.5 MG TABLET |
| 41607 | LOTRONEX 1 MG TABLET |
| 26473 | LUBIPROSTONE 24 MCG CAPSULE |
| 99658 | LUBIPROSTONE 8 MCG CAPSULE |
| 37725 | MOVANTIK 12.5 MG TABLET |
| 37726 | MOVANTIK 25 MG TABLET |
| 42925 | TRULANCE 3 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 53 Glucagon Agents

# Glucagon Agents
# Prior Authorization Criteria

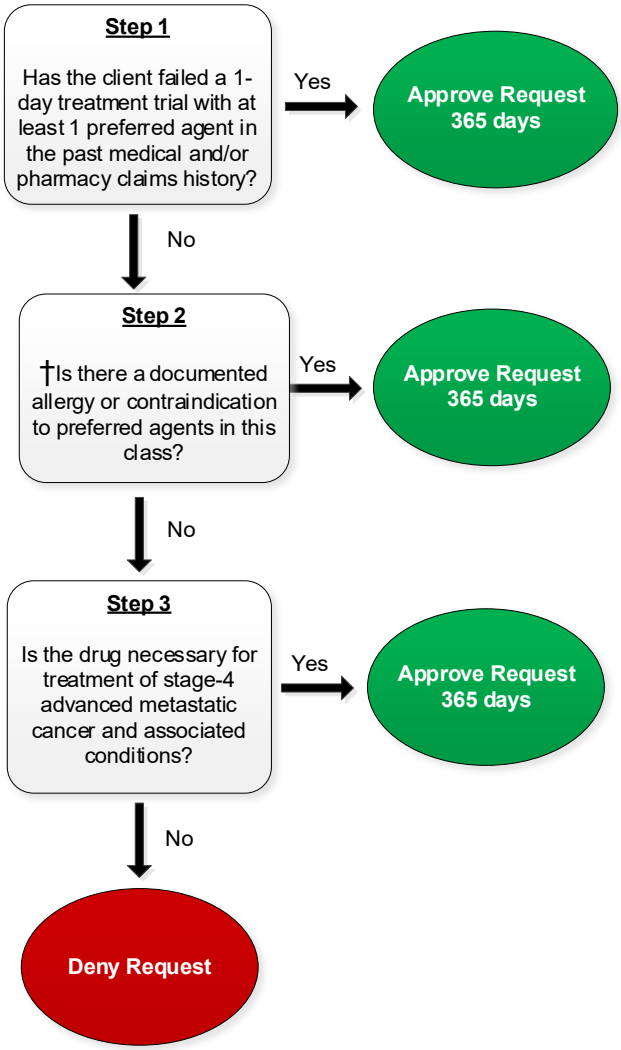
1. Has the client failed a 1-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Glucagon Agents
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Glucagon Agents
# Alternate Therapies

## Preferred Glucagon Agents

| GCN | Drug Name |
|---|---|
| 46726 | BAQSIMI 3 MG SPRAY |
| 46726 | BAQSIMI 3 MG SPRAY ONE PACK |
| 46726 | BAQSIMI 3 MG SPRAY TWO PACK |
| 25473 | GLUCAGON 1 MG EMERGENCY KIT |
| 25473 | GLUCAGON 1 MG VIAL |
| 51424 | GVOKE 1 MG/0.2 ML KIT |
| 51424 | GVOKE 1 MG/0.2 ML VIAL |
| 46907 | GVOKE HYPOPEN 1PK 0.5MG/0.1 ML |
| 46908 | GVOKE HYPOPEN 1-PK 1 MG/0.2 ML |
| 46907 | GVOKE HYPOPEN 2PK 0.5MG/0.1 ML |
| 46908 | GVOKE HYPOPEN 2-PK 1 MG/0.2 ML |
| 46905 | GVOKE PFS 1-PK 1 MG/0.2 ML SYR |
| 46905 | GVOKE PFS 2-PK 1 MG/0.2 ML SYR |
| 01280 | PROGLYCEM 50 MG/ML ORAL SUSP |
| 49402 | ZEGALOGUE 0.6 MG/0.6 ML SYRING |
| 49403 | ZEGALOGUE 0.6 MG/0.6ML AUTOINJ |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 54 Glucocorticoids, Inhaled

# Glucocorticoids, Inhaled
# Prior Authorization Criteria

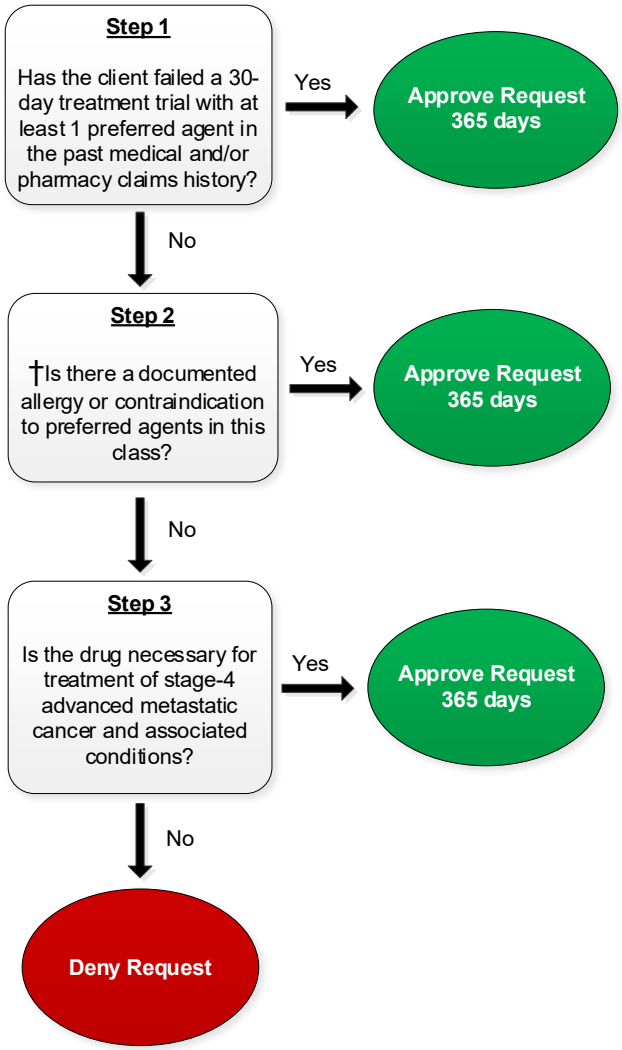
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Glucocorticoids, Inhaled
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Glucocorticoids, Inhaled Alternate Therapies

## Preferred Inhaled Glucocorticoids

| GCN | Drug Name |
|---|---|
| 50584 | ADVAIR 100-50 DISKUS |
| 50594 | ADVAIR 250-50 DISKUS |
| 50604 | ADVAIR 500-50 DISKUS |
| 97136 | ADVAIR HFA 115-21 MCG INHALER |
| 97137 | ADVAIR HFA 230-21 MCG INHALER |
| 97135 | ADVAIR HFA 45-21 MCG INHALER |
| 42957 | AIRDUO RESPICLICK 113-14 MCG |
| 42958 | AIRDUO RESPICLICK 232-14 MCG |
| 42956 | AIRDUO RESPICLICK 55-14 MCG |
| 53534 | AIRSUPRA 90-80 MCG INHALER |
| 37007 | ARNUITY ELLIPTA 100 MCG INH |
| 37008 | ARNUITY ELLIPTA 200 MCG INH |
| 44783 | ARNUITY ELLIPTA 50 MCG INH |
| 37566 | ASMANEX HFA 100 MCG INHALER |
| 37565 | ASMANEX HFA 200 MCG INHALER |
| 47599 | ASMANEX HFA 50 MCG INHALER |
| 99721 | ASMANEX TWISTHALER 110 MCG #30 |
| 24927 | ASMANEX TWISTHALER 220 MCG #14 |
| 24928 | ASMANEX TWISTHALER 220 MCG #30 |
| 24929 | ASMANEX TWISTHALER 220 MCG #60 |
| 18987 | ASMANEX TWISTHALR 220 MCG #120 |

| GCN | Drug Name |
|---|---|
| 17957 | BUDESONIDE 0.25 MG/2 ML SUSP |
| 17958 | BUDESONIDE 0.5 MG/2 ML SUSP |
| 62980 | BUDESONIDE 1 MG/2 ML INH SUSP |
| 28766 | DULERA 100 MCG-5 MCG INHALER |
| 28767 | DULERA 200 MCG-5 MCG INHALER |
| 30139 | DULERA 50 MCG-5 MCG INHALER |
| 98025 | PULMICORT 180 MCG FLEXHALER |
| 98024 | PULMICORT 90 MCG FLEXHALER |
| 43724 | QVAR REDIHALER 40 MCG |
| 43725 | QVAR REDIHALER 80 MCG |
| 98500 | SYMBICORT 160-4.5 MCG INHALER |
| 98499 | SYMBICORT 80-4.5 MCG INHALER |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 55 Glucocorticoids, Oral

# Glucocorticoids, Oral
# Prior Authorization Criteria

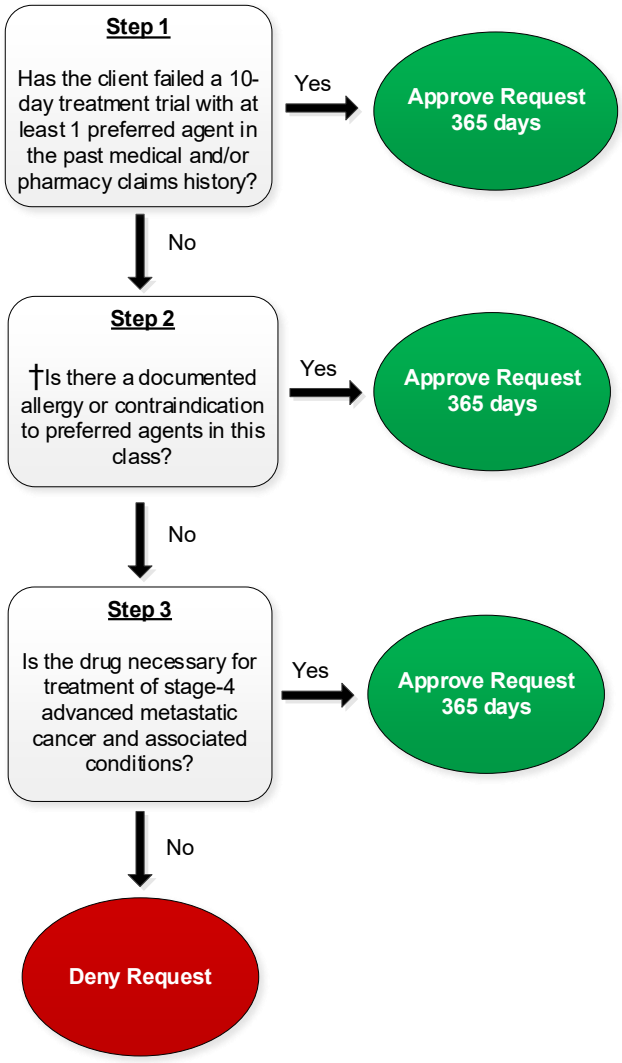
1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Glucocorticoids, Oral
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Glucocorticoids, Oral
# Alternate Therapies

## Preferred Oral Glucocorticoids

| GCN | Drug Name |
|---|---|
| 28680 | BUDESONIDE DR 3 MG CAPSULE |
| 27422 | DEXAMETHASONE 0.5 MG TABLET |
| 27400 | DEXAMETHASONE 0.5 MG/5 ML ELX |
| 27411 | DEXAMETHASONE 0.5 MG/5 ML LIQ |
| 27425 | DEXAMETHASONE 0.75 MG TABLET |
| 27424 | DEXAMETHASONE 1 MG TABLET |
| 27427 | DEXAMETHASONE 1.5 MG TABLET |
| 27426 | DEXAMETHASONE 2 MG TABLET |
| 27428 | DEXAMETHASONE 4 MG TABLET |
| 27429 | DEXAMETHASONE 6 MG TABLET |
| 26781 | HYDROCORTISONE 10 MG TABLET |
| 26782 | HYDROCORTISONE 20 MG TABLET |
| 26783 | HYDROCORTISONE 5 MG TABLET |
| 37499 | METHYLPRED DP 4 MG DOSEPAK |
| 26800 | PREDNISOLONE 15 MG/5 ML SOLN |
| 33806 | PREDNISOLONE 15 MG/5 ML SOLN |
| 33348 | PREDNISOLONE 15MG/5ML SOLN CUP |
| 09115 | PREDNISOLONE 5 MG/5 ML SOLN |
| 93945 | PREDNISOLONE SOD PH 25 MG/5 ML |
| 27171 | PREDNISONE 1 MG TABLET |
| 27172 | PREDNISONE 10 MG TABLET |

| GCN | Drug Name |
|---|---|
| 27173 | PREDNISONE 2.5 MG TABLET |
| 27174 | PREDNISONE 20 MG TABLET |
| 27176 | PREDNISONE 5 MG TABLET |
| 27160 | PREDNISONE 5 MG/5 ML SOLN CUP |
| 27177 | PREDNISONE 50 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 56 Growth Hormone

# Growth Hormone
# Prior Authorization Criteria

1. Has the client been stable on 1 non-preferred agent for 30 days in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

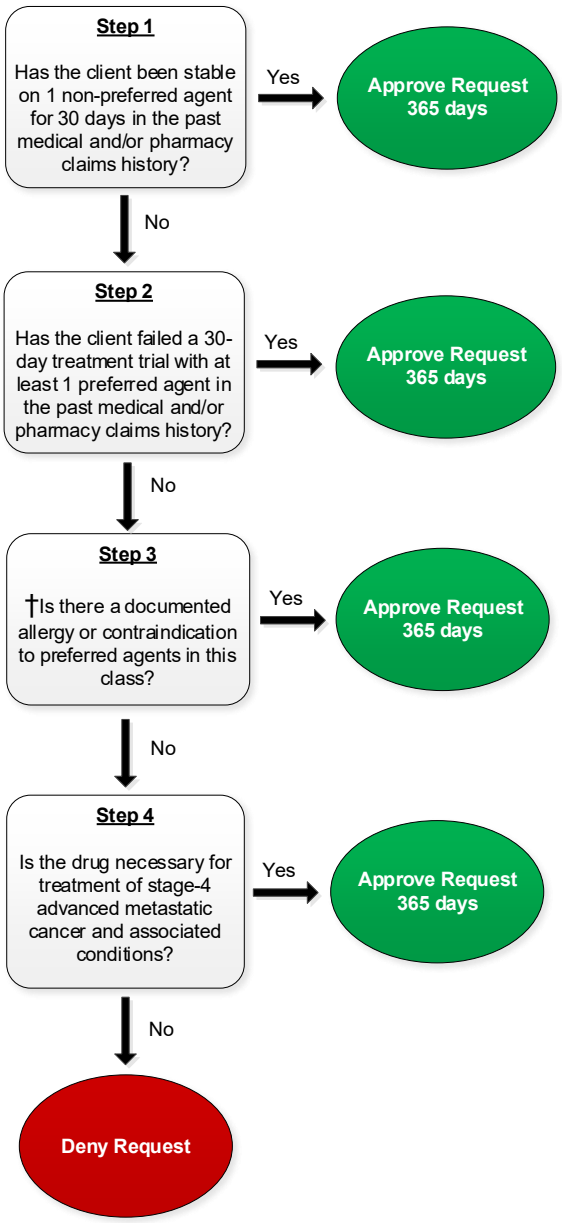
2. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #4)

4. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Growth Hormone
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Growth Hormone Alternate Therapies

## Preferred Growth Hormones

| GCN | Drug Name |
|---|---|
| 10554 | GENOTROPIN 12 MG CARTRIDGE |
| 63408 | GENOTROPIN 5 MG CARTRIDGE |
| 50177 | GENOTROPIN MINIQUICK 0.2 MG |
| 50187 | GENOTROPIN MINIQUICK 0.4 MG |
| 50197 | GENOTROPIN MINIQUICK 0.6 MG |
| 50207 | GENOTROPIN MINIQUICK 0.8 MG |
| 50217 | GENOTROPIN MINIQUICK 1 MG |
| 21450 | GENOTROPIN MINIQUICK 1.2 MG |
| 21451 | GENOTROPIN MINIQUICK 1.4 MG |
| 21452 | GENOTROPIN MINIQUICK 1.6 MG |
| 21453 | GENOTROPIN MINIQUICK 1.8 MG |
| 21454 | GENOTROPIN MINIQUICK 2 MG |
| 24146 | NORDITROPIN FLEXPRO 10 MG/1.5 |
| 24147 | NORDITROPIN FLEXPRO 15 MG/1.5 |
| 25816 | NORDITROPIN FLEXPRO 30 MG/3 ML |
| 24145 | NORDITROPIN FLEXPRO 5 MG/1.5 |
| 50235 | SKYTROFA 11 MG CARTRIDGE |
| 50245 | SKYTROFA 13.3 MG CARTRIDGE |
| 50164 | SKYTROFA 3 MG CARTRIDGE |
| 50174 | SKYTROFA 3.6 MG CARTRIDGE |
| 50184 | SKYTROFA 4.3 MG CARTRIDGE |

| GCN | Drug Name |
|---|---|
| 50194 | SKYTROFA 5.2 MG CARTRIDGE |
| 50204 | SKYTROFA 6.3 MG CARTRIDGE |
| 50215 | SKYTROFA 7.6 MG CARTRIDGE |
| 50225 | SKYTROFA 9.1 MG CARTRIDGE |
| 48603 | SOGROYA 10 MG/1.5 ML PEN |
| 54124 | SOGROYA 15 MG/1.5 ML PEN |
| 52946 | SOGROYA 5 MG/1.5 ML PEN |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 57 H. Pylori Treatment

# H. Pylori Treatment
# Prior Authorization Criteria

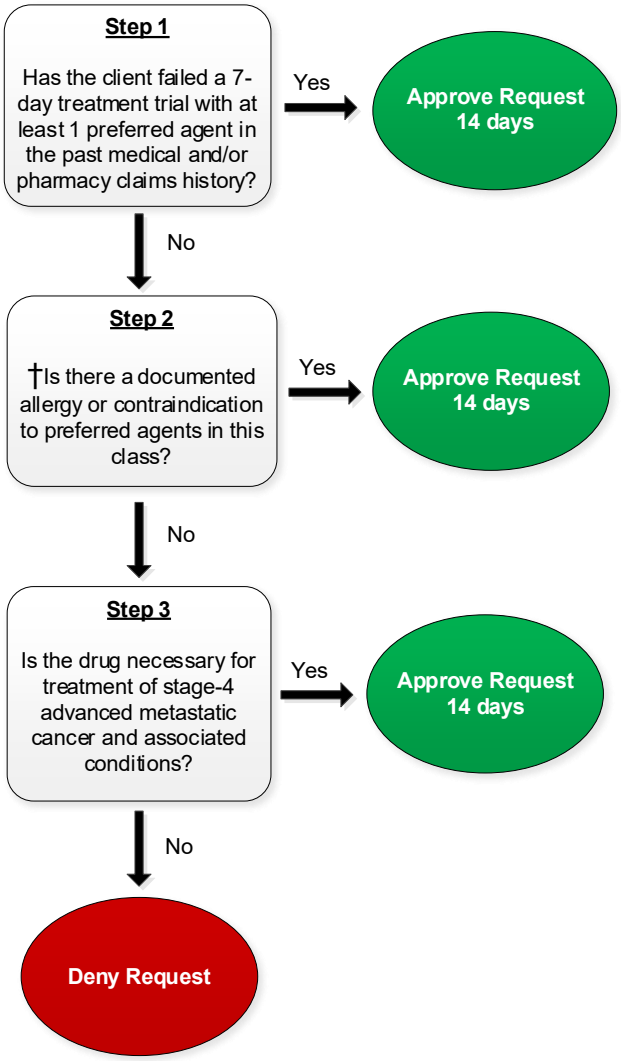
1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 14 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 14 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 14 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# H. Pylori Treatment
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# H. Pylori Treatment Alternate Therapies

## Preferred H. Pylori Treatment

| GCN | Drug Name |
|---|---|
| 98238 | PYLERA CAPSULE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 58 Hemophilia Treatment

# Hemophilia Treatment Alternate Therapies

All products in this class are preferred and have no PDL prior authorization criteria.
To verify formulary coverage for any drugs listed on PDL, search the Medicaid formulary.

# 59 Hepatitis C Agents

# Hepatitis C Agents
# Prior Authorization Criteria

1. Has the client been stable on a non-preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 60 days)
   [ ] No (Go to #2)

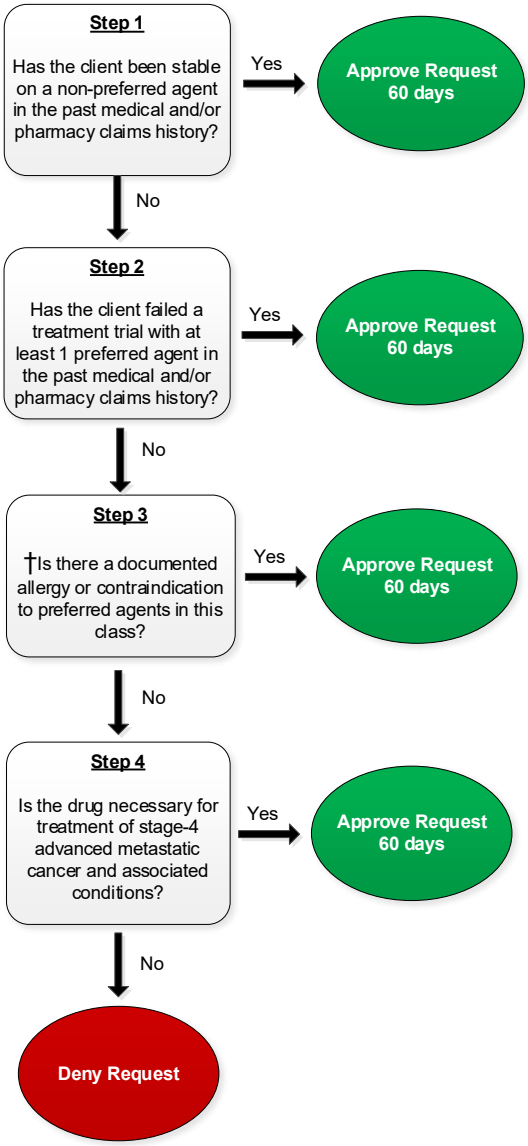
2. Has the client failed a 30-day treatment trial with at least a preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 60 days)
   [ ] No (Go to #3)

3. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 60 days)
   [ ] No (Go to #4)

4. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 60 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hepatitis C Agents
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hepatitis C Agents
# Alternate Therapies

## Preferred Hepatitis C Agents

| GCN | Drug Name |
|---|---|
| 43699 | MAVYRET 100-40 MG TABLET |
| 49863 | MAVYRET 50-20 MG PELLET PACKET |
| 14179 | RIBAVIRIN 200 MG CAPSULE |
| 18969 | RIBAVIRIN 200 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 60 Hereditary Angioedema Agents

# Hereditary Angioedema Agents
# Prior Authorization Criteria

1. Has the client been stable on a non-preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

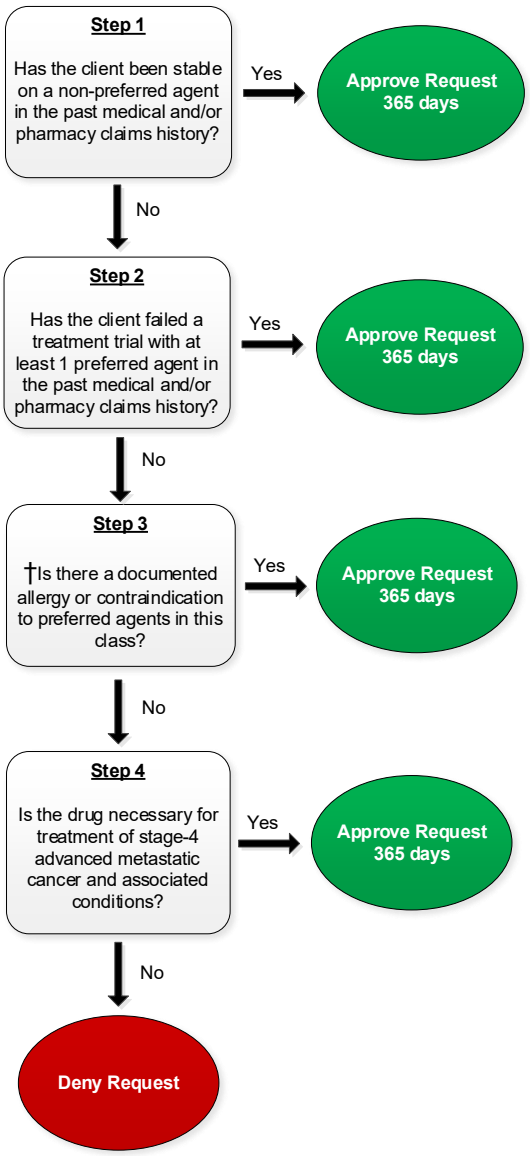
2. Has the client failed a treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #4)

4. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hereditary Angioedema Agents
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hereditary Angioedema Agents
# Alternate Therapies

## Preferred Hereditary Angioedema Agents

| GCN | Drug Name |
|---|---|
| 31159 | BERINERT 500 UNIT KIT |
| 32074 | BERINERT 500 UNIT VIAL |
| 10495 | CINRYZE 500 UNIT VIAL |
| 39478 | HAEGARDA 2,000 UNIT VIAL |
| 43356 | HAEGARDA 3,000 UNIT VIAL |
| 14778 | ICATIBANT 30 MG/3 ML SYRINGE |
| 28088 | KALBITOR 10 MG/ML VIAL |
| 14778 | SAJAZIR 30MG/3ML SYRINGE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 61 HIV/AIDS

# HIV/AIDS
# Alternate Therapies

All products in this class are preferred and have no PDL prior authorization criteria.
To verify formulary coverage for any drugs listed on PDL, search the Medicaid formulary.

# 62 Hypoglycemics, Incretin Mimetics/Enhancers

# Hypoglycemics, Incretin Mimetics/Enhancers Prior Authorization Criteria

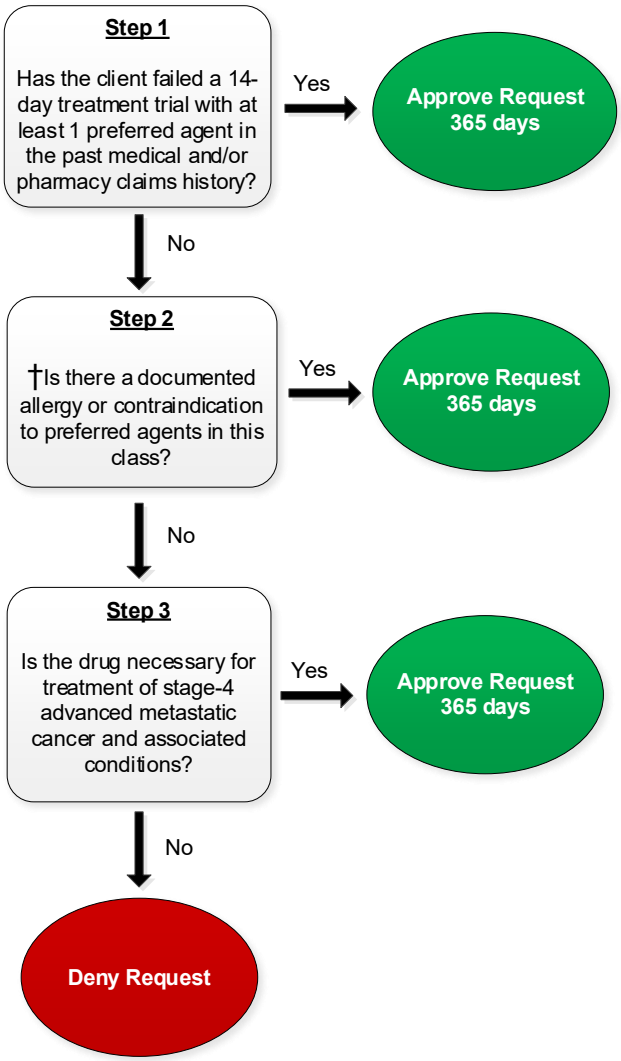
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hypoglycemics, Incretin Mimetics/Enhancers Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hypoglycemics, Incretin Mimetics/Enhancers Alternate Therapies

## Preferred Incretin Mimetics/Enhancer Therapies

| GCN | Drug Name |
|---|---|
| 24614 | BYETTA 10 MCG DOSE PEN INJ |
| 24613 | BYETTA 5 MCG DOSE PEN INJ |
| 37832 | GLYXAMBI 10 MG-5 MG TABLET |
| 37833 | GLYXAMBI 25 MG-5 MG TABLET |
| 98307 | JANUMET 50-1,000 MG TABLET |
| 98306 | JANUMET 50-500 MG TABLET |
| 31348 | JANUMET XR 100-1,000 MG TABLET |
| 31340 | JANUMET XR 50-1,000 MG TABLET |
| 31339 | JANUMET XR 50-500 MG TABLET |
| 97400 | JANUVIA 100 MG TABLET |
| 97398 | JANUVIA 25 MG TABLET |
| 97399 | JANUVIA 50 MG TABLET |
| 31317 | JENTADUETO 2.5 MG-1000 MG TAB |
| 31315 | JENTADUETO 2.5 MG-500 MG TAB |
| 31316 | JENTADUETO 2.5 MG-850 MG TAB |
| 41637 | JENTADUETO XR 2.5 MG-1,000 MG |
| 41639 | JENTADUETO XR 5 MG-1,000 MG TB |
| 29225 | KOMBIGLYZE XR 2.5-1,000 MG TAB |
| 29224 | KOMBIGLYZE XR 5-1,000 MG TAB |
| 29118 | KOMBIGLYZE XR 5-500 MG TABLET |
| 27393 | ONGLYZA 2.5 MG TABLET |

| GCN | Drug Name |
|---|---|
| 27394 | ONGLYZA 5 MG TABLET |
| 44163 | OZEMPIC 0.25-0.5 MG/DOSE PEN |
| 53536 | OZEMPIC 0.25-0.5 MG/DOSE PEN |
| 48208 | OZEMPIC 1 MG/DOSE (4 MG/3 ML) |
| 52125 | OZEMPIC 2 MG/DOSE (8 MG/3 ML) |
| 99450 | SYMLINPEN 120 PEN INJECTOR |
| 99514 | SYMLINPEN 60 PEN INJECTOR |
| 29890 | TRADJENTA 5 MG TABLET |
| 47672 | TRIJARDY XR 10-5-1,000 MG TAB |
| 47671 | TRIJARDY XR 12.5-2.5-1,000 MG |
| 47673 | TRIJARDY XR 25-5-1,000 MG TAB |
| 47669 | TRIJARDY XR 5-2.5-1,000 MG TAB |
| 37169 | TRULICITY 0.75 MG/0.5 ML PEN |
| 37171 | TRULICITY 1.5 MG/0.5 ML PEN |
| 48574 | TRULICITY 3 MG/0.5 ML PEN |
| 48573 | TRULICITY 4.5 MG/0.5 ML PEN |
| 26189 | VICTOZA 18 MG/3 ML PEN |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 63 Hypoglycemics, Insulin

# Hypoglycemics, Insulin
# Prior Authorization Criteria

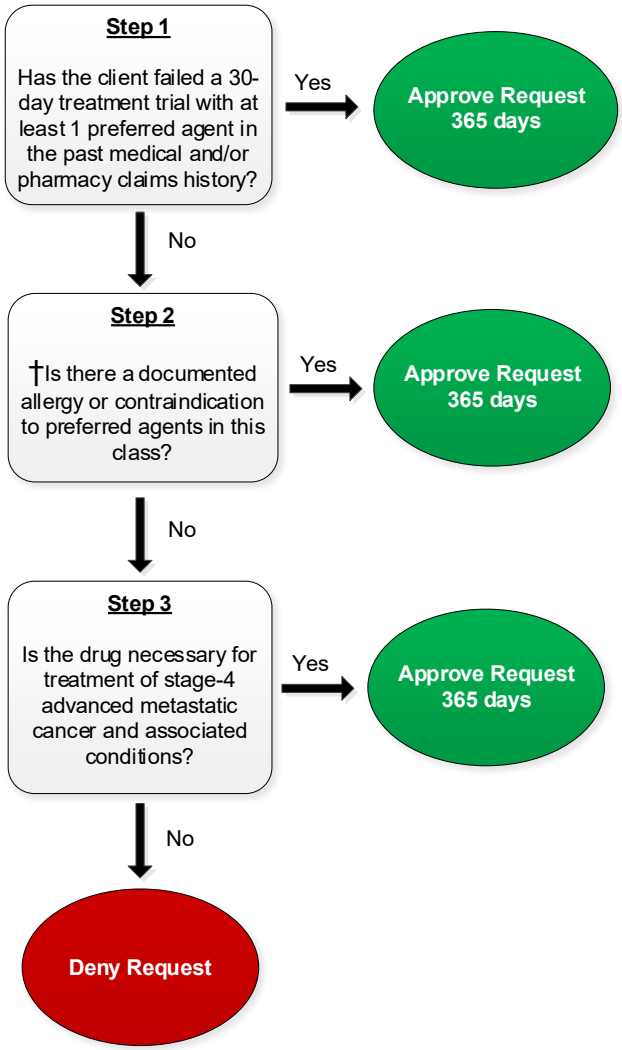
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hypoglycemics, Insulin
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hypoglycemics, Insulin Alternate Therapies

