

Texas Preferred Drug List

Preferred drugs are medications recommended by the Texas Drug Utilization Review Board for their efficaciousness, clinical significance, cost-effectiveness, and safety.

Formulary

Everyone enrolled in Medicaid adheres to the same formulary. The Medicaid formulary includes legend and over-the-counter drugs. Certain supplies and select vitamin and mineral products are also available as a pharmacy benefit. Some drugs are subject to one or both types of prior authorization: clinical or non-preferred. The [Formulary Drug Search](#) identifies the list of Medicaid-covered drugs and whether the drug requires prior authorization

Preferred Drug List

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

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

CHIP drugs are not subject to PDL requirements.

The [PDL Criteria Guide](#) explains the criteria used to evaluate prior authorization requests.

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

Pharmacy Prior Authorization

Each MCO administers pharmacy prior authorization services for people enrolled in Medicaid managed care. The Texas Prior Authorization Call Center administers traditional Medicaid prior authorizations

PDL Prior Authorization

Drugs identified as “non-preferred” require a PDL prior authorization. The PDL Criteria Guide explains the criteria used to evaluate the non-preferred prior authorization requests.

Clinical Prior Authorization

Clinical prior authorizations may apply to any individual drug or an entire drug class on the formulary, including some preferred and non-preferred drugs. HHSC requires MCOs to perform specific clinical prior authorizations. Usage of all other clinical prior authorizations will vary between MCOs at the discretion of each MCO. The Texas Medicaid Drug Utilization Board approves all criteria.

- Review the [list of clinical prior authorizations](#) allowable in Medicaid managed care
- Review the [list of clinical prior authorizations](#) active in Medicaid fee-for-service

The [Clinical Prior Authorization Assistance Chart](#) identifies which MCOs utilize each clinical prior authorization.

Obtaining Prior Authorization

Prescribing providers can help people enrolled in Medicaid receive medications quickly and conveniently with a few simple steps by contacting one of the following:

Medicaid Managed Care

Pharmacy prior authorization call centers vary by MCO. Refer to each MCO’s prior authorization call center number and other [contact information](#).

Traditional Medicaid

The [Texas Prior Authorization Call Center](#) accepts prior authorization requests by phone at 877-PA-TEXAS (877-728-3927) or online. Online submission is only available for non-preferred prior authorization requests.

- [Online Account Registration Instructions](#)
- [Provider Quick Reference](#)

Texas Drug Utilization Review Board

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

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

Education

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

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To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

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REVISION HISTORY

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

DATE	ISSUES/UPDATES
07/28/2022	Published
08/03/2022	VITAFOL-ONE (ORAL) added to appendices to correct inadvertent omission.
08/10/2022	Opiate Dependence Treatment -naloxone nasal spray added to document. Hep C agents- description changed to Polymerase/Protease Inhibitors (Direct Acting Antivirals).
9/27/2022	Hyperlinks of the Drug Regimen Optimization clinical PA removed

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ACNE AGENTS, ORAL

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ACCUTANE (isotretinoin)	ABSORICA (isotretinoin)
AMNESTEEM (isotretinoin)	ABSORICA LD (isotretinoin)
CLARAVIS (isotretinoin)	isotretinoin (Absorica)
Isotretinoin	
MYORISAN (isotretinoin)	
ZENATANE (isotretinoin)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ACNE AGENTS, TOPICAL

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

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

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

- [Retinoids](#)
- [Topical Acne Agents](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIBIOTICS	
clindamycin gel	AMZEEQ (minocycline)
clindamycin pledgets	CLEOCIN-T (clindamycin)
clindamycin solution	clindamycin foam
erythromycin gel, solution	clindamycin gel AG (Clindagel)
	clindamycin lotion
	erythromycin medicated swab
BENZOYL PEROXIDE	
benzoyl peroxide gel (Rx)	BENZEFOAM FOAM OTC (topical)
benzoyl peroxide lotion (OTC)	benzoyl peroxide cleanser
benzoyl peroxide wash	benzoyl peroxide cream
	benzoyl peroxide foam
	benzoyl peroxide gel
	benzoyl peroxide kit
	benzoyl peroxide towelette
RETINOIDS	
tretinoin cream (Avita, Retin-A)	AKLIEF (trifarotene)
tretinoin gel (Avita, Retin-A)	adapalene
	ALTRENO (tretinoin)
	ARAZLO (tazarotene)
	ATRALIN (tretinoin)
	AVITA (tretinoin)
	DIFFERIN (adapalene)
	FABIOR (tazarotene)
	Tazarotene
	TAZORAC (tazarotene)
	tretinoin gel (Atralin)
	tretinoin microspheres

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PREFERRED AGENTS	NON-PREFERRED AGENTS
COMBINATION AND OTHER AGENTS	
BENZACLIN GEL (benzoyl peroxide/clindamycin)	ACZONE (dapsone)
BENZACLIN GEL PUMP (benzoyl peroxide/clindamycin)	AZELEX (azelaic acid)
benzoyl peroxide/clindamycin (Duac)	adapalene/benzoyl peroxide (Epiduo/Epiduo Forte)
EPIDUO FORTE (benzoyl peroxide/adapalene)	clindamycin/benzoyl peroxide (Acanya)
erythromycin/benzoyl peroxide	clindamycin/tretinoin
	dapsone
	DERMACINRX ATRIX CLEANSER OTC (TOPICAL)
	DERMACINRX ATRIX CREAM OTC (TOPICAL)
	DERMACINRX ATRIX SOLUTION OTC (TOPICAL)
	sulfacetamide
	sulfacetamide sodium
	sulfacetamide sodium/sulfur
	sulfacetamide/sulfur
	sulfacetamide/sulfur/urea
	WINLEVI (clascoterone)
	ZIANA (clindamycin/tretinoin)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ALZHEIMER'S AGENTS

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
CHOLINESTERASE INHIBITORS	
donepezil 5, 10 mg tablet	ARICEPT (donepezil)
donepezil ODT	donepezil 23 mg tablet
EXELON (rivastigmine) transdermal	galantamine
	galantamine ER
	RAZADYNE ER (galantamine ER)
	rivastigmine capsules
	rivastigmine transdermal
NMDA RECEPTOR ANTAGONIST	
memantine tablets	memantine ER
	memantine solution
	memantine tablet dose pack
	NAMENDA (memantine) tablets
	NAMENDA XR (memantine)
CHOLINESTERASE INHIBITOR/NMDA RECEPTOR ANTAGONIST COMBINATIONS	
	NAMZARIC (donepezil/memantine)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANALGESICS, NARCOTIC – LONG ACTING

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

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- Methadone oral solution will be authorized for patients less than 24 months of age.

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

- [Opioid Policy Criteria](#)
- [Opiate Overutilization](#)
- [Opiate/Benzodiazepine/Muscle Relaxant](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
BUTRANS (buprenorphine)	BELBUCA (buprenorphine)
fentanyl patch (12, 25, 50, 75, 100 mcg)	buprenorphine buccal
morphine ER (generic MS Contin)	buprenorphine patch
tramadol ER (Ultram ER)	CONZIP (tramadol)
tramadol ER (generic Ryzolt)	fentanyl patch (37.5, 62.5, 87.5 mcg)
XTAMPZA ER (oxycodone)	hydrocodone ER
	hydromorphone ER
	HYSINGLA ER (hydrocodone)
	KADIAN (morphine)
	methadone
	methadone brand sol tablet
	MORPHABOND ER (morphine)
	morphine ER (generic Avinza, Kadian)
	MS CONTIN (morphine)
	NUCYNTA ER (tapentadol)
	oxycodone ER
	OXYCONTIN (oxycodone)
	oxymorphone ER
	tramadol ER (generic Conzip)
	ZOHYDRO ER (hydrocodone ER)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANALGESICS, NARCOTIC – SHORT ACTING (NON-PARENTERAL)

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

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

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

- [Opioid Policy Criteria](#)
- [Opiate Overutilization](#)
- [Opiate/Benzodiazepine/Muscle Relaxant](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
APAP/codeine	ACTIQ (fentanyl)
hydrocodone/APAP	APADAZ (benzhydrocodone/APAP)
hydromorphone tablet	benzhydrocodone/APAP
morphine tablets	butalbital/ASA/caffeine/codeine
morphine solution	butalbital/APAP/caffeine/codeine
oxycodone solution	butorphanol
oxycodone tablet	carisoprodol/aspirin/codeine
oxycodone/APAP	codeine
tramadol 50mg	dihydrocodeine/APAP/caffeine
tramadol/APAP	DILAUDID (hydromorphone)
	DSUVIA (sufentanil citrate)
	fentanyl buccal
	FENTORA (fentanyl)
	FIORICET W/CODEINE (butalbital/APAP/caffeine/codeine)
	FIORINAL W/CODEINE (butalbital/ASA/caffeine/codeine)
	hydrocodone/ibuprofen
	hydromorphone liquid
	hydromorphone suppositories
	levorphanol
	LORTAB (hydrocodone/APAP)
	meperidine
	morphine concentrated solution
	morphine disp syr, oral
	morphine suppositories
	NUCYNTA (tapentadol)
	OXAYDO (oxycodone)
	oxycodone/ASA
	oxycodone capsule
	oxycodone concentrate solution

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	oxycodone syr (oral)
	oxymorphone
	pentazocine/naloxone
	PERCOCET (oxycodone/APAP)
	QDOLO (tramadol)
	ROXICODONE (oxycodone)
	tramadol 100mg
	tramadol solution
	ULTRACET (tramadol/APAP)
	ULTRAM (tramadol)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANDROGENIC AGENTS, TOPICAL

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

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

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

- [Androgenic Agents](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANDROGEL (testosterone) pump	ANDRODERM (testosterone)
	ANDROGEL (testosterone) packet
	FORTESTA (testosterone)
	NATESTO (testosterone)
	TESTIM (testosterone)
	testosterone gel
	VOGELXO (testosterone)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANGIOTENSIN MODULATORS

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

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- Epaned will be authorized for patients six years of age and under

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ACE INHIBITORS	
benazepril	ACCUPRIL (quinapril)
EPANED (enalapril)	ALTACE (ramipril)
enalapril tablet	captopril
fosinopril	enalapril solution
lisinopril	LOTENSIN (benazepril)
quinapril	moexipril
ramipril	perindopril
	PRINIVIL (lisinopril)
	QBRELIS (lisinopril) solution
	trandolapril
	VASOTEC (enalapril)
	ZESTRIL (lisinopril)

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

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

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

- [Duplicate Therapy](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ACE INHIBITOR/DIURETIC COMBINATIONS	
enalapril/HCTZ	ACCURETIC (quinapril/HCTZ)
lisinopril/HCTZ	benazepril/HCTZ
	captopril/HCTZ
	fosinopril/HCTZ
	LOTENSIN HCT (benazepril/HCTZ)
	quinapril/HCTZ

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: [txvendordrug.com/formulary/formulary-search](https://www.txvendordrug.com/formulary/formulary-search). Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	VASERETIC (enalapril/HCTZ)
	ZESTORETIC (lisinopril/HCTZ)
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)	
DIOVAN (valsartan)	ATACAND (candesartan)
irbesartan	AVAPRO (irbesartan)
losartan	BENICAR (olmesartan)
	candesartan
	COZAAR (losartan)
	EDARBI (azilsartan)
	eprosartan
	MICARDIS (telmisartan)
	olmesartan
	telmisartan
	valsartan
ARB/DIURETIC COMBINATIONS	
irbesartan/HCTZ	ATACAND-HCT (candesartan/HCTZ)
losartan/HCTZ	AVALIDE (irbesartan/HCTZ)
	BENICAR-HCT (olmesartan/HCTZ)
	candesartan/HCTZ
	DIOVAN-HCT (valsartan/HCTZ)
	EDARBYCLOR (azilsartan/chlorthalidone)
	HYZAAR (losartan/HCTZ)
	MICARDIS-HCT (telmisartan/HCTZ)
	olmesartan/HCTZ
	telmisartan /HCTZ
	valsartan/HCTZ
DIRECT RENIN INHIBITORS	
	aliskiren
	TEKTURNA (aliskerin)
DIRECT RENIN INHIBITOR/DIURETIC COMBINATIONS	
	TEKTURNA HCT (aliskerin/HCTZ)
ARB/NEPRILYSIN INHIBITOR COMBINATIONS	
ENTRESTO (valsartan/sacubitril)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: [txvendordrug.com/formulary/formulary-search](https://www.txvendordrug.com/formulary/formulary-search). Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANGIOTENSIN MODULATOR COMBINATIONS

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
benazepril /amlodipine	AZOR (olmesartan/amlodipine)
valsartan/amlodipine	EXFORGE (valsartan/amlodipine)
	EXFORGE HCT (valsartan/amlodipine/HCTZ)
	LOTREL (benazepril/amlodipine)
	olmesartan/amlodipine
	olmesartan/amlodipine/HCTZ
	telmisartan/amlodipine
	trandolapril/verapamil
	TRIBENZOR (olmesartan/amlodipine/HCTZ)
	valsartan/amlodipine/HCTZ

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTI-ALLERGENS, ORAL

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
	ORALAIR (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass mixed pollens allergen extract)
	PALFORZIA MAINTENANCE SACHET (peanut allergen powder)
	PALFORZIA TITRATION CAPSULE (peanut allergen powder)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIBIOTICS, GASTROINTESTINAL

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
FIRVANQ (vancomycin)	AEMCOLO (rifamycin)
metronidazole tablet	DIFICID (fidaxomicin)
neomycin	FLAGYL (metronidazole)
tinidazole	metronidazole capsule
	nitazoxanide
	paromomycin
	VANCOGIN (vancomycin)
	vancomycin
	XIFAXAN (rifaximin)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIBIOTICS, INHALED