## Preferred Hypoglycemics, Insulin

| GCN | Drug Name |
|---|---|
| 43053 | FIASP 100 UNIT/ML FLEXTOUCH |
| 43054 | FIASP 100 UNIT/ML VIAL |
| 43049 | FIASP PENFILL 100 UNIT/ML CART |
| 54585 | FIASP PUMPCART 100 UNIT/ML |
| 05678 | HUMALOG 100 UNIT/ML CARTRIDGE |
| 05679 | HUMALOG 100 UNIT/ML VIAL |
| 43753 | HUMALOG JR 100 UNIT/ML KWIKPEN |
| 50461 | HUMALOG MIX 50-50 KWIKPEN |
| 93717 | HUMALOG MIX 75-25 KWIKPEN |
| 22681 | HUMALOG MIX 75-25 VIAL |
| 54975 | HUMALOG TEMPO PEN 100 UNIT/ML |
| 24486 | HUMULIN 70/30 KWIKPEN |
| 50001 | HUMULIN 70-30 VIAL |
| 11660 | HUMULIN N 100 UNIT/ML VIAL |
| 11642 | HUMULIN R 100 UNIT/ML VIAL |
| 40542 | HUMULIN R 500 UNIT/ML KWIKPEN |
| 09633 | HUMULIN R 500 UNIT/ML VIAL |
| 92886 | INSULIN ASPART 100 UNIT/ML CRT |
| 92336 | INSULIN ASPART 100 UNIT/ML PEN |
| 92326 | INSULIN ASPART 100 UNIT/ML VL |
| 17075 | INSULIN ASPART PRO MIX70-30 PN |
| 19057 | INSULIN ASPART PRO MIX70-30 VL |

| GCN | Drug Name |
|---|---|
| 96719 | INSULIN LISPRO 100UNITS/ML PEN |
| 13072 | LANTUS 100 UNIT/ML VIAL |
| 98637 | LANTUS SOLOSTAR 100 UNIT/ML |
| 18488 | NOVOLIN N 100 UNIT/ML FLEXPEN |
| 44561 | TOUJEO MAX SOLOSTR 300 UNIT/ML |
| 37988 | TOUJEO SOLOSTAR 300 UNIT/ML |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 64 Hypoglycemics, Meglitinides

# Hypoglycemics, Meglitinides
# Prior Authorization Criteria

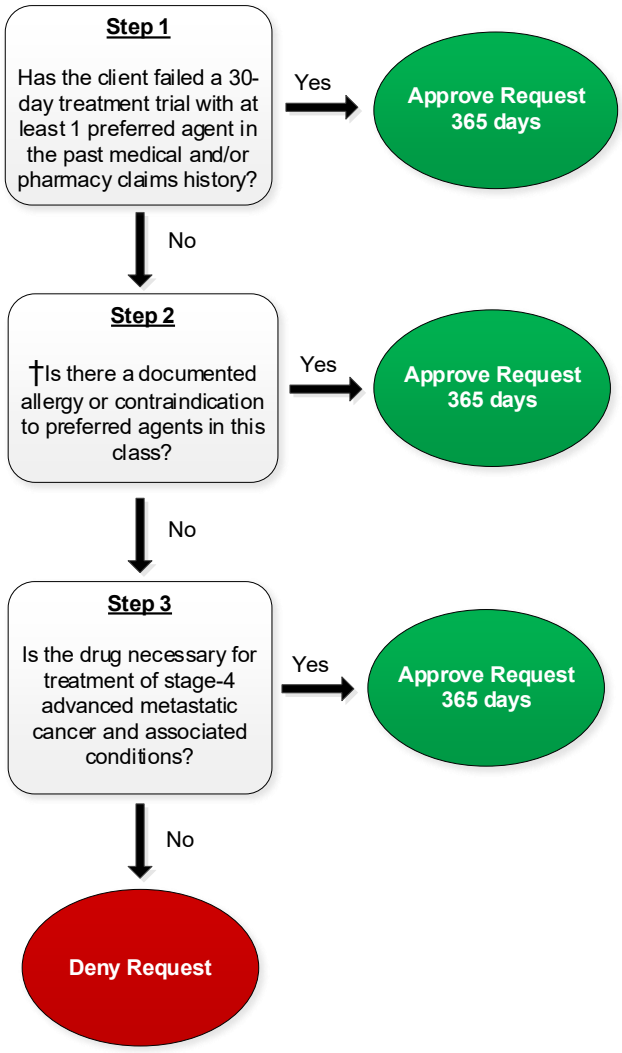
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hypoglycemics, Meglitinides Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hypoglycemics, Meglitinides Alternate Therapies

## Preferred Hypoglycemics, Meglitinides

| GCN | Drug Name |
|---|---|
| 34027 | NATEGLINIDE 120 MG TABLET |
| 12277 | NATEGLINIDE 60 MG TABLET |
| 26311 | REPAGLINIDE 0.5 MG TABLET |
| 26312 | REPAGLINIDE 1 MG TABLET |
| 26313 | REPAGLINIDE 2 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

*** Separate prescriptions for the individual components of combination agents should be used instead of the combination product.*

# 65 Hypoglycemics, Metformin

# Hypoglycemics, Metformin
# Prior Authorization Criteria

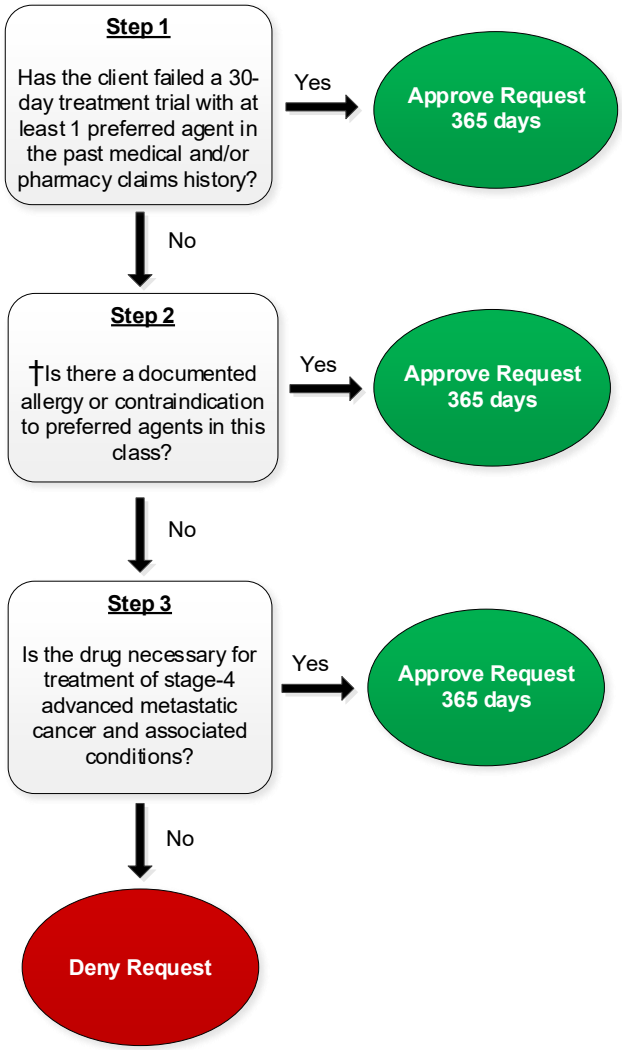
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hypoglycemics, Metformin Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hypoglycemics, Metformin Alternate Therapies

## Preferred Hypoglycemics, Metformin

| GCN | Drug Name |
|---|---|
| 97067 | GLUMETZA ER 1,000 MG TABLET |
| 97061 | GLUMETZA ER 500 MG TABLET |
| 92889 | GLYBURIDE-METFORMIN 2.5-500 MG |
| 89879 | GLYBURIDE-METFORMIN 5-500 MG |
| 89878 | GLYBURID-METFORMIN 1.25-250 MG |
| 10857 | METFORMIN HCL 1,000 MG TABLET |
| 10810 | METFORMIN HCL 500 MG TABLET |
| 10811 | METFORMIN HCL 850 MG TABLET |
| 89863 | METFORMIN HCL ER 500 MG TABLET |
| 19578 | METFORMIN HCL ER 750 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

*** Separate prescriptions for the individual components of combination agents should be used instead of the combination product.*

# 66 Hypoglycemics, SGLT2 Inhibitors

# Hypoglycemics, SGLT2 Inhibitors Prior Authorization Criteria

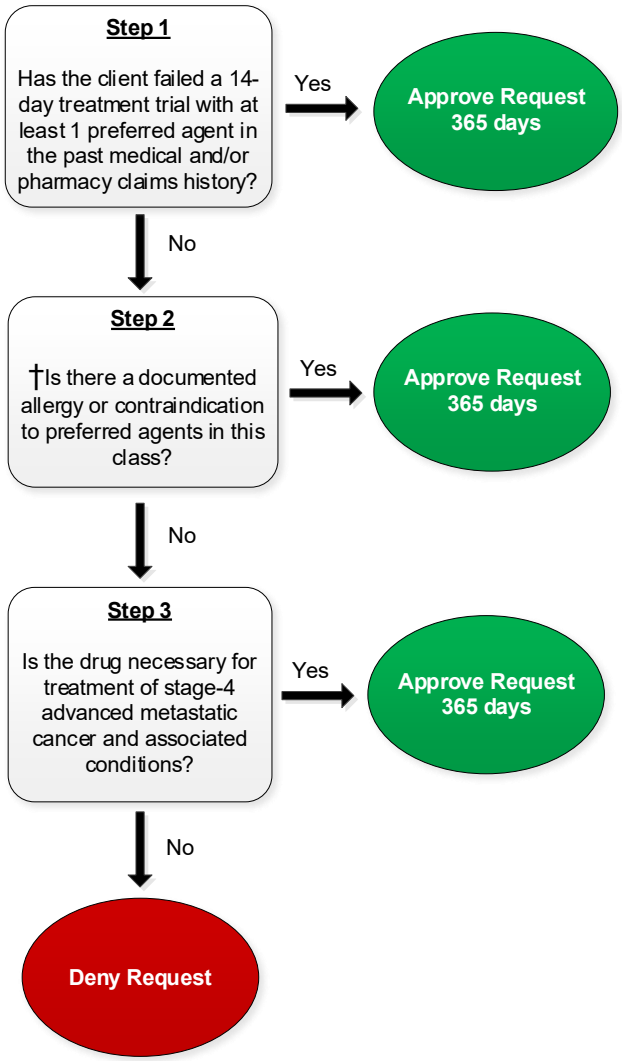
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hypoglycemics, SGLT2 Inhibitors Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hypoglycemics, SGLT2 Inhibitors Alternate Therapies

## Preferred Hypoglycemics, SGLT2 Inhibitors

| GCN | Drug Name |
|---|---|
| 34394 | FARXIGA 10 MG TABLET |
| 35698 | FARXIGA 5 MG TABLET |
| 36716 | JARDIANCE 10 MG TABLET |
| 36723 | JARDIANCE 25 MG TABLET |
| 38932 | SYNJARDY 12.5-1,000 MG TABLET |
| 39378 | SYNJARDY 12.5-500 MG TABLET |
| 38929 | SYNJARDY 5-1,000 MG TABLET |
| 39377 | SYNJARDY 5-500 MG TABLET |
| 42788 | SYNJARDY XR 10-1,000 MG TABLET |
| 42787 | SYNJARDY XR 12.5-1,000 MG TAB |
| 42789 | SYNJARDY XR 25-1,000 MG TABLET |
| 42786 | SYNJARDY XR 5-1,000 MG TABLET |
| 37344 | XIGDUO XR 10 MG-1,000 MG TAB |
| 37342 | XIGDUO XR 10 MG-500 MG TABLET |
| 44304 | XIGDUO XR 2.5 MG-1,000 MG TAB |
| 37343 | XIGDUO XR 5 MG-1,000 MG TABLET |
| 37339 | XIGDUO XR 5 MG-500 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 67 Hypoglycemics, TZD

# Hypoglycemics, TZD
# Prior Authorization Criteria

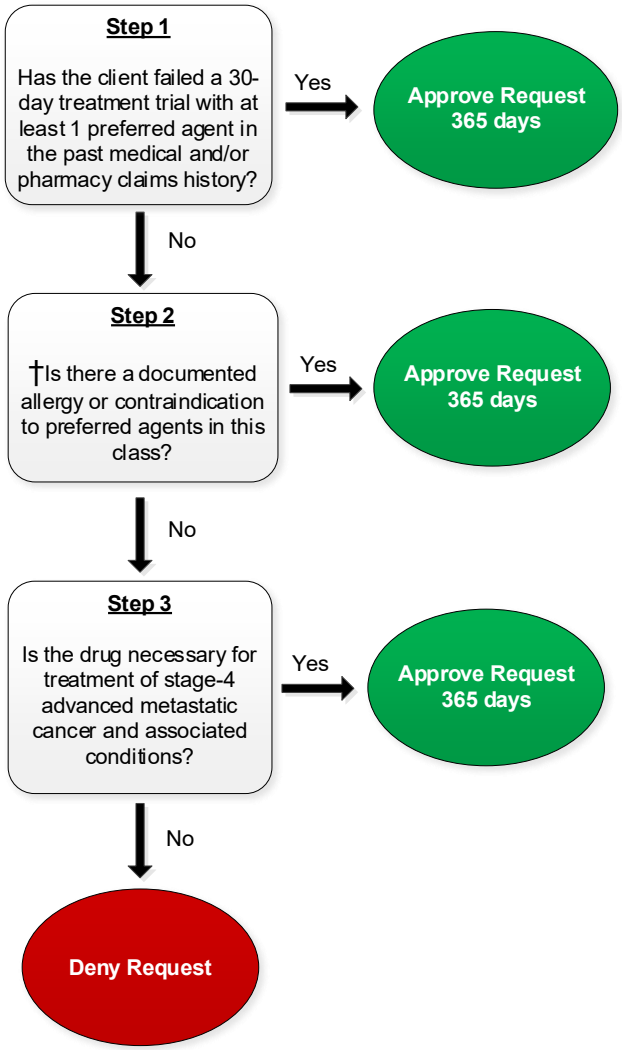
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hypoglycemics, TZD
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Hypoglycemics, TZD Alternate Therapies

## Preferred Hypoglycemics, TZD

| GCN | Drug Name |
|---|---|
| 97181 | DUETACT 30-2 MG TABLET |
| 97180 | DUETACT 30-4 MG TABLET |
| 92991 | PIOGLITAZONE HCL 15 MG TABLET |
| 93001 | PIOGLITAZONE HCL 30 MG TABLET |
| 93011 | PIOGLITAZONE HCL 45 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

*** Separate prescriptions for the individual components should be used instead of the combination drugs.*

# 68 Immune Globulins

# Immune Globulins
# Prior Authorization Criteria

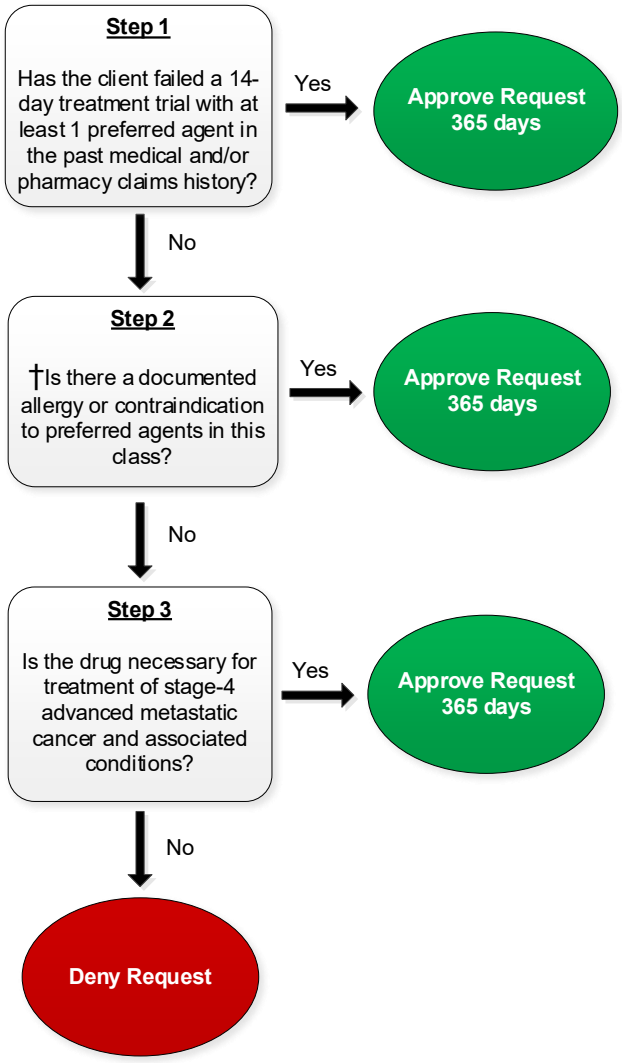
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Immune Globulins
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Immune Globulins
# Alternate Therapies

## Preferred Immune Globulins

| GCN | Drug Name |
|---|---|
| 42328 | CUVITRU 1 GRAM/5 ML VIAL |
| 46829 | CUVITRU 10 GRAM/50 ML VIAL |
| 42329 | CUVITRU 2 GRAM/10 ML VIAL |
| 42335 | CUVITRU 4 GRAM/20 ML VIAL |
| 42277 | CUVITRU 8 GRAM/ 40 ML VIAL |
| 43712 | GAMASTAN VIAL |
| 38016 | GAMMAGARD LIQUID 10% VIAL |
| 07392 | GAMMAGARD S-D 10 G (IGA<1) SOL |
| 06951 | GAMMAGARD S-D 5 G (IGA<1) SOLN |
| 29305 | GAMMAKED 1 GRAM/10 ML VIAL |
| 29308 | GAMMAKED 10 GRAM/100 ML VIAL |
| 29309 | GAMMAKED 20 GRAM/200 ML VIAL |
| 29307 | GAMMAKED 5 GRAM/50 ML VIAL |
| 29305 | GAMUNEX-C 1 GRAM/10 ML VIAL |
| 29308 | GAMUNEX-C 10 GRAM/100 ML VIAL |
| 29306 | GAMUNEX-C 2.5 GRAM/25 ML VIAL |
| 29309 | GAMUNEX-C 20 GRAM/200 ML VIAL |
| 37322 | GAMUNEX-C 40 GRAM/400 ML VIAL |
| 29307 | GAMUNEX-C 5 GRAM/50 ML VIAL |
| 26815 | HEPAGAM B 5 ML VIAL |
| 26814 | HEPAGAM B VIAL |
| 26815 | HEPAGAM B VIAL |

| GCN | Drug Name |
|---|---|
| 44679 | HIZENTRA 1 GRAM/5 ML SYRINGE |
| 28385 | HIZENTRA 1 GRAM/5 ML VIAL |
| 55066 | HIZENTRA 10 GRAM/50 ML SYRINGE |
| 35316 | HIZENTRA 10 GRAM/50 ML VIAL |
| 44686 | HIZENTRA 2 GRAM/10 ML SYRINGE |
| 28386 | HIZENTRA 2 GRAM/10 ML VIAL |
| 47882 | HIZENTRA 4 GRAM/20 ML SYRINGE |
| 28387 | HIZENTRA 4 GRAM/20 ML VIAL |
| 45566 | PANZYGA 10% (1 G/10 ML) VIAL |
| 45566 | PANZYGA 10% (10 G/100 ML) VIAL |
| 45566 | PANZYGA 10% (2.5 G/25 ML) VIAL |
| 45566 | PANZYGA 10% (20 G/200 ML) VIAL |
| 45566 | PANZYGA 10% (30 G/300 ML) VIAL |
| 45566 | PANZYGA 10% (5 G/50 ML) VIAL |
| 46706 | XEMBIFY 20% (1 G/5 ML) VIAL |
| 46709 | XEMBIFY 20% (10 G/50 ML) VIAL |
| 46707 | XEMBIFY 20% (2 G/10 ML) VIAL |
| 46708 | XEMBIFY 20% (4 G/20 ML) VIAL |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 69 Immunomodulators, Asthma

# Immunomodulators, Asthma Prior Authorization Criteria

*Note: if the request is for Dupixent, please see the Immunomodulators, Dupixent section*

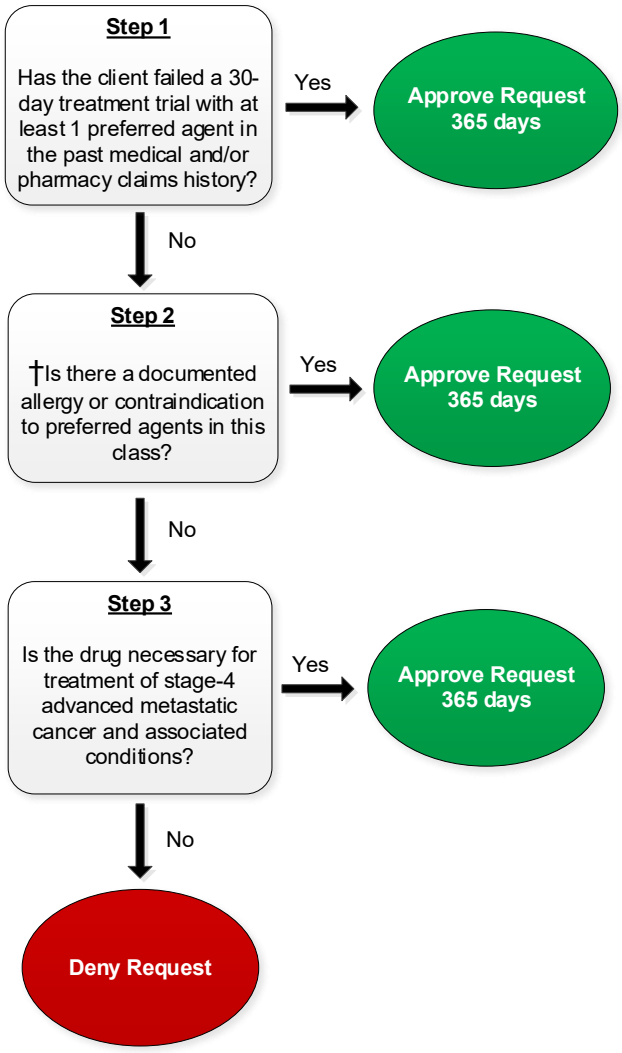
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Immunomodulators, Asthma
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Immunomodulators, Asthma Alternate Therapies

## Preferred Immunomodulators, Asthma

| GCN | Drug Name |
|---|---|
| 47019 | FASENRA PEN 30 MG/ML |
| 53116 | TEZSPIRE 210 MG/1.91 ML PEN |
| 55223 | XOLAIR 150 MG/ML AUTOINJECTOR |
| 30556 | XOLAIR 150 MG/ML SYRINGE |
| 55225 | XOLAIR 300 MG/2 ML AUTOINJECT |
| 55224 | XOLAIR 300 MG/2 ML SYRINGE |
| 55222 | XOLAIR 75 MG/0.5 ML AUTOINJECT |
| 30555 | XOLAIR 75 MG/0.5 ML SYRINGE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 70 Immunomodulators, Atopic Dermatitis (Excluding Dupixent)

# Immunomodulators, Atopic Dermatitis (Excluding Dupixent) Prior Authorization Criteria

*Note: if the request is for Dupixent, please see the Immunomodulators, Dupixent section.*

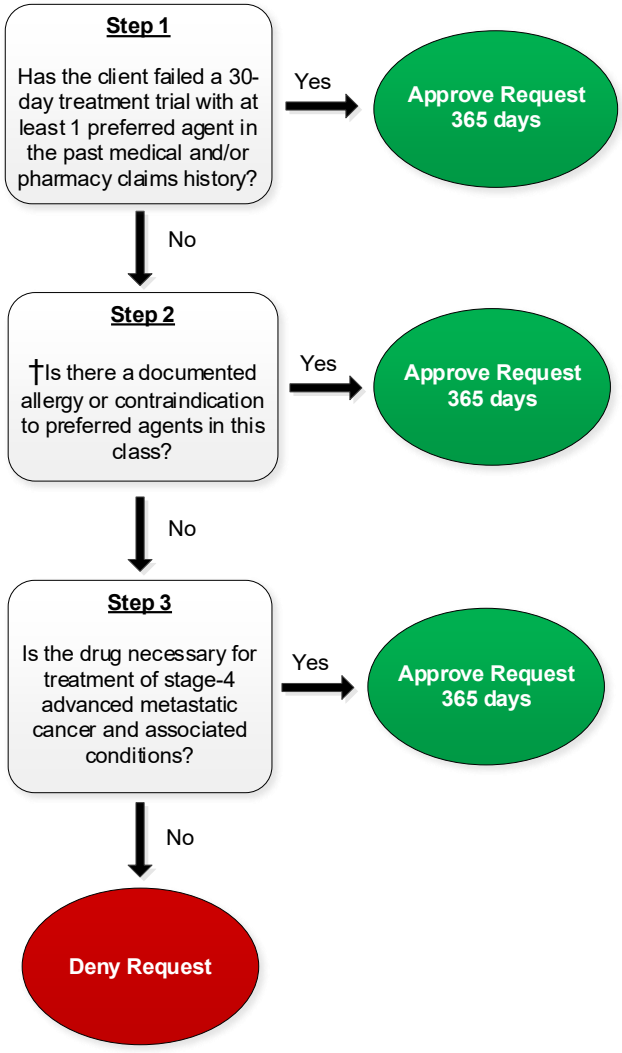
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Immunomodulators, Atopic Dermatitis (Excluding Dupixent) Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Immunomodulators, Atopic Dermatitis (Excluding Dupixent) Alternate Therapies

## Preferred Immunomodulators, Atopic Dermatitis

| GCN | Drug Name |
|---|---|
| 15348 | ELIDEL 1% CREAM |
| 42792 | EUCRISA 2% OINTMENT |
| 12289 | TACROLIMUS 0.03% OINTMENT |
| 12302 | TACROLIMUS 0.1% OINTMENT |
| 52657 | ZORYVE 0.3% CREAM |
| 55119 | ZORYVE 0.3% FOAM |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 71 Immunomodulators, Dupixent

# Immunomodulators, Dupixent Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent from the atopic dermatitis, immunomodulators class in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. Has the client failed a 30-day treatment trial with at least 1 preferred agent from the asthma immunomodulators class in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

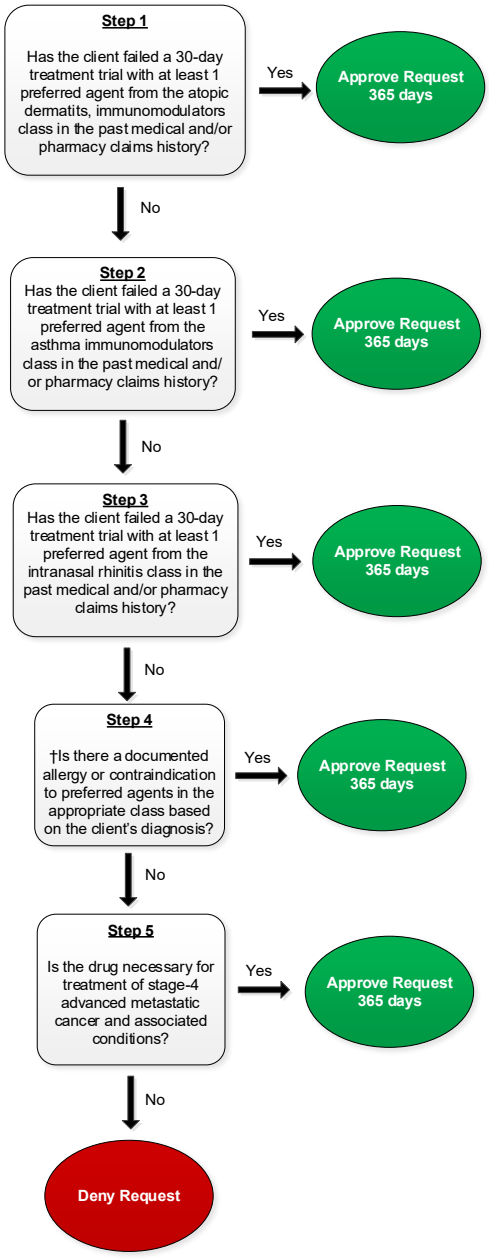
3. Has the client had a 30-day treatment trial with at least 1 preferred agent from the intranasal rhinitis class in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #4)

4. †Is there a documented allergy or contraindication to preferred agents in the appropriate class based on the client's diagnosis?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #5)

5. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Immunomodulators, Dupixent
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Immunomodulators, Dupixent Prior Authorization Criteria

## Preferred Immunomodulators, Dupixent

| GCN | Drug Name |
|---|---|
| 51385 | DUPIXENT 100 MG/0.67 ML SYRING |
| 43222 | DUPIXENT 300 MG/2 ML SYRINGE |
| 48277 | DUPIXENT 300 MG/2 ML PEN |
| 45522 | DUPIXENT 200 MG/1.14 ML SYRING |
| 48785 | DUPIXENT 200 MG/1.14 ML PEN |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# Immunomodulators, Dupixent Alternate Therapies

## Preferred Immunomodulators, Atopic Dermatitis

| GCN | Drug Name |
|---|---|
| 15348 | ELIDEL 1% CREAM |
| 42792 | EUCRISA 2% OINTMENT |
| 12289 | TACROLIMUS 0.03% OINTMENT |
| 12302 | TACROLIMUS 0.1% OINTMENT |
| 52657 | ZORYVE 0.3% CREAM |
| 55119 | ZORYVE 0.3% FOAM |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

## Preferred Immunomodulators, Asthma

| GCN | Drug Name |
|---|---|
| 47019 | FASENRA PEN 30 MG/ML |
| 53116 | TEZSPIRE 210 MG/1.91 ML PEN |
| 55223 | XOLAIR 150 MG/ML AUTOINJECTOR |
| 30556 | XOLAIR 150 MG/ML SYRINGE |
| 55225 | XOLAIR 300 MG/2 ML AUTOINJECT |
| 55224 | XOLAIR 300 MG/2 ML SYRINGE |
| 55222 | XOLAIR 75 MG/0.5 ML AUTOINJECT |
| 30555 | XOLAIR 75 MG/0.5 ML SYRINGE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

## Preferred Intranasal Rhinitis Agents

| GCN | Drug Name |
|---|---|
| 36145 | 24H NASAL ALLERGY 55 MCG SPRAY |
| 36145 | ALLER-CORT 55 MCG NASAL SPRAY |
| 52083 | ALLERGY NASAL 50 MCG SPRAY |
| 60544 | AZELASTINE 0.1% (137 MCG) SPRY |
| 36145 | CVS NASAL ALLERGY 24HR SPRAY |
| 32099 | DYMISTA NASAL SPRAY |
| 36145 | EQ NASAL ALLERGY 24HR SPRAY |
| 36145 | EQL NASAL ALLERGY 24HR SPRAY |
| 62263 | FLUTICASONE PROP 50 MCG SPRAY |
| 36145 | FT 24H NASAL ALLERGY 55MCG SPR |
| 36145 | GNP 24H NASAL ALLERGY 55 MCG |
| 36145 | GS NASAL ALLERGY 24HR SPRAY |
| 36145 | HM 24H NASAL ALLERGY 55MCG SPR |
| 42239 | IPRATROPIUM 0.03% SPRAY |
| 42238 | IPRATROPIUM 0.06% SPRAY |
| 36145 | KRO NASAL ALLERGY 24HR SPRAY |
| 36145 | NASACORT ALLERGY 24HR SPRAY |
| 36145 | NASAL ALLERGY 24HR SPRAY |
| 52083 | NASONEX 24HR ALLERGY 50MCG SPR |
| 97453 | OMNARIS 50 MCG NASAL SPRAY |
| 31769 | QNASL 80 MCG NASAL SPRAY |
| 36145 | RA NASAL ALLERGY 24HR SPRAY |
| 36145 | TRIAMCINOLONE 55 MCG NASAL SPR |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 72 Immunosuppressives

# Immunosuppressives
# Prior Authorization Criteria

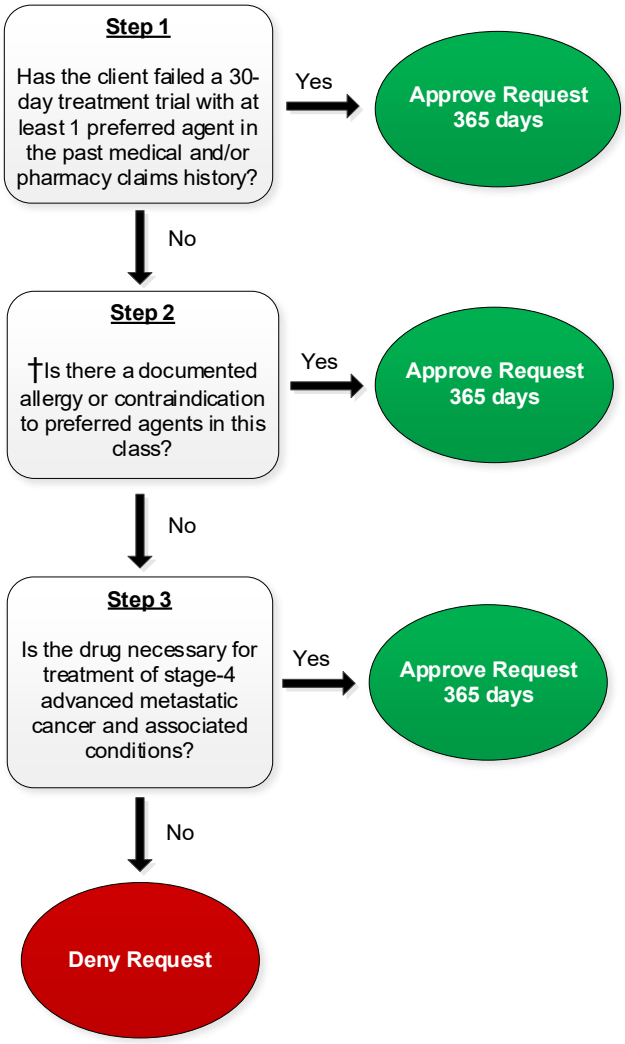
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Immunosuppressives
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Immunosuppressives Alternate Therapies