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

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

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

- [Antibiotics, Inhaled](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
BETHKIS (tobramycin)	ARIKAYCE (amikacin)
CAYSTON (aztreonam)	TOBI (tobramycin) solution
KITABIS PAK (tobramycin)	tobramycin solution
TOBI PODHALER (tobramycin)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIBIOTICS, TOPICAL

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
bacitracin ointment	bacitracin packet
mupirocin ointment	bacitracin/polymixin
triple antibiotic ointment	CENTANY (mupirocin)
	gentamicin
	mupirocin cream
	mupirocin ointment syringe
	neomycin/polymyxin/pramoxine
	XEPI (ozenoxacin)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIBIOTICS, VAGINAL

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
CLEOCIN (clindamycin) ovules	CLEOCIN (clindamycin) cream
CLINDESSE (clindamycin)	clindamycin
NUVESSA (metronidazole)	METROGEL-VAGINAL (metronidazole)
	metronidazole
	SOLOSEC (secnidazole)
	VANDAZOLE (metronidazole)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTICOAGULANTS

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

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

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

- [Duplicate Therapy](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ELIQUIS (apixaban)	ARIXTRA (fondaparinux)
enoxaparin	fondaparinux
JANTOVEN (warfarin)	FRAGMIN (dalteparin)
PRADAXA (dabigatran)	LOVENOX (enoxaparin)
warfarin	SAVAYSA (edoxaban)
XARELTO (rivaroxaban) tablet, dosepak	XARELTO (rivaroxaban) suspension

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTICONVULSANTS

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

- All of the agents in the Anticonvulsants class are preferred

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
APTIOM (eslicarbazine)	
BANZEL (rufinamide)	
BRIVIACT (brivaracetam)	
carbamazepine	
carbamazepine ER, XR	
CARBATROL (carbamazepine)	
CELONTIN (methsuximide)	
clobazam	
clonazepam	
DEPAKOTE (divalproex sodium)	
DEPAKOTE ER (divalproex sodium)	
DIACOMIT (stiripentol)	
DIASTAT (diazepam)	
DIASTAT ACUDIAL (diazepam)	
diazepam	
DILANTIN (phenytoin)	
DILANTIN INFATAB (phenytoin)	
divalproex	
divalproex ER	
ELEPSIA XR (levetiracetam)	
EPIDIOLEX (cannabidiol)	
EPITOL (carbamazepine)	
EPRONTIA (topiramate)	
EQUETRO (carbamazepine)	
ethosuximide	
felbamate	
FELBATOL (felbamate)	
FINTEPLA (fenfluramine)	
FYCOMPA (perampanel)	
GABITRIL (tiagabine)	
KEPPRA (levetiracetam)	
KEPPRA XR (levetiracetam)	
KLONOPIN (clonazepam)	
lacosamide	
LAMICTAL (lamotrigine) tablet, ODT	
LAMICTAL XR (lamotrigine)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PREFERRED AGENTS	NON-PREFERRED AGENTS
lamotrigine tablet, ER, ODT	
levetiracetam	
levetiracetam XR	
MYSOLINE (primidone)	
NAYZILAM (midazolam)	
ONFI (clobazam)	
oxcarbazepine	
OXTELLAR XR (oxcarbazepine)	
phenobarbital	
PHENYTEK (phenytoin)	
phenytoin	
primidone	
QUDEXY XR (topiramate)	
ROWEEPRA (levetiracetam)	
rufinamide suspension	
rufinamide tablet	
SABRIL (vigabatrin)	
SPRITAM (levetiracetam)	
SUBVENITE (lamotrigine)	
SYMPAZAN (clobazam)	
TEGRETOL (carbamazepine)	
TEGRETOL XR (carbamazepine)	
tiagabine	
TOPAMAX (topiramate)	
topiramate	
topiramate ER	
TRILEPTAL (oxcarbazepine)	
TROKENDI XR (topiramate)	
valproic acid	
VALTOCO (diazepam)	
vigabatrin	
VIGADRONE (vigabatrin)	
VIMPAT (lacosamide)	
XCOPRI (cenobamate)	
ZARONTIN (ethosuximide)	
zonisamide	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIDEPRESSANTS, OTHER

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
bupropion	APLENZIN (bupropion)
bupropion SR	bupropion XL (Forfivo XL)
bupropion XL	desvenlafaxine ER
FORFIVO XL (bupropion)	EFFEXOR XR (venlafaxine)
mirtazapine	EMSAM (selegiline)
phenelzine	FETZIMA (levomilnacipran)
PRISTIQ (desvenlafaxine)	MARPLAN (isocarboxazid)
trazodone	NARDIL (phenelzine)
venlafaxine ER capsules	nefazodone
venlafaxine IR	REMERON (mirtazapine)
	tranylcypromine
	TRINTELLIX (vortioxetine)
	venlafaxine ER tablets
	VIIBRYD (vilazodone)
	vilazodone
	WELLBUTRIN SR (bupropion)
	WELLBUTRIN XL (bupropion)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIDEPRESSANTS, SSRIS

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
citalopram tablets, solution	BRISDELLE (paroxetine)
escitalopram tablets	CELEXA (citalopram)
fluoxetine capsule	escitalopram solution
fluvoxamine	fluoxetine capsule DR
paroxetine	fluoxetine tablets
sertraline conc, tablet	fluvoxamine ER
	LEXAPRO (escitalopram)
	paroxetine (Brisdelle)
	paroxetine CR
	PAXIL (paroxetine)
	PAXIL CR (paroxetine)
	PEXEVA (paroxetine)
	PROZAC (fluoxetine)
	sertraline capsule
	ZOLOFT (sertraline)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIDEPRESSANTS, TRICYCLIC

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
amitriptyline	amoxapine
doxepin	ANAFRANIL (clomipramine)
imipramine	clomipramine
nortriptyline capsule	desipramine
	imipramine pamoate
	maprotiline
	NORPRAMIN (desipramine)
	nortriptyline solution
	PAMELOR (nortriptyline)
	protriptyline
	trimipramine

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIEMETIC-ANTIVERTIGO AGENTS (EXCLUDES INJECTABLES)

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

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

The following Clinical Prior Authorization may apply to drugs in the class:

- [Antiemetic Agents](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTICHOLINERGICS, ANTIHISTAMINES, DOPAMINE ANTAGONISTS	
dimenhydrinate	ANTIVERT (meclizine)
meclizine	BONJESTA (doxylamine/pyridoxine)
metoclopramide solution, tablets	COMPRO (prochlorperazine)
phosphoric acid/dextrose/fructose	DICLEGIS (doxylamine/pyridoxine)
prochlorperazine tablets	doxylamine/pyridoxine
promethazine syrup, tablets	GIMOTI (metoclopramide)
	metoclopramide ODT
	prochlorperazine suppositories
	promethazine suppositories
	REGLAN (metoclopramide)
	scopolamine patches
	Tigan (trimethobenzamide)
	TRANSDERM-SCOP (scopolamine)
	trimethobenzamide
CANNABINOIDS	
	dronabinol
	MARINOL (dronabinol)
5-HT3 RECEPTOR ANTAGONISTS	
ondansetron	granisetron
	SANCUSO (granisetron)
	SUSTOL (granisetron)
SUBSTANCE P ANTAGONISTS AND COMBINATIONS	
	AKYNZEO (netupitant/palonosetron)
	aprepitant
	EMEND (aprepitant)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIFUNGALS, ORAL

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
clotrimazole	ANCOBON (flucytosine)
fluconazole	BREXAFEMME (ibrexafungerp)
griseofulvin suspension	CRESEMBA (isavuconazonium sulfate)
ketoconazole	DIFLUCAN (fluconazole)
NOXAFIL (posaconazole) tablet	flucytosine
nystatin	griseofulvin tablets
terbinafine	itraconazole
	NOXAFIL (posaconazole) susp
	posaconazole
	SPORANOX (itraconazole)
	TOLSURA (itraconazole)
	VFEND (voriconazole)
	voriconazole

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIFUNGALS, TOPICAL

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

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

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

- [Antifungal Agents, Topical](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIFUNGALS	
clotrimazole	ALEVAZOL (clotrimazole)
ketoconazole shampoo	BENSAL HP (benzoic acid/salicylic acid)
miconazole cream, powder	CICLODAN (ciclopirox)
NYAMYC (nystatin) powder	ciclopirox
nystatin	clotrimazole solution RX
NYSTOP (nystatin) powder	econazole
terbinafine	ERTACZO (sertaconazole)
tolnaftate cream, powder	EXELDERM (sulconazole)
	EXTINA (ketoconazole)
	FUNGOID (miconazole)
	JUBLIA (efinaconazole)
	KERYDIN (tavaborole)
	ketoconazole cream, foam
	KETODAN (ketoconazole)
	LOPROX (ciclopirox)
	LOTRIMIN AF(clotrimazole)
	LOTRIMIN ULTRA (butenafine)
	luliconazole
	LUZU (luliconazole)
	MENTAX (butenafine)
	MICONATATE OTC (miconazole/tolnaftate)
	miconazole ointment, spray
	naftifine
	NAFTIN (naftifine)
	oxiconazole
	OXISTAT (oxiconazole)
	sulconazole
	tavaborole
	tolnaftate solution, spray
	VUSION (miconazole/zinc/petrolatum)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIFUNGAL/STEROID COMBINATIONS	
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion
	nystatin/triamcinolone
	TRIAMAZOLE KIT (econazole/triamcinolone)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIHISTAMINES, FIRST GENERATION

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

- Treatment failure after no less than a 30-day trial of preferred drugs
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

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

- [Duplicate Therapy](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIHISTAMINES	
BANOPHEN (diphenhydramine)	AHIST (chlorcyclizine)
carbinoxamine liquid	carbinoxamine tablets
clorpheniramine IR tablets	clemastine tablets
cyproheptadine syrup, tablet	diphenhydramine chew, elixir
diphenhydramine capsules, liquid, tablet	ED CHLORPRED (chlorpheniramine/phenylephrine)
HISTEX (triprolidine) liquid, PD DROPS	HISTEX (triprolidine) chew, PDX drop
hydroxyzine	KARBINAL ER (carbinoxamine) suspension
PEDIACLEAR PD DROPS OTC (triprolidine)	PEDIAVENT (dexbrompheniramine)
PEDIACLEAR-8 LIQUID OTC (pryramine maleate)	RYCLORA (dexchlorpheniramine)
	RYVENT (carbinoxamine)
	triprolidine
	VISTARIL (hydroxyzine)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: [txvendordrug.com/formulary/formulary-search](https://www.txvendordrug.com/formulary/formulary-search). Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIHISTAMINES, MINIMALLY SEDATING

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

- Treatment failure after no less than a 30-day trial of preferred drugs
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

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

- [Duplicate Therapy](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIHISTAMINES	
cetirizine solution, tablets	cetirizine chewable, capsule
loratadine solution, tablets	CLARINEX (desloratadine)
	desloratadine
	fexofenadine
	levocetirizine
	loratadine ODT, chew

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

- Treatment failure after no less than a 30-day trial of preferred drugs
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

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

- [Duplicate Therapy](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIHISTAMINE/DECONGESTANT COMBINATIONS	
	cetirizine/pseudoephedrine
	CLARINEX-D (desloratadine/pseudoephedrine)
	fexofenadine/pseudoephedrine
	loratadine/pseudoephedrine
	SEMPREX-D (acrivastine/pseudoephedrine)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: [tvendordrug.com/formulary/formulary-search](https://www.texas.gov/vendordrug.com/formulary/formulary-search). Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIHYPERTENSIVES, SYMPATHOLYTICS

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
CATAPRES-TTS (clonidine)	CATAPRES (clonidine)
clonidine IR tablets	clonidine transdermal
guanfacine IR	methyldopa / HCTZ
methyldopa	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIHYPURICEMICS

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
allopurinol	colchicine
COLCRYS (colchicine)	febuxostat
probenecid	GLOPERBA (colchicine)
probenecid/colchicine	MITIGARE (colchicine)
	ULORIC (febuxostat)
	ZYLOPRIM (allopurinol)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIMIGRAINE AGENTS

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

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

The following Clinical Prior Authorization may apply to drugs in the class:

- [Antimigraine Agents, Triptans](#)

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

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

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIPARASITICS, TOPICAL

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
NATROBA (spinosad)	CROTAN (crotamiton)
permethrin	ELIMITE (permethrin)
VANALICE GEL OTC (piperonyl butoxide/pyrethrins)	EURAX (crotamiton)
	ivermectin
	lindane
	malathion
	OVIDE (malathion)
	piperonyl butoxide/pyrethrins
	piperonyl butox/pyrethr/permet
	SKLICE (ivermectin)
	spinosad

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIPARKINSON'S AGENTS (ORAL/TRANSDERMAL)

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTICHOLINERGICS	
benztropine	
trihexyphenidyl	
COMT INHIBITORS	
	COMTAN (entacapone)
	entacapone
	ONGENTYS (opicapone)
	TASMAR (tolcapone)
	tolcapone
DOPAMINE AGONISTS	
pramipexole	APOKYN (apomorphine)
ropinirole	apomorphine
	bromocriptine
	KYNMOBI (apomorphine)
	MIRAPEX ER (pramipexole)
	NEUPRO transdermal (rotigotine)
	PARLODEL (bromocriptine)
	pramipexole ER
	ropinirole ER
MAO-B INHIBITORS	
	AZILECT (rasagiline)
	rasagiline
	selegiline
	XADAGO (safinamide)
	ZELAPAR (selegiline)
OTHERS	
amantadine	carbidopa
carbidopa/levodopa tablets	carbidopa/levodopa ODT
carbidopa/levodopa ER	DHIVY (carbidopa/levodopa)
carbidopa/levodopa/entacapone	DUOPA (carbidopa/levodopa)
	GOCOVRI (amantadine)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

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

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIPSYCHOTICS

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

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

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

- [Antipsychotics](#)

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

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

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	ZYPREXA ZYDIS (olanzapine)
ANTIPSYCHOTIC/SSRI COMBINATIONS	
amitriptyline/perphenazine	olanzapine/fluoxetine
	SYMBYAX (olanzapine/fluoxetine)
ANTIPSYCHOTIC/SEROTONIN ANTAGONIST COMBINATIONS	
	LYBALVI (olanzapine/samidorphan)
LONG-ACTING INJECTABLES	
ABILIFY MAINTENA (aripiprazole)	ZYPREXA RELPREVV (olanzapine)
ARISTADA (aripiprazole)	
ARISTADA INITIO (aripiprazole)	
INVEGA HAFYERA (paliperidone)	
INVEGA SUSTENNA (paliperidone)	
INVEGA TRINZA (paliperidone)	
PERSERIS (risperidone)	
RISPERDAL CONSTA (risperidone)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIVIRALS (ORAL/NASAL)

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIHERPETIC	
acyclovir	SITAVIG (acyclovir)
famciclovir	VALTREX (valacyclovir)
valacyclovir	ZOVIRAX (acyclovir)
ANTI-INFLUENZA	
oseltamivir	FLUMADINE (rimantadine)
	RELENZA (zanamivir)
	rimantadine
	TAMIFLU (oseltamivir)
	XOFLUZA (baloxavir)
ANTI-CMV	
VALCYTE (valganciclovir) solution	VALCYTE (valganciclovir) tablets
valganciclovir tablets	valganciclovir solution

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANTIVIRALS, TOPICAL

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
DENAVIR (penciclovir)	acyclovir cream, ointment
ZOVIRAX (acyclovir) cream, ointment	docosanol
	XERESE (acyclovir/hydrocortisone)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ANXIOLYTICS

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

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

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

- [Anxiolytics](#)
- [Opiate/Benzodiazepine/Muscle Relaxant](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
alprazolam tablet	alprazolam ER
buspirone	alprazolam intensol
chlordiazepoxide	alprazolam ODT
clorazepate	ATIVAN (lorazepam)
diazepam solution	diazepam intensol
diazepam tablet	LOREEV XR (lorazepam)
lorazepam intensol	meprobamate
lorazepam tablet	oxazepam
	TRANXENE T-TAB (clorazepate)
	XANAX XR (alprazolam)
	XANAX (alprazolam) tablet

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

BETA BLOCKERS (ORAL)

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
BETA BLOCKERS	
acebutolol	BETAPACE/ AF (sotalol)
atenolol	betaxolol
bisoprolol	BYSTOLIC (nebivolol)
HEMANGEOL (propranolol)	CORGARD (nadolol)
metoprolol IR	INDERAL LA/XL (propranolol)
metoprolol XL	INNOPRAN XL (propranolol)
propranolol IR	KAPSPARGO (metoprolol succinate)
SORINE (sotalol)	LOPRESSOR (metoprolol)
sotalol	nadolol
	nebivolol
	pindolol
	propranolol ER
	SOTYLIZE (sotalol)
	TENORMIN (atenolol)
	timolol
	TOPROL XL (metoprolol succinate)
BETA BLOCKER COMBINATIONS	
atenolol/chlorthalidone	metoprolol/HCTZ
bisoprolol/HCTZ	propranolol/HCTZ
	TENORETIC (atenolol/HCTZ)
	ZIAC (bisoprolol/HCTZ)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
BETA- AND ALPHA-BLOCKERS	
carvedilol	carvedilol ER
COREG CR (carvedilol)	COREG (carvedilol)
labetalol	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

BILE SALTS

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ursodiol tablet	BYLVAY (odevixibat) cap/pellet
	CHENODAL (chenodiol)
	CHOLBAM (cholic acid)
	LIVMARLI (maralixibat)
	OCALIVA (obeticholic acid)
	RELTONE (ursodiol)
	URSO (ursodiol)
	URSO FORTE (urosodiol)
	ursodiol capsule

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

BLADDER RELAXANT PREPARATIONS

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
oxybutynin IR	darifenacin ER
oxybutynin ER	DETROL (tolterodine)
TOVIAZ (fesoterodine)	DETROL LA (tolterodine)
VESICARE (solifenacin)	DITROPAN XL (oxybutynin)
	flavoxate
	GELNIQUE (oxybutynin)
	MYRBETRIQ (mirabegron)
	OXYTROL (oxybutynin)
	solifenacin
	tolterodine
	tolterodine ER
	tropium
	tropium ER
	VESICARE LS (solifenacin)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

BONE RESORPTION SUPPRESSION AND RELATED AGENTS

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
BISPHOSPHONATES	
alendronate tablets	ACTONEL (risedronate)
	alendronate solution
	ATELVIA (risedronate)
	BONIVA (ibandronate) etidronate
	EVENITY (romosozumab-aqqg)
	FOSAMAX (alendronate)
	FOSAMAX PLUS D (alendronate/vitamin D)
	ibandronate
	risedronate
OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS	
EVISTA (raloxifene)	calcitonin nasal
FORTEO (teriparatide)	PROLIA (denosumab)
	raloxifene
	teriparatide
	TYMLOS (abaloparatide)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

BPH AGENTS

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ALPHA BLOCKERS	
alfuzosin	CARDURA (doxazosin)
doxazosin	FLOMAX (tamsulosin)
tamsulosin	RAPAFLO (silodosin)
terazosin	silodosin
5-ALPHA-REDUCTASE (5AR) INHIBITORS	
finasteride	AVODART (dutasteride)
	dutasteride
	PROSCAR (finasteride)
ALPHA BLOCKER/5AR INHIBITOR COMBINATIONS	
	dutasteride/tamsulosin
	JALYN (dutasteride/tamsulosin)
PHOSPHODIESTERASE 5 INHIBITORS	
	tadalafil

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

BRONCHODILATORS, BETA AGONIST

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

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

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

- [Duplicate Therapy](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
INHALERS, SHORT-ACTING	
PROAIR HFA (albuterol)	albuterol HFA
PROVENTIL HFA (albuterol)	levalbuterol
VENTOLIN HFA (albuterol)	PROAIR DIGIHALER (albuterol)
	PROAIR RESPICLICK (albuterol)
	XOPENEX HFA (levalbuterol)
INHALERS, LONG-ACTING	
	SEREVENT (salmeterol)
	STRIVERDI RESPIMAT (olodaterol)
INHALATION SOLUTION	
albuterol	arformoterol
	BROVANA (arformoterol)
	formoterol
	levalbuterol
	PERFOROMIST (formoterol)
	XOPENEX (levalbuterol)
ORAL	
albuterol syrup	albuterol tablet
	albuterol ER
	metaproterenol
	terbutaline

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

CALCIUM CHANNEL BLOCKERS (ORAL)

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
SHORT-ACTING	
diltiazem	CARDIZEM (diltiazem)
verapamil	isradipine
	nicardipine
	nifedipine
	nimodipine
	NYMALIZE (nimodipine)
LONG-ACTING	
amlodipine	ADALAT CC (nifedipine)
CARTIA XT (diltiazem)	CALAN SR (verapamil)
DILT XR (diltiazem)	CARDIZEM CD (diltiazem)
diltiazem ER	CARDIZEM LA (diltiazem)
felodipine ER	diltiazem LA
nifedipine ER	KATERZIA (amlodipine)
TAZTIA XT (diltiazem)	levamlodipine
TIADYL ER (diltiazem)	MATZIM LA (diltiazem)
verapamil ER capsules, tablets	nisoldipine
	NORVASC (amlodipine)
	PROCARDIA XL (nifedipine)
	SULAR (nisoldipine)
	TIAZAC (diltiazem)
	verapamil 360 mg capsules
	verapamil ER PM
	VERELAN (verapamil)
	VERELAN PM (verapamil)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)

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

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

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

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

COLONY STIMULATING FACTORS

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
FULPHILA (pegfilgrastim-jmdb)	GRANIX (tbo-filgrastim)
NEUPOGEN (filgrastim) vial, syringe	LEUKINE (sargramostim)
	NEULASTA (pegfilgrastim)
	NIVESTYM (filgrastim-aafi)
	NYVEPRIA (pegfilgrastim-apgf)
	UDENYCA (pegfilgrastim-cbqv)
	ZARXIO (filgrastim-sndz)
	ZIEXTENZO SYRINGE (pegfilgrastim-bmez)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

COPD AGENTS

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

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

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

- [Duplicate Therapy](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTICHOLINERGICS	
ATROVENT HFA (ipratropium)	INCRUSE ELLIPTA (umeclidinium)
ipratropium inhalation solution	LONHALA MAGNAIR (glycopyrrolate)
SPIRIVA HANDIHALER (tiotropium)	SPIRIVA RESPIMAT (tiotropium)
	TUDORZA (aclidinium)
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS	
albuterol/ipratropium	BEVESPI AEROSPHERE (glycopyrrolate/formoterol)
ANORO ELLIPITA (umeclidinium/vilanterol)	DUAKLIR PRESSAIR (aclidinium/formoterol)
COMBIVENT RESPIMAT (albuterol/ipratropium)	YUPELRI (revefenacin)
STIOLTO RESPIMAT (tiotropium/olodaterol)	
PHOSPHODIESTERASE INHIBITORS	
	DALIRESP (roflumilast)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

COUGH AND COLD AGENTS

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

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

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

- [Cough & Cold PA criteria](#)

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

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

CYTOKINE AND CAM ANTAGONISTS

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

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

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

- [Cytokine and CAM Antagonists](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ENBREL (etanercept)	ACTEMRA (tocilizumab)
HUMIRA (adalimumab)	ARCALYST (rilonacept)
OTEZLA (apremilast)	CIMZIA (certolizumab)
	COSENTYX (secukinumab)
	ENSPRYNG (satralizumab-mwge)
	ILARIS (canakinumab)
	ILUMYA (tildrakizumab-asmn)
	KEVZARA (sarilumab)
	KINERET (anakinra)
	OLUMIANT (baricitinib)
	ORENCIA (abatacept)
	RINVOQ ER (upadacitinib)
	SILIQ (brodalumab)
	SIMPONI (golimumab)
	SKYRIZI (risankizumab-rzaa)
	SKYRIZI PEN (risankizumab-rzaa)
	STELARA (ustekinumab)
	TALTZ (ixekizumab)
	TREMFYA (guselkumab)
	XELJANZ (tofacitinib)
	XELJANZ soln (tofacitinib)
	XELJANZ XR (tofacitinib)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

EPINEPHRINE, SELF-INJECTED

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

- Treatment failure with preferred products
- Contraindication to preferred products
- Allergic reaction to preferred products
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
epinephrine (Mylan authorized generic EPIPEN and EPIPEN JR)	epinephrine (generic ADRENACLICK)
	epinephrine (generic EPIPEN and EPIPEN JR)
	EPIPEN (epinephrine)
	EPIPEN JR (epinephrine)
	SYMJEPI (epinephrine)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ERYTHROPOIESIS STIMULATING PROTEINS

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

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

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

- [Erythropoiesis-Stimulating Agents](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ARANESP (darbepoetin)	MIRCERA (PEG-EPO)
EPOGEN (RhUEPO)	PROCRIT (RhUEPO)
RETACRIT (RhUEPO)	REBLOZYL (luspatercept-aamt)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

FLUOROQUINOLONES, ORAL

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ciprofloxacin IR	BAXDELA (delafloxacin)
ciprofloxacin suspension	CIPRO (ciprofloxacin) tablets
levofloxacin tablets	CIPRO (ciprofloxacin) suspension
	levofloxacin solution
	moxifloxacin
	ofloxacin

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

GI MOTILITY, CHRONIC

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

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

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

- [GI Motility](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
AMITIZA (lubiprostone)	alosetron
LINZESS (linaclotide)	LOTRONEX (alosetron)
MOVANTIK (naloxegol)	lubiprostone
	MOTEGRITY (prucalopride)
	RELISTOR (methylnaltrexone) injection
	RELISTOR (methylnaltrexone) oral
	SYMPROIC (naldemedine)
	TRULANCE (plecanatide)
	VIBERZI (eluxadoline)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: [txvendordrug.com/formulary/formulary-search](https://www.txvendordrug.com/formulary/formulary-search). Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

GLUCAGON AGENTS

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

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

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

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

GLUCOCORTICIDS, INHALED

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

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

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

- [Duplicate Therapy](#)

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

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

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

GLUCOCORTICIDS, ORAL

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

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

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

- [Duplicate Therapy](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
budesonide EC	ALKINDI SPRINKLE (hydrocortisone)
dexamethasone elixir, solution, tablets	CORTEF (hydrocortisone)
hydrocortisone	cortisone
methylprednisolone tablet dose pack	dexamethasone intensol
prednisolone sodium phosphate	DEXPAK (dexamethasone)
prednisolone	EMFLAZA (deflazacort)
prednisone solution, tablets	HEMADY (dexamethasone)
	MEDROL (methylprednisolone)
	methylprednisolone tablets
	MILLIPRED (prednisolone)
	ORTIKOS CAPSULE ER (budesonide)
	prednisolone sodium phosphate ODT, solution
	prednisone intensol
	prednisone tablet dose pack
	RAYOS DR (prednisone)
	TAPERDEX (dexamethasone)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