## Preferred Immunosuppressives

| GCN | Drug Name |
|---|---|
| 19173 | AZATHIOPRINE 100 MG TABLET |
| 46771 | AZATHIOPRINE 50 MG TABLET |
| 19170 | AZATHIOPRINE 75 MG TABLET |
| 47563 | CELLCEPT 200 MG/ML ORAL SUSP |
| 13919 | CYCLOSPORINE MODIFIED 100 MG |
| 13917 | CYCLOSPORINE MODIFIED 100MG/ML |
| 13918 | CYCLOSPORINE MODIFIED 25 MG |
| 47560 | MYCOPHENOLATE 250 MG CAPSULE |
| 47561 | MYCOPHENOLATE 500 MG TABLET |
| 28502 | SIROLIMUS 0.5 MG TABLET |
| 13696 | SIROLIMUS 1 MG TABLET |
| 50356 | SIROLIMUS 1 MG/ML SOLUTION |
| 19299 | SIROLIMUS 2 MG TABLET |
| 28495 | TACROLIMUS 0.5 MG CAPSULE (IR) |
| 28491 | TACROLIMUS 1 MG CAPSULE (IR) |
| 28492 | TACROLIMUS 5 MG CAPSULE (IR) |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 73 Intranasal Rhinitis Agents

# Intranasal Rhinitis Agents
# Prior Authorization Criteria

**Note: if the request is for Dupixent, please see Immunomodulators, Dupixent section*
***For treatment of rhinosinusitis with nasal polyposis, Dupixent must be prescribed as adjunct therapy to an intranasal glucocorticoid. Any intranasal glucocorticoid may be used as adjunct therapy as long as a preferred intranasal glucocorticoid has been tried.*

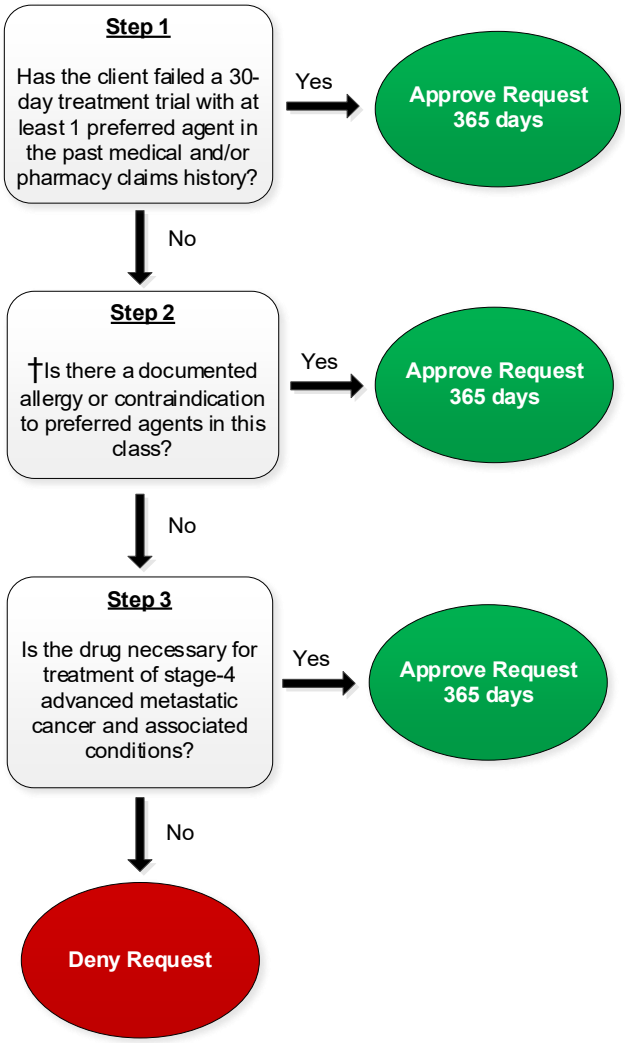
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Intranasal Rhinitis Agents
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Intranasal Rhinitis Agents
# Alternate Therapies

## Preferred Intranasal Rhinitis Agents

| GCN | Drug Name |
|---|---|
| 36145 | 24H NASAL ALLERGY 55 MCG SPRAY |
| 36145 | ALLER-CORT 55 MCG NASAL SPRAY |
| 52083 | ALLERGY NASAL 50 MCG SPRAY |
| 60544 | AZELASTINE 0.1% (137 MCG) SPRY |
| 36145 | CVS NASAL ALLERGY 24HR SPRAY |
| 32099 | DYMISTA NASAL SPRAY |
| 36145 | EQ NASAL ALLERGY 24HR SPRAY |
| 36145 | EQL NASAL ALLERGY 24HR SPRAY |
| 62263 | FLUTICASONE PROP 50 MCG SPRAY |
| 36145 | FT 24H NASAL ALLERGY 55MCG SPR |
| 36145 | GNP 24H NASAL ALLERGY 55 MCG |
| 36145 | GS NASAL ALLERGY 24HR SPRAY |
| 36145 | HM 24H NASAL ALLERGY 55MCG SPR |
| 42239 | IPRATROPIUM 0.03% SPRAY |
| 42238 | IPRATROPIUM 0.06% SPRAY |
| 36145 | KRO NASAL ALLERGY 24HR SPRAY |
| 36145 | NASACORT ALLERGY 24HR SPRAY |
| 36145 | NASAL ALLERGY 24HR SPRAY |
| 52083 | NASONEX 24HR ALLERGY 50MCG SPR |
| 97453 | OMNARIS 50 MCG NASAL SPRAY |
| 31769 | QNASL 80 MCG NASAL SPRAY |

| GCN | Drug Name |
|---|---|
| 36145 | RA NASAL ALLERGY 24HR SPRAY |
| 36145 | TRIAMCINOLONE 55 MCG NASAL SPR |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 74 Iron, Oral

# Iron, Oral
# Prior Authorization Criteria

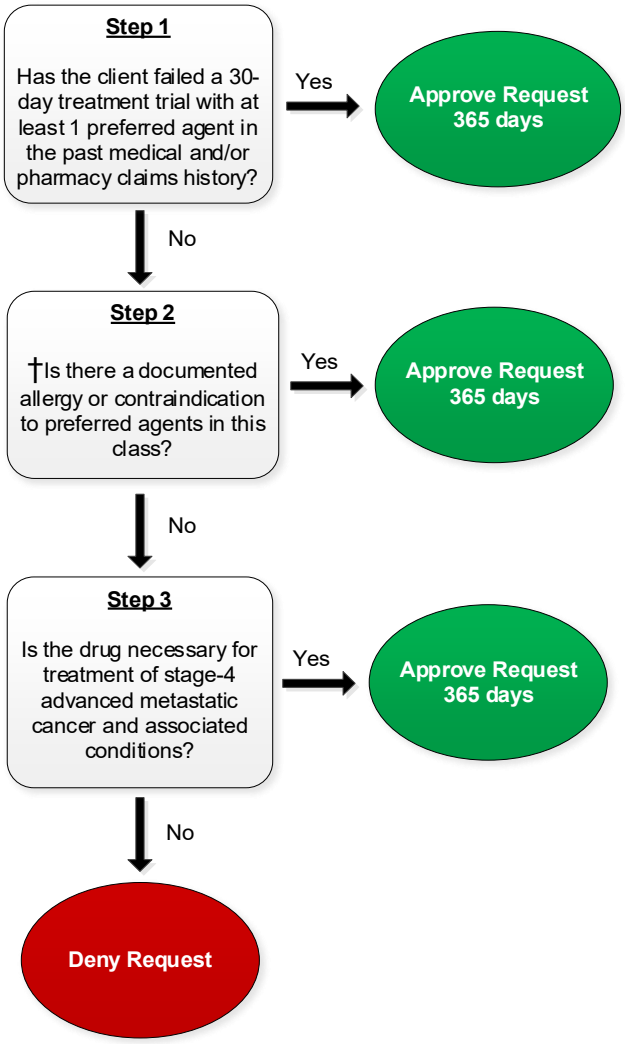
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Iron, Oral
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Iron, Oral
# Alternate Therapies

## Preferred Oral Iron Agents

| GCN | Drug Name |
|---|---|
| 13277 | CENTRATEX CAPSULE |
| 97721 | CHILD FERROUS SULFATE 15 MG/ML |
| 10510 | CVS IRON 27 MG TABLET |
| 04695 | CVS IRON 65 MG TABLET |
| 95145 | FE C TABLET |
| 04695 | FEOSOL 65MG TABLET |
| 04695 | FEROSUL 325MG TABLET |
| 04580 | FERREX 150 CAPSULE |
| 04515 | FERROCITE TABLET |
| 04695 | FERRO-TIME 325MG TABLET |
| 97503 | FERROUS GLUCONATE 324 MG TAB |
| 99233 | FERROUS SULF 220 MG/5 ML CUP |
| 41529 | FERROUS SULF 220 MG/5 ML ELIX |
| 04663 | FERROUS SULF 300 MG/5 ML CUP |
| 99233 | FERROUS SULF 44MG IRON/5ML LQ |
| 98527 | FERROUS SULF EC 324 MG TABLET |
| 04701 | FERROUS SULF EC 325 MG TABLET |
| 04695 | FERROUS SULFATE 325MG TABLET |
| 04695 | FERROUSUL 325MG TABLET |
| 29957 | GNP IRON 45 MG TABLET |
| 13277 | HEMOCYTE PLUS CAPSULE |

| GCN | Drug Name |
|---|---|
| 04580 | POLYSACCHARIDE IRON 150MG CAP |
| 26937 | PUREVIT DUALFE PLUS CAPSULE |
| 26937 | SE-TAN PLUS CAPSULE |
| 26937 | TANDEM PLUS CAPSULE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 75 Leukotriene Modifiers

# Leukotriene Modifiers
# Prior Authorization Criteria

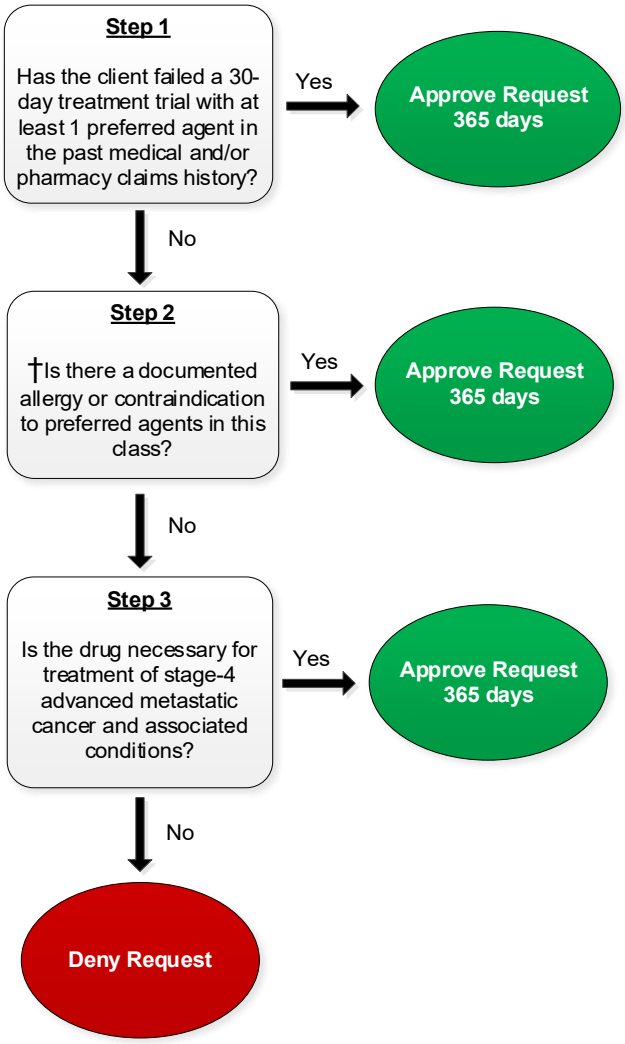
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Leukotriene Modifiers
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Leukotriene Modifiers Alternate Therapies

## Preferred Leukotriene Modifiers

| GCN | Drug Name |
|---|---|
| 42373 | MONTELUKAST SOD 4 MG TAB CHEW |
| 94440 | MONTELUKAST SOD 5 MG TAB CHEW |
| 94444 | MONTELUKAST SOD 10 MG TABLET |
| 40321 | ZYFLO 600 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 76 Lincosamides/Oxazolidinones/Streptogramins

# Lincosamides/Oxazolidinones/ Streptogramins Prior Authorization Criteria

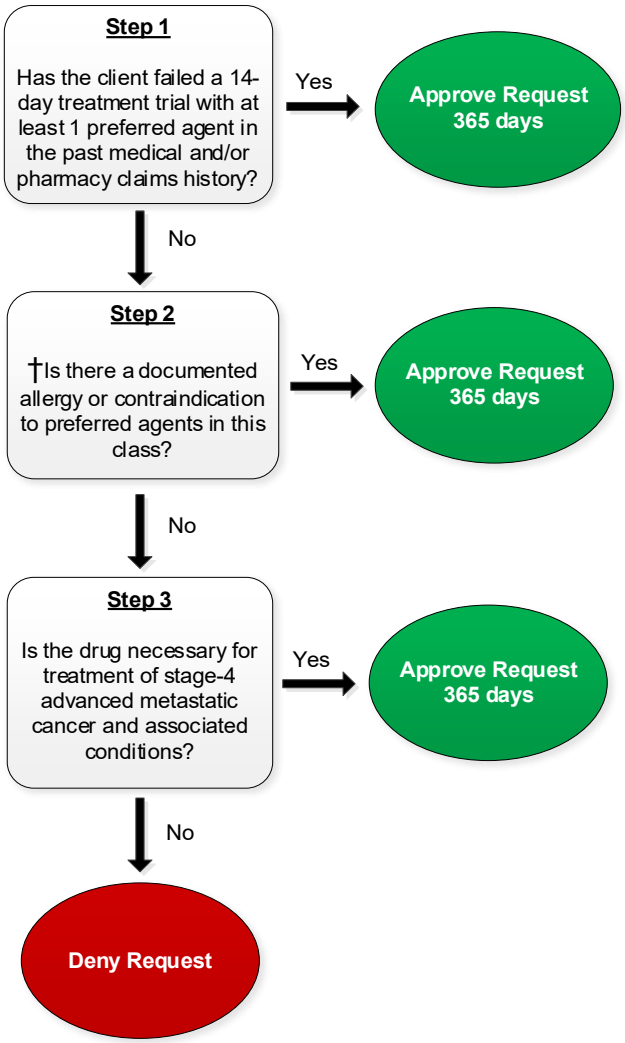
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Lincosamides/Oxazolidinones/ Streptogramins Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Lincosamides/Oxazolidinones/ Streptogramins Alternate Therapies

## Preferred Lincosamides/Oxazolidinones/Streptogramins

| GCN | Drug Name |
|---|---|
| 40860 | CLINDAMYCIN (PEDI) 75 MG/5 ML |
| 40830 | CLINDAMYCIN HCL 150 MG CAPSULE |
| 40832 | CLINDAMYCIN HCL 300 MG CAPSULE |
| 40831 | CLINDAMYCIN HCL 75 MG CAPSULE |
| 26870 | LINEZOLID 600 MG TABLET |
| 26873 | LINEZOLID 600 MG/300 ML-D5W |
| 39003 | LINEZOLID 600MG/300ML-0.9%NACL |
| 26871 | ZYVOX 100 MG/5 ML SUSPENSION |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 77 Lipotropics, Other

# Lipotropics, Other
# Prior Authorization Criteria

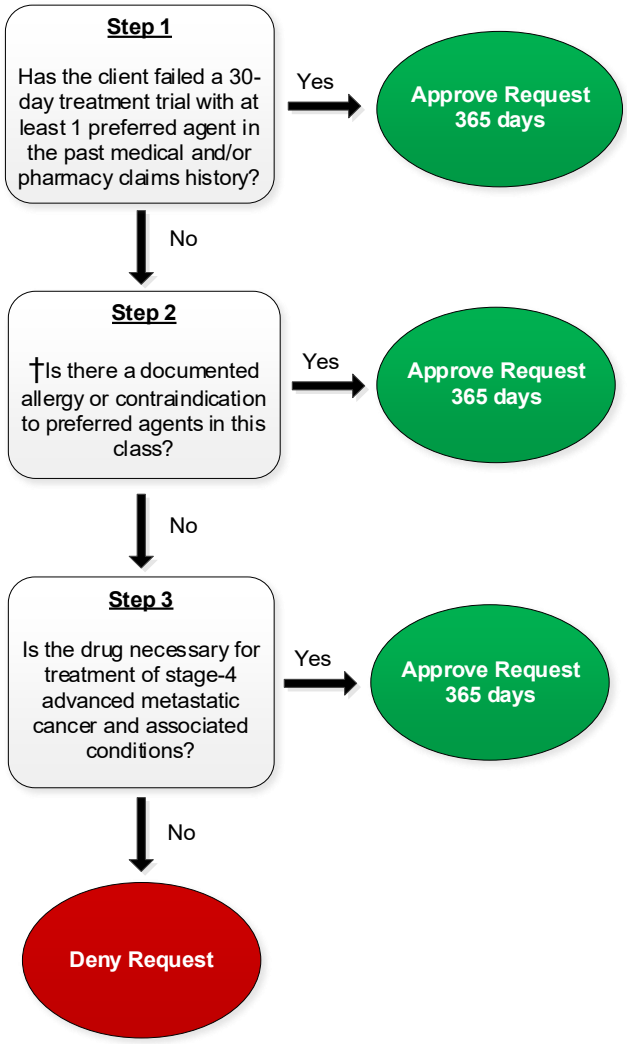
1. Has the client failed a 30-day treatment trial in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Lipotropics, Other
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Lipotropics, Other
# Prior Authorization Criteria

## Preferred Other Lipotropics

| GCN | Drug Name |
|---|---|
| 56757 | CHOLESTYRAMINE LIGHT PACKET |
| 56758 | CHOLESTYRAMINE LIGHT POWDER |
| 09920 | CHOLESTYRAMINE PACKET |
| 14295 | CHOLESTYRAMINE POWDER |
| 25442 | COLESTID 1 GM TABLET |
| 94891 | ENDUR-ACIN ER 500 MG TABLET |
| 18387 | EZETIMIBE 10 MG TABLET |
| 92504 | FENOFIBRATE 134 MG CAPSULE |
| 97003 | FENOFIBRATE 145 MG TABLET |
| 12595 | FENOFIBRATE 160 MG TABLET |
| 93437 | FENOFIBRATE 200 MG CAPSULE |
| 97002 | FENOFIBRATE 48 MG TABLET |
| 13266 | FENOFIBRATE 54 MG TABLET |
| 93446 | FENOFIBRATE 67 MG CAPSULE |
| 99412 | FENOGLIDE 120 MG TABLET |
| 99411 | FENOGLIDE 40 MG TABLET |
| 28126 | FISH OIL 1,000 MG SOFTGEL |
| 46508 | FISH OIL 1,000 MG SOFTGEL |
| 31469 | FISH OIL 500 MG SOFTGEL |
| 28126 | FISH OIL CONC 1,000 MG SOFTGEL |
| 29589 | FISH OIL EC 1,000 MG SOFTGEL |

| GCN | Drug Name |
|---|---|
| 25540 | GEMFIBROZIL 600 MG TABLET |
| 29589 | GNP FISH OIL EC 1,000 MG SFTGL |
| 23929 | LOVAZA 1 GM CAPSULE |
| 94884 | NIACIN 100 MG TABLET |
| 94872 | NIACIN 500 MG CAPSULE SA |
| 94881 | NIACIN 500 MG TABLET |
| 94891 | NIACIN ER 500 MG CAPLET |
| 94891 | NIACIN ER 500 MG TABLET |
| 94874 | NIACIN SA 250 MG CAPSULE |
| 94874 | NIACIN TR 250 MG CAPSULE |
| 94891 | NIACIN TR 500 MG TABLET |
| 94891 | NIAVASC SR 500 MG TABLET |
| 23929 | OMEGA-3 ETHYL ESTERS 1 GM CAP |
| 28126 | OMEGA-3 FISH OIL 1,000 MG SFGL |
| 29589 | OMEGA-3 FISH OIL EC 1,000 MG |
| 94881 | PLAIN NIACIN 500 MG TABLET |
| 56757 | PREVALITE PACKET |
| 56758 | PREVALITE POWDER |
| 94884 | RA NIACIN 100 MG TABLET |
| 94881 | RA NIACIN 500 MG TABLET |
| 38178 | REPATHA 140 MG/ML SURECLICK |
| 39363 | REPATHA 140 MG/ML SYRINGE |
| 41834 | REPATHA 420 MG/3.5ML PUSHTRONX |
| 94891 | SLO-NIACIN 500 MG TABLET |
| 97003 | TRICOR 145 MG TABLET |

| GCN | Drug Name |
|---|---|
| 97002 | TRICOR 48 MG TABLET |
| 16105 | TRILIPIX DR 135 MG CAPSULE |
| 16104 | TRILIPIX DR 45 MG CAPSULE |
| 42365 | VASCEPA 0.5 GM CAPSULE |
| 33238 | VASCEPA 1 GM CAPSULE |
| 28064 | WELCHOL 3.75G PACKET |
| 16300 | WELCHOL 625 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 78 Lipotropics, Statins

# Lipotropics, Statins
# Prior Authorization Criteria

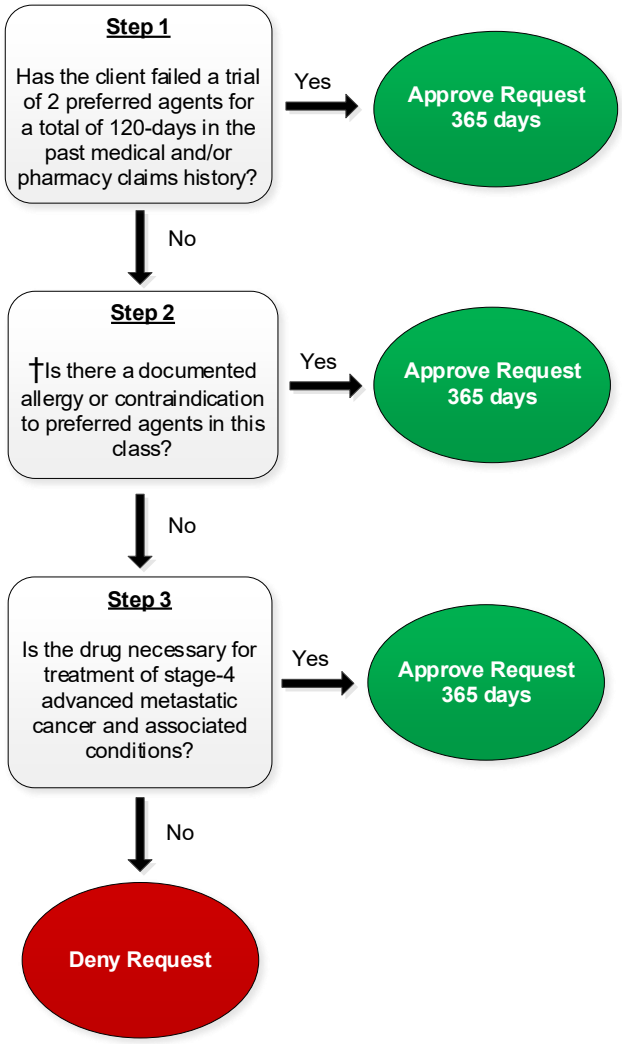
1. Has the client failed at least 2 preferred agent(s) for a total of 120 days in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Lipotropics, Statins
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Lipotropics, Statins Alternate Therapies

## Preferred Lipotropics, Statins

| GCN | Drug Name |
|---|---|
| 43720 | ATORVASTATIN 10 MG TABLET |
| 43721 | ATORVASTATIN 20 MG TABLET |
| 43722 | ATORVASTATIN 40 MG TABLET |
| 43723 | ATORVASTATIN 80 MG TABLET |
| 43720 | LIPITOR 10MG TABLET |
| 43721 | LIPITOR 20MG TABLET |
| 43722 | LIPITOR 40MG TABLET |
| 43723 | LIPITOR 80MG TABLET |
| 47042 | LOVASTATIN 10 MG TABLET |
| 47040 | LOVASTATIN 20 MG TABLET |
| 47041 | LOVASTATIN 40 MG TABLET |
| 48671 | PRAVASTATIN SODIUM 10 MG TAB |
| 48672 | PRAVASTATIN SODIUM 20 MG TAB |
| 48673 | PRAVASTATIN SODIUM 40 MG TAB |
| 15412 | PRAVASTATIN SODIUM 80 MG TAB |
| 19153 | ROSUVASTATIN CALCIUM 10 MG TAB |
| 19154 | ROSUVASTATIN CALCIUM 20 MG TAB |
| 19155 | ROSUVASTATIN CALCIUM 40 MG TAB |
| 20229 | ROSUVASTATIN CALCIUM 5 MG TAB |
| 26532 | SIMVASTATIN 10 MG TABLET |
| 26533 | SIMVASTATIN 20 MG TABLET |

| GCN | Drug Name |
|---|---|
| 26534 | SIMVASTATIN 40 MG TABLET |
| 26531 | SIMVASTATIN 5 MG TABLET |
| 26535 | SIMVASTATIN 80 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 79 Macrolides/Ketolides

# Macrolides/Ketolides
# Prior Authorization Criteria

1. Does the client have a diagnosis of gastroparesis or gastroesophageal reflux disease (GERD) associated with gastrostomy in the last 365 days?
   [ ] Yes (Approve – 90 days)
   [ ] No (Go to #2)

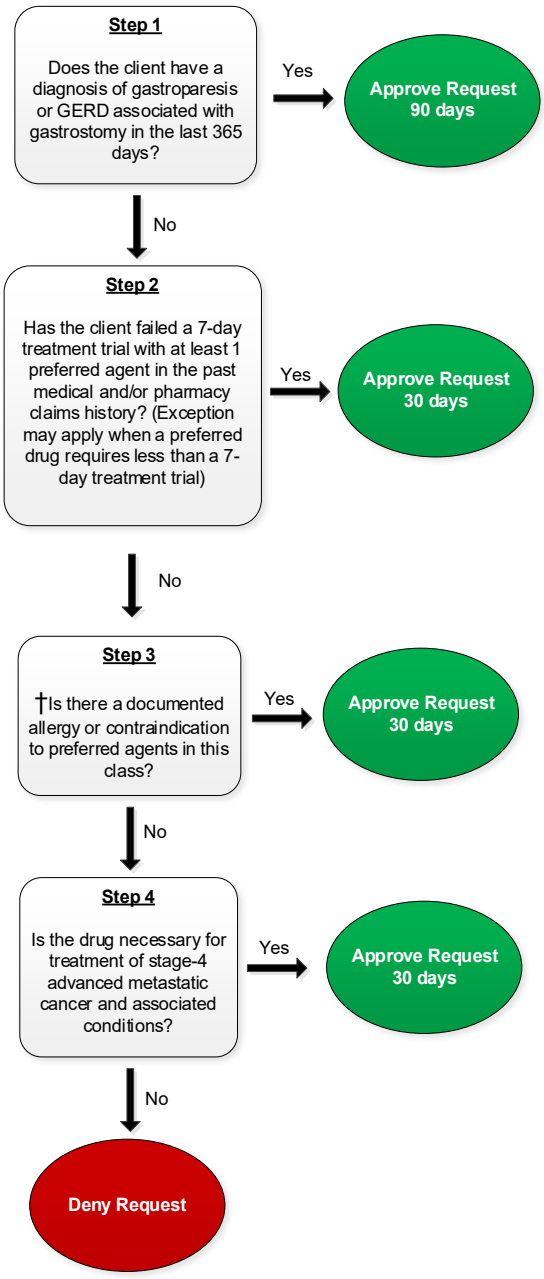
2. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history? (Exception may apply when a preferred drug requires less than a 7-day treatment trial)
   [ ] Yes (Approve – 30 days)
   [ ] No (Go to #3)

3. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 30 days)
   [ ] No (Go to #4)

4. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 30 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Macrolides/Ketolides
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Macrolides/Ketolides Alternate Therapies

## Preferred Macrolides/Ketolides

| GCN | Drug Name |
|---|---|
| 48790 | AZITHROMYCIN 1 GM PWD PACKET |
| 48792 | AZITHROMYCIN 100 MG/5 ML SUSP |
| 61199 | AZITHROMYCIN 200 MG/5 ML SUSP |
| 48793 | AZITHROMYCIN 250 MG TABLET |
| 61198 | AZITHROMYCIN 500 MG TABLET |
| 48794 | AZITHROMYCIN 600 MG TABLET |
| 48852 | CLARITHROMYCIN 250 MG TABLET |
| 48851 | CLARITHROMYCIN 500 MG TABLET |
| 40524 | ERYPED 400 MG/5 ML SUSPENSION |
| 40523 | ERYTHROMYCIN 200 MG/5 ML SUSP |
| 40660 | ERYTHROMYCIN DR 250 MG CAP |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# Macrolides/Ketolides Supporting Table

| Step 1 (diagnosis of gastroparesis or GERD associated with gastrostomy)<br>Required diagnosis: 1<br>Look back timeframe: 365 days | |
|---|---|
| **ICD-10 Code** | **Description** |
| E0843 | DIABETES MELLITUS DUE TO UNDERLYING CONDITION WITH DIABETIC AUTONOMIC (POLY)NEUROPATHY |
| E1043 | TYPE 1 DIABETES MELLITUS WITH DIABETIC AUTONOMIC (POLY)NEUROPATHY |
| E1143 | TYPE 2 DIABETES MELLITUS WITH DIABETIC AUTONOMIC (POLY)NEUROPATHY |
| E1343 | OTHER SPECIFIED DIABETES MELLITUS WITH DIABETIC AUTONOMIC (POLY)NEUROPATHY |
| K3184 | GASTROPARESIS |
| K9420 | GASTROSTOMY COMPLICATION, UNSPECIFIED |
| K9429 | OTHER COMPLICATIONS OF GASTROSTOMY |

# 80 Movement Disorders

# Movement Disorders
# Prior Authorization Criteria

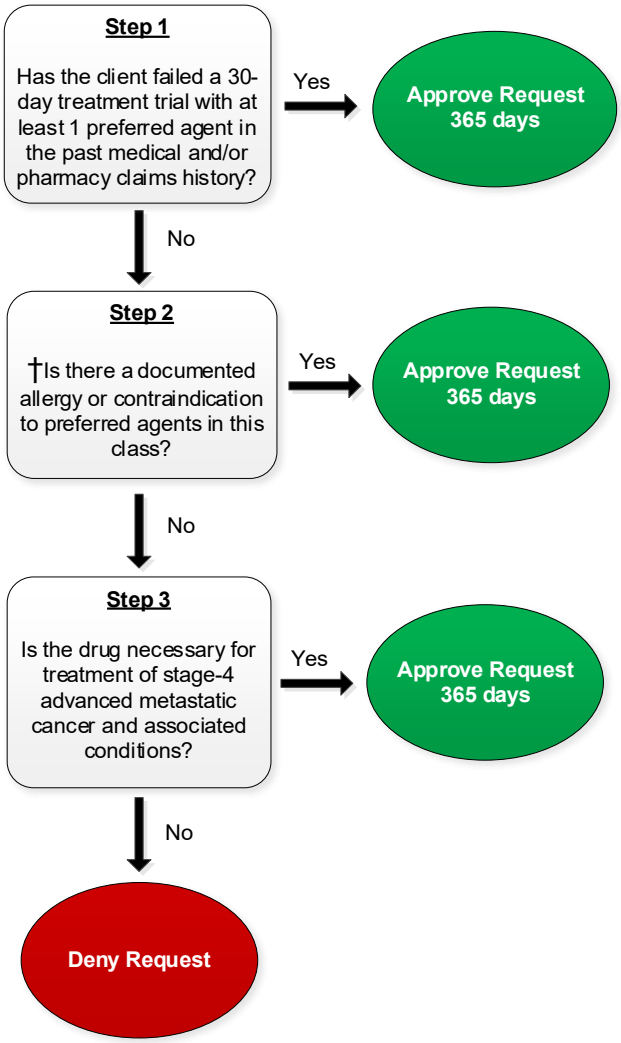
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Movement Disorders
# Prior Authorization Criteria

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# Movement Disorders Alternate Therapies

## Preferred Movement Disorder Agents

| GCN | Drug Name |
|---|---|
| 43237 | AUSTEDO 12 MG TABLET |
| 43228 | AUSTEDO 6 MG TABLET |
| 43236 | AUSTEDO 9 MG TABLET |
| 53737 | AUSTEDO XR 12 MG TABLET |
| 55959 | AUSTEDO XR 18 MG TABLET |
| 53738 | AUSTEDO XR 24 MG TABLET |
| 55819 | AUSTEDO XR 30 MG TABLET |
| 55824 | AUSTEDO XR 36 MG TABLET |
| 55823 | AUSTEDO XR 42 MG TABLET |
| 55822 | AUSTEDO XR 48 MG TABLET |
| 53736 | AUSTEDO XR 6 MG TABLET |
| 53741 | AUSTEDO XR TITR KT(6-12-24 MG) |
| 55964 | AUSTEDO XR TITR(12-18-24-30MG) |
| 43266 | INGREZZA 40 MG CAPSULE |
| 55669 | INGREZZA 40 MG SPRINKLE CAP |
| 49577 | INGREZZA 60 MG CAPSULE |
| 55672 | INGREZZA 60 MG SPRINKLE CAP |
| 43934 | INGREZZA 80 MG CAPSULE |
| 55673 | INGREZZA 80 MG SPRINKLE CAP |
| 46216 | INGREZZA INITIATION PK(TARDIV) |
| 15508 | TETRABENAZINE 12.5 MG TABLET |

| GCN | Drug Name |
|---|---|
| 49900 | TETRABENAZINE 25 MG TABLET |
| 15508 | XENAZINE 12.5 MG TABLET |
| 49900 | XENAZINE 25 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 81 Multiple Sclerosis Agents

# Multiple Sclerosis Agents Alternate Therapies

All products in this class are preferred and have no PDL prior authorization criteria.
To verify formulary coverage for any drugs listed on PDL, search the Medicaid formulary.