GROWTH HORMONE

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

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

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

- [Growth Hormone](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
GENOTROPIN	HUMATROPE
NORDITROPIN	NUTROPIN AQ
	OMNITROPE
	SAIZEN
	SEROSTIM
	SKYTROFA
	ZOMACTON
	ZORBITIVE

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

H. PYLORI TREATMENT

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
PYLERA (bismuth subcitrate/metronidazole/tetracycline)	lansoprazole/amoxicillin/clarithromycin
	OMECLAMOX PAK (omeprazole/amoxicillin/clarithromycin)
	TALICIA (omeprazole/amoxicillin/rifabutin)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

HEMOPHILIA TREATMENT

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

- All of the agents in the Hemophilia Treatment class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
FACTOR VIII	
ADVATE	
ADYNOVATE	
AFSTYLA	
ELOCTATE	
ESPEROCT	
HEMOFIL M	
HUMATE P	
JIVI	
KOATE DVI	
KOGENATE FS	
KOVALTRY	
NOVOEIGHT	
NUWIQ	
OBIZUR	
RECOMBINATE	
XYNTHA	
FACTOR IX	
ALPHANINE SD	
ALPROLIX	
BENEFIX	
IDELVION	
IXINITY	
PROFILNINE	
REBINYN	
RIXUBIS	
OTHER	
ALPHANATE (von Willebrand factor/Factor VIII)	
COAGADEX (Factor X)	
CORIFACT (Factor XIII)	
FEIBA NF (activated prothrombin complex)	
HEMLIBRA (emicizumab-kxwh)	
NOVOSEVEN RT (Factor VIIa)	
SEVENFACT (Factor VIIa-jncw)	
TRETTEN (Factor XIII)	
VOVENDI (von Willebrand factor)	
WILATE (von Willebrand factor/Factor VIII)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

HEPATITIS C AGENTS

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

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

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

- Manual Prior Authorization

PREFERRED AGENTS	NON-PREFERRED AGENTS
PEGYLATED INTERFERONS	
	PEGASYS (pegylated IFN alfa-2a)
POLYMERASE/PROTEASE INHIBITORS	
EPCLUSA (sofosbuvir/velpatasvir)	HARVONI (ledipasvir/sofosbuvir) tablets, pellet pack
MAVYRET (glecaprevir/pibrentasvir)	ledipasvir/sofosbuvir
VOSEVI (sofosbuvir, velpatasvir, voxilaprevir)	sofosbuvir/velpatasvir
	SOVALDI (sofosbuvir) tablets, pellet pack
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)
	ZEPATIER (elbasvir/grazoprevir)
RIBAVIRIN	
ribavirin capsule	
ribavirin tablet	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

HEREDITARY ANGIOEDEMA (HAE) TREATMENTS

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

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

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

- [Hereditary Angioedema](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
BERINERT (C1 esterase inhibitor)	icatibant
CINRYZE (C1 esterase inhibitor)	ORLADEYO (berotralstat)
FIRAZYR (icatibant)	RUCONEST (C1 esterase inhibitor)
HAEGARDA (C1 esterase inhibitor)	SAJAZIR (icatibant)
KALBITOR (ecallantide)	TAKHZYRO (lanadelumab-flyo)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

HIV/AIDS

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

- All of the agents in the HIV/AIDS class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTIRETROVIRAL SINGLE AGENT PRODUCTS	
abacavir	
APTIVUS (tipranavir)	
atazanavir	
didanosine	
EDURANT (rilpivirine)	
efavirenz	
EMTRIVA (emtricitabine)	
EPIVIR (lamivudine)	
fosamprenavir	
FUZEON (enfuvirtide)	
INTELENCE (etravirine)	
INVIRASE (saquinavir)	
ISENTRESS (raltegravir)	
lamivudine	
LEXIVA (fosamprenavir)	
maraviroc	
nevirapine	
NORVIR (ritonavir)	
PIFELTRO (doravirine)	
PREZCOBIX (darunavir/cobicistat)	
PREZISTA (darunavir)	
RETROVIR (zidovudine)	
REYATAZ (atazanavir)	
ritonavir	
RUKOBIA (fostemsavir)	
SELZENTRY (maraviroc)	
stavudine	
SUSTIVA (efavirenz)	
tenofovir disoproxil fumarate	
TIVICAY (dolutegravir)	
TROGARZO (ibalizumab-uiyk)	
TYBOST (cobicistat)	
VIRACEPT (nelfinavir)	
VIRAMUNE (nevirapine)	
VIRAMUNE XR (nevirapine)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PREFERRED AGENTS	NON-PREFERRED AGENTS
VIREAD (tenofovir disoproxil fumarate)	
ZIAGEN (abacavir)	
zidovudine	
ANTIRETROVIRAL COMBINATIONS	
abacavir/lamivudine	
abacavir/lamivudine/zidovudine	
ATRIPLA (efavirenz/emtricitabine/tenofovir)	
BIKTARVY (bictegravir/emtricitabine/tenofovir)	
CIMDUO (lamivudine/tenofovir DF)	
COMBIVIR (lamivudine/zidovudine)	
COMPLERA (emtricitabine/rilpivirine/tenofovir DF)	
DELSTRIGO (doravirine/lamivudine/ tenofovir DF)	
DESCOVY (emtricitabine/tenofovir alafenamide)	
DOVATO (dolutegravir/lamivudine)	
EPZICOM (abacavir/lamivudine)	
EVOTAZ (atazanavir/cobicistat)	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide)	
JULUCA (dolutegravir/rilpivirine)	
KALETRA (lopinavir/ritonavir)	
lamivudine/zidovudine	
lopinavir/ritonavir	
ODEFSEY (emtricitabine/rilpivirine/tenofovir alafenamide)	
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir DF)	
SYMFI (efavirenz/lamivudine/tenofovir DF)	
SYMFI LO (efavirenz/lamivudine/tenofovir DF)	
SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir DF)	
TEMIXYS (lamivudine/tenofovir DF)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	
TRIZIVIR (abacavir/lamivudine/zidovudine)	
TRUVADA (emtricitabine/tenofovir DF)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
AMYLIN ANALOGS	
SYMLIN (pramlintide)	

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

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

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

- [DPP4 Inhibitor](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
INCRETIN ENHANCERS	
JANUMET (sitagliptin/metformin)	alogliptin
JANUVIA (sitagliptin)	alogliptin/metformin
JENTADUETO (linagliptin/metformin)	alogliptin/pioglitazone
KOMBIGLYZE XR (saxagliptin/metformin)	JANUMET XR (sitagliptin/metformin)
ONGLYZA (saxagliptin)	JENTADUETO XR (linagliptin/metformin)
TRADJENTA (linagliptin)	KAZANO (alogliptin /metformin)
	NESINA (alogliptin)
	OSEN (alogliptin /pioglitazone)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

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

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

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

- [GLP-1 Receptor Antagonists](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
INCRETIN MIMETICS	
BYDUREON (exenatide ER) pens, vials	ADLYXIN (lixisenatide)
BYETTA (exenatide)	BYDUREON BCISE (exenatide ER)
TRULICITY (dulaglutide)	OZEMPIC (semaglutide)
VICTOZA (liraglutide)	RYBELSUS (semaglutide)

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

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

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

- [DPP4 Inhibitor](#)

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

- [GLP-1 Receptor Antagonists](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
INCRETIN ENHANCERS/SGLT2 INHIBITOR COMBINATIONS	
GLYXAMBI (empagliflozin/linagliptin)	QTERN (dapagliflozin/saxagliptin)
	STEGLUJAN (ertugliflozin/sitagliptin)
	TRIJARDY XR (empagliflozin/linagliptin/metformin)
INCRETIN MIMETIC/INSULIN COMBINATIONS	
	SOLIQUA (lixisenatide/insulin glargine)
	XULTOPHY (liraglutide/insulin degludec)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

HYPOGLYCEMICS, INSULIN

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
HUMALOG (insulin lispro) pens, vials	ADMELOG (insulin lispro)
HUMALOG JUNIOR KWIKPEN (insulin lispro)	AFREZZA (insulin)
HUMALOG MIX (insulin lispro/lispro protamine) pens, vials	APIDRA (insulin glulisine)
HUMULIN N (insulin) vials	BASAGLAR (insulin glargine)
HUMULIN R (insulin) vials	FIASP (insulin aspart)
HUMULIN R 500 UNITS/ML (insulin) pens, vials	HUMALOG 200 UNITS/ML
HUMULIN R 70/30 (insulin) pens, vials	HUMULIN N (insulin) pen
insulin aspart cartridge (ag)	insulin glargine vial
insulin aspart pen (ag)	insulin glargine pen
insulin aspart vial (ag)	LYUMJEV (insulin lispro)
insulin aspart/insulin aspart protamine insulin pen (ag)	NOVOLIN (insulin) pens
insulin aspart/insulin aspart protamine vial (ag)	NOVOLIN 70/30 (insulin)
insulin lispro junior kwikpen (ag)	SEMGLEE (insulin glargine) pen, vial
insulin lispro pen (ag)	TOUJEO (insulin glargine)
insulin lispro protamine mix kwikpen (ag)	TRESIBA (insulin degludec)
insulin lispro vial (ag)	
LANTUS (insulin glargine)	
LEVEMIR (insulin detemir)	
NOVOLIN (insulin) vials	
NOVOLOG (insulin aspart)	
NOVOLOG MIX (insulin aspart/aspart protamine)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

HYPOGLYCEMICS, MEGLITINIDES

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

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

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

- [Duplicate Therapy](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
nateglinide	repaglinide/metformin
repaglinide	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

HYPOGLYCEMICS, METFORMIN

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
glyburide/metformin	FORTAMET (metformin ER)
metformin	glipizide/metformin
metformin ER (GLUCOPHAGE XR)	GLUMETZA (metformin ER)
metformin ER (GLUMETZA)	metformin ER (FORTAMET)
	RIOMET (metformin)
	RIOMET ER (metformin)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

HYPOGLYCEMICS, SGLT2

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

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

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

- [SGLT2 Inhibitor](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
SUBCLASS	
FARXIGA (dapagliflozin)	STEGLATRO (ertugliflozin)
INVOKANA (canagliflozin)	
JARDIANCE (empagliflozin)	

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

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

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

- [SGLT2 Combinations](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
SGLT2 COMBINATIONS	
SYNJARDY (empagliflozin/metformin)	INVOKAMET (canagliflozin/metformin)
XIGDUO XR (dapagliflozin/metformin)	INVOKAMET XR (canagliflozin/metformin)
	SEGLUROMET (ertugliflozin/metformin)
	SYNJARDY XR (empagliflozin/metformin)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

HYPOGLYCEMICS, TZD

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

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

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

- [Thiazolidinediones](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
THIAZOLIDINEDIONES	
pioglitazone	ACTOS (pioglitazone)

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

- Separate prescriptions for the individual components should be used instead of the combination drug.
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- For drugs in a therapeutic class and/or subclass with no preferred option, the provider must obtain a PDL prior authorization

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

- [Thiazolidinediones](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
TZD COMBINATIONS	
	ACTOPLUS MET XR (pioglitazone/metformin)
	DUETACT (pioglitazone/glimepiride)
	pioglitazone/metformin
	pioglitazone/glimepiride

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: [txvendordrug.com/formulary/formulary-search](https://www.txvendordrug.com/formulary/formulary-search). Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

IMMUNE GLOBULINS

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
GAMMAGARD (immune globulin)	ASCENIV (immune globulin)
GAMMAKED (immune globulin)	BIVIGAM (immune globulin)
GAMUNEX-C (immune globulin)	CUTAQUIG (immune globulin)
	CUVITRU (immune globulin)
	CYTOGAM (CMV immune globulin)
	FLEBOGAMMA DIF (immune globulin)
	GAMASTAN S-D (immune globulin)
	HEPAGAM B (hepatitis B immune globulin)
	HYQVIA (immune globulin)
	HIZENTRA (immune globulin) syringe
	HIZENTRA (immune globulin) vial
	OCTAGAM (immune globulin)
	PANZYGA (immune globulin)
	PRIVIGEN (immune globulin)
	VARIZIG (varicella-zoster immune globulin)
	XEMBIFY (immune globulin)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

IMMUNOMODULATORS, ASTHMA

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

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- The PA criteria above apply to Dupixent for Asthma

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

- [Immunomodulators, Asthma](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
FASENRA PEN (benralizumab)	NUCALA (mepolizumab)
XOLAIR (omalizumab) syringe	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

IMMUNOMODULATORS, ATOPIC DERMATITIS

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

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- Dupixent, in this therapeutic PDL class, is for Atopic Dermatitis indication. The clinical prior authorization linked here includes the product's other indications.

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ELIDEL (pimecrolimus)	ADBRY (tralokinumab)
EUCRISA (crisaborole)	DUPIXENT (dupilumab)
PROTOPIC (tacrolimus)	OPZELURA (ruxolitinib)
	pimecrolimus
	tacrolimus

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

IMMUNOSUPPRESSIVES, ORAL/SQ

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
azathioprine	ASTAGRAF XL (tacrolimus)
cyclosporine, modified	AZASAN (azathioprine)
GENGRAF (cyclosporine modified) capsules, solution	BENLYSTA AUTOINJECTOR (belimumab.)
mycophenolate mofetil capsules, tablets	BENLYSTA SYRINGE (belimumab.)
NEORAL (cyclosporine, modified) capsules	CELLCEPT (mycophenolate mofetil)
RAPAMUNE (sirolimus) solution	cyclosporine capsule, softgel
RAPAMUNE (sirolimus) tablet	ENVARUSUS XR (tacrolimus)
tacrolimus	everolimus tablet
	IMURAN (azathioprine)
	LUPKYNIS (voclosporin)
	mycophenolate mofetil suspension
	mycophenolic acid
	MYFORTIC (mycophenolic acid)
	NEORAL (cyclosporine, modified) solution
	PROGRAF (tacrolimus)
	REZUROCK (belumosudil)
	SANDIMMUNE (cyclosporine)
	sirolimus solution
	sirolimus tablet
	ZORTRESS (everolimus)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

INTRANASAL RHINITIS AGENTS

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

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

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

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

IRON, ORAL

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

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

See separate **Preferred Oral Iron Drugs** listing.

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

LEUKOTRIENE MODIFIERS

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

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

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

- [Leukotriene Modifiers](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
montelukast tablets and chewable tablets	ACCOLATE (zafirlukast)
	montelukast granules
	SINGULAIR (montelukast)
	zafirlukast
	zileuton
	ZYFLO (zileuton)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS

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

- 14-day treatment trial with a preferred drug within the past 180 days
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
clindamycin capsules	CLEOCIN (clindamycin)
clindamycin solution	linezolid suspension
linezolid tablet, IV	linezolid suspension AG
linezolid tablet, IV (AG)	LINCOCIN (lincomycin)
ZYVOX (linezolid) suspension	SIVEXTRO (tedizolid)
	ZYVOX (linezolid) tablet, injection

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

LIPOTROPICS, OTHER

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ADENOSINE TRIPHOSPHATE-CITRATE LYASE INHIBITOR	
	NEXLETOL (bempedoic acid)
	NEXLIZET (bempedoic acid/ezetimibe)
BILE ACID SEQUESTRANTS	
cholestyramine	colesevelam
COLESTID (colestipol) tablet	COLESTID (colestipol) granules
PREVALITE (cholestyramine/aspartame) packet, powder	colestipol granules
WELCHOL (colesevalam)	colestipol tablets
	QUESTRAN (cholestyramine)
	QUESTRAN LIGHT (cholestyramine)
CHOLESTEROL ABSORPTION INHIBITORS	
ZETIA (ezetimibe)	ezetimibe
FIBRIC ACID DERIVATIVES	
fenofibrate (generic Lofibra, Tricor)	ANTARA (fenofibrate, micronized)
gemfibrozil	fenofibrate (generic Antara, Fenoglide, Lipofen)
	fenofibric acid (generic Fibracor, Trilipix)
	FENOGLIDE (fenofibrate)
	LIPOFEN (fenofibrate)
	LOPID (gemfibrozil)
	TRICOR (fenofibrate)
	TRILIPIX (fenofibric acid)
HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA TREATMENTS	
	JUXTAPID (lomitapide)
NIACIN	
niacin OTC	niacin ER
	NIASPAN (niacin)
OMEGA-3 FATTY ACIDS	
omega-3 fatty acids	icosapent ethyl
	LOVAZA (omega-3 fatty acids)
	VASCEPA (icosapent ethyl)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

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

- Trial of atorvastatin, rosuvastatin, and ezetimibe
- Concurrent therapy of atorvastatin or rosuvastatin
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

Clinical prior authorizations applies to all PCSK9 inhibitors:

- [Hyperlipidemia agents](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
PCSK9 INHIBITORS	
	PRALUENT (alirocumab)
	REPATHA (evolocumab)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

LIPOTROPICS, STATINS

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

- Treatment failure with at least two preferred drugs accounting for no less than 120 days of therapy combined
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

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

- [Duplicate Therapy](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
STATINS	
atorvastatin	ALTOPREV (lovastatin)
LIPITOR (atorvastatin)	CRESTOR (rosuvastatin)
lovastatin	EZALLOR SPRINKLE (rosuvastatin)
pravastatin	fluvastatin
rosuvastatin	fluvastatin ER
simvastatin	LESCOL XL (fluvastatin)
	LIVALO (pitavastatin)
	ZOCOR (simvastatin)
	ZYPITAMAG (pitavastatin)
STATIN COMBINATIONS	
	atorvastatin/amlodipine
	CADUET (atorvastatin/amlodipine)
	simvastatin/ezetimibe
	VYTORIN (simvastatin/ezetimibe)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

MACROLIDES (ORAL)

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

- A 7-day treatment trial with at least one preferred agent in the last 180 days (Exception may apply when a preferred drug requires less than a 7-day treatment trial)
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- For clients with diagnosis of Gastroparesis, Cerebral Palsy Gastroparesis, and GERD associated with Gastrostomy complications, a 90-day PA duration will be approved

PREFERRED AGENTS	NON-PREFERRED AGENTS
azithromycin	clarithromycin suspension
clarithromycin tablets	clarithromycin ER
E.E.S. (erythromycin) 200 suspension	E.E.S. (erythromycin) tablet
ERYPED 400 (erythromycin)	ERYPED 200 (erythromycin)
erythromycin base	ERY-TAB (erythromycin)
	ERYTHROCIN (erythromycin)
	erythromycin base filmtab
	erythromycin ethylsuccinate suspension
	ZITHROMAX (azithromycin)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

MOVEMENT DISORDERS

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

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

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

- [VMAT2 Inhibitors](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
AUSTEDO (deutetrabenazine)	XENAZINE (tetrabenazine)
INGREZZA (valbenazine)	
tetrabenazine	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

MULTIPLE SCLEROSIS AGENTS

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

- All of the agents in the Multiple Sclerosis class are preferred

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
AMPYRA (dalfampridine)	
AUBAGIO (teriflunomide)	
AVONEX (interferon beta-1a)	
BAFIERTAM (monomethyl fumarate)	
BETASERON (interferon beta-1b)	
COPAXONE (glatiramer)	
dalfampridine	
dimethyl fumarate	
EXTAVIA (interferon beta-1b)	
GILENYA (fingolimod)	
glatiramer	
GLATOPA (glatiramer)	
KESIMPTA (ofatumumab)	
MAVENCLAD (cladribine)	
MAYZENT (siponimod)	
PLEGRIDY (peginterferon beta-1a)	
PONVORY STARTER PACK (ponesimod)	
PONVORY TABLET (ponesimod)	
REBIF (interferon beta-1a)	
TECFIDERA (dimethyl fumarate)	
VUMERITY (diroximel fumarate)	
ZEPOSIA (ozanimod)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

NEUROPATHIC PAIN

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ORAL AGENTS	
duloxetine (Cymbalta)	CYMBALTA (duloxetine)
gabapentin	DRIZALMA SPRINKLE (duloxetine)
LYRICA (pregabalin)	duloxetine (Irenka)
	GRALISE (gabapentin)
	HORIZANT (gabapentin enacarbil ER)
	LYRICA CR (pregabalin)
	NEURONTIN (gabapentin)
	pregabalin capsule
	pregabalin ER, solution
	SAVELLA (milnacipran)
TOPICAL AGENTS	
capsaicin OTC	lidocaine patch
LIDODERM (lidocaine)	QUTENZA (capsaicin/skin cleanser)
	ZTLIDO (lidocaine)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: [txvendordrug.com/formulary/formulary-search](https://www.txvendordrug.com/formulary/formulary-search). Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

NSAIDS

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

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

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

- [Duplicate Therapy](#)

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

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

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	VIVLODEX (meloxicam, submicronized)
	ZIPSOR (diclofenac)
	ZORVOLEX (diclofenac)
NSAID/GI PROTECTANT COMBINATIONS	
	ARTHROTEC (diclofenac/misoprostol)
	diclofenac/misoprostol
	DUEXIS (ibuprofen/famotidine)
	ibuprofen/famotidine
	naproxen/esomeprazole mag
	VIMOVO (naproxen/ esomeprazole)
TOPICAL NSAIDS	
diclofenac gel 1%	diclofenac solution
VOLTAREN gel (diclofenac)	diclofenac patch
	DICLOFEX DC (diclofenac/capsicum)
	FLECTOR (diclofenac)
	INDOCIN (indomethacin) suppositories
	ketorolac nasal spray
	LICART PATCH (diclofenac epolamine)
	PENNSAID (diclofenac)
	SPRIX NASAL SPRAY (ketorolac nasal spray)

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

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

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

- [Duplicate Therapy](#)
- [Cox II Inhibitors](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
COX-II SELECTIVE	
meloxicam tablets	CELEBREX (celecoxib)
	celecoxib
	meloxicam capsules
	MOBIC (meloxicam)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ONCOLOGY, ORAL – BREAST

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

- All of the agents in the Oncology, Oral – Breast class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
anastrozole	
ARIMIDEX (anastrozole)	
AROMASIN (exemestane)	
capecitabine	
cyclophosphamide	
exemestane	
FARESTON (toremifene)	
FEMARA (letrozole)	
IBRANCE (palbociclib)	
KISQALI (ribociclib)	
KISQALI/FEMARA KIT (ribociclib/letrozole)	
lapatinib	
letrozole	
NERLYNX (neratinib)	
PIQRAY (alpelisib)	
SOLTAMOX (tamoxifen)	
TALZENNA (talazoparib)	
tamoxifen	
toremifene	
TUKYSA (tucatinib)	
TYKERB (lapatinib)	
VERZENIO (abemaciclib)	
XELODA (capecitabine)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ONCOLOGY, ORAL – HEMATOLOGIC

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

- All of the agents in the Oncology, Oral – Hematologic class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
ALKERAN (melphalan)	
BOSULIF (bosutinib)	
BRUKINSA (zanubrutinib)	
CALQUENCE (acalabrutinib)	
COPIKTRA (duvelisib)	
DAURISMO (glasdegib)	
FARYDAK (panobinostat)	
GLEEVEC (imatinib)	
HYDREA (hydroxyurea)	
ICLUSIG (ponatinib)	
IDHIFA (enasidenib)	
imatinib	
IMBRUVICA (ibrutinib)	
INQOVI (decitabine/cedazuridine)	
INREBIC (fedratinib)	
JAKAFI (ruxolitinib)	
LEUKERAN (chlorambucil)	
MATULANE (procarbazine)	
melphalan	
mercaptopurine	
MYLERAN (busulfan)	
NINLARO (ixazomib)	
ONUREG (azacytidine)	
POMALYST (pomalidomide)	
PURIXAN (mercaptopurine)	
REVLIMID (lenalidomide)	
RYDAPT (midostaurin)	
SCSEMBLIX (asciminib)	
SPRYCEL (dasatinib)	
TABLOID (thioguanine)	
TASIGNA (nilotinib)	
THALOMID (thalidomide)	
TIBSOVO (ivosidenib)	
tretinoin	
UKONIQ (umbralisib)	
VENCLEXTA (venetoclax)	
XOSPATA (gilteritinib)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PREFERRED AGENTS	NON-PREFERRED AGENTS
XPOVIO (selinexor)	
ZOLINZA (vorinostat)	
ZYDELIG (idelalisib)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ONCOLOGY, ORAL – LUNG

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

- All of the agents in the Oncology, Oral – Lung class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
ALECENSA (alectinib)	
ALUNBRIG (brigatinib)	
erlotinib	
EXKIVITY (mobocertinib)	
GAVRETO (pralsetinib)	
GILOTRIF (afatinib)	
HYCAMTIN (topotecan)	
IRESSA (gefitinib)	
LORBRENA (lorlatinib)	
LUMAKRAS (sotorasib)	
RETEVMO (selpercatinib)	
ROZLYTREK (entrectinib)	
TABRECTA (capmatinib)	
TAGRISSO (osimertinib)	
TARCEVA (erlotinib)	
TEPMETKO (tepotinib)	
VIZIMPRO (dacomitinib)	
XALKORI (crizotinib)	
ZYKADIA (ceritinib)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ONCOLOGY, ORAL – OTHER

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

- All of the agents in the Oncology, Oral – Other class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
AYVAKIT (avapritinib)	
BALVERSA (erdafitinib)	
CAPRELSA (vandetanib)	
COMETRIQ (cabozantinib)	
KOSELUGO (selumetinib)	
LONSURF (trifluridine/tipiracil)	
LYNPARZA (olaparib)	
PEMAZYRE (pemigatinib)	
QINLOCK (ripretinib)	
RUBRACA (rucaparib)	
STIVARGA (regorafenib)	
TAZVERIK (tazemetostat)	
TEMODAR (temozolomide)	
temozolomide	
TRUSELTIQ (infigratinib)	
TURALIO (pexidartinib)	
VITRAKVI (larotrectinib)	
ZEJULA (niraparib)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ONCOLOGY, ORAL – PROSTATE

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

- All of the agents in the Oncology, Oral – Prostate class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
abiraterone	
bicalutamide	
EMCYT (estramustine)	
ERLEADA (apalutamide)	
EULEXIN (flutamide)	
flutamide	
nilutamide	
NUBEQA (darolutamide)	
XTANDI (enzalutamide)	
YONSA (abiraterone)	
ZYTIGA (abiraterone)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ONCOLOGY, ORAL – RENAL CELL

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

- All of the agents in the Oncology, Oral – Renal Cell class are preferred

PREFERRED AGENTS	NON-PREFERRED AGENTS
AFINITOR (everolimus)	
CABOMETYX (cabozantinib)	
everolimus	
INLYTA (axitinib)	
LENVIMA (Lenvatinib)	
NEXAVAR (sorafenib)	
SUTENT (sunitinib)	
sunitinib	
VOTRIENT (pazopanib)	
WELIREG (belzutifan)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ONCOLOGY, ORAL – SKIN