# 82 Neuropathic Pain

# Neuropathic Pain
# Prior Authorization Criteria

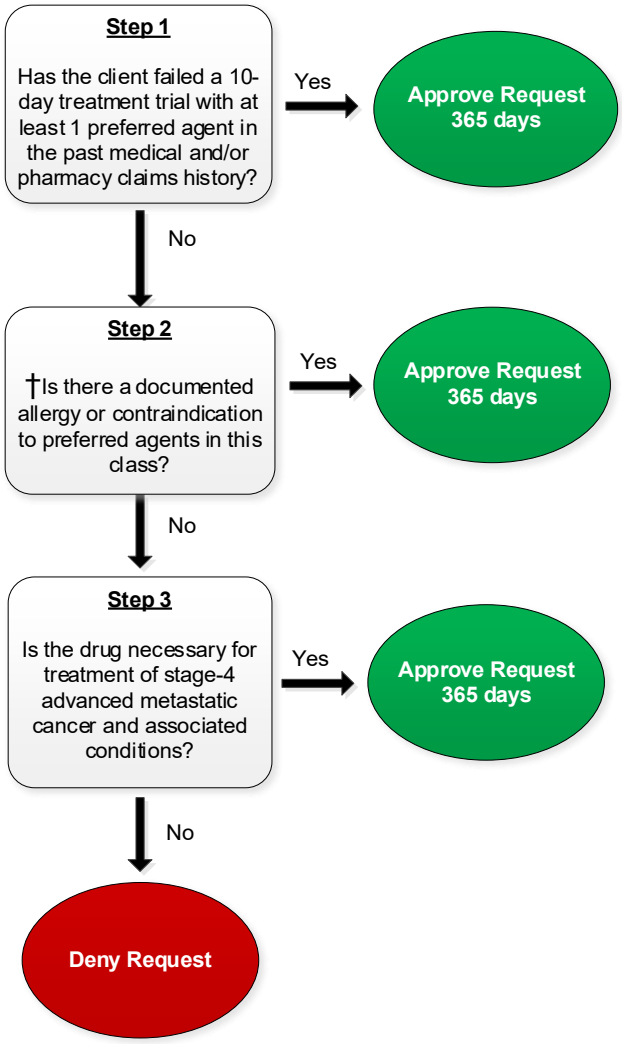
1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Neuropathic Pain
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Neuropathic Pain Alternate Therapies

## Preferred Agents for Neuropathic Pain

| GCN | Drug Name |
|---|---|
| 23373 | ARTHRITIS PAIN RELIEF 0.1% CRM |
| 33561 | ARTHRITIS PAIN RLF 0.075% CRM |
| 33560 | CAPSAICIN 0.025% CREAM |
| 33561 | CAPSAICIN 0.075% CREAM |
| 23373 | CAPSAICIN 0.1% CREAM |
| 99466 | CAPSAICIN 0.15% LIQUID |
| 23373 | CAPSAICIN HP 0.1% CREAM |
| 23373 | CAPSAID ES 0.1% CREAM |
| 23373 | CVS CAPSAICIN 0.1% CREAM |
| 23161 | DULOXETINE HCL DR 20 MG CAP |
| 23162 | DULOXETINE HCL DR 30 MG CAP |
| 23164 | DULOXETINE HCL DR 60 MG CAP |
| 00780 | GABAPENTIN 100 MG CAPSULE |
| 13235 | GABAPENTIN 250 MG/5 ML SOLN |
| 33065 | GABAPENTIN 250 MG/5ML SOLN CUP |
| 00781 | GABAPENTIN 300 MG CAPSULE |
| 33066 | GABAPENTIN 300 MG/6ML SOLN CUP |
| 00782 | GABAPENTIN 400 MG CAPSULE |
| 94624 | GABAPENTIN 600 MG TABLET |
| 94447 | GABAPENTIN 800 MG TABLET |
| 49678 | GRALISE 300-600 MG SAMPLE PACK |

| GCN | Drug Name |
|---|---|
| 30295 | GRALISE ER 300 MG TABLET |
| 54018 | GRALISE ER 450 MG TABLET |
| 30296 | GRALISE ER 600 MG TABLET |
| 54019 | GRALISE ER 750 MG TABLET |
| 54021 | GRALISE ER 900 MG TABLET |
| 35819 | HORIZANT ER 300 MG TABLET |
| 29888 | HORIZANT ER 600 MG TABLET |
| 50272 | LIDOCAINE 5% PATCH |
| 50272 | LIDODERM 5% PATCH |
| 23048 | LYRICA 100 MG CAPSULE |
| 23049 | LYRICA 150 MG CAPSULE |
| 32359 | LYRICA 20 MG/ML ORAL SOLUTION |
| 23051 | LYRICA 200 MG CAPSULE |
| 25019 | LYRICA 225 MG CAPSULE |
| 23039 | LYRICA 25 MG CAPSULE |
| 23052 | LYRICA 300 MG CAPSULE |
| 23046 | LYRICA 50 MG CAPSULE |
| 23047 | LYRICA 75 MG CAPSULE |
| 43987 | LYRICA CR 165 MG TABLET |
| 43988 | LYRICA CR 330 MG TABLET |
| 43986 | LYRICA CR 82.5 MG TABLET |
| 00780 | NEURONTIN 100 MG CAPSULE |
| 13235 | NEURONTIN 250 MG/5 ML SOLUTION |
| 00781 | NEURONTIN 300 MG CAPSULE |
| 00782 | NEURONTIN 400 MG CAPSULE |

| GCN | Drug Name |
|---|---|
| 94624 | NEURONTIN 600 MG TABLET |
| 94447 | NEURONTIN 800 MG TABLET |
| 22022 | SAVELLA 100 MG TABLET |
| 21979 | SAVELLA 12.5 MG TABLET |
| 22008 | SAVELLA 25 MG TABLET |
| 22019 | SAVELLA 50 MG TABLET |
| 22025 | SAVELLA TITRATION PACK |
| 23373 | ZOSTRIX HP 0.1% CREAM |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 83 Non-Narcotic Analgesics

# Non-Narcotic Analgesics
# Prior Authorization Criteria

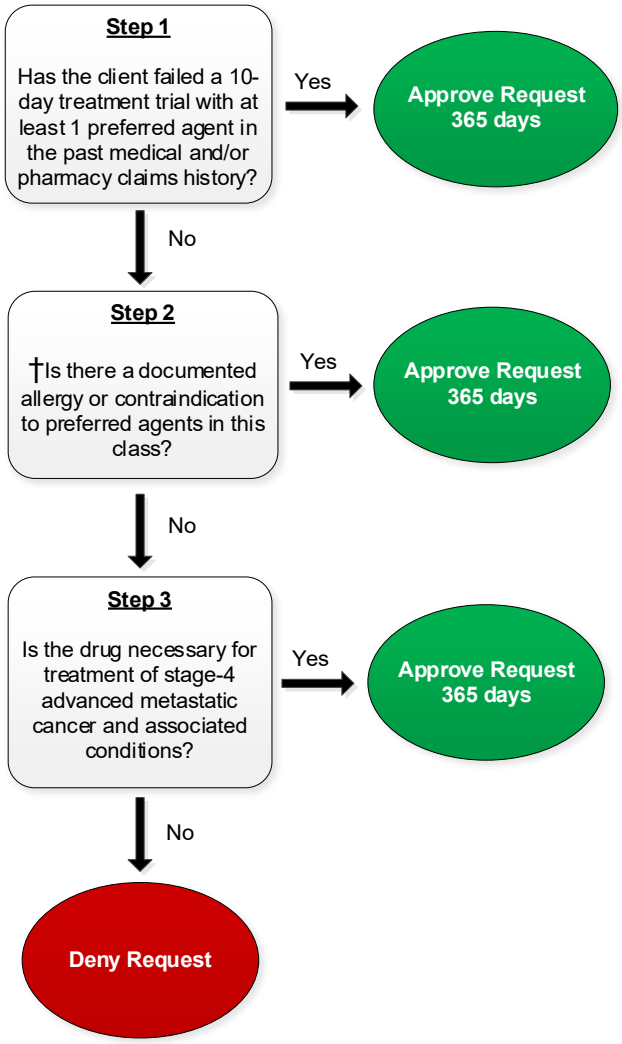
1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Non-Narcotic Analgesics
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Non-Narcotic Analgesics Alternate Therapies

## Preferred Generic Non-Narcotic Analgesics

| GCN | Drug Name |
|---|---|
| 42001 | CELEBREX 100 MG CAPSULE |
| 42002 | CELEBREX 200 MG CAPSULE |
| 18127 | CELEBREX 400 MG CAPSULE |
| 97785 | CELEBREX 50 MG CAPSULE |
| 42001 | CELECOXIB 100 MG CAPSULE |
| 42002 | CELECOXIB 200 MG CAPSULE |
| 18127 | CELECOXIB 400 MG CAPSULE |
| 97785 | CELECOXIB 50 MG CAPSULE |
| 13967 | DICLOFENAC POT 25 MG TABLET |
| 13960 | DICLOFENAC POT 50 MG TABLET |
| 35850 | DICLOFENAC SOD DR 25 MG TAB |
| 35851 | DICLOFENAC SOD DR 50 MG TAB |
| 35852 | DICLOFENAC SOD DR 75 MG TAB |
| 45680 | DICLOFENAC SODIUM 1% GEL |
| 35930 | IBUPROFEN 100MG/5ML SUSP |
| 35431 | IBUPROFEN 200 MG SOFTGEL |
| 35743 | IBUPROFEN 200 MG TABLET |
| 35741 | IBUPROFEN 400MG TABLET |
| 35742 | IBUPROFEN 600MG TABLET |
| 35744 | IBUPROFEN 800MG TABLET |
| 35749 | IBUPROFEN JR STR 100 MG TB CHW |

| GCN | Drug Name |
|---|---|
| 35680 | INDOMETHACIN 25 MG CAPSULE |
| 35681 | INDOMETHACIN 50 MG CAPSULE |
| 35931 | INFANT IBUPROFEN 50 MG/1.25 ML |
| 32531 | KETOROLAC 10 MG TABLET |
| 31662 | MELOXICAM 15 MG TABLET |
| 31661 | MELOXICAM 7.5 MG TABLET |
| 35790 | NAPROXEN 250 MG TABLET |
| 35792 | NAPROXEN 375 MG TABLET |
| 35793 | NAPROXEN 500 MG KIT |
| 61850 | NAPROXEN DR 375 MG TABLET |
| 61851 | NAPROXEN DR 500 MG TABLET |
| 47132 | NAPROXEN SODIUM 220 MG CAPLET |
| 29254 | NAPROXEN SODIUM 220 MG CAPSULE |
| 35800 | SULINDAC 150 MG TABLET |
| 35801 | SULINDAC 200 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 84 Oncology, Oral - Breast

# Oncology, Oral - Breast Alternate Therapies

All products in this class are preferred and have no PDL prior authorization criteria.
To verify formulary coverage for any drugs listed on PDL, search the Medicaid formulary.

# 85 Oncology, Oral - Hematologic

# Oncology, Oral - Hematologic Alternate Therapies

All products in this class are preferred and have no PDL prior authorization criteria.
To verify formulary coverage for any drugs listed on PDL, search the Medicaid formulary.

# 86 Oncology, Oral - Lung

# Oncology, Oral – Lung Alternate Therapies

All products in this class are preferred and have no PDL prior authorization criteria.
To verify formulary coverage for any drugs listed on PDL, search the Medicaid formulary.

# 87 Oncology, Oral - Other

# Oncology, Oral – Other
# Alternate Therapies

All products in this class are preferred and have no PDL prior authorization criteria.
To verify formulary coverage for any drugs listed on PDL, search the Medicaid formulary.

# 88 Oncology, Oral - Prostate

# Oncology, Oral - Prostate Alternate Therapies

All products in this class are preferred and have no PDL prior authorization criteria.
To verify formulary coverage for any drugs listed on PDL, search the Medicaid formulary.

# 89 Oncology, Oral – Renal Cell

# Oncology, Oral – Renal Cell Alternate Therapies

All products in this class are preferred and have no PDL prior authorization criteria.
To verify formulary coverage for any drugs listed on PDL, search the Medicaid formulary.

# 90 Oncology, Oral - Skin

# Oncology, Oral - Skin
# Alternate Therapies

All products in this class are preferred and have no PDL prior authorization criteria.
To verify formulary coverage for any drugs listed on PDL, search the Medicaid formulary.

# 91 Ophthalmics, Antibiotic - Steroid Combinations

# Ophthalmics, Antibiotic - Steroid Combinations Prior Authorization Criteria

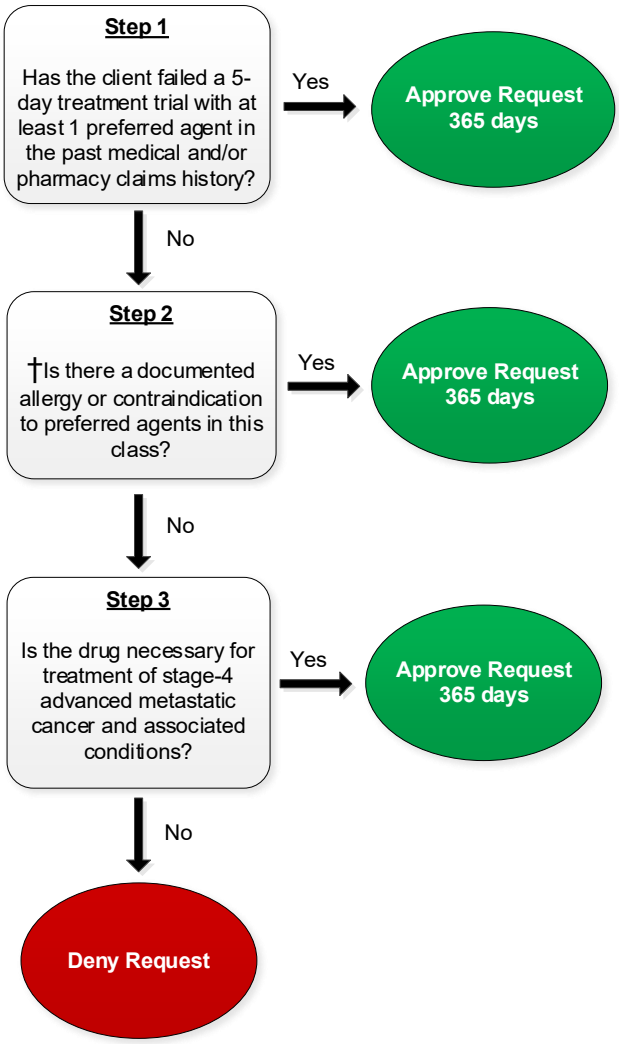
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Ophthalmics, Antibiotic-Steroid Combinations Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Ophthalmics, Antibiotic-Steroid Combinations Alternate Therapies

## Preferred Ophthalmic Antibiotic-Steroid Combinations

| GCN | Drug Name |
|---|---|
| 14285 | NEOMYC-POLYM-DEXAMET EYE OINTM |
| 14286 | NEOMYC-POLYM-DEXAMETH EYE DROP |
| 86903 | SULF-PRED 10-0.23% EYE DROPS |
| 92280 | TOBRADEX EYE DROPS |
| 92270 | TOBRADEX EYE OINTMENT |
| 24089 | ZYLET EYE DROPS |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 92 Ophthalmics, Antibiotic

# Ophthalmics, Antibiotic
# Prior Authorization Criteria

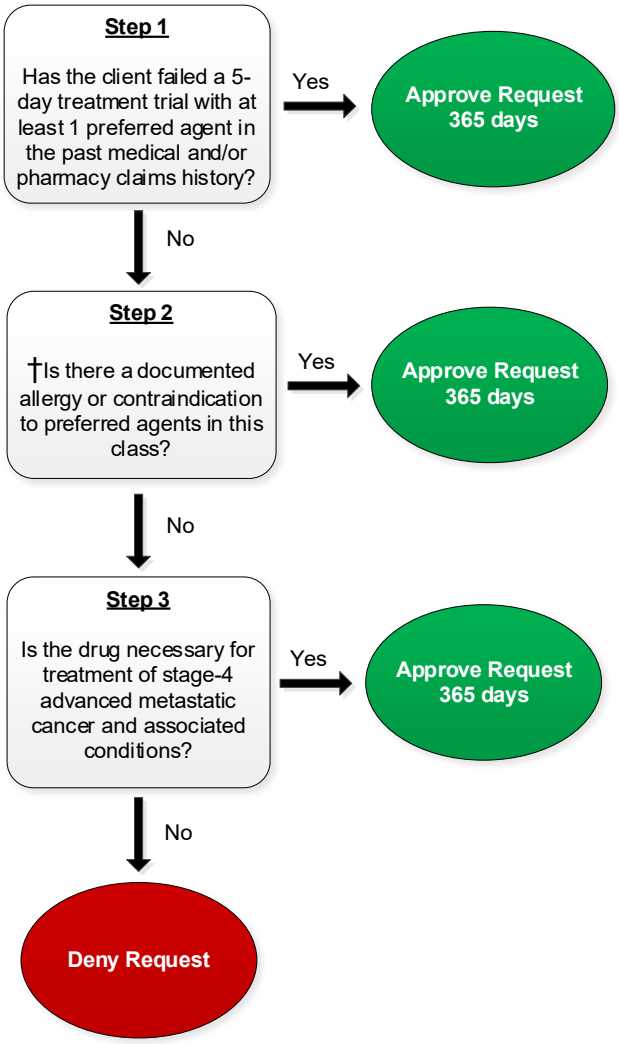
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Ophthalmics, Antibiotic
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Ophthalmics, Antibiotic Alternate Therapies

## Preferred Ophthalmic Antibiotics

| GCN | Drug Name |
|---|---|
| 98599 | AZASITE 1% EYE DROPS |
| 25486 | BACITRACIN-POLYMYXIN EYE OINT |
| 24317 | BESIVANCE 0.6% SUSP |
| 09076 | CILOXAN 0.3% OINTMENT |
| 33580 | CIPROFLOXACIN 0.3% EYE DROP |
| 33540 | ERYTHROMYCIN 0.5% EYE OINTMENT |
| 33600 | GENTAMICIN 0.3% EYE DROP |
| 19542 | MOXIFLOXACIN 0.5% EYE DROPS |
| 36600 | OFLOXACIN 0.3% EYE DROPS |
| 14294 | POLYMYXIN B-TMP EYE DROPS |
| 09384 | TOBRAMYCIN 0.3% EYE DROP |
| 09383 | TOBREX 0.3% EYE OINTMENT |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 93 Ophthalmics, Allergic Conjunctivitis

# Ophthalmics, Allergic Conjunctivitis
# Prior Authorization Criteria

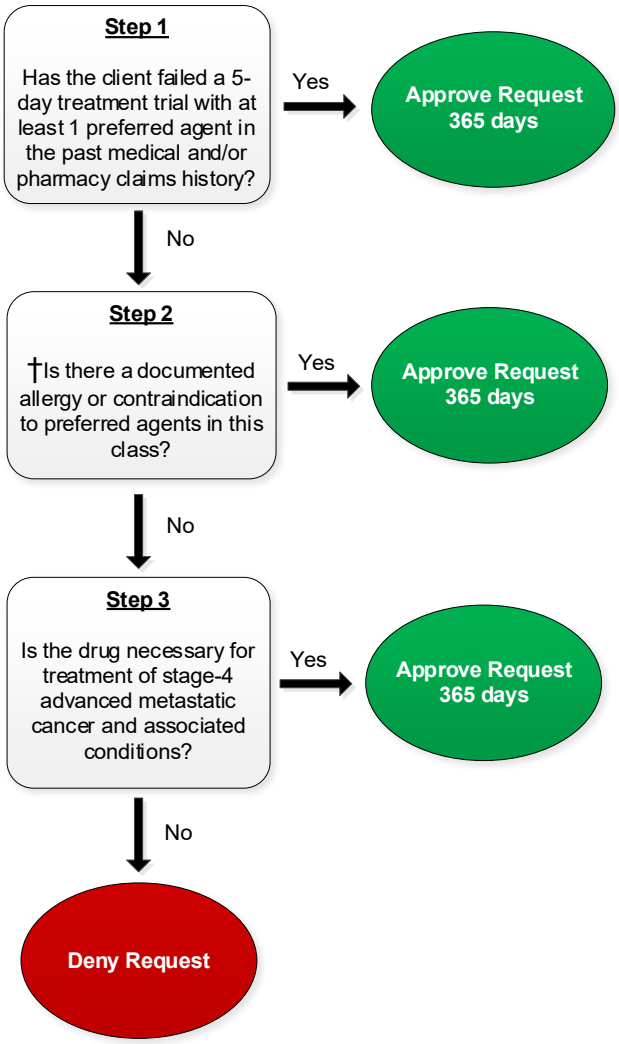
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Ophthalmics, Allergic Conjunctivitis Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Ophthalmics, Allergic Conjunctivitis Alternate Therapies

## Preferred Ophthalmic Allergic Conjunctivitis Agents

| GCN | Drug Name |
|---|---|
| 27606 | BEPREVE 1.5% EYE DROPS |
| 69069 | CROMOLYN 4% EYE DROPS |
| 68321 | CVS OLOPATADINE 0.1% EYE DROPS |
| 92451 | KETOTIFEN FUM 0.025% EYE DROPS OTC |
| 97848 | OLOPATADINE HCL 0.2% EYE DROPS OTC |
| 37855 | PATADAY XS ONCE DAILY 0.7% DROPS |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 94 Ophthalmics, Anti-Inflammatories

# Ophthalmics, Anti-Inflammatories Prior Authorization Criteria

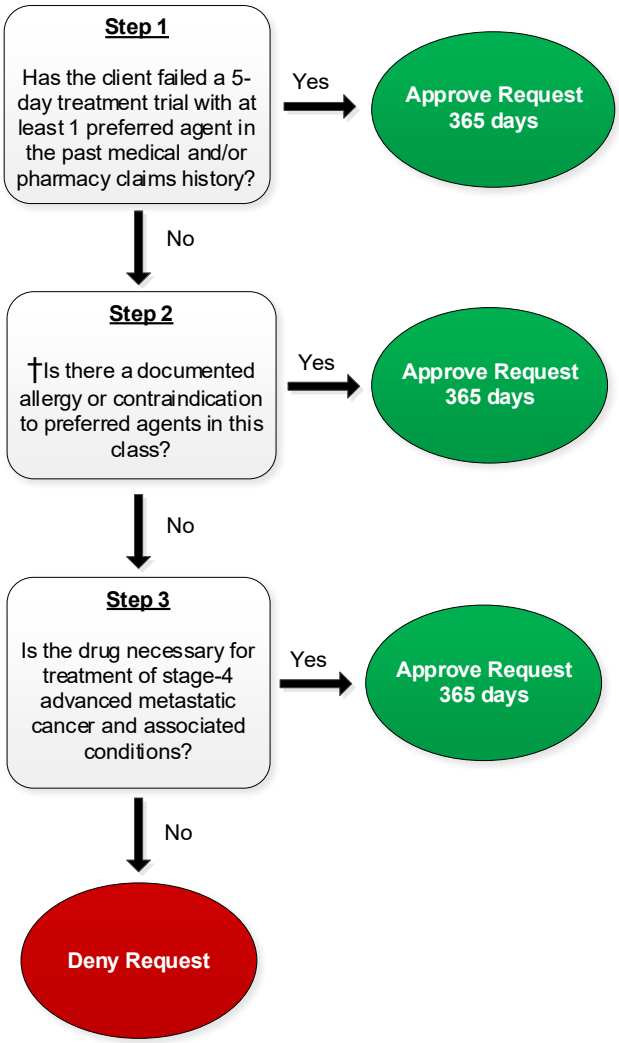
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Ophthalmics, Anti-Inflammatories Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Ophthalmics, Anti-Inflammatories Alternate Therapies

## Preferred Ophthalmics, Anti-Inflammatories

| GCN | Drug Name |
|---|---|
| 33831 | DICLOFENAC 0.1% EYE DROPS |
| 13635 | DUREZOL 0.05% EYE DROPS |
| 52700 | KETOROLAC 0.5% OPHTH SOLUTION |
| 95464 | LOTEMAX 0.5% EYE DROPS |
| 30304 | LOTEMAX 0.5% EYE OINTMENT |
| 33385 | LOTEMAX 0.5% OPHTHALMIC GEL |
| 33153 | PREDNISOLONE AC 1% EYE DROP |
| 44855 | PREDNISOLONE ACET 1% EYE DROP |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 95 Ophthalmics, Anti-Inflammatory/Immunomodulators

# Ophthalmics, Anti-Inflammatory/ Immunomodulators Prior Authorization Criteria

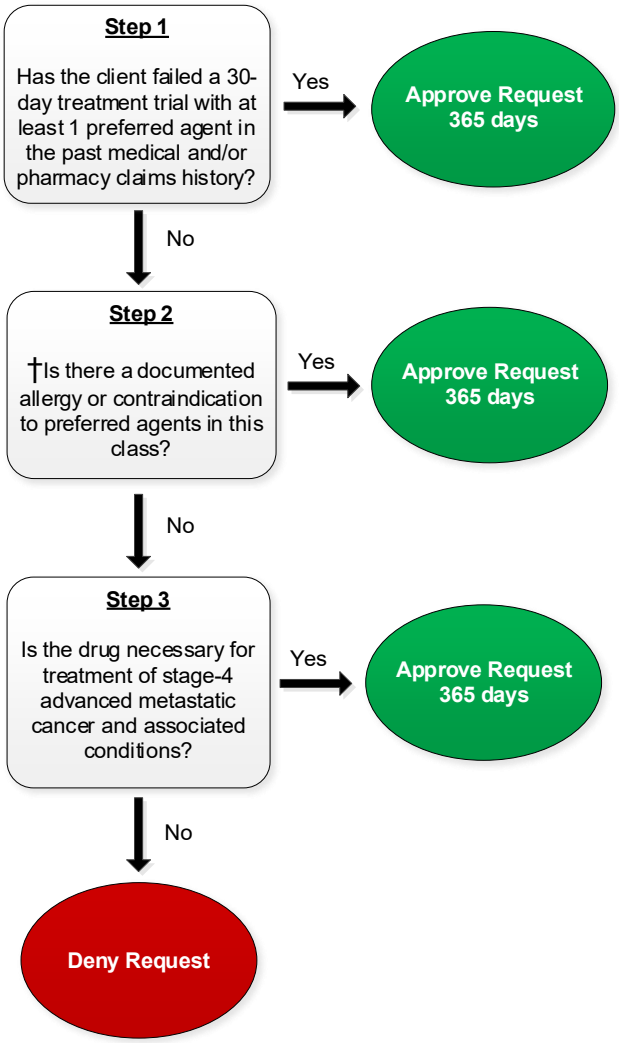
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Ophthalmics, Anti-Inflammatory/ Immunomodulators Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Ophthalmics, Anti-Inflammatory/ Immunomodulator Alternate Therapies

## Preferred Ophthalmics, Anti-Inflammatory/Immunomodulator

| GCN | Drug Name |
|---|---|
| 19216 | RESTASIS 0.05% EYE EMULSION |
| 41847 | XIIDRA 5% EYE DROPS |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 96 Ophthalmics, Glaucoma Agents

# Ophthalmics, Glaucoma Agents Prior Authorization Criteria

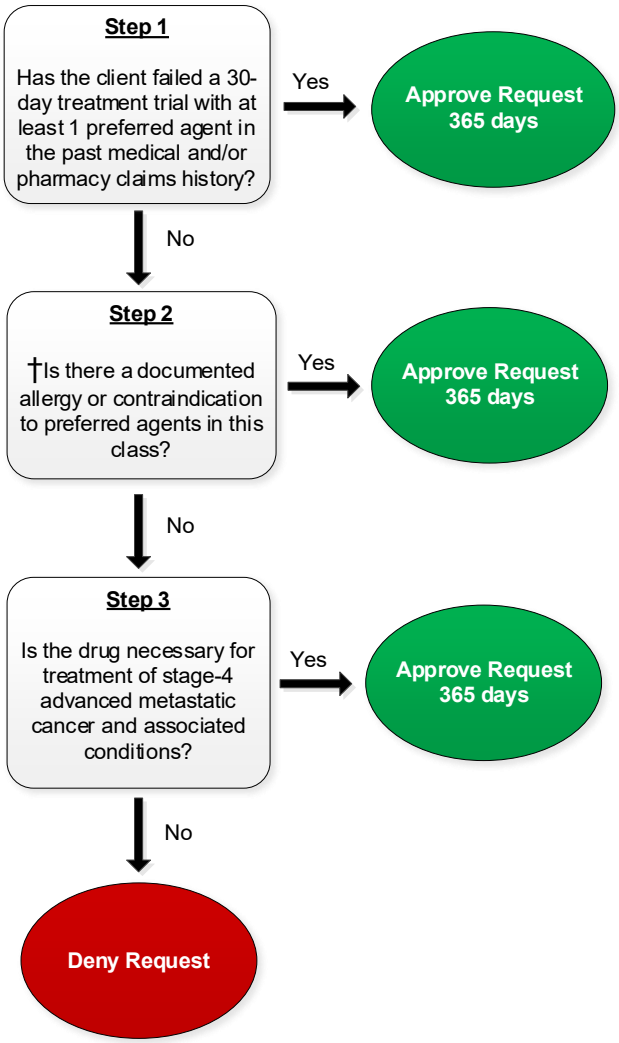
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Ophthalmics, Glaucoma Agents Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Ophthalmics, Glaucoma Agents Alternate Therapies

## Preferred Ophthalmic Glaucoma Agents

| GCN | Drug Name |
|---|---|
| 95773 | AZOPT 1% EYE DROPS |
| 32829 | BETIMOL 0.25% EYE DROPS |
| 32828 | BETIMOL 0.5% EYE DROPS |
| 36281 | BRIMONIDINE 0.2% EYE DROP |
| 32261 | CARTEOLOL HCL 1% EYE DROPS |
| 20876 | COMBIGAN 0.2%-0.5% EYE DROPS |
| 33380 | DORZOLAMIDE HCL 2% EYE DROPS |
| 95919 | DORZOLAMIDE-TIMOLOL EYE DROPS |
| 24615 | ISTALOL 0.5% EYE DROPS |
| 32749 | LATANOPROST 0.005% EYE DROPS |
| 32704 | PILOCARPINE 1% EYE DROPS |
| 32706 | PILOCARPINE 2% EYE DROPS |
| 32752 | PILOCARPINE 4% EYE DROPS |
| 44308 | RHOPRESSA 0.02% OPHTH SOLUTION |
| 46097 | ROCKLATAN 0.02%-0.005% EYE DRP |
| 34579 | SIMBRINZA 1%-0.2% EYE DROP |
| 32822 | TIMOLOL 0.25% GEL-SOLUTION |
| 32823 | TIMOLOL 0.5% GEL-SOLUTION |
| 32820 | TIMOLOL MALEATE 0.25% EYE DROP |
| 32821 | TIMOLOL MALEATE 0.5% EYE DROPS |
| 13002 | TRAVATAN Z 0.004% EYE DROP |
| 27370 | XALATAN 0.005% EYE DROPS |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 97 Opiate Dependence Treatments

# Opiate Dependence Treatments
# Prior Authorization Criteria

All products in this class are preferred and have no PDL prior authorization criteria.
To verify formulary coverage for any drugs listed on PDL, search the Medicaid formulary.

# 98 Otic Antibiotics

# Otic Antibiotics
# Prior Authorization Criteria

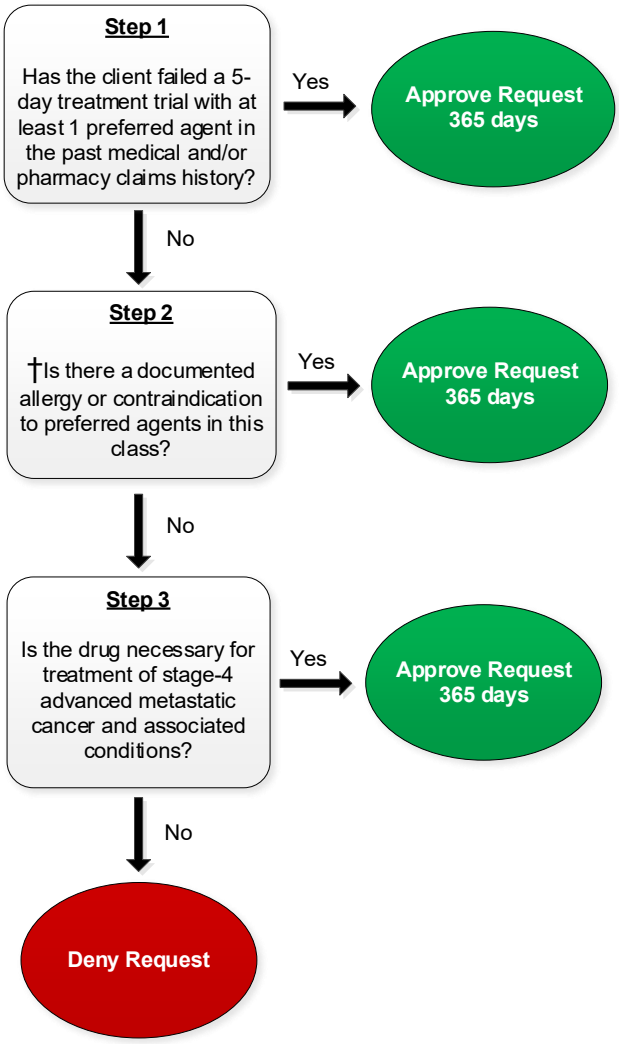
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Otic Antibiotics
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Otic Antibiotics
# Alternate Therapies

## Preferred Otic Antibiotics

| GCN | Drug Name |
|---|---|
| 20188 | CIPRODEX OTIC SUSPENSION |
| 20188 | CIPROFLOXACIN-DEXAMETHASONE |
| 14023 | NEOMYCIN-POLYMYXIN-HC EAR SOLN |
| 14025 | NEOMYCIN-POLYMYXIN-HC EAR SUSP |
| 13880 | OFLOXACIN 0.3% EAR DROPS |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 99 Otic Anti-Infectives/Anesthetics

# Otic Anti-Infectives/Anesthetics Prior Authorization Criteria

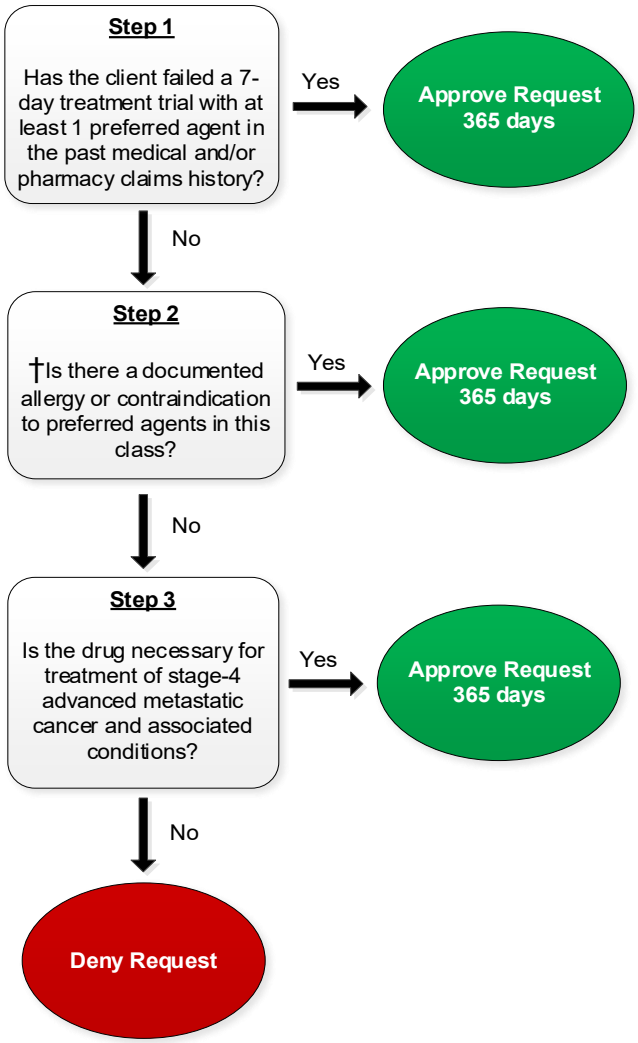
1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Otic Anti-Infectives/Anesthetics Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Otic Anti-Infectives/Anesthetics Alternate Therapies

## Preferred Otic Anti-Infectives/Anesthetics

| GCN | Drug Name |
|---|---|
| 34341 | ACETIC ACID 2% EAR SOLUTION |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 100 PAH Agents, Oral and Inhaled

# PAH Agents, Oral and Inhaled
# Prior Authorization Criteria

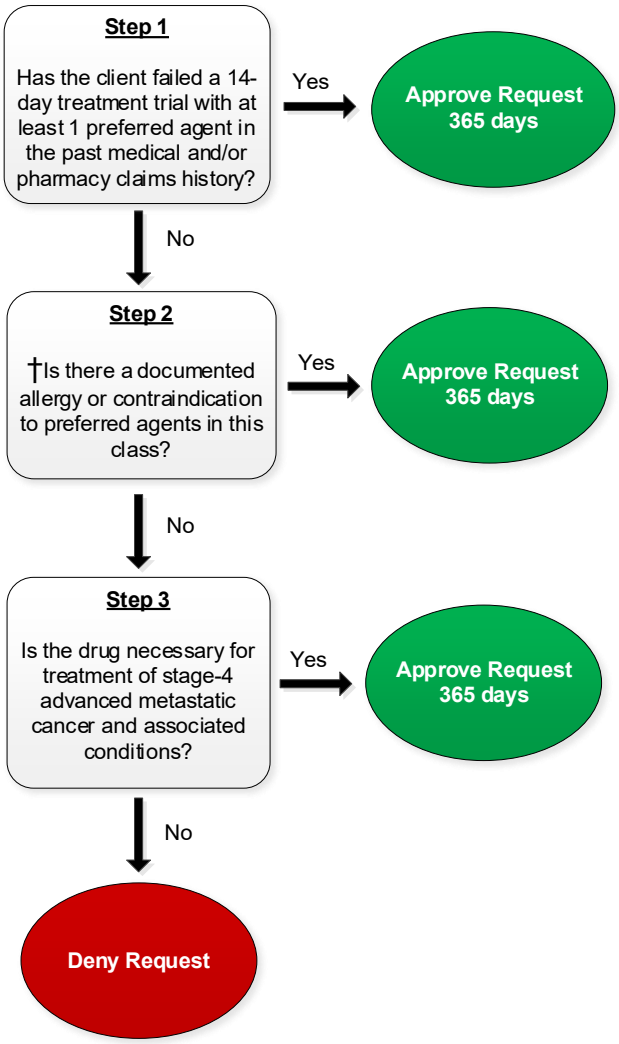
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# PAH Agents, Oral and Inhaled
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# PAH Agents, Oral and Inhaled
# Alternate Therapies

## Preferred PAH Agents, Oral and Inhaled

| GCN | Drug Name |
|---|---|
| 26587 | ADCIRCA 20 MG TABLET |
| 26587 | ALYQ 20 MG TABLET |
| 98567 | LETAIRIS 10 MG TABLET |
| 98566 | LETAIRIS 5 MG TABLET |
| 33186 | REVATIO 10 MG/ML ORAL SUSP |
| 24758 | REVATIO 20 MG TABLET |
| 33186 | SILDENAFIL 10 MG/ML ORAL SUSP |
| 14978 | TRACLEER 125 MG TABLET |
| 14979 | TRACLEER 62.5 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 101 Pancreatic Enzymes

# Pancreatic Enzymes
# Prior Authorization Criteria

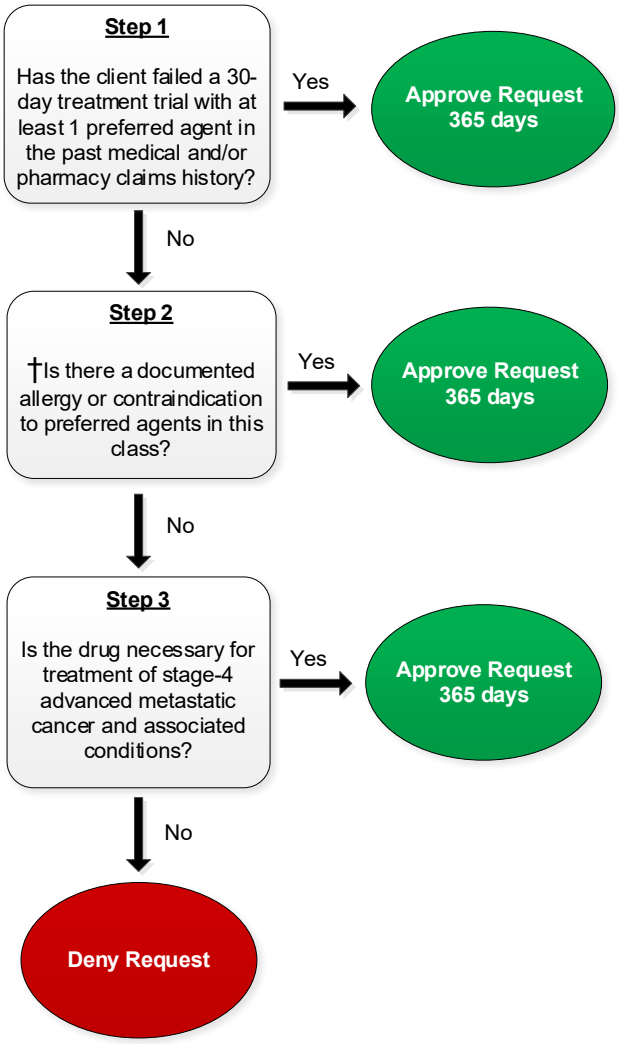
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Pancreatic Enzymes
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Pancreatic Enzymes Alternate Therapies

## Preferred Pancreatic Enzymes

| GCN | Drug Name |
|---|---|
| 26177 | CREON DR 12,000 UNIT CAPSULE |
| 26178 | CREON DR 24,000 UNIT CAPSULE |
| 30217 | CREON DR 3,000 UNIT CAPSULE |
| 34557 | CREON DR 36,000 UNIT CAPSULE |
| 26176 | CREON DR 6,000 UNIT CAPSULE |
| 44601 | ZENPEP DR 10,000 UNIT CAPSULE |
| 44697 | ZENPEP DR 15,000 UNIT CAPSULE |
| 44131 | ZENPEP DR 20,000 UNIT CAPSULE |
| 44449 | ZENPEP DR 25,000 UNIT CAPSULE |
| 44742 | ZENPEP DR 3,000 UNIT CAPSULE |
| 44136 | ZENPEP DR 40,000 UNIT CAPSULE |
| 44448 | ZENPEP DR 5,000 UNIT CAPSULE |
| 55126 | ZENPEP DR 60,000 UNIT CAPSULE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 102 Pediatric Vitamin Preparations

# Pediatric Vitamin Preparations Prior Authorization Criteria

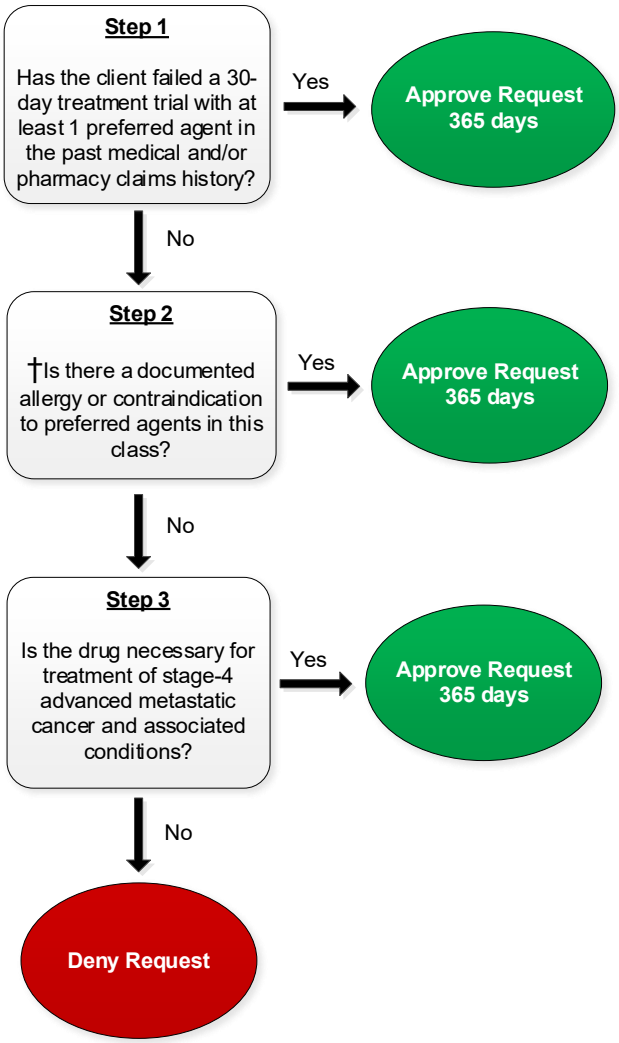
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Pediatric Vitamin Preparations Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Pediatric Vitamin Preparations Alternate Therapies

## Preferred Pediatric Vitamin Preparations

| GCN | Drug Name |
|---|---|
| 28186 | MULTIVIT-FLUOR 0.25 MG TAB CHW |
| 36433 | MULTIVIT-FLUOR 0.25 MG/ML DROP |
| 28187 | MULTIVIT-FLUOR 0.5 MG TAB CHEW |
| 36434 | MULTIVIT-FLUOR 0.5 MG/ML DROP |
| 28188 | MULTIVIT-FLUORIDE 1 MG TAB CHW |
| 36455 | MULTIVIT-FLUOR-IRON 0.25 MG/ML |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 103 Penicillins

# Penicillins
# Prior Authorization Criteria

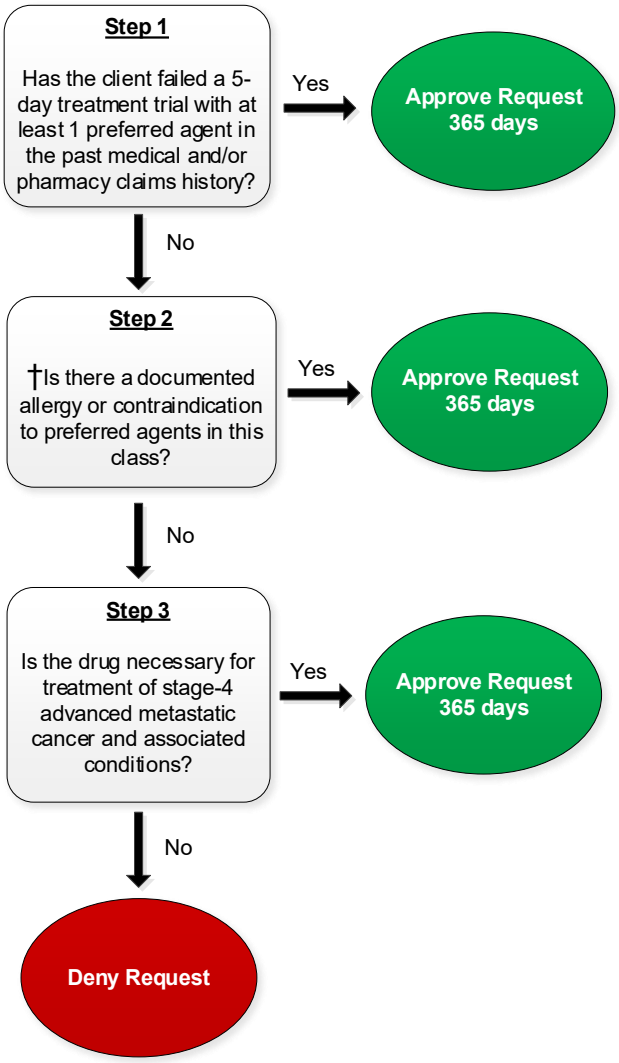
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Penicillins
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Penicillins
# Alternate Therapies

## Preferred Penicillins

| GCN | Drug Name |
|---|---|
| 39650 | AMOXICILLIN 125 MG TAB CHEW |
| 39681 | AMOXICILLIN 125 MG/5 ML SUSP |
| 93385 | AMOXICILLIN 200 MG/5 ML SUSP |
| 39660 | AMOXICILLIN 250 MG CAPSULE |
| 39651 | AMOXICILLIN 250 MG TAB CHEW |
| 39683 | AMOXICILLIN 250 MG/5 ML SUSP |
| 93375 | AMOXICILLIN 400 MG/5 ML SUSP |
| 39661 | AMOXICILLIN 500 MG CAPSULE |
| 61252 | AMOXICILLIN 500 MG TABLET |
| 39632 | AMOXICILLIN 875 MG TABLET |
| 39272 | AMPICILLIN 500 MG CAPSULE |
| 39541 | DICLOXACILLIN 250 MG CAPSULE |
| 39542 | DICLOXACILLIN 500 MG CAPSULE |
| 39022 | PENICILLIN VK 125 MG/5 ML SOLN |
| 39053 | PENICILLIN VK 250 MG TABLET |
| 39024 | PENICILLIN VK 250 MG/5 ML SOLN |
| 39055 | PENICILLIN VK 500 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 104 Phosphate Binders

# Phosphate Binders
# Prior Authorization Criteria

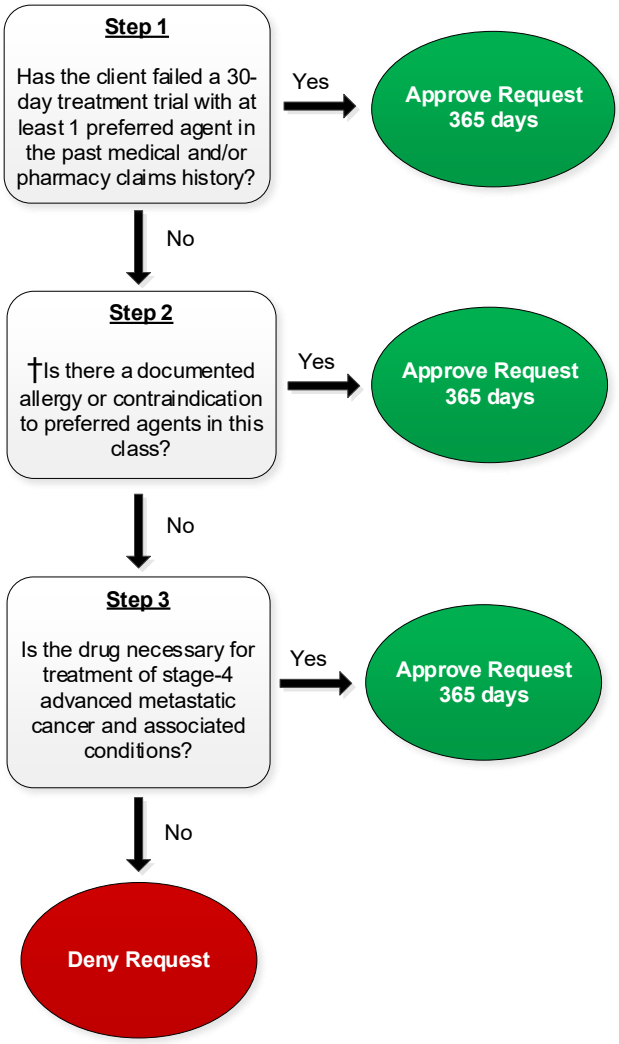
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Phosphate Binders
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Phosphate Binders Alternate Therapies

## Preferred Phosphate Binders

| GCN | Drug Name |
|---|---|
| 13675 | CALCIUM ACETATE 667 MG CAPSULE |
| 03694 | CALCIUM ACETATE 667 MG TABLET |
| 75051 | CALCIUM ACETATE 667 MG TABLET |
| 49608 | MAGNEBIND 400 TABLET |
| 16853 | RENAGEL 800 MG TABLET |
| 27483 | RENVELA 0.8 GM POWDER PACKET |
| 27484 | RENVELA 2.4 GM POWDER PACKET |
| 99200 | RENVELA 800 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 105 Platelet Aggregation Inhibitors

# Platelet Aggregation Inhibitors
# Prior Authorization Criteria

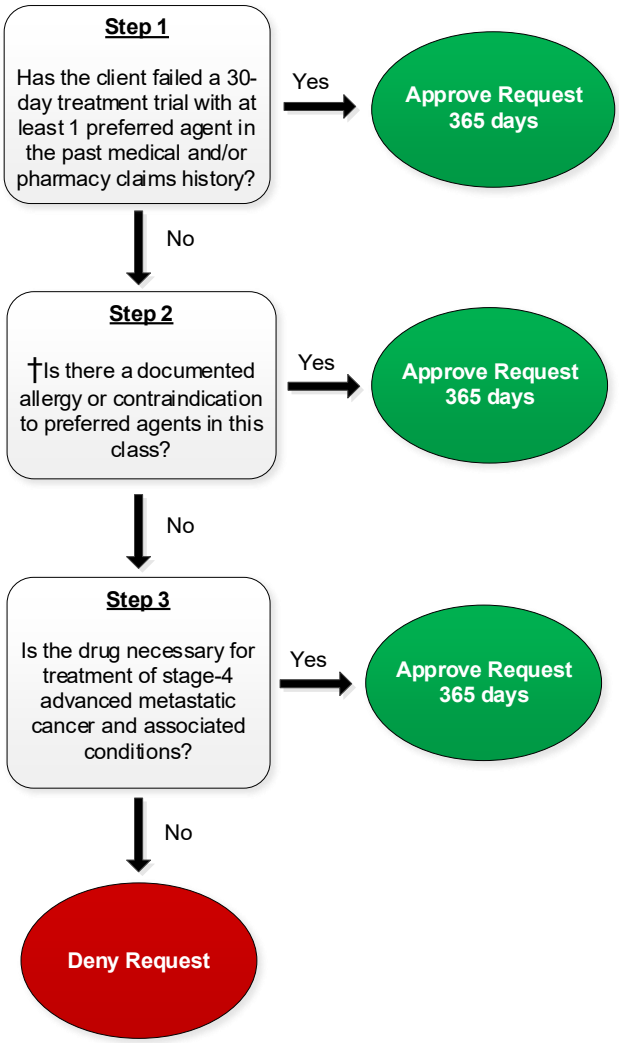
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Platelet Aggregation Inhibitors
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Platelet Aggregation Inhibitors Alternate Therapies

## Preferred Platelet Aggregation Inhibitors

| GCN | Drug Name |
|---|---|
| 95347 | ASPIRIN-DIPYRIDAM ER 25-200 MG |
| 42297 | ASPIRIN-OMEPRAZOLE DR 81-40 MG |
| 39407 | BRILINTA 60 MG TABLET |
| 29385 | BRILINTA 90 MG TABLET |
| 99266 | CLOPIDOGREL 300 MG TABLET |
| 96010 | CLOPIDOGREL 75 MG TABLET |
| 17157 | PRASUGREL 10 MG TABLET |
| 17056 | PRASUGREL 5 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 106 Potassium Binders

# Potassium Binders
# Prior Authorization Criteria

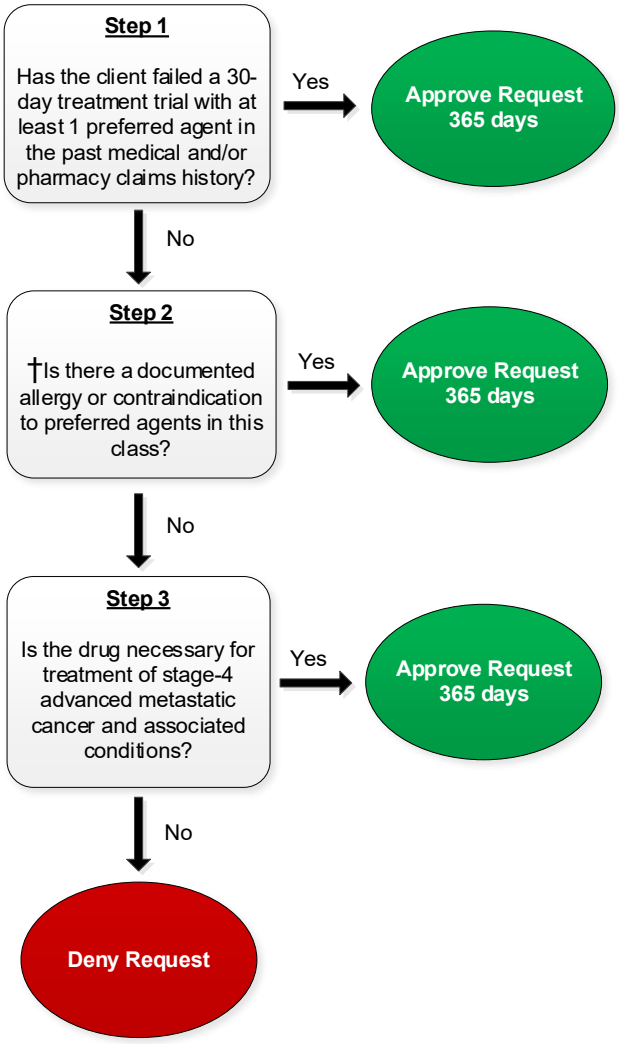
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Potassium Binders
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Potassium Binders Alternate Therapies

## Preferred Potassium Binders

| GCN | Drug Name |
|---|---|
| 44775 | LOKELMA 10 GRAM POWDER PACKET |
| 44774 | LOKELMA 5 GRAM POWDER PACKET |
| 02890 | SOD POLYSTYRENE SULF 15 GM CUP |
| 40066 | VELTASSA 16.8 GM POWDER PACKET |
| 40067 | VELTASSA 25.2 GM POWDER PACKET |
| 40065 | VELTASSA 8.4 GM POWDER PACKET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 107 Prenatal Vitamins

# Prenatal Vitamins
# Prior Authorization Criteria

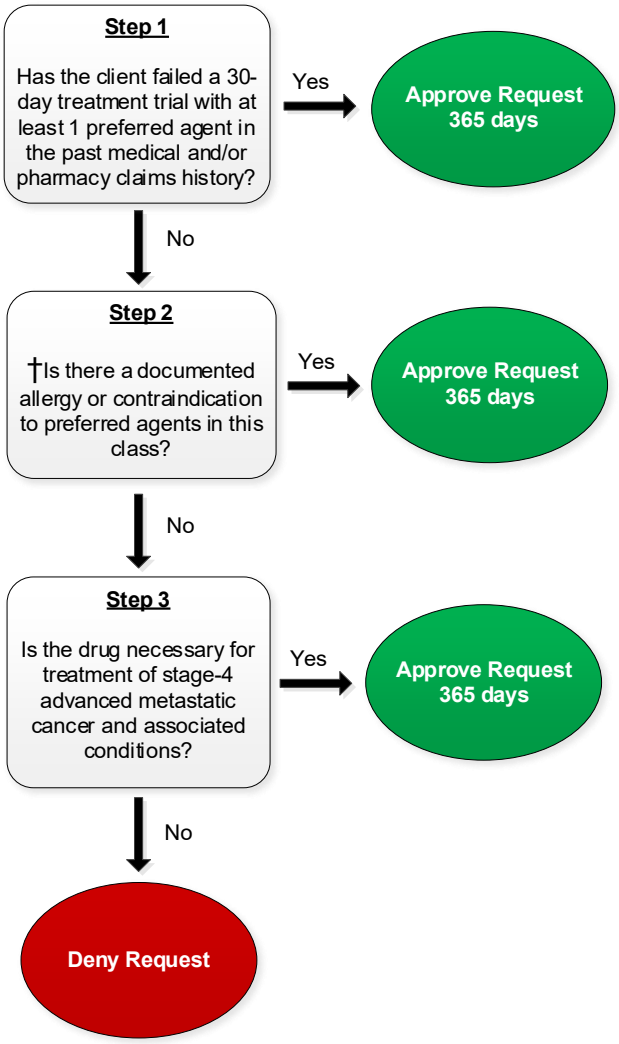
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Prenatal Vitamins
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Prenatal Vitamins
# Alternate Therapies

## Preferred Prenatal Vitamins

| GCN | Drug Name |
|---|---|
| 24967 | COMPLETE NATAL DHA |
| 21573 | FOLIVANE-OB CAPSULE |
| 28688 | M-NATAL PLUS TABLET |
| 28796 | PNV 29-1 TABLET |
| 28688 | PRENATAL VITAMIN PLUS LOW IRON |
| 28688 | PREPLUS CA-FE 27 MG-FA 1 MG TAB |
| 30684 | SELECT-OB + DHA PACK |
| 28796 | THRIVITE RX TABLET |
| 32229 | TRICARE PRENATAL TABLET |
| 99629 | TRINATAL RX 1 TABLET |
| 40957 | VITAFOL GUMMIES |
| 35169 | VITAFOL ULTRA SOFTGEL |
| 97624 | VITAFOL-OB CAPLET |
| 98019 | VITAFOL-OB+DHA COMBO PACK |
| 30046 | VITAFOL-ONE CAPSULE |
| 28688 | WESTAB PLUS TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 108 Progestins for Cachexia

# Progestins for Cachexia
# Prior Authorization Criteria

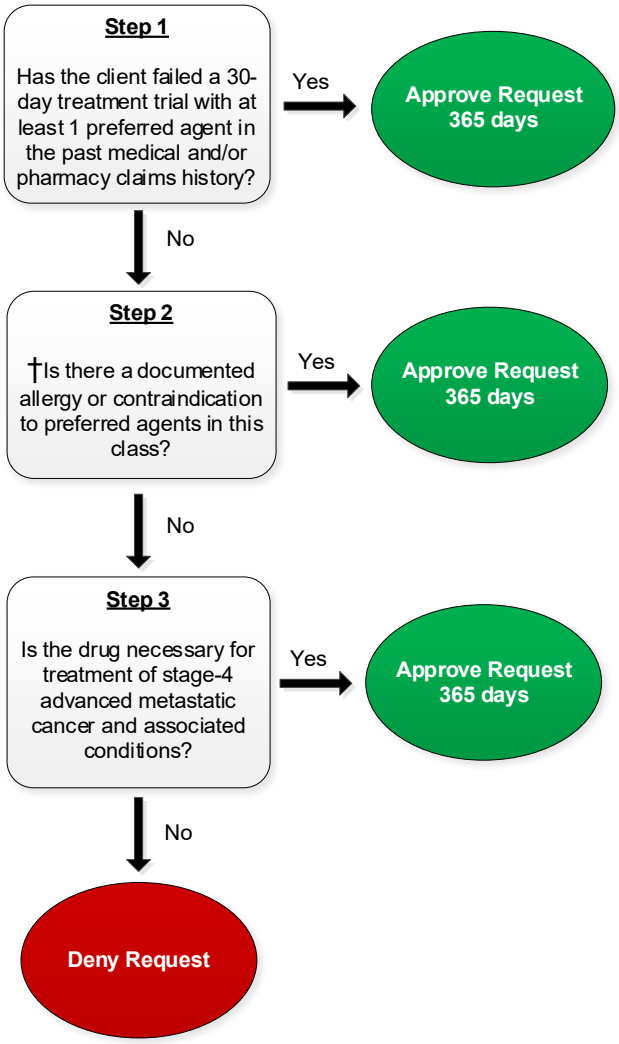
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Progestins for Cachexia
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Progestins for Cachexia Alternate Therapies

## Preferred Progestins for Cachexia

| GCN | Drug Name |
|---|---|
| 38680 | MEGESTROL 20 MG TABLET |
| 38681 | MEGESTROL 40 MG TABLET |
| 33559 | MEGESTROL 400 MG/10 ML CUP |
| 33569 | MEGESTROL 800 MG/20ML SUSP CUP |
| 40381 | MEGESTROL ACET 40 MG/ML SUSP |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 109 Proton Pump Inhibitors

# Proton Pump Inhibitors
# Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with each* preferred agent within the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

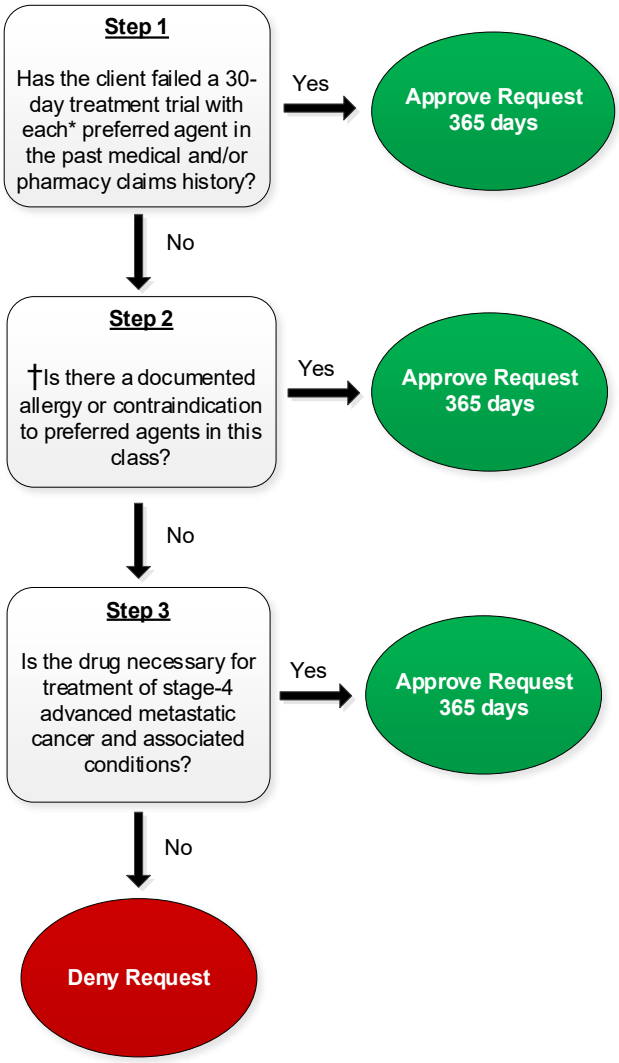
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

**Clients are not required to try different formulations or different strengths of each preferred agent.*

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Proton Pump Inhibitors
# Prior Authorization Criteria




**Clients are not required to try different formulations or different strengths of each preferred agent.*

†Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Proton Pump Inhibitors Alternate Therapies

## Preferred Proton Pump Inhibitors

| GCN | Drug Name |
|---|---|
| 99389 | NEXIUM DR 10 MG PACKET |
| 33128 | NEXIUM DR 2.5 MG PACKET |
| 98030 | NEXIUM DR 20 MG PACKET |
| 98031 | NEXIUM DR 40 MG PACKET |
| 33135 | NEXIUM DR 5 MG PACKET |
| 92989 | OMEPRAZOLE DR 10 MG CAPSULE |
| 04348 | OMEPRAZOLE DR 20 MG CAPSULE |
| 92999 | OMEPRAZOLE DR 40 MG CAPSULE |
| 95976 | PANTOPRAZOLE SOD DR 20 MG TAB |
| 40120 | PANTOPRAZOLE SOD DR 40 MG TAB |
| 01697 | PREVACID 24HR DR 15 MG CAPSULE |
| 99418 | PROTONIX 40 MG SUSPENSION |
| 95976 | PROTONIX DR 20 MG TABLET |
| 40120 | PROTONIX DR 40 MG TABLET |
| 26632 | ZEGERID 20 MG CAPSULE |
| 26634 | ZEGERID 20 MG PACKET |
| 26633 | ZEGERID 40 MG CAPSULE |
| 26635 | ZEGERID 40 MG PACKET |
| 26632 | ZEGERID OTC 20-1,100 MG CAP |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 110 Rosacea Agents, Topical

# Rosacea Agents, Topical
# Prior Authorization Criteria

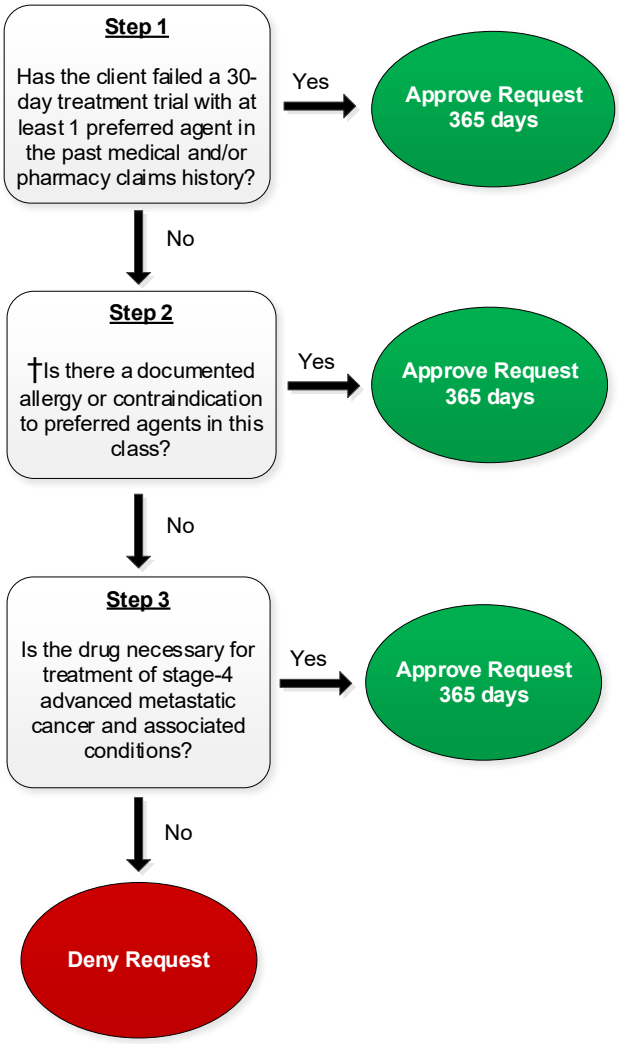
1. Has the client failed a 30-day treatment trial with a preferred agent within the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Rosacea Agents, Topical
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Rosacea Agents, Topical Alternate Therapies