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

- All of the agents in the Oncology, Oral – Skin class are preferred

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
BRAFTOVI (encorafenib)	
COTELLIC (cobimetinib)	
ERIVEDGE (vismodegib)	
MEKINIST (trametinib)	
MEKTOVI (binimetinib)	
ODOMZO (sonidegib)	
TAFINLAR (dabrafenib)	
ZELBORAF (vemurafenib)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

OPHTHALMICS, ANTIBIOTIC – STEROID COMBINATIONS

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
neomycin/polymyxin/dexamethasone	BLEPHAMIDE (sulfacetamide/prednisolone)
sulfacetamide/prednisolone	BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone)
TOBRADEX (tobramycin/dexamethasone) ointment	MAXITROL (neomycin/polymyxin/ dexamethasone)
	neomycin/bacitracin/polymyxin/hydrocortisone
	neomycin/polymyxin/hydrocortisone
	PRED-G (gentamicin/prednisolone)
	TOBRADEX (tobramycin/dexamethasone) suspension
	TOBRADEX ST (tobramycin/dexamethasone)
	tobramycin/dexamethasone
	ZYLET (tobramycin/loteprednol)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

OPHTHALMIC ANTIBIOTICS

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
AMINOGLYCOSIDES	
GENTAK (gentamicin)	TOBREX (tobramycin) solution
gentamicin	
tobramycin	
TOBREX (tobramycin) ointment	
QUINOLONES	
ciprofloxacin	BESIVANCE (besifloxacin)
ofloxacin	CILOXAN (ciprofloxacin)
	gatifloxacin
	levofloxacin
	MOXEZA (moxifloxacin)
	moxifloxacin
	OCUFLOX (ofloxacin)
	VIGAMOX (moxifloxacin)
	ZYMAXID (gatifloxacin)
MACROLIDES	
erythromycin	AZASITE (azithromycin)
OTHER, ANTIFUNGAL	
	NATACYN (natamycin)
OTHER, MISC	
bacitracin/polymyxin	bacitracin
POLYCIN (bacitracin/polymyxin B sulfate)	neomycin/bacitracin/polymyxin
polymyxin/trimethoprim	neomycin/polymyxin/gramicidin
	POLYTRIM (polymyxin/trimethoprim)
	sulfacetamide ointment, solution

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
cromolyn	ALOCRIL (nedocromil)
PATADAY XS ONCE DAILY OTC (olopatadine)	ALOMIDE (lodoxamide)
	ALREX (loteprednol)
	azelastine
	bepotastine
	BEPREVE (bepotastine)
	epinastine
	ketotifen
	LASTACAPT (alcaftadine)
	olopatadine
	PATADAY (olopatadine)
	PATADAY OTC (olopatadine)
	PATANOL (olopatadine)
	ZADITOR OTC (ketotifen)
	ZERVIAE (cetirizine)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

OPHTHALMICS, ANTI-INFLAMMATORIES

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
NSAIDS	
diclofenac	ACULAR (ketorolac)
ketorola	ACULAR LS (ketorolac)
	ACUVAIL (ketorolac)
	bromfenac
	BROMSITE (bromfenac)
	flurbiprofen
	ILEVRO (nepafenac)
	ketorolac LS
	NEVANAC (nepafenac)
	PROLENSA (bromfenac)
STEROIDS	
DUREZOL (difluprednate)	dexamethasone
Lotemax (loteprednol) drops, ointment	difluprednate
prednisolone acetate	FLAREX (fluorometholone)
	fluorometholone
	FML (fluorometholone)
	FML FORTE (fluorometholone)
	FML S.O.P. (fluorometholone)
	INVELTYS (loteprednol)
	LOTEMAX (loteprednol) gel
	loteprednol
	MAXIDEX (dexamethasone)
	PRED FORTE (prednisolone)
	PRED MILD (prednisolone)
	prednisolone sodium phosphate

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

OPHTHALMICS, ANTI-INFLAMMATORY IMMUNOMODULATORS

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
RESTASIS (cyclosporine)	RESTASIS MULTIDOSE (cyclosporine)
XIIDRA (lifitegrast)	CEQUA (cyclosporine)
	cyclosporine
	EYSUVIS (loteprednol etabonate)
	TYRVAYA (varenicline)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

OPHTHALMICS, GLAUCOMA AGENTS

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

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

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

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: [txvendordrug.com/formulary/formulary-search](https://www.txvendordrug.com/formulary/formulary-search). Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PREFERRED AGENTS	NON-PREFERRED AGENTS
SIMBRINZA (brinzolamide/brimonidine)	COSOPT PF (dorzolamide/timolol)
	dorzolamide/timolol
MISCELLANEOUS	
	phospholine iodide

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

OPIATE DEPENDENCE TREATMENTS

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

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

The following Clinical Prior Authorization applies to drugs with an “*” in the class:

- [Duplicate Therapy](#)
- [Opiate/Benzodiazepine/Muscle Relaxant](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
buprenorphine *	
buprenorphine/naloxone *	
KLOXXADO (naloxone) nasal	
LUCEMYRA (lofexidine)	
naloxone syringe, vial, nasal spray	
naltrexone	
NARCAN (naloxone) nasal	
SUBOXONE (buprenorphine/naloxone) film *	
VIVITROL (naltrexone)	
ZUBSOLV (buprenorphine/naloxone) *	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

OTIC ANTIBIOTICS

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
CIPRODEX (ciprofloxacin/dexamethasone)	CIPRO HC (ciprofloxacin/hydrocortisone)
neomycin/polymyxin/hydrocortisone	ciprofloxacin
ofloxacin	ciprofloxacin/dexamethasone
	ciprofloxacin HCl/fluocinolone
	CORTISPORIN-TC (neomyc/colist/hydrocort/thonzn
	OTIPRIO (ciprofloxacin)
	OTOVEL (ciprofloxacin/fluocinolone)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

OTIC ANTI-INFECTIVES/ANESTHETICS

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
acetic acid	acetic acid/hydrocortisone

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PAH AGENTS (ORAL, INHALATION)

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

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

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

- [Pulmonary HTN Agents](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ADCIRCA (tadalafil)	ADEMPAS (riociguat)
LETAIRIS (ambrisentan)	ALYQ (tadalafil)
REVATIO (sildenafil)	ambrisentan
TRACLEER (bosentan) tablet	bosentan
	OPSUMIT (macitentan)
	ORENITRAM ER (treprostinil)
	sildenafil suspension (generic Revatio)
	sildenafil tablet (generic Revatio)
	tadalafil (generic Adcirca)
	TRACLEER (bosentan) suspension
	TYVASO Inhalation (treprostinil)
	UPTRAVI (selexipag)
	VENTAVIS Inhalation (iloprost)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PANCREATIC ENZYMES

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
CREON (pancrelipase)	PERTZYE (pancrelipase)
PANCREAZE (pancrelipase)	VIOKACE (pancrelipase)
ZENPEP (pancrelipase)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PEDIATRIC VITAMIN PREPARATIONS

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

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

See separate **Preferred Pediatric Vitamin Preparations** listing.

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PENICILLINS

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
amoxicillin	
ampicillin	
dicloxacillin	
penicillin VK	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PHOSPHATE BINDERS

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

- Treatment failure with preferred drug
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- Diagnosis of ESRD, hyperphosphatemia AND at least one of the following:
 - Hypercalcemia (corrected serum calcium > 10.2 mg/dL)
 - Plasma PTH levels < 150 pg/mL on two consecutive measurements
 - Dialysis patients with severe vascular and/or soft tissue calcifications

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
calcium acetate	AURYXIA (ferric citrate)
RENAGEL (sevelamer HCl)	FOSRENOL (lanthanum)
RENVELA (sevelamer carbonate)	lanthanum
	PHOSLYRA (calcium acetate)
	sevelamer
	sevelamer carbonate
	VELPHORO (sucroferric oxyhydroxide)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PLATELET AGGREGATION INHIBITORS

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

- Treatment failure with preferred drug
- Contraindication to preferred drug
- Allergic reaction to preferred drug
- Treatment of stage-four advanced, metastatic cancer and associated conditions

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
aspirin/dipyridamole	dipyridamole
BRILINTA (ticagrelor)	EFFIENT (prasugrel)
clopidogrel	PLAVIX (clopidogrel)
prasugrel	ZONTIVITY (vorapaxar)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

POTASSIUM BINDERS

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

- Treatment failure with preferred drug
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
Lokelma (sodium zirconium cyclosilicate)	Veltassa (patiomer calcium sorbitex)
sodium polystyrene sulfonate	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PRENATAL VITAMINS

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

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

See separate **Preferred Prenatal Vitamins** listing.

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PROGESTATIONAL AGENTS

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

- Treatment failure with preferred drug
- Contraindication to preferred drug
- Allergic reaction to preferred drug
- Treatment of stage-four advanced, metastatic cancer and associated conditions

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
MAKENA AUTO INJECTOR (hydroxyprogesterone)	hydroxyprogesterone

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PROGESTINS FOR CACHEXIA

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

- Treatment failure with preferred drug
- Contraindication to preferred drug
- Allergic reaction to preferred drug
- Treatment of stage-four advanced, metastatic cancer and associated conditions

PREFERRED AGENTS	NON-PREFERRED AGENTS
megestrol suspension, tablets	megestrol ES suspension (generic Megace ES)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PROTON PUMP INHIBITORS (ORAL)

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

- Treatment failure after no less than a 30-day trial of each preferred drug
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- Prevacid Solutabs will be approved for children 10 years of age and under

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

- [Proton Pump Inhibitor](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
NEXIUM suspension (esomeprazole)	ACIPHEX (rabeprazole)
omeprazole Rx	DEXILANT (dexlansoprazole)
pantoprazole	esomeprazole
PROTONIX (pantoprazole) suspension	lansoprazole
	NEXIUM capsules (esomeprazole)
	NEXIUM OTC (esomeprazole)
	omeprazole OTC
	omeprazole/sodium bicarbonate
	pantoprazole suspension
	PREVACID (lansoprazole)
	PRILOSEC (omeprazole)suspension
	PROTONIX tablets (pantoprazole)
	rabeprazole
	ZEGERID (omeprazole/sodium bicarbonate)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ROSACEA AGENTS, TOPICAL

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

- Treatment failure after no less than a 30-day trial of every preferred drug
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs
- Treatment of stage-four advanced, metastatic cancer and associated conditions

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

- [Rosacea Agents, Topical](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
metronidazole cream, gel	azelaic acid
	FINACEA (azelaic acid)
	ivermectin
	METROCREAM (metronidazole)
	METROGEL (metronidazole)
	metronidazole lotion
	MIRVASO (brimonidine)
	NORITATE (metronidazole)
	RHOFADE (oxymetazoline)
	ROSADAN KIT (metronidazole)
	SOOLANTRA (ivermectin)
	ZILXI (minocycline)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

SEDATIVE HYPNOTICS

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

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

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

- [Anxiolytics and Sedatives/Hypnotics](#)
- [Opiate/Benzodiazepine/Muscle Relaxant](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
BENZODIAZEPINES	
flurazepam	DAYVIGO (lemborexant)
temazepam 15, 30 mg	estazolam
triazolam	HALCION (triazolam)
	RESTORIL (temazepam)
	temazepam 7.5, 22.5 mg

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
OTHERS	
eszopiclone	AMBIEN (zolpidem)
zaleplon	AMBIEN CR (zolpidem)
zolpidem	BELSOMRA (suvorexant)
	doxepin
	EDLUAR (zolpidem)
	HETLIOZ (tasimelteon)
	HETLIOZ LQ (tasimelteon)
	LUNESTA (eszopiclone) ramelteon
	ROZEREM (ramelteon)
	SILENOR (doxepin)
	zolpidem ER/SL

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: [txvendordrug.com/formulary/formulary-search](https://www.texas.gov/vendor-drug-com/formulary/formulary-search). Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

SICKLE CELL ANEMIA TREATMENTS

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

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

The following Clinical Prior Authorization applies to drugs with an “*” in the class:

- [Sickle Cell Anemia Treatments](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
DROXIA (hydroxyurea)	
ENDARI (glutamine)	
hydroxyurea	
OXBRYTA (voxelotor)*	
SIKLOS (hydroxyurea)	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

SKELETAL MUSCLE RELAXANTS

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

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

The following Clinical Prior Authorization applies to drugs with an “*” in the class:

- [Opiate/Benzodiazepine/Muscle Relaxant](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
baclofen tablet	AMRIX (cyclobenzaprine ER)*
carisoprodol (except 250 mg)*	baclofen solution
cyclobenzaprine *	carisoprodol 250 mg *
methocarbamol*	carisoprodol compound
tizanidine tablets	chlorzoxazone*
	cyclobenzaprine ER
	DANTRIUM (dantrolene)
	dantrolene
	FEXMID (cyclobenzaprine)*
	LORZONE (chlorzoxazone)*
	metaxolone*
	NORGESIC FORTE (orphenadrine/aspirin/caffeine)
	orphenadrine*
	SKELAXIN (metaxolone)*
	SOMA (carisoprodol)*
	tizanidine capsules
	ZANAFLEX (tizanidine)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

SMOKING CESSATION

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
bupropion SR	NICOTROL (nicotine)
CHANTIX (varenicline)	NICOTROL NS (nicotine)
nicotine gum	varenicline tartrate
nicotine lozenge	
nicotine patch	