## Preferred Rosacea Agents, Topical

| GCN | Drug Name |
|---|---|
| 39274 | FINACEA 15% FOAM |
| 43203 | METRONIDAZOLE 0.75% CREAM |
| 31774 | METRONIDAZOLE TOP 1% GEL PUMP |
| 43202 | METRONIDAZOLE TOPICAL 0.75% GL |
| 24926 | METRONIDAZOLE TOPICAL 1% GEL |
| 43204 | NORITATE 1% CREAM |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 111 Sedatives and Hypnotics

# Sedatives and Hypnotics
# Prior Authorization Criteria

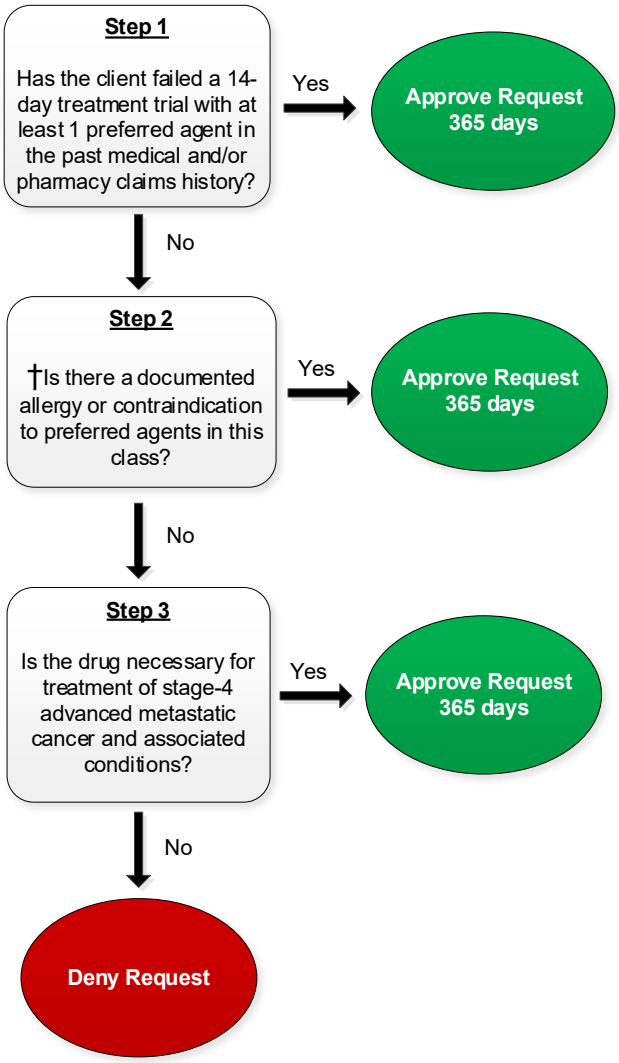
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Sedatives and Hypnotics Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Sedatives and Hypnotics Alternate Therapies

## Preferred Sedatives and Hypnotics

| GCN | Drug Name |
|---|---|
| 00871 | AMBIEN 10 MG TABLET |
| 00870 | AMBIEN 5 MG TABLET |
| 25457 | AMBIEN CR 12.5 MG TABLET |
| 25456 | AMBIEN CR 6.25 MG TABLET |
| 25456 | AMBIEN CR 6.25 MG TABLET |
| 23927 | ESZOPICLONE 1 MG TABLET |
| 23926 | ESZOPICLONE 2 MG TABLET |
| 23925 | ESZOPICLONE 3 MG TABLET |
| 13840 | RESTORIL 15 MG CAPSULE |
| 24036 | RESTORIL 22.5 MG CAPSULE |
| 13841 | RESTORIL 30 MG CAPSULE |
| 13845 | RESTORIL 7.5 MG CAPSULE |
| 13840 | TEMAZEPAM 15 MG CAPSULE |
| 13841 | TEMAZEPAM 30 MG CAPSULE |
| 14282 | TRIAZOLAM 0.125 MG TABLET |
| 14280 | TRIAZOLAM 0.25 MG TABLET |
| 92723 | ZALEPLON 10 MG CAPSULE |
| 92713 | ZALEPLON 5 MG CAPSULE |
| 00871 | ZOLPIDEM TARTRATE 10 MG TABLET |
| 00870 | ZOLPIDEM TARTRATE 5 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 112 Sickle Cell Anemia Treatments

# Sickle Cell Anemia Treatments Prior Authorization Criteria

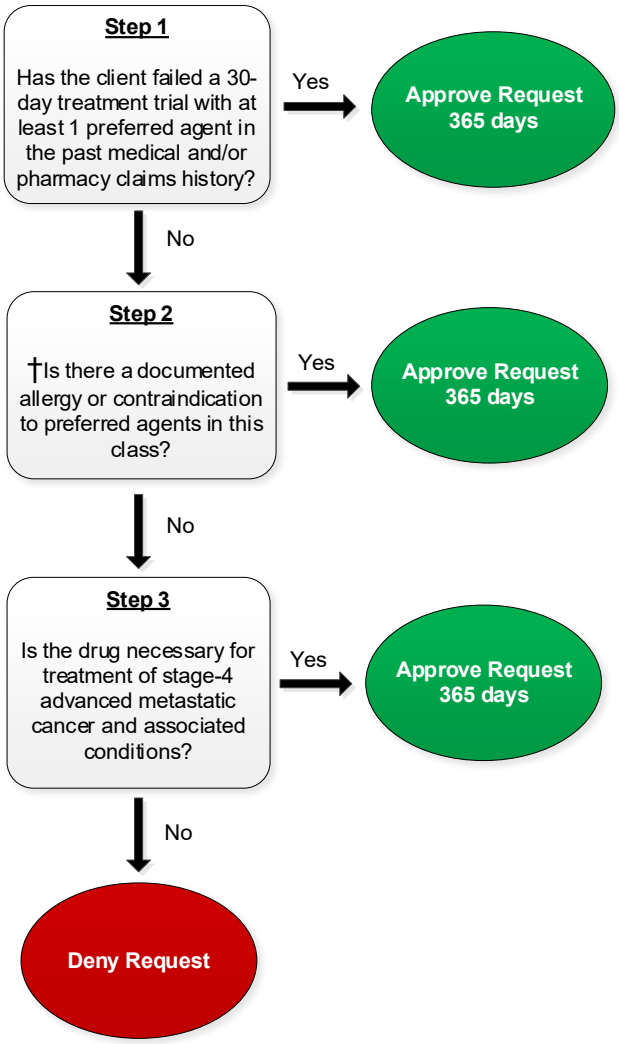
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Sickle Cell Anemia Treatments Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Sickle Cell Anemia Treatments Alternate Therapies

## Preferred Sickle Cell Anemia Treatments

| GCN | Drug Name |
|---|---|
| 38402 | DROXIA 200 MG CAPSULE |
| 38403 | DROXIA 300 MG CAPSULE |
| 38404 | DROXIA 400 MG CAPSULE |
| 44283 | ENDARI 5 GRAM POWDER PACKET |
| 44626 | SIKLOS 1,000 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 113 Skeletal Muscle Relaxants

# Skeletal Muscle Relaxants
# Prior Authorization Criteria

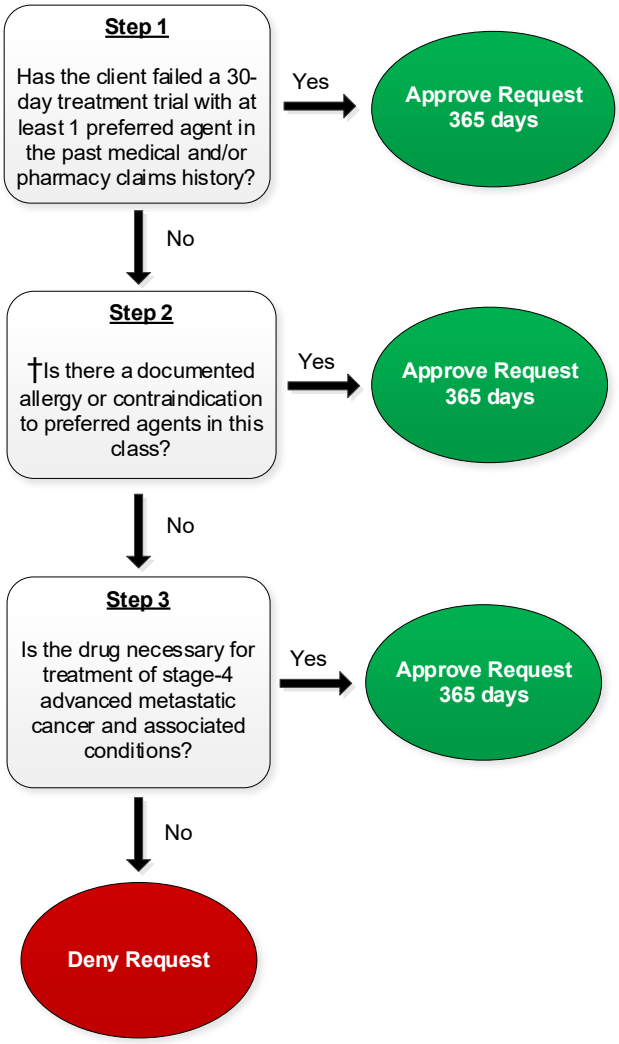
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Skeletal Muscle Relaxants Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Skeletal Muscle Relaxants Alternate Therapies

## Preferred Skeletal Muscle Relaxants

| GCN | Drug Name |
|---|---|
| 18010 | BACLOFEN 10 MG TABLET |
| 18011 | BACLOFEN 20 MG TABLET |
| 18012 | BACLOFEN 5 MG TABLET |
| 98857 | CARISOPRODOL 250 MG TABLET |
| 17912 | CARISOPRODOL 350 MG TABLET |
| 18020 | CYCLOBENZAPRINE 10 MG TABLET |
| 12805 | CYCLOBENZAPRINE 5 MG TABLET |
| 98299 | CYCLOBENZAPRINE 7.5 MG TABLET |
| 17892 | METHOCARBAMOL 500 MG TABLET |
| 17893 | METHOCARBAMOL 750 MG TABLET |
| 14690 | TIZANIDINE HCL 2 MG TABLET |
| 14693 | TIZANIDINE HCL 4 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 114 Smoking Cessation

# Smoking Cessation
# Prior Authorization Criteria

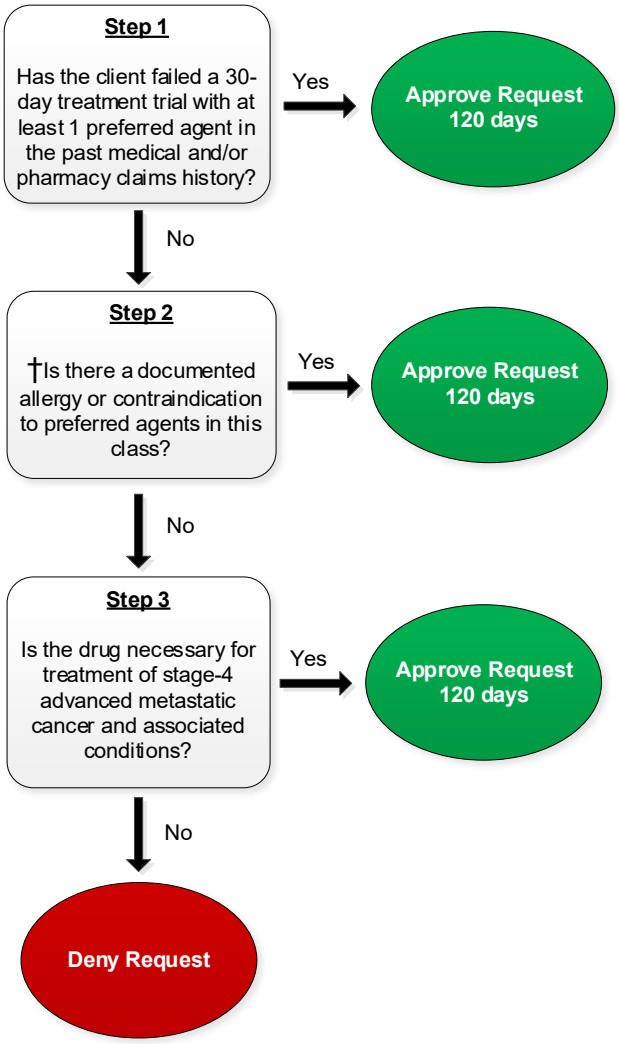
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 120 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 120 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 120 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Smoking Cessation
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Smoking Cessation Alternate Therapies

## Preferred Smoking Cessation Agents

| GCN | Drug Name |
|---|---|
| 27046 | APO-VARENICLINE 0.5 MG TABLET |
| 27047 | APO-VARENICLINE 1 MG TABLET |
| 27901 | BUPROPION HCL SR 150 MG TABLET |
| 27046 | CHANTIX 0.5MG TABLET |
| 27047 | CHANTIX 1MG TABLET |
| 27048 | CHANTIX STARTING MONTH BOX |
| 27048 | CHANTIX STARTING MONTH BOX |
| 03422 | CVS NICOTINE 14 MG/24HR PATCH |
| 03200 | CVS NICOTINE 2 MG CHEWING GUM |
| 14689 | CVS NICOTINE 2 MG LOZENGE |
| 43057 | CVS NICOTINE 2 MG MINI LOZENGE |
| 03423 | CVS NICOTINE 21 MG/24HR PATCH |
| 03201 | CVS NICOTINE 4 MG CHEWING GUM |
| 14688 | CVS NICOTINE 4 MG LOZENGE |
| 43056 | CVS NICOTINE 4 MG MINI LOZENGE |
| 03421 | CVS NICOTINE 7 MG/24HR PATCH |
| 43057 | GS NICOTINE 2 MG MINI LOZENGE |
| 43057 | NICOTINE 2 MG MINI LOZENGE |
| 18772 | NICOTINE TRANSDERMAL SYSTEM |
| 27046 | VARENICLINE 0.5 MG TABLET |
| 27047 | VARENICLINE 1 MG TABLET |

| GCN | Drug Name |
|---|---|
| 27048 | VARENICLINE STARTING MONTH BOX |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 115 Steroids, Topical

# Steroids, Topical
# Prior Authorization Criteria

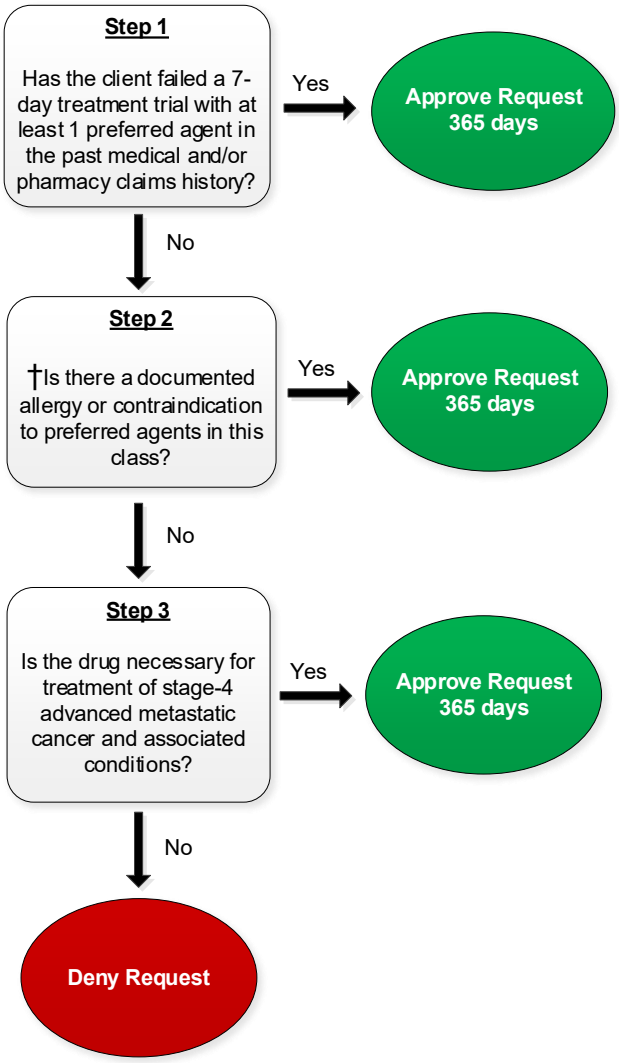
1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Steroids, Topical
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Steroids, Topical
# Alternate Therapies

## Preferred Topical Steroids, Low

| GCN | Drug Name |
|---|---|
| 30942 | ALA-CORT 1% CREAM |
| 28850 | ANUSOL-HC 2.5% CREAM |
| 30951 | AQUAPHOR ITCH RELIEF 1% OINT |
| 92421 | CORTIZONE-10 FEM ITCH 1% CREME |
| 85080 | DERMA-SMOOTHE-FS BODY OIL |
| 24484 | DERMA-SMOOTHE-FS SCALP OIL |
| 30841 | GNP HYDROCORT ACETATE 1% CR |
| 30842 | GNP HYDROCORTISONE 0.5% CRM |
| 30941 | HYDROCORTISONE 0.5% CREAM |
| 30946 | HYDROCORTISONE 1% CREAM PACKET |
| 30851 | HYDROCORTISONE 1% OINTMENT |
| 30943 | HYDROCORTISONE 2.5% CREAM |
| 28850 | HYDROCORTISONE 2.5% CREAM |
| 28850 | HYDROCORTISONE 2.5% CREAM |
| 30952 | HYDROCORTISONE 2.5% OINTMENT |
| 28850 | PROCTO-MED HC 2.5% CREAM |
| 28850 | PROCTOSOL-HC 2.5% CREAM |
| 28850 | PROCTOZONE-HC 2.5% CREAM |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

## Preferred Topical Steroids, Medium

| GCN | Drug Name |
|---|---|
| 48641 | FLUTICASONE PROP 0.005% OINT |
| 43951 | FLUTICASONE PROP 0.05% CREAM |
| 45850 | MOMETASONE FUROATE 0.1% CREAM |
| 45930 | MOMETASONE FUROATE 0.1% OINT |
| 06034 | MOMETASONE FUROATE 0.1% SOLN |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

## Preferred Topical Steroids, High

| GCN | Drug Name |
|---|---|
| 31080 | BETAMETHASONE DP 0.05% LOT |
| 31890 | BETAMETHASONE DP AUG 0.05% CRM |
| 31101 | BETAMETHASONE VA 0.1% CREAM |
| 31110 | BETAMETHASONE VALER 0.1% OINTM |
| 31910 | DIPROLENE 0.05% OINTMENT |
| 31231 | TRIAMCINOLONE 0.025% CREAM |
| 31260 | TRIAMCINOLONE 0.025% LOTION |
| 31241 | TRIAMCINOLONE 0.025% OINT |
| 31243 | TRIAMCINOLONE 0.05% OINTMENT |
| 31232 | TRIAMCINOLONE 0.1% CREAM |
| 31261 | TRIAMCINOLONE 0.1% LOTION |
| 31242 | TRIAMCINOLONE 0.1% OINTMENT |
| 31233 | TRIAMCINOLONE 0.5% CREAM |
| 31244 | TRIAMCINOLONE 0.5% OINTMENT |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

## Preferred Topical Steroids, Very High

| GCN | Drug Name |
|---|---|
| 32140 | CLOBETASOL 0.05% CREAM |
| 15892 | CLOBETASOL 0.05% GEL |
| 32130 | CLOBETASOL 0.05% OINTMENT |
| 15891 | CLOBETASOL 0.05% SOLUTION |
| 34141 | CLOBETASOL EMOLLIENT 0.05% CRM |
| 31251 | HALOBETASOL PROP 0.05% CREAM |
| 31211 | HALOBETASOL PROP 0.05% OINTMNT |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 116 Stimulants and Related Agents

# Stimulants and Related Agents
# Prior Authorization Criteria

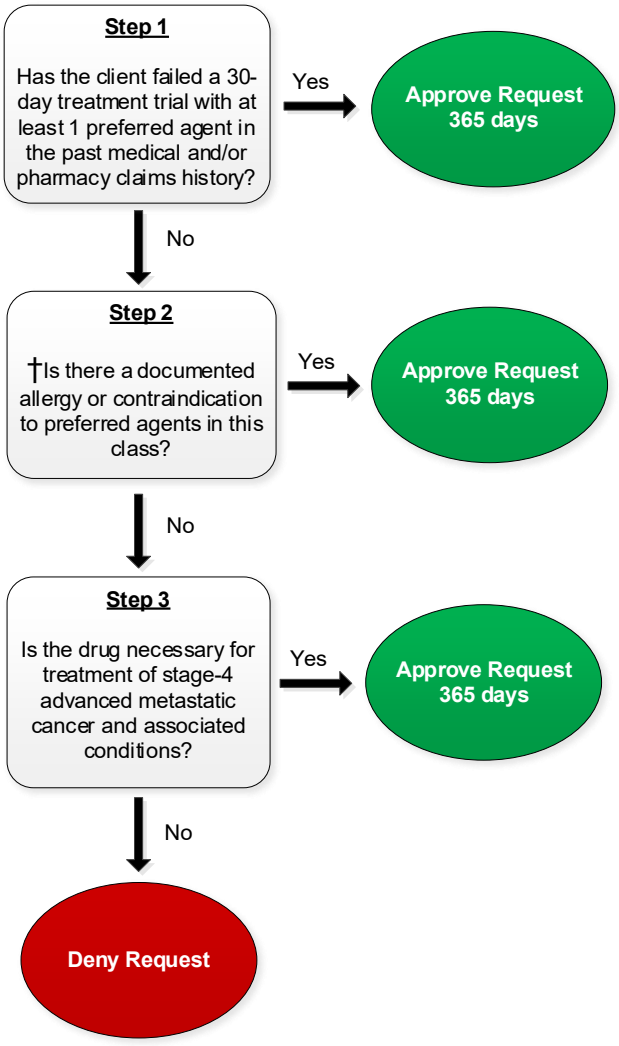
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Stimulants and Related Agents
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Stimulants and Related Agents
# Alternate Therapies

## Preferred Stimulants and Related Agents

| GCN | Drug Name |
|---|---|
| 56971 | ADDERALL 10 MG TABLET |
| 29008 | ADDERALL 12.5 MG TABLET |
| 29009 | ADDERALL 15 MG TABLET |
| 56973 | ADDERALL 20 MG TABLET |
| 56972 | ADDERALL 30 MG TABLET |
| 56970 | ADDERALL 5 MG TABLET |
| 29007 | ADDERALL 7.5 MG TABLET |
| 14635 | ADDERALL XR 10 MG CAPSULE |
| 17468 | ADDERALL XR 15 MG CAPSULE |
| 14636 | ADDERALL XR 20 MG CAPSULE |
| 17469 | ADDERALL XR 25 MG CAPSULE |
| 14637 | ADDERALL XR 30 MG CAPSULE |
| 17459 | ADDERALL XR 5 MG CAPSULE |
| 18776 | ATOMOXETINE HCL 10 MG CAPSULE |
| 26539 | ATOMOXETINE HCL 100 MG CAPSULE |
| 18777 | ATOMOXETINE HCL 18 MG CAPSULE |
| 18778 | ATOMOXETINE HCL 25 MG CAPSULE |
| 18779 | ATOMOXETINE HCL 40 MG CAPSULE |
| 18781 | ATOMOXETINE HCL 60 MG CAPSULE |
| 26538 | ATOMOXETINE HCL 80 MG CAPSULE |
| 12567 | CONCERTA ER 18 MG TABLET |

| GCN | Drug Name |
|---|---|
| 17123 | CONCERTA ER 27 MG TABLET |
| 12568 | CONCERTA ER 36 MG TABLET |
| 12248 | CONCERTA ER 54 MG TABLET |
| 26801 | DAYTRANA 10 MG/9 HR PATCH |
| 26802 | DAYTRANA 15 MG/9 HR PATCH |
| 26803 | DAYTRANA 20 MG/9 HOUR PATCH |
| 26804 | DAYTRANA 30 MG/9 HOUR PATCH |
| 19850 | DEXEDRINE SPANSULE 10 MG |
| 14975 | DEXMETHYLPHENIDATE 10 MG TAB |
| 14973 | DEXMETHYLPHENIDATE 2.5 MG TAB |
| 14974 | DEXMETHYLPHENIDATE 5 MG TAB |
| 29008 | DEXTROAMP-AMPHETAM 12.5 MG TAB |
| 29007 | DEXTROAMP-AMPHETAM 7.5 MG TAB |
| 56971 | DEXTROAMP-AMPHETAMIN 10 MG TAB |
| 29009 | DEXTROAMP-AMPHETAMIN 15 MG TAB |
| 56973 | DEXTROAMP-AMPHETAMIN 20 MG TAB |
| 56972 | DEXTROAMP-AMPHETAMIN 30 MG TAB |
| 56970 | DEXTROAMP-AMPHETAMINE 5 MG TAB |
| 19880 | DEXTROAMPHETAMINE 10 MG TAB |
| 19885 | DEXTROAMPHETAMINE 15 MG TAB |
| 34734 | DEXTROAMPHETAMINE 2.5 MG TAB |
| 36463 | DEXTROAMPHETAMINE 20 MG TAB |
| 36464 | DEXTROAMPHETAMINE 30 MG TAB |
| 19881 | DEXTROAMPHETAMINE 5 MG TAB |
| 34735 | DEXTROAMPHETAMINE 7.5 MG TAB |

| GCN | Drug Name |
|---|---|
| 39686 | DYANAVEL XR 2.5 MG/ML SUSP |
| 24734 | FOCALIN XR 10 MG CAPSULE |
| 97111 | FOCALIN XR 15 MG CAPSULE |
| 24735 | FOCALIN XR 20 MG CAPSULE |
| 30305 | FOCALIN XR 25 MG CAPSULE |
| 28035 | FOCALIN XR 30 MG CAPSULE |
| 30306 | FOCALIN XR 35 MG CAPSULE |
| 28933 | FOCALIN XR 40 MG CAPSULE |
| 24733 | FOCALIN XR 5 MG CAPSULE |
| 27576 | GUANFACINE HCL ER 1 MG TABLET |
| 27578 | GUANFACINE HCL ER 2 MG TABLET |
| 27579 | GUANFACINE HCL ER 3 MG TABLET |
| 27582 | GUANFACINE HCL ER 4 MG TABLET |
| 45110 | JORNAY PM 100 MG CAPSULE |
| 45106 | JORNAY PM 20 MG CAPSULE |
| 45107 | JORNAY PM 40 MG CAPSULE |
| 45108 | JORNAY PM 60 MG CAPSULE |
| 45109 | JORNAY PM 80 MG CAPSULE |
| 22686 | METHYLIN 10 MG/5 ML SOLUTION |
| 22685 | METHYLIN 5 MG/5 ML SOLUTION |
| 15911 | METHYLPHENIDATE 10 MG TABLET |
| 15920 | METHYLPHENIDATE 20 MG TABLET |
| 15913 | METHYLPHENIDATE 5 MG TABLET |
| 26101 | PROVIGIL 100 MG TABLET |
| 26102 | PROVIGIL 200 MG TABLET |

| GCN | Drug Name |
|---|---|
| 49447 | QELBREE ER 100 MG CAPSULE |
| 49449 | QELBREE ER 150 MG CAPSULE |
| 49452 | QELBREE ER 200 MG CAPSULE |
| 33887 | QUILLIVANT XR 25 MG/5 ML SUSP |
| 21763 | RITALIN LA 10 MG CAPSULE |
| 20387 | RITALIN LA 20 MG CAPSULE |
| 20388 | RITALIN LA 30 MG CAPSULE |
| 20391 | RITALIN LA 40 MG CAPSULE |
| 37674 | VYVANSE 10 MG CAPSULE |
| 42969 | VYVANSE 10 MG CHEWABLE TABLET |
| 99366 | VYVANSE 20 MG CAPSULE |
| 43058 | VYVANSE 20 MG CHEWABLE TABLET |
| 98071 | VYVANSE 30 MG CAPSULE |
| 43059 | VYVANSE 30 MG CHEWABLE TABLET |
| 99367 | VYVANSE 40 MG CAPSULE |
| 43063 | VYVANSE 40 MG CHEWABLE TABLET |
| 98072 | VYVANSE 50 MG CAPSULE |
| 43064 | VYVANSE 50 MG CHEWABLE TABLET |
| 99368 | VYVANSE 60 MG CAPSULE |
| 43065 | VYVANSE 60 MG CHEWABLE TABLET |
| 98073 | VYVANSE 70 MG CAPSULE |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 117 Tetracyclines

# Tetracyclines
# Prior Authorization Criteria

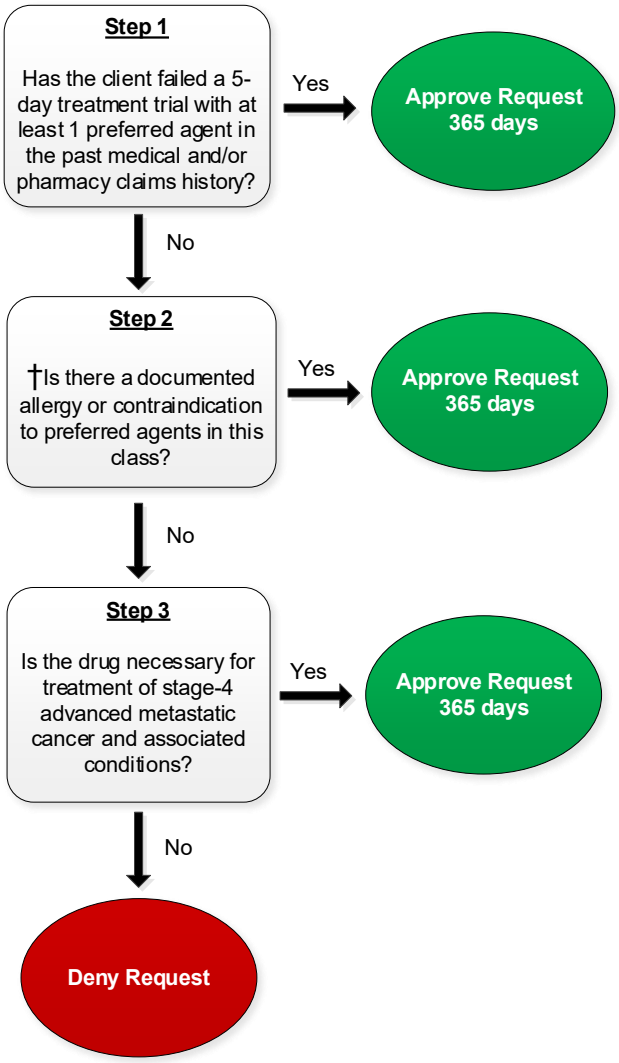
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Tetracyclines
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Tetracyclines
# Alternate Therapies

## Preferred Tetracyclines

| GCN | Drug Name |
|---|---|
| 40370 | DOXYCYCLINE 25 MG/5 ML SUSP |
| 40331 | DOXYCYCLINE HYCLATE 100 MG CAP |
| 40333 | DOXYCYCLINE HYCLATE 50 MG CAP |
| 40651 | DOXYCYCLINE MONO 100 MG CAP |
| 40652 | DOXYCYCLINE MONO 50 MG CAP |
| 40410 | MINOCYCLINE 100 MG CAPSULE |
| 40411 | MINOCYCLINE 50 MG CAPSULE |
| 93387 | MINOCYCLINE 75 MG CAPSULE |
| 40370 | VIBRAMYCIN 25MG/5ML SUSP |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 118 Thrombopoiesis Stimulating Proteins

# Thrombopoiesis Stimulating Proteins Prior Authorization Criteria

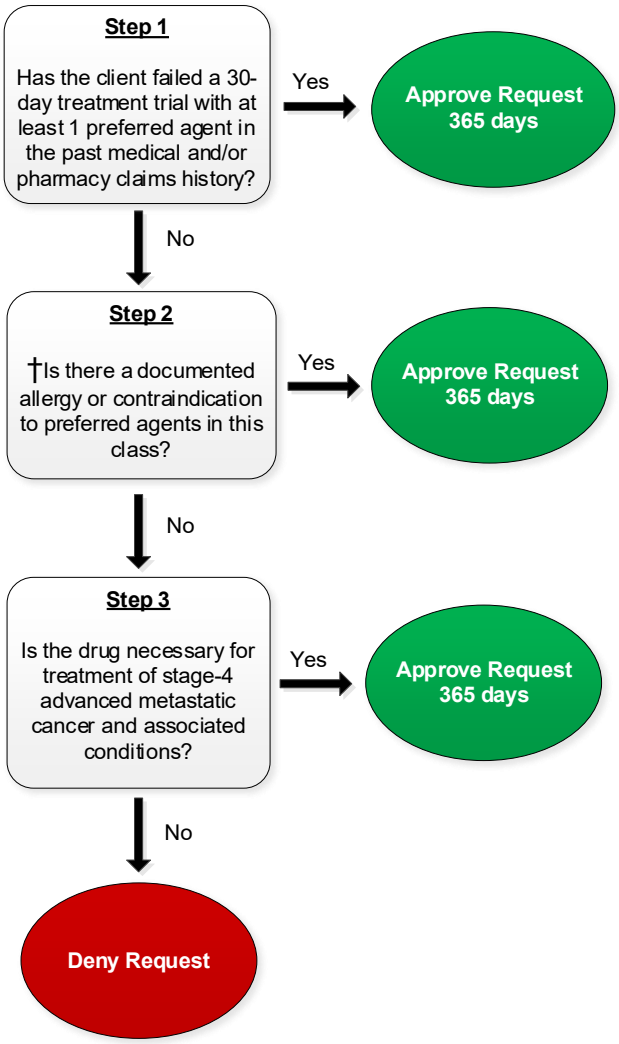
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Thrombopoiesis Stimulating Proteins Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Thrombopoiesis Stimulating Proteins Alternate Therapies