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

STEROIDS, TOPICAL

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
LOW POTENCY	
DERMA-SMOOTH/FS (fluocinolone)	alclometasone
hydrocortisone cream, ointment	AQUA GLYCOLIC (hydrocortisone/skin cleanser)
hydrocortisone/aloe cream	CAPEX(fluocinolone) shampoo
PROCTOSOL-HC (hydrocortisone)	desonide
	fluocinolone oil
	hydrocortisone lotion (Rx)
	SCALPICIN (hydrocortisone)
	TEXACORT (hydrocortisone) solution
MEDIUM POTENCY	
fluticasone propionate cream, ointment	betamethasone valerate foam
mometasone cream, ointment, solution	BESER KIT (fluticasone)
	clocortolone cream
	CLODERM (clocortolone)
	CUTIVATE (fluticasone)
	fluocinolone acetonide
	flurandrenolide
	fluticasone propionate lotion
	hydrocortisone butyrate
	hydrocortisone valerate
	LOCOID (hydrocortisone butyrate)
	LUXIQ (betamethasone)
	PANDEL (hydrocortisone probutate)
	prednicarbate
	SYNALAR (fluocinolone)
HIGH POTENCY	
betamethasone dipropionate lotion	amcinonide
betamethasone dipropionate/propylene glycol cream	betamethasone dipropionate cream, gel, ointment
betamethasone valerate cream, ointment	betamethasone dipropionate/ propylene glycol lotion, ointment
triamcinolone acetonide cream, lotion, ointment	betamethasone valerate lotion
	desoximetasone
	diflorasone
	DIPROLENE (betamethasone dipropionate)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	fluocinonide
	HALOG (halcinonide)
	HALOG SOLUTION (halcinonide)
	KENALOG aerosol (triamcinolone)
	PSORCON diflorasone
	SANADERMRX (triamcinolone/dimeth/silicone)
	TOPICORT (desoximetasone)
	triamcinolone acetonide aerosol
	TRIANEX (triamcinolone)
	VANOS (fluocinonide)
VERY HIGH POTENCY	
clobetasol emollient	APEXICON E (diflorasone)
clobetasol propionate cream, gel, ointment, solution	BRYHALI (halobetasol propionate)
halobetasol cream, ointment	clobetasol lotion, shampoo
	clobetasol propionate foam, spray
	CLOBEX (clobetasol)
	CLODAN (clobetasol)
	halobetasol foam
	IMPEKLO LOTION (clobetasol propionate)
	LEXETTE (halobetasol propionate)
	OLUX (clobetasol)
	TEMOVATE (clobetasol)
	TOVET (clobetasol)
	ULTRAVATE (halobetasol propionate)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

STIMULANTS AND RELATED AGENTS

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

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
STIMULANTS	
ADDERALL XR (amphetamine salt combination)	ADHANSIA XR (methylphenidate)
amphetamine salt combination IR	ADZENYS XR ODT (amphetamine)
CONCERTA (methylphenidate)	ADZENYS ER (amphetamine) suspension
DAYTRANA (methylphenidate)	amphetamine salt combination ER
dexmethylphenidate IR	amphetamine sulfate
dextroamphetamine IR	APTENSIO XR (methylphenidate)
DYANAVEL XR (amphetamine)	armodafinil
FOCALIN XR (dexmethylphenidate)	AZSTARYS (serdexmethylphenidate/dexmethyl)
JORNAY PM (methylphenidate ER)	COTEMPLA XR ODT (methylphenidate)
METHYLIN (methylphenidate) solution	DESOXYN (methamphetamine)
methylphenidate IR	DEXEDRINE (dextroamphetamine)
QUILLICHEW ER (methylphenidate)	dexmethylphenidate ER
QUILLIVANT XR (methylphenidate)	dextroamphetamine ER
VYVANSE (lisdexamfetamine)	dextroamphetamine solution
VYVANSE (lisdexamfetamine) chewable tablets	EVEKEO (amphetamine)
	FOCALIN (dexmethylphenidate)
	methamphetamine
	methylphenidate CD
	methylphenidate chewable tablets
	methylphenidate ER
	methylphenidate solution
	modafinil
	MYDAYIS (amphetamine salt combination ER)
	NUVIGIL (armodafinil)
	PROCENTRA (dextroamphetamine)
	PROVIGIL (modafinil)
	RITALIN (methylphenidate)
	RITALIN LA (methylphenidate ER)
	SUNOSI (solriamfetol)
	WAKIX (pitolisant)
	ZENZEDI (dextroamphetamine)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

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

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

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

- [ADHD Agents](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
NON-STIMULANTS	
atomoxetine	clonidine ER
guanfacine ER	INTUNIV (guanfacine ER)
	QELBREE (viloxazine)
	STRATTERA (atomoxetine)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

TETRACYCLINES

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
doxycycline hyclate capsule	demeclocycline
doxycycline monohydrate 50, 100 mg capsules	DORYX (doxycycline hyclate)
minocycline capsules	doxycycline hyclate IR
VIBRAMYCIN (doxycycline) suspension	doxycycline hyclate DR
	doxycycline monohydrate 40, 75, 150 mg capsules
	doxycycline monohydrate suspension, tablets
	minocycline tablets
	minocycline ER
	MINOLIRA ER (minocycline)
	MORGIDOX KIT (doxycycline/skin cleanser no19)
	NUZYRA tablet (omadacycline)
	ORACEA (doxycycline)
	SOLODYN (minocycline)
	TARGADOX (doxycycline hyclate)
	tetracycline
	VIBRAMYCIN (doxycycline) capsule, syrup
	XIMINO (minocycline)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

THROMBOPOIESIS STIMULATING PROTEINS

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
PROMACTA (eltrombopag) tablet	DOPTELET (avatrombopag)
	MULPLETA (lusutrombopag)
	PROMACTA (eltrombopag) suspension
	TAVALISSE (fostamatinib)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

ULCERATIVE COLITIS

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

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ORAL	
DELZICOL (mesalamine)	APRISO (mesalamine)
LIALDA (mesalamine)	ASACOL HD (mesalamine)
sulfasalazine	AZULFIDINE (sulfasalazine)
sulfasalazine DR	balsalazide
	budesonide DR
	COLAZAL (balsalazide)
	DIPENTUM (olsalazine)
	mesalamine
	PENTASA (mesalamine)
	UCERIS (budesonide)
RECTAL	
mesalamine	CANASA (mesalamine)
	mesalamine (SFROWASA)
	mesalamine kit (ROWASA)
	UCERIS (budesonide)

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

UREA CYCLE DISORDERS

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

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

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

- [Urea Cycle Disorders](#)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
BUPHENYL (sodium phenylbutyrate)	CARBAGLU (carglumic acid)
	carglumic acid
	RAVICTI (glycerol phenylbutyrate)
	sodium phenylbutyrate powder

To verify formulary coverage for any drugs listed on PDL, search the Medicaid Formulary: txvendordrug.com/formulary/formulary-search. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

2021 Review	CLASS	Date of Most Recent PDL Change	Date of Next PDL Change (Tentative)	2022 Review (Tentative)
JAN	ACNE AGENTS, ORAL	7/1/2022	7/1/2023	JAN
JAN	ACNE AGENTS, TOPICAL	7/1/2022	7/1/2023	JAN
JAN	ANALGESICS, NARCOTICS LONG	7/1/2022	7/1/2023	JAN
JAN	ANALGESICS, NARCOTICS SHORT	7/1/2022	7/1/2023	JAN
JAN	ANGIOTENSIN MODULATOR COMBINATIONS	7/1/2022	7/1/2023	JAN
JAN	ANGIOTENSIN MODULATORS	7/1/2022	7/1/2023	JAN
JAN	ANTIMIGRAINE AGENTS, OTHER	7/1/2022	7/1/2023	JAN
JAN	ANTIMIGRAINE AGENTS, TRIPTANS	7/1/2022	7/1/2023	JAN
JAN	BLADDER RELAXANT PREPARATIONS	7/1/2022	7/1/2023	JAN
JAN	GLUCAGON AGENTS	7/1/2022	7/1/2023	JAN
JAN	H. PYLORI TREATMENT	7/1/2022	7/1/2023	JAN
JAN	IMMUNOMODULATORS, ATOPIC DERMATITIS	7/1/2022	7/1/2023	JAN
JAN	INTRANASAL RHINITIS AGENTS	7/1/2022	7/1/2023	JAN
JAN	MOVEMENT DISORDERS	7/1/2022	7/1/2023	JAN
JAN	NEUROPATHIC PAIN	7/1/2022	7/1/2023	JAN
JAN	ONCOLOGY, ORAL - BREAST	7/1/2022	7/1/2023	JAN
JAN	ONCOLOGY, ORAL - HEMATOLOGIC	7/1/2022	7/1/2023	JAN
JAN	ONCOLOGY, ORAL - LUNG	7/1/2022	7/1/2023	JAN
JAN	ONCOLOGY, ORAL - OTHER	7/1/2022	7/1/2023	JAN
JAN	ONCOLOGY, ORAL - PROSTATE	7/1/2022	7/1/2023	JAN
JAN	ONCOLOGY, ORAL - RENAL CELL	7/1/2022	7/1/2023	JAN
JAN	ONCOLOGY, ORAL - SKIN	7/1/2022	7/1/2023	JAN
JAN	PHOSPHATE BINDERS	7/1/2022	7/1/2023	JAN
JAN	PLATELET AGGREGATION INHIBITORS	7/1/2022	7/1/2023	JAN
NA	POTASSIUM BINDERS	7/1/2022	7/1/2023	JAN
JAN	PROGESTINS FOR CACHEXIA	7/1/2022	7/1/2023	JAN
JAN	PROTON PUMP INHIBITORS	7/1/2022	7/1/2023	JAN
JAN	SMOKING CESSATION	7/1/2022	7/1/2023	JAN
JAN	STIMULANTS AND RELATED AGENTS	7/1/2022	7/1/2023	JAN
APR	ANTI-ALLERGENS, ORAL	7/1/2022	7/1/2023	APR
APR	ANTIBIOTICS, INHALED	7/1/2022	7/1/2023	APR
APR	ANTICOAGULANTS	7/1/2022	7/1/2023	APR
APR	ANTIDEPRESSANTS, OTHER	7/1/2022	7/1/2023	APR
APR	ANTIDEPRESSANTS, SSRIs	7/1/2022	7/1/2023	APR
APR	ANTIDEPRESSANTS, TRICYCLIC	7/1/2022	7/1/2023	APR
APR	ANTIHYPERURICEMICS	7/1/2022	7/1/2023	APR
JAN	ANTIPARKINSONS AGENTS	7/1/2022	7/1/2023	APR
APR	ANTIVIRALS, ORAL	7/1/2022	7/1/2023	APR
APR	ANXIOLYTICS	7/1/2022	7/1/2023	APR
APR	BETA-BLOCKERS	7/1/2022	7/1/2023	APR
APR	BILE SALTS	7/1/2022	7/1/2023	APR
APR	BPH TREATMENTS	7/1/2022	7/1/2023	APR
APR	BRONCHODILATORS, BETA AGONIST	7/1/2022	7/1/2023	APR

2021 Review	CLASS	Date of Most Recent PDL Change	Date of Next PDL Change (Tentative)	2022 Review (Tentative)
APR	COPD AGENTS	7/1/2022	7/1/2023	APR
APR	COUGH AND COLD	7/1/2022	7/1/2023	APR
APR	ERYTHROPOIESIS STIMULATING PROTEINS	7/1/2022	7/1/2023	APR
APR	GLUCOCORTICOIDS, INHALED	7/1/2022	7/1/2023	APR
APR	HAE TREATMENTS	7/1/2022	7/1/2023	APR
APR	HEMOPHILIA TREATMENT	7/1/2022	7/1/2023	APR
APR	IMMUNE GLOBULINS, IV	7/1/2022	7/1/2023	APR
APR	IMMUNOMODULATORS, ASTHMA	7/1/2022	7/1/2023	APR
APR	LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS	7/1/2022	7/1/2023	APR
APR	LIPOTROPICS, OTHER	7/1/2022	7/1/2023	APR
APR	LIPOTROPICS, STATINS	7/1/2022	7/1/2023	APR
APR	MULTIPLE SCLEROSIS AGENTS	7/1/2022	7/1/2023	APR
APR	PAH AGENTS, ORAL AND INHALED	7/1/2022	7/1/2023	APR
APR	PANCREATIC ENZYMES	7/1/2022	7/1/2023	APR
APR	PEDIATRIC VITAMIN PREPARATIONS	7/1/2022	7/1/2023	APR
APR	PRENATAL VITAMINS	7/1/2022	7/1/2023	APR
APR	SEDATIVE HYPNOTICS	7/1/2022	7/1/2023	APR
APR	SICKLE CELL ANEMIA TREATMENTS	7/1/2022	7/1/2023	APR
APR	THROMBOPOIESIS STIMULATING PROTEINS	7/1/2022	7/1/2023	APR
APR	UREA CYCLE DISORDER, ORAL	7/1/2022	7/1/2023	APR
JUL	ALZHEIMERS AGENTS	1/1/2022	1/1/2023	JUL
JUL	ANTIHISTAMINES, MINIMALLY SEDATING	1/1/2022	1/1/2023	JUL
JUL	ANTIHYPERTENSIVES, SYMPATHOLYTIC	1/1/2022	1/1/2023	JUL
JUL	CALCIUM CHANNEL BLOCKERS	1/1/2022	1/1/2023	JUL
JUL	CEPHALOSPORINS AND RELATED ANTIBIOTICS	1/1/2022	1/1/2023	JUL
JUL	CYTOKINE AND CAM ANTAGONISTS	1/1/2022	1/1/2023	JUL
JUL	FLUOROQUINOLONES, ORAL	1/1/2022	1/1/2023	JUL
JUL	GLUCOCORTICOIDS, ORAL	1/1/2022	1/1/2023	JUL
NA	IMMUNOMODULATORS, LUPUS	1/1/2022	1/1/2023	JUL
JUL	IMMUNOSUPPRESSIVES, ORAL	1/1/2022	1/1/2023	JUL
JUL	IRON, ORAL	1/1/2022	1/1/2023	JUL
JUL	LEUKOTRIENE MODIFIERS	1/1/2022	1/1/2023	JUL
JUL	NSAIDS	1/1/2022	1/1/2023	JUL
JUL	OPHTHALMIC ANTIBIOTICS	1/1/2022	1/1/2023	JUL
JUL	OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	1/1/2022	1/1/2023	JUL
JUL	OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	1/1/2022	1/1/2023	JUL
JUL	OPHTHALMICS, ANTI-INFLAMMATORY	1/1/2022	1/1/2023	JUL
JUL	OPHTHALMIC ANTI-INFLAMMATORY/IMMUNOMODULATORS	1/1/2022	1/1/2023	JUL
JUL	OPHTHALMICS, GLAUCOMA AGENTS	1/1/2022	1/1/2023	JUL
JUL	OTIC ANTIBIOTICS	1/1/2022	1/1/2023	JUL
JUL	OTIC ANTI-INFECTIVES & ANESTHETICS	1/1/2022	1/1/2023	JUL