## Preferred Thrombopoiesis Stimulating Proteins

| GCN | Drug Name |
|---|---|
| 31176 | PROMACTA 12.5 MG TABLET |
| 15994 | PROMACTA 25 MG TABLET |
| 15995 | PROMACTA 50 MG TABLET |
| 28344 | PROMACTA 75 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 119 Ulcerative Colitis Agents

# Ulcerative Colitis Agents
# Prior Authorization Criteria

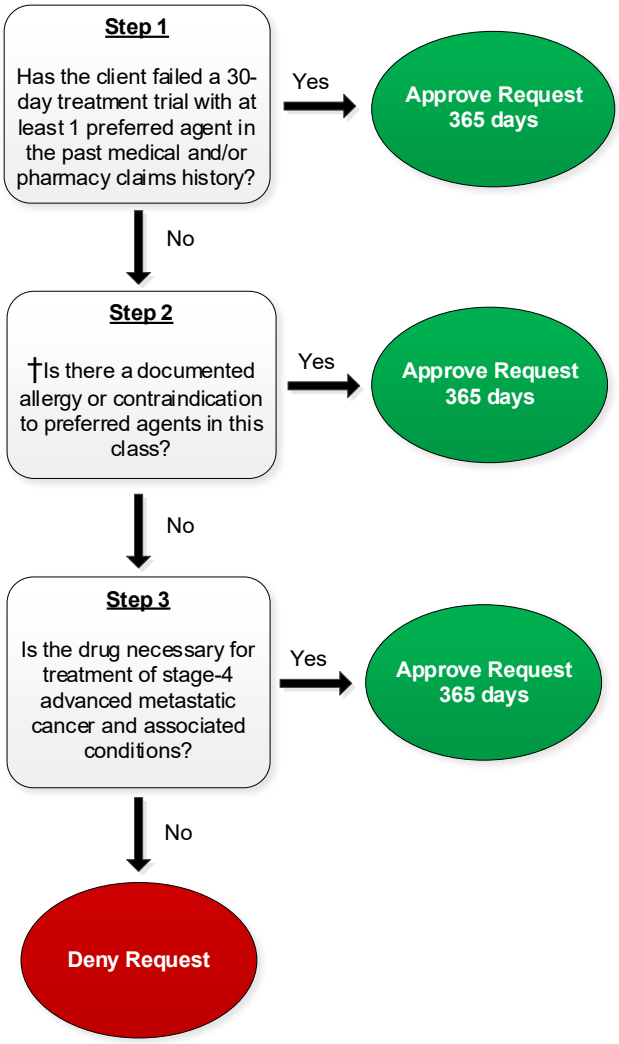
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Ulcerative Colitis Agents
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Ulcerative Colitis Agents Alternate Therapies

## Preferred Ulcerative Colitis Agents

| GCN | Drug Name |
|---|---|
| 16159 | APRISO ER 0.375 GRAM CAPSULE |
| 48490 | CANASA 1,000 MG SUPPOSITORY |
| 41428 | DELZICOL DR 400 MG CAPSULE |
| 33401 | DIPENTUM 250 MG CAPSULE |
| 97842 | MESALAMINE DR 1.2 GM TABLET |
| 30220 | PENTASA 250 MG CAPSULE |
| 23422 | PENTASA 500 MG CAPSULE |
| 47270 | SFROWASA 4 GM/60 ML ENEMA |
| 41611 | SULFASALAZINE 500 MG TABLET |
| 41620 | SULFASALAZINE DR 500 MG TAB |
| 34063 | UCERIS 9 MG ER TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 120 Uterine Disorder Treatments

# Uterine Disorder Treatments
# Prior Authorization Criteria

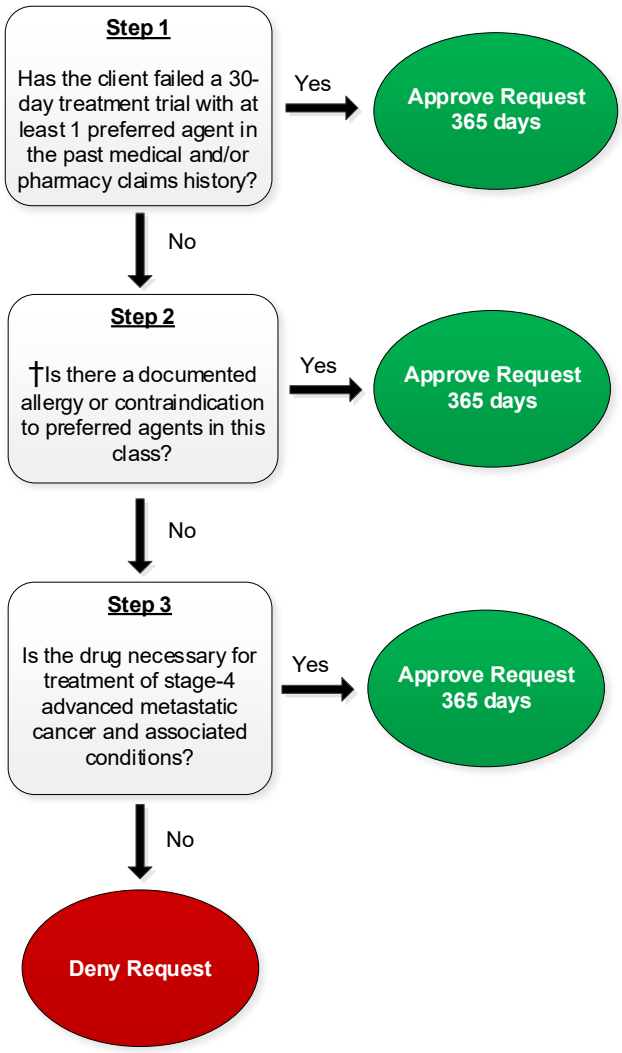
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Uterine Disorder Treatments Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Uterine Disorder Treatments Alternate Therapies

## Preferred Uterine Disorder Treatments

| GCN | Drug Name |
|---|---|
| 49699 | MYFEMBREE 40 MG-1 MG-0.5 MG TB |
| 48158 | ORIAHNN 300-1-0.5MG/300MG CAPS |
| 45026 | ORILISSA 150 MG TABLET |
| 45028 | ORILISSA 200 MG TABLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 121 Urea Cycle Disorders, Oral

# Urea Cycle Disorders, Oral
# Prior Authorization Criteria

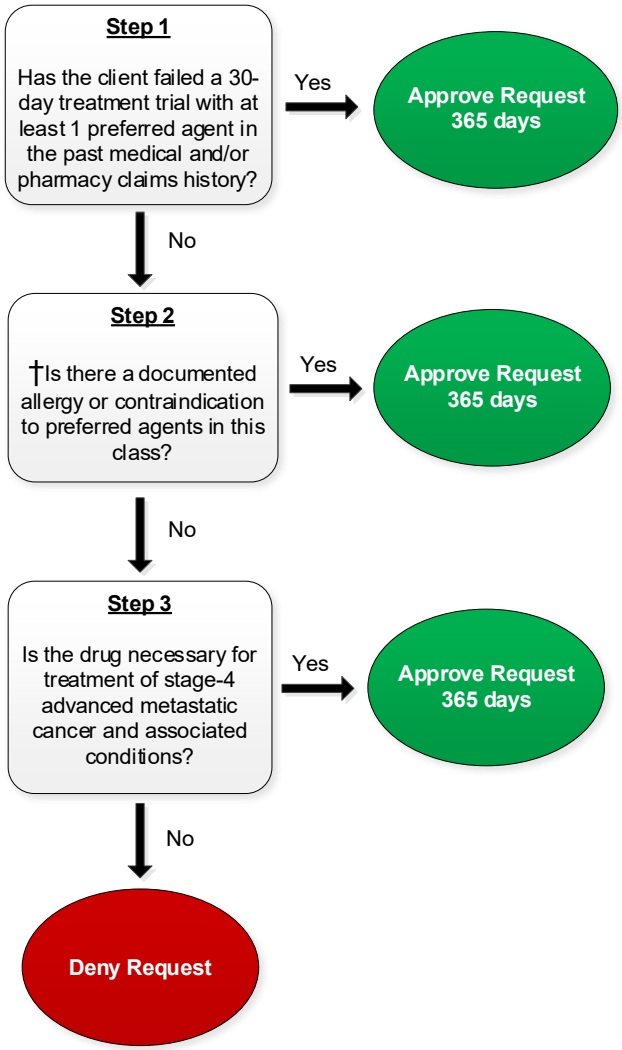
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Urea Cycle Disorders, Oral
# Prior Authorization Criteria




† Specific PDL exceptions in reference to contraindications, adverse drug reactions, and drug ineffectiveness fall under the PDL criteria exception section and are located on page 1 of the PDL Criteria Guide in the Document Overview section.

# Urea Cycle Disorders, Oral Alternate Therapies

## Preferred Urea Cycle Disorders, Oral

| GCN | Drug Name |
|---|---|
| 43371 | BUPHENYL 500 MG TABLET |
| 43370 | BUPHENYL POWDER |
| 20522 | CARBAGLU 200 MG TAB FOR SUSP |
| 36733 | PHEBURANE PELLET |

** The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.*

# 122 Version History

The Version History records the publication history of this document. See the Change Log for more details regarding the changes and enhancements included in each version.

| Publication Date | Version Number | Comments |
|---|---|---|
| 09/22/2010 | .01 | Delivery of final draft |
| 11/11/2010 | .02 | Revised per comment log received from HHSC and to improve navigation and usability |
| 03/03/2014 | .03 | Updated PDL classes and GCNs |
| 01/22/2015 | .04 | Updated PDL classes and GCNs |
| 07/23/2015 | .05 | Updated PDL classes and GCNs |
| 10/06/2015 | .06 | Updated Stimulant and Related Agents criteria |
| 01/28/2016 | .07 | Updated PDL classes and GCNs |
| 07/21/2016 | .08 | Updated PDL classes and GCNs |
| 01/26/2017 | .09 | Updated PDL classes and GCNs |
| 07/27/2017 | .10 | Updated PDL classes and GCNs |
| 08/29/2017 | .11 | Updated Ophthalmics, Anti-Inflammatory/Immunomodulator criteria |
| 02/01/2018 | .12 | Updated PDL classes and GCNs |
| 03/09/2018 | .13 | Updated PDL classes and GCNs |
| 07/25/2018 | .14 | Updated PDL classes and GCNs |
| 01/31/2019 | .15 | Updated PDL classes and GCNs |
| 05/15/2019 | .16 | Verified GCNs for all preferred agents |
| 07/25/2019 | .17 | Updated PDL classes and GCNs |
| 08/06/2019 | .18 | Updated PPI criteria |
| 11/22/2019 | .19 | Removed references to Part I: PDL Criteria on title page and on purpose of document, page 1 |
| 01/30/2020 | .20 | Added question for advanced cancer to all criteria and updated PDL classes and GCNs |
| 07/30/2020 | .21 | Updated PDL classes and GCNs |

| Publication Date | Version Number | Comments |
|---|---|---|
| 08/14/2020 | .22 | Updated Macrolide criteria and approval duration |
| 10/08/2020 | .23 | Updated Immunomodulators, Dupixent lookback timeframe for preferred agents |
| 12/15/2020 | .24 | Removed criteria logic and logic diagram for Methylin – medication is currently preferred |
| 12/21/2020 | .25 | Rearranged criteria logic and logic diagram for Macrolides |
| 12/29/2020 | .26 | Removed duloxetine 40mg from preferred agent table in Neuropathic Pain Agents |
| 01/28/2021 | .27 | Added new classes and updated preferred drug lists and GCNs |
| 02/23/2021 | .28 | Removed exemption criteria for ondansetron solution because it is currently a preferred agent<br>Removed GCNs for clemastine fum 2.68mg, methylphenidate ER, metronidazole 0.75% vaginal gel and Granix<br>Added the following statement to Hypoglycemics, TZD: Separate prescriptions for the individual components should be used instead of the combination drugs<br>Added subsection for PCSK9 inhibitors under Lipotropics, Other<br>Added the following statement to Anti-Allergens: For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization<br>Added the following statement to Prenatal Vitamins: Prenatal vitamins are covered only for females less than 50 years of age.<br>Removed diagnosis check of CVD and intolerable side effects for Inhaled Bronchodilators |
| 04/13/2021 | .29 | For Macrolides criteria: revised prior therapy question to read: Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history? (Exception may apply when a preferred drug requires less than a 7-day treatment trial) |
| 07/29/2021 | .30 | Updated PDL classes and GCNs<br>Updated criteria for Phosphate Binders – removed checks for lab values and diagnosis |
| 08/13/2021 | .31 | Revised lookback time frame for Ophthalmics, Anti-Inflammatory/Immunomodulators from 180 days therapy with a preferred agent in the last 200 days to 30 days therapy in the last 180 days |

| Publication Date | Version Number | Comments |
|---|---|---|
| 10/12/2021 | .32 | Added GCN for Lotemax 0.5% drops to preferred agents |
| 12/20/2021 | .33 | Updated logic diagram for Topical antibiotics, question 1, to look for a 5-days supply of a preferred agent in the last 60 days |
| 12/21/2021 | .34 | Updated PDL classes and GCNs |
| 04/05/2022 | .35 | Updated Phosphate Binders criteria |
| 06/22/2022 | .36 | Moved criteria for Rinvoq to Cytokine and CAM class section.<br>Added diagnoses of ankylosing spondylitis and ulcerative colitis for Rinvoq – for clients with these diagnoses, preferred therapy is from the Cytokine and CAM class |
| 07/28/2022 | .37 | Updated PDL classes and GCNs |
| 08/10/2022 | .38 | Added diagnosis of eosinophilic esophagitis for Dupixent |
| 09/16/2022 | .39 | Updated lookback for a preferred agent to 14 days supply in the last 180 days for Bronchodilators, Beta Agonists and 1 day supply in the last 180 days for Glucagon agents |
| 01/01/2023 | .40 | Updated the preferred Hepatitis C Agents |
| 01/26/2023 | .41 | Added criteria for Uterine Disorder Treatments<br>Updated PDL classes and GCNs |
| 07/27/2023 | .42 | Updated PDL classes and GCNs |
| 08/04/2023 | .43 | Updated Rinvoq and Dupixent criteria<br>Added ribavirin GCNs to Hepatitis C preferred agents |
| 01/25/2024 | .44 | Updated PDL classes and GCNs<br>Added information detailed in HB 3286, Section 2, 88th Legislature, Regular Session, 2023 |
| 07/25/2024 | .45 | Updated PDL classes and GCNs<br>Added information to Antidepressant criteria logic regarding discharge from an inpatient facility or risk of experiencing complications if switched from a non-preferred agent to a preferred agent<br>Removed age exemption from Epaned<br>Removed Criteria for Xifaxan, Progestational Agents, and PCSK9 Inhibitors<br>Removed diagnosis question from Rinvoq and Dupixent criteria logic |

| Publication Date | Version Number | Comments |
|---|---|---|
| | | Rephrased PA system from RxPert to Gainwell Technologies PA System<br>Updated and/or reviewed all preferred drug tables |
| 01/30/2025 | .46 | Updated PDL classes and GCNs<br>Removed statement 'prenatal vitamins are covered only for females less than 50 years of age from document |
| 07/28/2025 | .47 | Updated PDL classes and GCNs<br>Removed "Oral/SQ" from "Immunosuppressives, Oral/SQ"<br>Renamed "NSAIDs" to "Non-Narcotic Analgesics"<br>Updated "PAH Agents, Oral" to "PAH Agents, Oral and Inhaled"<br>Removed "Cytokine and CAM Antagonists, Rinvoq" section and added Rinvoq GCNs to the "Cytokine and CAM Antagonists" section |
| 08/08/2025 | .48 | Removed GCNs for Accutane (59841, 59842, 20383, 59843) and Myorisan (59841, 59842, 20383, 59843) from the "Acne Agents, Oral" section<br>Removed GCNs for Flovent HFA (53636, 53639, 53638) and Flovent Diskus (53633, 53634) from the "Glucocorticoids, Inhaled" section |

# 123 Change Log

The Change Log records the changes and enhancements included in each version.

| Version Number | Chapter/Section | Change |
|---|---|---|
| .01 | N/A | N/A |
| .02 | Purpose | Updated paragraph to explain the division of the criteria guide |
| | Organization | Added descriptions for diagnosis codes, procedure codes |
| | Organization | Removed note at end of section |
| | All sections | Revised formatting to support consecutive page numbering |
| | All sections | Replaced all occurrences of patient with client |
| | All checklist pages | Removed the approval duration note at the end of a checklist |
| | All checklist pages | Added the approval duration for all actions of a rule that results in approval |
| | All flowchart pages | Added the approval duration to all Approve Request ovals |
| | All list pages | Updated table format to be consistent with previous documents |
| | All list titles | Added the RxPert form code in title |
| | All checklists and flowcharts | Updated the RxPert form code in title where necessary |
| | Checklists and flowchart for:<br>Alzheimer's Agents<br>Antidepressants, Other<br>Antidepressants, SSRI<br>Antipsychotics, Oral<br>Growth Hormones<br>Hepatitis C Agents | Added missing stable therapy step |
| | Analgesics, Narcotic – Long Acting<br>Analgesics, Narcotic – Short Acting | Updated titles for checklist, flowchart, and list to correspond with the section title |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Analgesics, Narcotic – Long Acting<br>Analgesics, Narcotic – Short Acting | Updated the RxPert form code in title |
| | Anticoagulants, Injectable | Added allergy and contraindication step to checklist and flowchart |
| | Antidepressants | Divided section into Antidepressants, Other and Antidepressants, SSRI as shown in the PDL |
| | Antiparkinson's Agents | Updated Step 1 in the checklist and flowchart to read "14-day treatment trial" |
| | Bile Salts | Added checklist, flowchart, and list |
| | Bronchodilators, Beta Agonist | Added step 3 to the checklist and flowchart |
| | Bronchodilators, Beta Agonist | Added diagnosis code list for step 2 |
| | Fluoroquinolones, Oral – Cipro Suspension | Modified step 1 to read "less than 11 years of age" |
| | Glucocorticoids, Inhaled | Added checklist, flowchart, and list for Pulmicort |
| | Hypoglycemics, Incretin Mimetics/Enhancers – Symlin | Added sub-section |
| | Impetigo Agents, Topical | Updated approval duration to 5-days in checklist and flowchart |
| | Lipotropics, Statins | Updated step 1 in checklist and flowchart to read "Has the client failed at least 2 preferred agent(s) for a total of 120 days within the past 180 days?" |
| | Macrolides/Ketolides | Updated approval duration to 30 days |
| | Ophthalmics, Quinolones/Macrolides | Updated step 1 to read "7-day treatment trial" |
| | PAH Agents, Oral | Added step 2 for allergy and contraindication to checklist and flowchart |
| | Phosphate Binders | Added checklist, flowchart, and lists |
| | Proton Pump Inhibitors | Added checklist, flowchart, and list for Prevacid Solutabs |
| .03 | Bronchodilators, Beta Agonist | Corrected list of diagnosis codes related to step 2 |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Hypoglycemics, Incretin Mimetics/Enhancers – Symlin | Corrected list of diagnosis codes related to step 2 |
| | Cover page | Replaced Texas state seal image with higher resolution image |
| .04 | Antimigraine Agents, Other | Added checklist, flowchart, and list |
| | HAE Treatments | Added checklist, flowchart, and list |
| | H.Pylori Treatment | Added checklist, flowchart, and list |
| | Immune Globulins | Added checklist, flowchart, and list |
| | Lincosamides/Oxazolidinones/ Streptogramins | Added checklist, flowchart, and list |
| | Progestins for Cachexia | Added checklist, flowchart, and list |
| | Smoking Cessation | Added checklist, flowchart, and list |
| | Acne Agents, Topical<br>Analgesics, Narcotics Long<br>Analgesics, Narcotics Short<br>Angiotensin Modulators<br>Bladder Relaxant Preparations<br>Intranasal Rhinitis Agents<br>Neuropathic Pain<br>Platelet Aggregation Inhibitors<br>Proton Pump Inhibitors<br>Stimulants and Related Agents<br>Anticoagulants<br>Antidepressants, Other<br>Antiparkinson's Agents<br>Beta-Blockers<br>Bronchodilators, Beta Agonist<br>Glucocorticoids, Inhaled<br>Lipotropics, Other<br>Lipotropics, Statins | Updated list of preferred agents |
| .05 | All PDL Sections | Reviewed and updated all lists of preferred agents |

| Version Number | Chapter/Section | Change |
|---|---|---|
| .06 | Stimulants and Related Agents | Added criteria for Methylin solution |
| .07 | Alzheimer's Agents<br>Androgenic Agents<br>Antibiotics, GI<br>Antibiotics, Topical<br>Antibiotics, Vaginal<br>Antiemetic/Antivertigo Agents<br>Antifungals, Oral<br>Antifungals, Topical<br>Antihistamines, Minimally Sedating<br>Antihypertensives, Sympatholytics<br>Antiparasitics, Topical<br>Antipsychotics<br>Antivirals, Oral<br>Antivirals, Topical<br>Bone Resorption Suppression and Related Agents<br>Calcium Channel Blockers<br>Cephalosporins and Related Antibiotics<br>Colony Stimulating Factors<br>Cytokine and CAM Antagonists<br>Epinephrine, Self-Injected<br>Fluoroquinolones, Oral<br>GI Motility, Chronic<br>Glucocorticoids, Oral<br>Growth Hormone<br>Hypoglycemics, Incretin<br>Hypoglycemics, Insulin and Related Agents<br>Hypoglycemics, Meglitinides<br>Hypoglycemics, TZDs<br>Immunosuppressives, Oral<br>Iron, Oral<br>Leukotriene Modifiers | Updated list of preferred agents |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Macrolides/Ketolides<br>NSAIDs<br>Ophthalmic Antibiotics<br>Ophthalmic Antibiotic-Steroid<br>Ophthalmics for Allergic Conjunctivitis<br>Ophthalmics, Anti-Inflammatories<br>Ophthalmics, Glaucoma Agents<br>Opiate Dependence Treatments<br>Otic Antibiotics<br>Otic Anti-Infectives & Anesthetics<br>Penicillins<br>Prenatal Vitamins<br>Skeletal Muscle Relaxants<br>Steroids, Topical<br>Tetracyclines<br>Ulcerative Colitis Agents | |
| | Antibiotics, Topical | Changed PDL Class Name from Agents for Impetigo to Topical Antibiotics |
| .08 | Acne Agents, Oral<br>Analgesics, Narcotic-Long Acting<br>Angiotensin Modulator Combinations<br>Antimigraine Agents<br>Antiparkinson's Agents, Oral/Transdermal<br>Antipsychotics<br>Antivirals, Oral/Nasal<br>Bile Salts<br>BPH Agents<br>COPD Agents<br>GI Motility, Chronic<br>Glucocorticoids, Inhaled<br>Hepatitis C Agents<br>Hypoglycemics, Insulin | Updated list of preferred agents and GCNs |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Hypoglycemics, SGLT2<br>Immune Globulins<br>Immunomodulators, Atopic Dermatitis<br>Immunosuppressives, Oral<br>Iron, Oral<br>Lincosamides/ Oxazolidinones/ Streptogramins<br>Lipotropics, Other<br>Lipotropics, Statins<br>Neuropathic Pain<br>Opiate Dependence Treatments<br>PAH Agents, Oral/Inhalation<br>Prenatal Vitamins<br>Steroids, Topical<br>Stimulants and Related Agents | |
| .09 | Hypoglycemics, Metformin | New class: Added criteria logic, logic diagram and table of preferred agents |
| | Alzheimer's Agents<br>Androgenic Agents<br>Antibiotics, GI<br>Antibiotics, Topical<br>Antibiotics, Vaginal<br>Antiemetic/Antivertigo Agents<br>Antifungals, Oral<br>Antifungals, Topical<br>Antihistamines, Minimally Sedating<br>Antihypertensives, Symmpatholytics<br>Antiparasitics, Topical<br>Antipsychotics<br>Antivirals, Oral<br>Antivirals, Topical<br>Bone Resorption Suppression and Related Agents | Updated list of preferred agents and GCNs |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Calcium Channel Blockers<br>Cephalosporins and Related Antibiotics<br>Colony Stimulating Factors<br>Cytokine and CAM Antagonists<br>Epinephrine, Self-Injected<br>Fluoroquinolones, Oral<br>GI Motility, Chronic<br>Glucocorticoids, Oral<br>Growth Hormone<br>Hypoglycemics, Incretin Mimetics/Enhancers<br>Hypoglycemics, Insulin and Related Agents<br>Hypoglycemics, Meglitinides<br>Hypoglycemics, TZD<br>Immunosuppressives, Oral<br>Iron, Oral<br>Leukotriene Modifiers<br>Macrolides/Ketolides<br>NSAIDs<br>Ophthalmic Antibiotics<br>Ophthalmic Antibiotic-Steroid Combinations<br>Ophthalmics for Allergic Conjunctivitis<br>Ophthalmics, Anti-Inflammatories<br>Ophthalmics, Glaucoma Agents<br>Opiate Dependence Treatments<br>Otic Antibiotics<br>Otic Anti-Infectives & Anesthetics<br>Penicillins<br>Prenatal Vitamins<br>Skeletal Muscle Relaxants<br>Steroids, Topical<br>Tetracyclines | |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Ulcerative Colitis Agents | |
| .10 | Antidepressants, Tricyclic<br>Anxiolytics<br>Ophthalmics, Anti-Inflammatory/Immunomodulators<br>Urea Cycle Disorders | New classes: Added criteria logic, logic diagram and table of preferred agents |
| | Acne Agents, Oral<br>Acne Agents, Topical<br>Analgesics, Narcotics Long<br>Analgesics, Narcotics Short<br>Angiotensin Modulators<br>Angiotensin Modulator Combinations<br>Anti-Allergens, Oral<br>Antibiotics, Inhaled<br>Anticoagulants<br>Antidepressants, Other<br>Antidepressants, SSRIs<br>Antihyperuricemics<br>Antimigraine Agents, Other<br>Antimigraine Agents, Triptans<br>Antiparkinson's Agents<br>Beta-Blockers<br>Bladder Relaxant Preparations<br>Bile Salts<br>BPH Treatments<br>Bronchodilators, Beta Agonist<br>COPD Agents<br>Cough and Cold, Cold<br>Cough and Cold, Narcotic<br>Cough and Cold, Non-Narcotic<br>Erythropoiesis Stimulating Proteins<br>Glucocorticoids, Inhaled<br>H. Pylori Treatment | Updated list of preferred agents and GCNs |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | HAE Treatments<br>Hepatitis C Agents<br>Hypoglycemics, SGLT2<br>Immune Globulins<br>Immunomodulators, Atopic Dermatitis<br>Intranasal Rhinitis Agents<br>Lincosamides / Oxazolidinones / Streptogramins<br>Lipotropics, Other<br>Lipotropics, Statins<br>Neuropathic Pain<br>PAH, Oral and Inhaled<br>Pancreatic Enzymes<br>Phosphate Binders<br>Platelet Aggregation Inhibitors<br>Progestins for Cachexia<br>Proton Pump Inhibitors<br>Sedative Hypnotics<br>Smoking Cessation<br>Stimulants and Related Agents | |
| | Angiotensin Modulators<br>Antiemetic and Antivertigo Agents | Updated criteria logic and logic diagram |
| .11 | Opthalmics, Anti-Inflammatory / Immunomodulators | Changed prior therapy requirements to 180 day trial of a preferred agent in the last 200 days |
| .12 | Progestational Agents | New classes: Added criteria logic, logic diagram and table of preferred agents |
| | Alzheimer's Agents<br>Antihistamines, Minimally Sedating<br>Antihypertensives, Sympatholytics<br>Antivirals, Oral/Nasal<br>Calcium Channel Blockers<br>Cephalosporins and Related Antibiotics<br>Fluoroquinolones, Oral | Updated list of preferred agents and GCNs |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Glucocorticoids, Oral<br>Hypoglycemics, SGLT2<br>Immunosupressives, Oral<br>Iron, Oral<br>Leukotriene Modifiers<br>NSAIDs<br>Ophthalmic Antibiotics<br>Ophthalmic Antibiotic-Steroid Combinations<br>Ophthalmics for Allergic Conjunctivitis<br>Ophthalmics, Anti-Inflammatories<br>Ophthalmics, Glaucoma Agents<br>Otic Antibiotics<br>Otic Anti-Infectives and Anesthetics<br>Prenatal Vitamins<br>Skeletal Muscle Relaxants<br>Steroids, Topical<br>Ulcerative Colitis Agents | |
| .13 | Antihistamines, First Generation<br>Pediatric Vitamin Preparations | New classes: Added criteria logic, logic diagram and table of preferred agents |
| | Analgesics, Narcotic-Long Acting<br>Androgenic Agents<br>Antibiotics, GI<br>Antibiotics, Topical<br>Antibiotics, Vaginal<br>Antiemetic/Antivertigo Agents<br>Antifungals, Oral<br>Antifungals, Topical<br>Antihistamines, Minimally Sedating<br>Antiparasitics, Topical<br>Antiparkinson's Agents<br>Antipsychotics<br>Antivirals, Oral/Nasal | Updated list of preferred agents and GCNs |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Antivirals, Topical<br>Bile Salts<br>Bone Resorption Suppression and Related Agents<br>Colony Stimulating Factors<br>Cytokine and CAM Antagonists<br>Epinephrine, Self-Injected<br>GI Motility, Chronic<br>Growth Hormone<br>Hepatitis C Agents<br>Hypoglycemics, Incretin Mimetics/Enhancers<br>Hypoglycemics, Insulin and Related Agents<br>Hypoglycemics, Meglitinides<br>Hypoglycemics, Metformins<br>Hypoglycemics, TZD<br>Macrolides/Ketolides<br>Opiate Dependence Treatments<br>Penicillins<br>Stimulants and Related Agents<br>Tetracyclines | |
| .14 | Movement Disorders<br><br><br><br>Acne Agents, Oral<br>Acne Agents, Topical<br>Analgesics, Narcotics Long<br>Analgesics, Narcotics Short<br>Angiotensin Modulator Combinations<br>Angiotensin Modulators<br>Anti-Allergens, Oral<br>Antibiotics, GI<br>Antibiotics, Inhaled | New classes: Added criteria logic, logic diagram and table of preferred agents<br><br>Updated list of preferred agents and GCNs |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Anticoagulants<br>Antidepressants, Other<br>Antidepressants, SSRIs<br>Antidepressants, Tricyclic<br>Antihyperuricemics<br>Antimigraine Agents, Other<br>Antimigraine Agentsm Triptans<br>Antiparkinson's Agents<br>Anxiolytics<br>Beta-Blockers<br>Bile Salts<br>Bladder Relaxant Preparations<br>BPH Treatments<br>Bronchodilators, Beta Agonist<br>COPD Agents<br>Cough and Cold Agents<br>Cytokine and CAM Antagonists<br>Erythropoiesis Stimulating Proteins<br>GI Motility, Chronic<br>Glucocorticoids, Inhaled<br>Glucocorticoids, Oral<br>HAE Treatments<br>H. Pylori Treatment<br>Hypoglycemics, Incretin Mimetics/Enhancers<br>Hypoglycemics, Insulin and Related<br>Hypoglycemics, SGLT2<br>Immune Globulins<br>Immunomodulators, Atopic Dermatitis<br>Intranasal Rhinitis Agents<br>Lincosamides/ Oxazolidinones/ Streptogramins<br>Lipotropics, Other<br>Lipotropics, Statins | |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Neuropathic Pain<br>Ophthalmics, Glaucoma Agents<br>Ophthalmics, Anti-Inflammatory/ Immunomodulator<br>PAH Agents, Oral and Inhaled<br>Pancreatic Enzymes<br>Phosphate Binders<br>Platelet Aggregation Inhibitors<br>Progestins for Cachexia<br>Proton Pump Inhibitors<br>Sedative Hypnotics<br>Smoking Cessation<br>Stimulants and Related Agents<br>Tetracyclines<br>Urea Cycle Disorders, Oral | |
| .15 | Alzheimer's Agents<br>Analgesics, Narcotics Short<br>Androgenic Agents<br>Antibiotics, GI<br>Antibiotics, Topical<br>Antibiotics, Vaginal<br>Anticoagulants<br>Antiemetic/Antivertigo Agents<br>Antifungals, Oral<br>Antifungals, Topical<br>Antihistamines, First Generation<br>Antihistamines, Minimally Sedating<br>Antihypertensives, Sympatholytics<br>Antimigraine Agents, Other<br>Antiparasitics, Topical<br>Antiparkinson's Agents<br>Antipsychotics<br>Antivirals, Oral<br>Antiviarals, Topical | Updated list of preferred agents and GCNs |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Bone Resorption Suppression and Related Agents<br>Calcium Channel Blockers<br>Cephalosporins and Related Antibiotics<br>Colony Stimulating Factors<br>COPD Agents<br>Cytokine and CAM Antagonists<br>Epinephrine, Self-Injected<br>Erythropoiesis Stimulating Proteins<br>Fluoroquinolones, Oral<br>GI Motility, Chronic<br>Glucocorticoids, Oral<br>Growth Hormone<br>Hepatitis C Agents<br>Hypoglycemics, Incretin Mimetics/Enhancers<br>Hypoglycemics, Insulin and Related Agents<br>Hypoglycemics, Meglitinides<br>Hypoglycemics, Metformins<br>Hypoglycemics, SGLT2<br>Hypoglycemics, TZD<br>Immunomodulators, Atopic Dermatitis<br>Immunosuppressives, Oral<br>Iron, Oral<br>Leukotriene Modifiers<br>Lipotropics, Statins<br>Macrolides/Ketolides<br>NSAIDs<br>Ophthalmic Antibiotics<br>Ophthalmic Antibiotic-Steroid Combinations<br>Ophthalmics for Allergic Conjunctivitis<br>Ophthalmics, Anti-Inflammatories | |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Ophthalmics, Glaucoma Agents<br>Opiate Dependence Treatments<br>Otic Antibiotics<br>Otic Anti-Infectives & Anesthetics<br>Pediatric Vitamin Preparations<br>Penicillins<br>Prenatal Vitamins<br>Progestational Agents<br>Skeletal Muscle Relaxants<br>Steroids, Topical<br>Tetracyclines<br>Ulcerative Colitis Agents | |
| .16 | All Classes | Reviewed and updated GCNs for all preferred agents |
| .17 | Thrombopoiesis Stimulating Proteins<br><br>Acne Agents, Oral<br>Acne Agents, Topical<br>Analgesics, Narcotics Long<br>Analgesics, Narcotics Short<br>Angiotensin Modulator Combinations<br>Angiotensin Modulators<br>Anti-Allergens, Oral<br>Antibiotics, Inhaled<br>Anticoagulants<br>Antidepressants, Other<br>Antidepressants, SSRIs<br>Antidepressants, Tricyclics<br>Antifungals, Oral<br>Antihistamines, First Generation<br>Antihyperuricemics<br>Antimigraine Agents, Other<br>Antimigraine Agents, Triptans | New classes: Added criteria logic, logic diagram and table of preferred agents<br><br>Updated list of preferred agents and GCNs |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Antiparasitics, Topical<br>Antiparkinson's Agents<br>Antivirals, Oral<br>Anxiolytics<br>Beta-Blockers<br>Bile Salts<br>Bladder Relaxant Preparations<br>BPH Treatments<br>Bronchodilators, Beta Agonist<br>COPD Agents<br>Colony Stimulating Factors<br>Cough and Cold Agents<br>Cytokine and CAM Antagonists<br>Epinephrine, Self-Injected<br>Erythropoiesis Stimulating Proteins<br>Glucocorticoids, Inhaled<br>H. Pylori Treatment<br>HAE Treatments<br>Hypoglycemics, Insulin and Related Agents<br>Hypoglycemics, SGLT2<br>Immune Globulins<br>Immunomodulators, Atopic Dermatitis<br>Intranasal Rhinitis Agents<br>Lincosamides/ Oxazolidinones/ Streptogramins<br>Lipotropics, Other<br>Lipotropics, Statins<br>Movement Disorders<br>Neuropathic Pain<br>Ophthalmics, Anti-Inflammatories<br>Ophthalmics, Anti-Inflammatory/ Immunomodulator<br>Ophthalmics, Glaucoma Agents<br>PAH Agents, Oral and Inhaled | |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Pancreatic Enzymes<br>Pediatric Vitamin Preparations<br>Prenatal Vitamins<br>Phosphate Binders<br>Platelet Aggregation Inhibitors<br>Progestins for Cachexia<br>Proton Pump Inhibitors<br>Sedative-Hypnotics<br>Smoking Cessation<br>Steroids, Topical<br>Stimulants and Related Agents<br>Tetracyclines<br>Urea Cycle Disorders, Oral | |
| .18 | Proton Pump Inhibitors | Updated criteria to indicate that a minimum of 30-day trial of all preferred agents in the preceding 365 days is required before approval of a non-preferred agent. |
| .19 | Title Page<br>Document Overview | Removed references to Part I: PDL Criteria on title page and on purpose of document, page 1 |
| .20 | Updated all criteria logic and logic diagrams | Added the following question to all criteria: Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? |
| .20 | Alzheimer's Agents<br>Analgesics, Narcotic Short<br>Androgenic Agents<br>Antibiotics, GI<br>Antibiotics, Topical<br>Antibiotics, Vaginal<br>Antiemetic/Antivertigo Agents<br>Antifungals, Oral<br>Antifungals, Topical<br>Antihistamines, First Generation<br>Antihistamines, Minimally Sedating<br>Antihypertensives, Sympatholytics | Updated preferred agents and GCNs |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Antimigraine Agents, Other<br>Antiparasitics, Topical<br>Antiparkinson's Agents<br>Antipsychotic Agents<br>Antivirals, Topical<br>Bone Resorption Suppression and Related Agents<br>BPH Agents<br>Calcium Channel Blockers<br>Cephalosporins and Related Antibiotics<br>Colony Stimulating Factors<br>Cytokine and CAM Antagonists<br>Epinephrine Self-Injected<br>Fluoroquinolones, Oral<br>GI Motility, Chronic<br>Glucocorticoids, Oral<br>Growth Hormone<br>Hepatitis C Agents<br>Hypoglycemics, Incretin Mimetics/Enhancers<br>Hypoglycemics, Insulin and Related Agents<br>Hypoglycemics, Meglitinides<br>Hypoglycemics, Metformins<br>Hypoglycemics, SGLT2<br>Hypoglycemics, TZD<br>Immune Globulins<br>Immunosuppressives, Oral<br>Iron, Oral<br>Leukotriene Modifiers<br>Lipotropics, Statins<br>Macrolides and Ketolides<br>Movement Disorders<br>Neuropathic Pain<br>NSAIDs | |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Ophthalmic Antibiotics<br>Ophthalmic Antibiotic-Steroid Combinations<br>Ophthalmics for Allergic Conjunctivitis<br>Ophthalmics, Anti-inflammatories<br>Ophthalmics, Anti-inflammatory / Immunomodulator<br>Ophthalmics, Glaucoma Agents<br>Opiate Dependence Treatments<br>Otic Antibiotics<br>Otic Anti-infectives & Anesthetics<br>Penicillins<br>Progestational Agents<br>Skeletal Muscle Relaxants<br>Steroids, Topical<br>Stimulants and Related Agents<br>Tetracyclines<br>Ulcerative Colitis Agents | |
| .21 | Glucagon Agents<br>Immunomodulators, Asthma<br>Sickle Cell Anemia Treatment<br><br>Acne Agents, Oral<br>Acne Agents, Topical<br>Analgesics, Narcotics Long<br>Analgesics, Narcotics Short<br>Angiotensin Modulator Combinations<br>Angiotensin Modulators<br>Anti-Allergens, Oral<br>Anticoagulants<br>Antidepressants, Other<br>Antidepressants, SSRIs<br>Antidepressants, Tricyclics | Added new classes and updated preferred drug lists and GCNs |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Antihyperuricemics<br>Antimigraine Agents, Other<br>Antimigraine Agents, Triptans<br>Antiparkinson's Agents<br>Antipsychotics<br>Antivirals, Oral/Nasal<br>Anxiolytics<br>Beta-Blockers<br>Bile Salts<br>Bladder Relaxant Preparations<br>BPH Treatments<br>Bronchodilators, Beta Agonist<br>Colony Stimulating Factors<br>COPD Agents<br>Cough and Cold Agents<br>Erythropoiesis Stimulating Proteins<br>Glucocorticoids, Inhaled<br>HAE Treatments<br>H. Pylori Treatment<br>Hypoglycemics, Incretin Mimetics/Enhancers<br>Hypoglycemics, Insulin and Related Agents<br>Immune Globulins<br>Intranasal Rhinitis Agents<br>Linconsamides/Oxazolidinones/Streptogramins<br>Lipotropics, Other<br>Lipotropics, Statins<br>Movement Disorders<br>Neuropathic Pain<br>PAH Agents, Oral and Inhaled<br>Pancreatic Enzymes<br>Pediatric Vitamin Preparations<br>Phosphate Binders | |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Platelet Aggregation Inhibitors<br>Prenatal Vitamins<br>Progestins for Cachexia<br>Proton Pump Inhibitors<br>Sedative Hypnotics<br>Smoking Cessation<br>Stimulants and Related Agents<br>Thrombopoiesis Stimulating Proteins<br>Urea Cycle Disorders, Oral | |
| .22 | Macrolides | Updated criteria and approval duration<br>Updated diagnosis lookback timeframe for Immunomodulators, Dupixent |
| .23 | Immunomodulators, Atopic Dermatitis<br>Immunomodulators, Dupixent (atopic dermatitis step) | Updated lookback timeframe for preferred agents |
| .24 | Stimulants and Related Agents | Removed Methylin criteria logic and logic diagram – medication is currently preferred |
| .25 | Macrolides | Rearranged criteria logic and logic diagram for Macrolides |
| .26 | Neuropathic Pain | Removed duloxetine 40mg from the preferred agents table |
| .27 | Acne Agents Topical<br>Alzheimer's Agents<br>Androgenic Agents<br>Antiallergens, Oral<br>Antibiotics, GI<br>Antibiotics, Topical<br>Antibiotics, Vaginal<br>Anticonvulsants<br>Antiemetic/Antivertigo Agents<br>Antifungals, Oral<br>Antifungals, Topical<br>Antihistamines, First Generation | Added new classes and updated preferred drug lists and GCNs |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Antihistamines, Minimally Sedating<br>Antihypertensives, Sympatholytics<br>Antimigraine Agents, Other<br>Antiparasitics, Topical<br>Antipsychotics<br>Antipsychotics, Long-Acting Injectables<br>Antivirals, Topical<br>Bone Resorption Suppression and Related Agents<br>Calcium Channel Blockers<br>Cephalosporins and Related Antibiotics<br>Colony Stimulating Factors<br>Cytokine and CAM Antagonists<br>Epinephrine Self-Injected<br>Fluoroquinolones, Oral<br>GI Motility, Chronic<br>Glucocorticoids, Oral<br>Growth Hormone<br>Hemophilia Treatment<br>Hepatitis C Agents<br>HIV/AIDS<br>Hypoglycemics, Incretin Mimetics/Enhancers<br>Hypoglycemics, Insulin and Related Agents<br>Hypoglycemics, Meglitinides<br>Hypoglycemics, Metformin<br>Hypoglycemics, SGLT2<br>Hypoglycemics, TZD<br>Immune Globulins<br>Immunomodulators, Atopic Dermatitis<br>Immunosuppressives, Oral<br>Iron, Oral<br>Leukotriene Modifiers | |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Lipotropics, Other<br>Macrolides/Ketolides<br>Multiple Sclerosis Agents<br>NSAIDs<br>Oncology, Oral – Breast<br>Oncology, Oral – Hematologic<br>Oncology, Oral – Lung<br>Oncology, Oral – Other<br>Oncology, Oral – Prostate<br>Oncology, Oral – Renal Cell<br>Oncology, Oral - Skin<br>Ophthalmic Antibiotics<br>Ophthalmic Antibiotic-Steroid Combinations<br>Ophthalmics for Allergic Conjunctivitis<br>Ophthalmics, Anti-Inflammatories<br>Ophthalmics, Anti-Inflammatory/Immunomodulator<br>Ophthalmics, Glaucoma Agents<br>Opiate Dependence Treatments<br>Otic Antibiotics<br>Otic Anti-Infectives and Anesthetics<br>Penicillins<br>Progestational Agents<br>Rosacea Agents, Topical<br>Sedative/Hypnotics<br>Skeletal Muscle Relaxants<br>Steroids, Topical<br>Tetracyclines<br>Ulcerative Colitis Agents | |
| .28 | Anti-Allergen Agents<br>Antibiotics, Vaginal<br>Antiemetic-Antivertigo Agents | Removed exemption criteria for ondansetron solution because it is currently a preferred agent |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Bronchodilators, Inhaled<br>Colony Stimulating Factors<br>First Generation Antihistamines<br>Hypoglycemics, TZDs<br>Lipotropics, Other<br>Prenatal Vitamins<br>Stimulants and Related Agents | Removed GCNs for clemastine fum 2.68mg, methylphenidate ER, metronidazole 0.75% vaginal gel and Granix<br>Added the following statement to Hypoglycemics, TZD: Separate prescriptions for the individual components should be used instead of the combination drugs<br>Added subsection for PCSK9 inhibitors under Lipotropics, Other<br>Added the following statement to Anti-Allergens: For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization<br>Added the following statement to Prenatal Vitamins: Prenatal vitamins are covered only for females less than 50 years of age.<br>Removed diagnosis check of CVD and intolerable side effects for Inhaled Bronchodilators |
| .29 | Macrolides | Revised prior therapy question to read: Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history? (Exception may apply when a preferred drug requires less than a 7-day treatment trial) |
| .30 | Acne Agents, Oral<br>Acne Agents, Topical<br>Analgesics, Narcotics Long<br>Analgesics, Narcotics Short<br>Angiotensin Modulator Combinations<br>Angiotensin Modulators<br>Anti-allergens, Oral<br>Antibiotics, GI<br>Antibiotics, Inhaled<br>Anticoagulants<br>Antidepressants, Other<br>Antidepressants, SSRI<br>Antidepressants, Tricyclic<br>Antihyperuricemics | Updated preferred drug lists and GCNs |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Antimigraine Agents, Other<br>Antimigraine Agents, Triptans<br>Antiparkinson's Agents<br>Antivirals, Oral<br>Anxiolytics<br>Beta-Blockers<br>Bile Salts<br>Bladder Relaxant Preparations<br>BPH Treatments<br>Bronchodilators, Beta Agonist<br>Colony Stimulating Factors<br>COPD Agents<br>Cough and Cold<br>Cytokine and CAM Antagonists<br>Erythropoiesis Stimulating Proteins<br>Glucagon Agents<br>Glucocorticoids, Inhaled<br>Glucocorticoids, Oral<br>HAE Treatments<br>Hemophilia Treatment<br>H.Pylori Treatment<br>Hypoglycemics, Incretin Mimetics/Enhancers<br>Hypoglycemics, Insulin and Related Agents<br>Immune Globulins<br>Immunomodulators, Asthma<br>Immunomodulators, Atopic Dermatitis<br>Intranasal Rhinitis Agents<br>Lincosamides/ Oxazolidinones/ Streptogramins<br>Lipotropics, Other<br>Lipotropics, Statins<br>Movement Disorders<br>Multiple Sclerosis | |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Neuropathic Pain<br>NSAIDs<br>Oncology, Oral-Breast<br>Oncology, Oral-Hematologic<br>Oncology, Oral-Lung<br>Oncology, Oral-Other<br>Oncology, Oral-Prostate<br>Oncology, Oral-Renal Cell<br>Oncology, Oral-Skin<br>Ophthalmics for Allergic Conjunctivitis<br>Ophthalmics, Anti-Inflammatory/ Immunomodulators<br>PAH Agents, Oral and Inhaled<br>Pancreatic Enzymes<br>Pediatric Vitamin Preparations<br>Phosphate Binder<br>Platelet Aggregation Inhibitors<br>Prenatal Vitamins<br>Progestins for Cachexia<br>Proton Pump Inhibitors<br>Sedative Hypnotics<br>Sickle Cell Anemia Treatments<br>Smoking Cessation<br>Steroids, Topical<br>Stimulants and Related Agents<br>Thrombopoiesis Stimulating Proteins<br>Urea Cycle Disorders, Oral | |
| .31 | Ophthalmics, Anti-Inflammatory / Immunomodulators | Revised lookback timeframe from 180 days therapy with a preferred agent in the last 200 days to 30 days therapy in the last 180 days |
| .32 | Ophthalmics, Anti-Inflammatory Agents | Added GCN for Lotemax 0.5% drops to preferred agents |

| Version Number | Chapter/Section | Change |
|---|---|---|
| .33 | Antibiotics, Topical | Updated logic diagram, question 1, to look for a 5-days supply of a preferred agent in the last 60 days |
| .34 | Immunomodulators, Rinvoq | Added criteria for atopic dermatitis and check for prior therapy with preferred atopic dermatitis agents |
| | Macrolides | Updated heading to Macrolides/Ketolides |
| | Alzheimer's Agents<br>Androgenic Agents<br>Antibiotics, GI<br>Antibiotics, Topical<br>Antibiotics, Vaginal<br>Anticonvulsants<br>Antiemetic/Antivertigo Agents<br>Antifungals, Oral<br>Antifungals, Topical<br>Antihistamines, First Generation<br>Antihistamines, Minimally Sedating<br>Antihypertensives Sympatholytics<br>Antiparasitics, Topical<br>Antipsychotics<br>Antivirals, Topical<br>Bladder Relaxant Preparations<br>Bone Resorption Suppression and Related Agents<br>Calcium Channel Blockers<br>Cephalosporins and Related Antibiotics<br>Colony Stimulating Factors<br>Cytokine and CAM Antagonists<br>Epinephrine, Self-Injected<br>Fluoroquinolones, Oral<br>GI Motility, Chronic<br>Glucagon Agents<br>Glucocorticoids, Oral | Updated preferred drug lists and GCNs |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Growth Hormone<br>Hepatitis C Agents<br>HIV/AIDS<br>Hypoglycemics, Insulin and Related Agents<br>Hypoglycemics, Meglitinides<br>Hypoglycemics, Metformins<br>Hypoglycemics, SGLT2<br>Hypoglycemics, TZD<br>Immunosuppressives, Oral<br>Iron, Oral<br>Leukotriene Modifiers<br>Macrolides/Ketolides<br>Multiple Sclerosis Agents<br>NSAIDs<br>Oncology, Oral - Hematologic<br>Oncology, Oral – Lung<br>Oncology, Oral - Other<br>Ophthalmic Antibiotics<br>Ophthalmic Antibiotics-Steroid Combinations<br>Ophthalmics for Allergic Conjunctivitis<br>Opththalmics, Anti-Inflammatories<br>Ophthalmics, Anti-Inflammatory/Immunomodulator<br>Ophthalmics, Glaucoma Agents<br>Opiate Dependence Treatments<br>Otic Antibiotics<br>Otic Anti-Infectives & Anesthetics<br>Penicillins<br>Platelet Aggregation Inhibitors<br>Progestational Agents<br>Rosacea Agents, Topical<br>Sedative Hypnotics<br>Skeletal Muscle Relaxants | |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Steroids, Topical<br>Stimulants and Related Agents<br>Tetracyclines<br>Ulcerative Colitis Agents | |
| .35 | Phosphate Binders | Updated criteria |
| .36 | Rinvoq | Moved Rinvoq criteria to Cytokine and CAM Antagonist class section<br>Added diagnoses of ankylosing spondylitis and ulcerative colitis. Clients with these diagnoses requires preferred therapy from the Cytokine and CAM class. |
| .37 | Potassium Binders | Added criteria for the new class, Potassium Binders |
| | Acne Agents, Oral<br>Acne Agents, Topical<br>Analgesics, Narcotic Long<br>Analgesics, Narcotic Short<br>Angiotensin Modulator Combinations<br>Angiotensin Modulators<br>Anti-Allergens, Oral<br>Anticoagulants<br>Antidepressants, Other<br>Antidepressants, SSRIs<br>Antidepressants, TCAs<br>Antihyperuricemics<br>Antimigraine Agents, Other<br>Antimigraine Agents, Triptans<br>Antiparkinson's Agents<br>Antipsychotic Agents<br>Antivirals, Oral<br>Anxiolytics<br>Beta Blockers<br>Bile Salts<br>Bladder Relaxant Preparations | Updated classes and GCNs |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | BPH Treatments<br>Bronchodilators, Beta Agonist<br>COPD Agents<br>Cough and Cold Agents<br>Erythropoiesis Stimulating Proteins<br>Glucagon Agents<br>Glucocorticoids, Inhaled<br>HAE Treatments<br>Hemophilia Treatments<br>H. Pylori Treatment<br>Immune Globulins<br>Immunomodulators, Asthma<br>Immunomodulators, Atopic Dermatitis<br>Intranasal Rhinitis Agents<br>Lincosamides/ Oxazolidinones/ Streptogramins<br>Lipotropics, Other<br>Lipotropics, Statins<br>Movement Disorders<br>Multiple Sclerosis Agents<br>Neuropathic Pain<br>Oncology, Oral-Breast<br>Oncology, Oral-Hematologic<br>Oncology, Oral-Lung<br>Oncology, Oral-Other<br>Oncology, Oral – Prostate<br>Oncology, Oral-Renal Cell<br>Oncology, Oral-Skin<br>PAH Agents, Oral and Inhaled<br>Pancreatic Enzymes<br>Pediatric Vitamin Preparations<br>Phosphate Binders<br>Platelet Aggregation Inhibitors<br>Prenatal Vitamins | |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Progestins for Cachexia<br>PPIs<br>Sedative Hypnotics<br>Sickle Cell Anemia Treatments<br>Smoking Cessation<br>Stimulants and Related Agents<br>Thrombopoiesis Stimulating Proteins<br>Urea Cycle Disorders, Oral | |
| .38 | Immunomodulators, Dupixent | Added diagnosis of eosinophilic esophagitis for Dupixent |
| .39 | Bronchodilators, Beta Agonists<br>Glucagon Agents | Updated lookback for a preferred agent to 14 days supply in the last 180 days for Bronchodilators, Beta Agonists and 1 day supply in the last 180 days for Glucagon agents |
| .40 | Hepatitis C Agents | Updated preferred agents |
| .41 | Uterine Disorder Treatments | Added criteria for Uterine Disorder Treatments |
| | Acne Agents, Topical<br>Alzheimer's Agents<br>Analgesics, Narcotic – Short<br>Androgenic Agents<br>Antibiotics, Vaginal<br>Antiemetic/Antivertigo Agents<br>Antifungals, Oral<br>Antifungals, Topical<br>Antihistamines, First Generation<br>Antipsychotic Agents<br>Antiviral Agents<br>Calcium Channel Blockers<br>Colony Stimulating Factors<br>Cytokine and CAM Antagonists<br>Epinephrine, Self-injected<br>Fluroquinolones, Oral | Updated GCNs for preferred and nonpreferred agents |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Glucocorticoids, Oral<br>GI Motility Agents<br>HAE Agents<br>HIV/AIDs<br>Hypoglycemics, Incretin Mimetics/Enhancers<br>Hypoglycemics, Insulin and Related Agents<br>Hypoglycemics, Metformin<br>Hypoglycemics, SGLT2<br>Immunosuppressives, Oral<br>Macrolides/Ketolides<br>NSAIDs<br>Ophthalmic Antibiotics<br>Ophthalmic Antibiotic-Steroid Combinations<br>Ophthalmics for Allergic Conjunctivitis<br>Opiate Dependence Treatments<br>PAH Agents, Oral and Inhaled<br>Rosacea Agents, Topical<br>Sedative/Hypnotics<br>Skeletal Muscle Relaxants<br>Tetracyclines<br>Ulcerative Colitis Agents | |
| .42 | Acne Agents, Oral<br>Acne Agents, Topical<br>Analgesics, Narcotic (Long)<br>Analgesics, Narcotic (Short)<br>Anti-allergens, Oral<br>Antibiotics, Inhaled<br>Anticoagulants<br>Antidepressants, Other<br>Antidepressants, SSRIs<br>Antidepressants, Tricyclic | Updated GCNs for preferred and nonpreferred agents |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Antifungals, Oral<br>Angiotensin Modulator Combinations<br>Angiotensin Modulators<br>Antihypertensives, Sympatholytics<br>Antihyperuricemics<br>Antimigraine Agents, Other<br>Antimigraine Agents, Triptans<br>Antiparkinson's Agents<br>Antivirals, Oral<br>Anxiolytics<br>Beta-Blockers<br>Bile Salts<br>Bladder Relaxant Preparations<br>BPH Treatments<br>Bronchodilators, Beta Agonist<br>Colony Stimulating Factors<br>COPD Agents<br>Cough and Cold, Cold<br>Cough and Cold, Narcotic<br>Cough and Cold, Non-Narcotic<br>Cytokine and CAM Antagonists<br>Erythropoiesis Stimulating Proteins<br>Glucagon Agents<br>Glucocorticoids, Inhaled<br>HAE Treatments<br>Hemophilia Treatments<br>HIV/AIDS<br>H. Pylori Treatment<br>Hypoglycemics, Insulin and Related Agents<br>Immune Globulins<br>Immunomodulators, Asthma<br>Immunomodulators, Atopic Dermatitis | |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Intranasal Rhinitis Agents<br>Lincosamides/Oxazolidinones/Streptogramins<br>Lipotropics, Other<br>Lipotropics, Statins<br>Movement Disorders<br>MS Agents<br>Neuropathic Pain<br>Oncology, Oral-Breast<br>Oncology, Oral-Hematologic<br>Oncology, Oral-Lung<br>Oncology, Oral-Other<br>Oncology, Oral-Prostate<br>Oncology, Oral-Renal Cell<br>Oncology, Oral-Skin<br>PAH Agents, Oral and Inhaled<br>Pancreatic Enzymes<br>Pediatric Vitamin Preparations<br>Phosphate Binders<br>Platelet Aggregation Inhibitors<br>Potassium Binders<br>Prenatal Vitamins<br>Progesterones for Cachexia<br>Proton Pump Inhibitors<br>Sedative Hypnotics<br>Sickle Cell Treatments<br>Smoking Cessation<br>Stimulants and Related Agents<br>Thrombopoiesis Stimulating Proteins<br>Urea Cycle Disorders, Oral | |
| .43 | Rinvoq<br>Dupixent<br>Hepatitis C Agents | Added diagnosis of prurigo nodularis to Dupixent criteria<br>Added diagnoses of Crohn's disease and non-radiographic axial spondyloarthritis to Rinvoq criteria |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | | Added GCNs for ribavirin to preferred Hepatitis C Agents table |
| .44 | Alzheimer's Agents<br>Androgenic Agents<br>Antibiotics, GI<br>Antibiotics, Topical<br>Antibiotics, Vaginal<br>Anticonvulsants<br>Antiemetic/Antivertigo Agents<br>Antifungals, Oral<br>Antifungals, Topical<br>Antihistamines, First Generation<br>Antihistamines, Minimally Sedating<br>Antimigraine Agents, Other<br>Antiparasitics, Topical<br>Antipsychotics<br>Antivirals, Topical<br>Bone Resorption Suppression and Related Agents<br>Calcium Channel Blockers<br>Cephalosporins and Related Antibiotics<br>Colony Stimulating Factors<br>Cytokine and CAM Antagonists<br>Epinephrine, Self-injected<br>Fluoroquinolones, Oral<br>GI Motility, Chronic<br>Glucocorticoids, Oral<br>Growth Hormone<br>Hemophilia Treatment<br>HIV/AIDS<br>Hypoglycemics, Incretin Mimetics/Enhancers<br>Insulin and Related Agents<br>Meglitinides | Updated GCNs for preferred and nonpreferred agents<br>Added information from HB 3286, Section 2, 88th Legislature, Regular Session, 2023, including PDL criteria exceptions and additional criteria for the Antipsychotic PDL class |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Metformins<br>SGLT2<br>TZD<br>Immunomodulators, Lupus<br>Immunosuppressives, Oral<br>Iron, Oral<br>Leukotriene Modifiers<br>Macrolides/Ketolides<br>Movement Disorders<br>NSAIDs<br>Oncology, Oral<br>Ophthalmic Antibiotics<br>Ophthalmic Antibiotic-Steroid Combinations<br>Ophthalmics for Allergic Conjunctivitis<br>Ophthalmics, Anti-Inflammatories<br>Ophthalmics, Anti-Inflammatories/Immunomodulator<br>Ophthalmics, Glaucoma Agents<br>Opiate Dependence Treatments<br>Otic Antibiotics<br>Otic Anti-Infectives & Anesthetics<br>PAH Agents, Oral and Inhaled<br>Penicillins<br>Proton Pum Inhibitors<br>Rosacea Agents, Topical<br>Sedative Hypnotics<br>Skeletal Muscle Relaxants<br>Steroids, Topical<br>Tetracyclines<br>Ulcerative Colitis Agents<br>Uterine Disorder Treatments | |
| 08/08/2024 | Acne Agents, Oral<br>Acne Agents, Topical | Updated PDL classes and GCNs<br>Added information to Antidepressant criteria logic regarding discharge from an inpatient |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Analgesics, Narcotics Long<br>Analgesics, Narcotics Short<br>Angiotensin Modulator Combinations<br>Angiotensin Modulators<br>Anti-Allergans<br>Antibiotics, GI<br>Antibiotics, Inhaled<br>Anticoagulants<br>Antidepressants, Other<br>Antidepressants, SSRIs<br>Antidepressants, Tricyclic<br>Antihypertensives, Sympatholytics<br>Anticonvulsants<br>Antihyperuricemics<br>Antimigraine Agents, Other<br>Antimigraine Agents, Triptans<br>Antivirals<br>Antiparkinson's Agents<br>Anxiolytics<br>Beta-Blockers<br>Bladder Relaxant Preparations<br>Bile Salts<br>BPH Agents<br>Bronchodilators, Beta Agonist<br>COPD Agents<br>Cough and Cold, Cold<br>Cough and Cold, Narcotics<br>Cough and Cold, Non-Narcotic<br>Cytokine and CAM Antagonists<br>Erythropoiesis Stimulating Agents<br>Glucagon Agents<br>Glucocorticoids, Inhaled<br>Hemophilia Treatment<br>HAE Treatments | facility or risk of experiencing complications if switched from a non preferred agent to a preferred agent<br>Removed age exemption from Epaned<br>Removed Criteria for Xifaxan, Progestational Agents, and PCSK9 Inhibitors<br>Removed diagnosis question from Rinvoq and Dupixent criteria logic<br>Rephrased PA system from RxPert to GW PA System<br>Updated and/or reviewed all preferred drug tables |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | H. Pylori Treatment<br>Immune Globulins<br>Immunomodulators, Asthma<br>Immunomodulators, Atopic Dermatitis<br>Intranasal Rhinitis Agents<br>Lincosamides/Oxazolidinones/Streptogramins<br>Lipotropics, Other<br>Lipotropics, Statins<br>Movement Disorders<br>Multiple Sclerosis Agents<br>Neuropathic Pain<br>Oncology, Oral-Breast<br>Oncology, Oral-Hematologic<br>Oncology, Oral-Lung<br>Oncology, Oral-Other<br>Oncology, Oral-Prostate<br>Oncology, Oral-Renal Cell<br>Oncology, Oral-Skin<br>Opioid Dependence Treatments<br>Ophthalmics, Anti-Inflammatory Immunomodulators<br>PAH Agents<br>Pancreatic Enzymes<br>Pediatric Vitamin Preparations<br>Prenatal Vitamins<br>Phosphate Binders<br>Platelet Aggregation Inhibitors<br>Potassium Binders<br>Progestins for Cachexia<br>Proton Pump Inhibitors<br>Sedative Hypnotic<br>Sickle Cell Anemia Treatments<br>Smoking Cessation | |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Stimulants and Related Agents<br>Thrombopoiesis Stimulating Proteins<br>Ulcerative Colitis<br>Urea Cycle Disorder | |
| 01/30/2025 | Androgenic Agents<br>Angiotensin Modulators<br>Antibiotics, GI<br>Antibiotics, Topical<br>Antibiotics, Vaginal<br>Antiemetic/Antivertigo Agents<br>Antifungals, Oral<br>Antifungals, Topical<br>Antihistamines, Minimally Sedating<br>Antipsychotics<br>Antivirals, Topical.<br>Bile Salts<br>Calcium Channel Blockers<br>Cephalosporins and Related Antibiotics<br>Cytokine and CAM Antagonists<br>GI Motility, Chronic<br>Glucocorticoids, Inhaled<br>Glucocorticoids, Oral<br>Growth Hormone<br>Hypoglycemics, Incretin Mimetics<br>Hypoglycemics, Insulin and Related Agents<br>Hypoglycemics, SGLT2<br>Hypoglycemics, TZD<br>Immunomodulators, Asthma<br>Immunomodulators, Atopic Dermatitis<br>Immunosuppressives, Oral<br>Leukotriene Modifiers | Updated PDL classes and GCNs<br>Removed statement “prenatal vitamins are covered only for females less than 50 years of age” from document |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Macrolides/Ketolides<br>Movement Disorder<br>NSAIDs<br>Ophthalmic Antibiotics<br>Ophthalmic Antibiotic-Steroid Combinations<br>Ophthalmics, Anti-Inflammatories<br>Ophthalmics for Allergic Conjunctivitis<br>Ophthalmics, Glaucoma Agents<br>PAH Agent, Oral<br>Rosacea Agents, Topical<br>Steroids, Topical High<br>Ulcerative Colitis Agents | |
| 07/28/2025 | Acne Agents, Topical<br>Analgesics, Narcotics Long Acting<br>Angiotensin Modulators<br>Anti-Allergens, Oral<br>Anticoagulants<br>Antidepressants, Other<br>Antidepressants, SSRIs<br>Antihypertensives, Sympatholytics<br>Antimigraine Agents, Other<br>Antimigraine Agents, Triptans<br>Antiparkinson's Agents<br>Antipsychotics<br>Antivirals, Oral/Nasal<br>Anxiolytics<br>Beta Blockers, Oral<br>Bladder Relaxant Preparations<br>BPH Agents<br>Cough and Cold<br>Cytokine and CAM Antagonists<br>Glucagon Agents<br>Glucocorticoids, Inhaled | Updated PDL classes and GCNs<br>Removed "Oral/SQ" from "Immunosuppressives, Oral/SQ"<br>Renamed "NSAIDs" to "Non-Narcotic Analgesics"<br>Updated "PAH Agents, Oral" to "PAH Agents, Oral and Inhaled"<br>Removed "Cytokine and CAM Antagonists, Rinvoq" section and added Rinvoq GCNs to the "Cytokine and CAM Antagonists" section |

| Version Number | Chapter/Section | Change |
|---|---|---|
| | Immune Globulins<br>Immunomodulators, Asthma<br>Immunomodulators, Atopic Dermatitis<br>Intranasal Rhinitis Agents<br>Lipotropics, Other<br>Long-Acting Injectables Alternate Therapies<br>Movement Disorders<br>Neuropathic Pain<br>PAH Agents, Oral<br>Proton Pump Inhibitors<br>Sedative Hypnotics<br>Stimulants and Related Agents | |
| 08/08/2025 | Acne Agents, Oral<br>Glucocorticoids, Inhaled | Removed GCNs for Accutane (59841, 59842, 20383, 59843), Myorisan (59841, 59842, 20383, 59843), Flovent HFA (53636, 53639, 53638), and Flovent Diskus (53633, 53634) |