2021 Review	CLASS	Date of Most Recent PDL Change	Date of Next PDL Change (Tentative)	2022 Review (Tentative)
JUL	PENICILLINS	1/1/2022	1/1/2023	JUL
JUL	PROGESTATIONAL AGENTS	1/1/2022	1/1/2023	JUL
JUL	ROSACEA AGENTS, TOPICAL	1/1/2022	1/1/2023	JUL
JUL	SKELETAL MUSCLE RELAXANTS	1/1/2022	1/1/2023	JUL
JUL	STEROIDS, TOPICAL	1/1/2022	1/1/2023	JUL
JUL	ULCERATIVE COLITIS	1/1/2022	1/1/2023	JUL
NA	UTERINE DISORDER TREATMENTS	NA	1/1/2023	JUL
OCT	ANDROGENIC AGENTS	1/1/2022	1/1/2023	OCT
OCT	ANTIBIOTICS, GI	1/1/2022	1/1/2023	OCT
OCT	ANTIBIOTICS, TOPICAL	1/1/2022	1/1/2023	OCT
OCT	ANTIBIOTICS, VAGINAL	1/1/2022	1/1/2023	OCT
OCT	ANTICONVULSANTS	1/1/2022	1/1/2023	OCT
OCT	ANTIEMETICS/ANTIVERTIGO AGENTS	1/1/2022	1/1/2023	OCT
OCT	ANTIFUNGALS, ORAL	1/1/2022	1/1/2023	OCT
OCT	ANTIFUNGALS, TOPICAL	1/1/2022	1/1/2023	OCT
OCT	ANTIHISTAMINES, FIRST GENERATION	1/1/2022	1/1/2023	OCT
OCT	ANTIPARASITICS, TOPICAL	1/1/2022	1/1/2023	OCT
OCT	ANTIPSYCHOTICS	1/1/2022	1/1/2023	OCT
OCT	ANTIVIRALS, TOPICAL	1/1/2022	1/1/2023	OCT
OCT	BONE RESORPTION SUPPRESSION AND RELATED	1/1/2022	1/1/2023	OCT
OCT	COLONY STIMULATING FACTORS	1/1/2022	1/1/2023	OCT
OCT	EPINEPHRINE, SELF-INJECTED	1/1/2022	1/1/2023	OCT
OCT	GI MOTILITY, CHRONIC	1/1/2022	1/1/2023	OCT
OCT	GROWTH HORMONE	1/1/2022	1/1/2023	OCT
OCT	HEPATITIS C AGENTS	1/1/2022	1/1/2023	NA
OCT	HIV / AIDS	1/1/2022	1/1/2023	OCT
APR	HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS	7/1/2021	1/1/2023	OCT
OCT	HYPOGLYCEMICS, INSULIN AND RELATED	1/1/2022	1/1/2023	OCT
OCT	HYPOGLYCEMICS, MEGLITINIDES	1/1/2022	1/1/2023	OCT
OCT	HYPOGLYCEMICS, METFORMIN	1/1/2022	1/1/2023	OCT
OCT	HYPOGLYCEMICS, SGLT2	1/1/2022	1/1/2023	OCT
OCT	HYPOGLYCEMICS, TZD	1/1/2022	1/1/2023	OCT
OCT	MACROLIDES-KETOLIDES	1/1/2022	1/1/2023	OCT
OCT	OPIATE DEPENDENCE TREATMENTS	1/1/2022	1/1/2023	OCT
OCT	TETRACYCLINES	1/1/2022	1/1/2023	OCT

APPENDICES**For all classes listed below the standard PA criteria apply:**

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

COUGH AND COLD ORAL

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

COUGH AND COLD NASAL

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

COUGH AND COLD, NARCOTIC

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

APPENDICES

For all classes listed below the standard PA criteria apply:

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

COUGH AND COLD, NON-NARCOTIC

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

APPENDICES**For all classes listed below the standard PA criteria apply:**

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IRON, ORAL			
Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
FERROUS FUMARATE TABLET OTC (ORAL)	ferrous fumarate	CORVITE 150 TABLET (ORAL)	iron,carb/folate6/mv,min no.41
FERROUS FUMARATE/FA/MULTIVITAMIN & MINERALS CAPSULE (ORAL)	iron fum/folic acid/mv,min 15	CORVITE FE TABLET (ORAL)	iron/folate no.6/mv,mins no.40
FERROUS FUMARATE/IRON POLYSACCHARIDES/FA/MULTIVITAMIN CAPSULE (ORAL)	iron fm,ps no.1/folic/mv no.18	FEOSOL TABLET OTC (ORAL)	iron polysacch/iron heme polyp
FERROUS GLUCONATE TABLET OTC (ORAL)	ferrous gluconate	FER-IN-SOL DROPS OTC (ORAL)	ferrous sulfate
FERROUS SULFATE DROPS OTC (ORAL)	ferrous sulfate	FERGON TABLET OTC (ORAL)	ferrous gluconate
FERROUS SULFATE SOLUTION OTC (ORAL)	ferrous sulfate	FERIVA 21-7 (ORAL)	iron/C/folate/B12/zinc/succin
FERROUS SULFATE TABLET OTC (ORAL)	ferrous sulfate	FERIVA FA CAPSULE (ORAL)	iron/C/folate/B12/biot/cupric
FERROUS SULFATE, DRIED TABLET ER OTC (ORAL)	ferrous sulfate, dried	FERRIMIN 150 TABLET OTC (ORAL)	ferrous fumarate
IRON CARBONYL/ASCORBIC ACID TABLET OTC (ORAL)	iron,carbonyl/ascorbic acid	FERROUS SULFATE/ASCORBIC ACID/FA TABLET ER OTC (ORAL)	ferrous sulfate/vit C/folic ac
IRON POLYSACCHARIDES CAPSULE OTC (ORAL)	iron polysaccharide complex	IROSPAN TABLET (ORAL)	iron bg,ps/folic/B,C no.12/suc
		NEPHRON FA TABLET (ORAL)	vit B comp C no.24/iron/folic
		TARON FORTE CAPSULE (ORAL)	iron bg,ps/vitC/B12/FA/calcium

PEDIATRIC VITAMIN PREPARATIONS			
Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
MULTIVITAMINS WITH FLUORIDE DROPS (ORAL)	pedi multivit no.2 w-fluoride	FLORIVA CHEW (ORAL)	pedi multivit no.85/fluoride
MULTIVITS WITH IRON & FLUORIDE DROPS (ORAL)	pedi multivit 45/fluoride/iron	FLORIVA PLUS DROPS OTC (ORAL)	pedi multivit no.161/fluoride
PEDI MVI NO.16 WITH FLUORIDE TAB CHEW (ORAL)	pedi multivit no.16 w-fluoride	FLUORIDE/VITAMINS A,C,AND D DROPS (ORAL)	ped mvit A,C,D3 no.21/fluoride
		PEDI MVI NO.17 WITH FLUORIDE CHEW (ORAL)	pedi multivit no.17 w-fluoride
		POLY-VI-FLO CHEW (ORAL)	pedi multivit no.33/fluoride
		POLY-VI-FLO DROPS (ORAL)	pedi multivit no.37 w-fluoride
		POLY-VI-FLO WITH IRON CHEW (ORAL)	pedi multivit 33/fluoride/iron
		POLY-VI-FLO WITH IRON DROPS (ORAL)	pedi multivit 37/fluoride/iron
		QUFLORA (ORAL)	pedi multivit 84 with fluoride
		QUFLORA (ORAL)	pedi multivit no.63 w-fluoride
		QUFLORA (ORAL)	pedi multivit no.83 w-fluoride
		QUFLORA FE (ORAL)	ped multivit 142/iron/fluoride
		QUFLORA FE (ORAL)	ped multivit 151/iron/fluoride
		QUFLORA OTC (ORAL)	pedi multivit no.157/fluoride
		TRI-VI-FLO DROPS (ORAL)	ped mvit A,C,D3 no.38/fluoride
		TRI-VITAMIN WITH FLUORIDE (ORAL)	ped mvit A,C,D3 no.21/fluoride

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PRENATAL VITAMINS			
Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
PNV2/IRON B-G SUC-P/FA/OMEGA-3 (ORAL)	PNV cmb 52/iron/FA/omega-3/dha	CITRANATAL B-CALM (ORAL)	prenatal 48/iron/folic acid/B6
SELECT-OB + DHA (ORAL)	prenatal vit 33/iron/folic/dha	COMPLETENATE CHEW TABLET (ORAL)	prenatal vit 14/iron fum/folic
TRICARE (ORAL)	prenatal vit103/iron fum/folic	FE C/FA (ORAL)	multivit-min69/iron/folic acid
TRINATAL RX 1 (ORAL)	prenatal vit27,calcium/iron/FA	NESTABS (ORAL)	prenatal vit86/iron/folic acid
VITAFOL NANO (ORAL)	prenatal no.75/iron/folate no1	NESTABS ABC (ORAL)	prenatal 86/iron/folic/dha/epa
VITAFOL TAB CHEW (ORAL)	PNV 112/iron/folic/om3/dha/epa	NESTABS DHA (ORAL)	prenatal 87/iron bis/folic/dha
VITAFOL ULTRA (ORAL)	PNV 67/iron ps/folate no.1/dha	OB COMPLETE ONE (ORAL)	PNV 85/iron/folic/dha/fish oil
VITAFOL-OB (ORAL)	prenatal vit 10/iron fum/folic	OB COMPLETE PETITE (ORAL)	prenatal56/iron/folic acid/dha
VITAFOL-OB+DHA (ORAL)	prenatal vit 10/iron/folic/dha	OB COMPLETE PREMIER (ORAL)	PNV83/iron,carb,asp/folic acid
VITAFOL-ONE (ORAL)	prenatal 26/iron ps/folic/dha	OB COMPLETE TABLET (ORAL)	multivit-min69/iron/folic acid
		PNV COMBO#47/IRON/FA #1/DHA (ORAL)	multivit 47/iron/folate 1/dha
		PNV NO.118/IRON FUMARATE/FA CHEW TABLET (ORAL)	PNV no.118/iron fumarate/FA
		PNV NO.15/IRON FUM & PS CMP/FA (ORAL)	mn-min 74/iron fum/iron/FA
		PNV W-CA NO.40/IRON FUM/FA CMB NO.1 (ORAL)	prenatal,calc.40/iron/folate 1
		PNV WITH CA NO.68/IRON/FA NO.1/DHA (ORAL)	mv-mins 71/iron/folic no.1/dha
		PNV WITH CA,NO.72/IRON/FA (ORAL)	PNV,calcium 72/iron/folic acid
		PNV#16/IRON FUM & PS/FA/OM-3 (ORAL)	mn-min75/iron/iron ps/om3/dha
		PNV119/IRON FUMARATE/FA/DSS TABLET (ORAL)	PNV 119/iron fum/folic acid
		PRENATAL VIT #76/IRON,CARB/FA (ORAL)	prenatal vit,calc76/iron/folic
		PRENATE AM (ORAL)	multivit 38/folate no.6/ginger
		PRENATE CHEWABLE TABLET (ORAL)	multivitamin no.36/folate no.6
		PRENATE DHA (ORAL)	prenatal 78/iron/folate 1/dha
		PRENATE ELITE (ORAL)	prenatal 114/iron a-g/folate 1
		PRENATE ENHANCE (ORAL)	prenatal vit68/iron/FA no6/dha
		PRENATE ESSENTIAL (ORAL)	multivit no.40/iron/folat1/dha
		PRENATE MINI (ORAL)	prenatal vit 87/iron/folic/dha
		PRENATE PIXIE (ORAL)	prenatal vit 85/iron/FA 1/dha
		PRENATE RESTORE (ORAL)	prenatal vit69/iron/folate6/dh
		PRENATE STAR (ORAL)	prenatal no.77/iron asp gly/FA
		SELECT-OB TAB CHEW (ORAL)	prenatal vit128/iron/folic acid
		TENDERA-OB OTC (ORAL)	prenatal 148/iron/folate 6/dha
		TRISTART DHA (ORAL)	prenatal 93/iron/folate 9/dha
		VP-PNV-DHA (ORAL)	prenatal no.52/iron/FA/dha
		WESTGEL DHA (ORAL)	prenatal 93/iron/folate 9/dha