



# **Criteria Guide** for the **Texas Prior Authorization Program**

## **PDL Criteria**

**August 8, 2024**

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# Document Overview

## Purpose

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

## Organization

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

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

A section may also include the following information:

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

## PDL Criteria Exceptions

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

Table 1:

- |   |
|---|
| <ul style="list-style-type: none"><li>• <b>Treatment failure with preferred drugs within any subclass</b></li><li>• <b>Contraindication to preferred drugs†</b></li><li>• <b>Allergic reaction to preferred drugs†</b></li><li>• <b>Treatment of stage-four advanced, metastatic cancer and associated conditions</b></li></ul> |
|---|

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

Table 2:

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

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

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

Table 3:

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

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

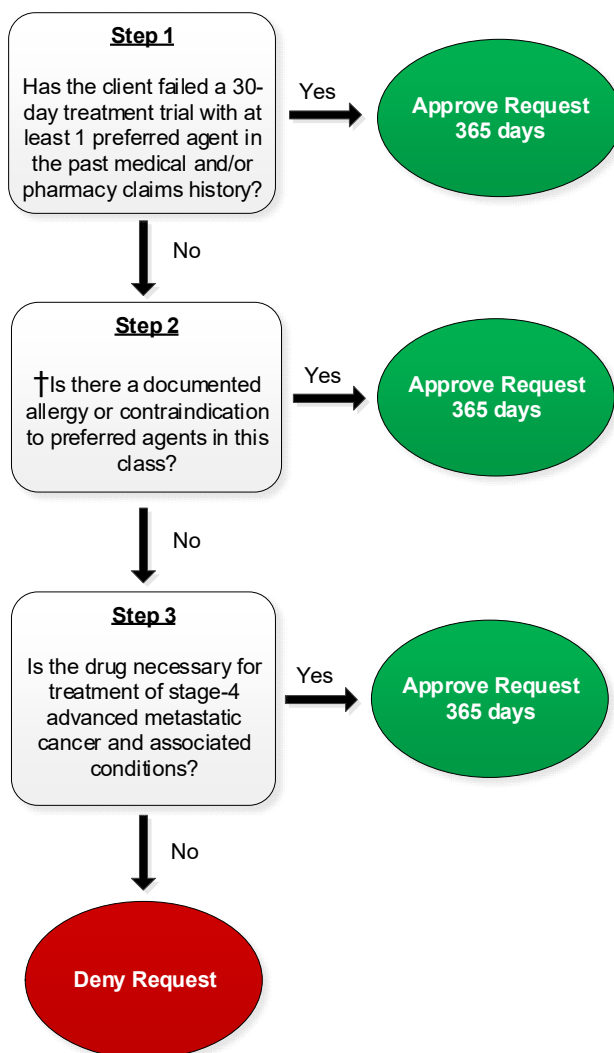
## Acne Agents, Oral

## Acne Agents, Oral Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Acne Agents, Oral Prior Authorization Criteria



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

## Acne Agents, Oral Alternate Therapies

### Preferred Oral Acne Agents

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

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



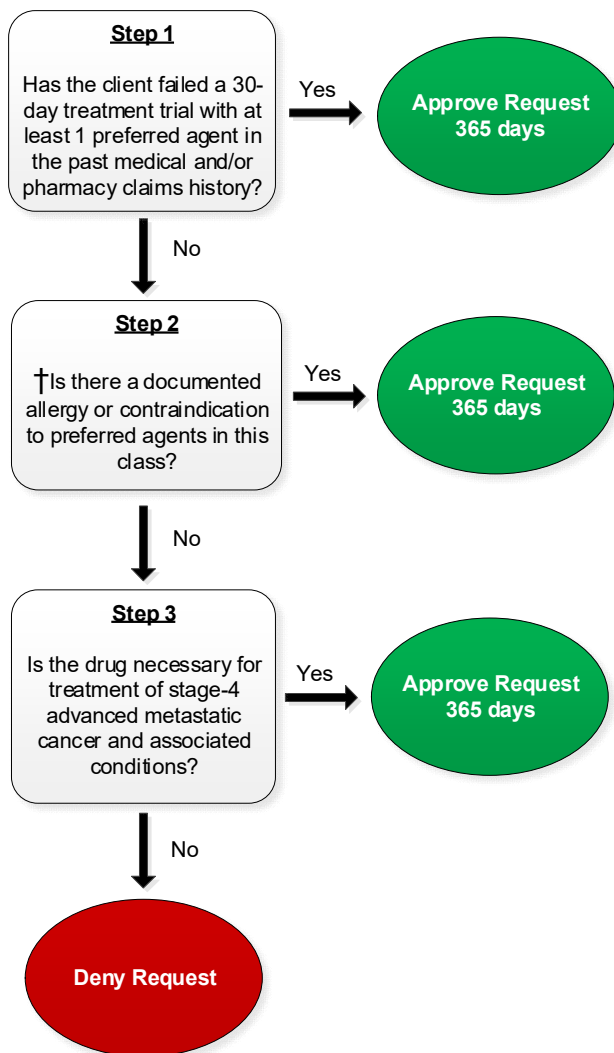
## Acne Agents, Topical

## Acne Agents, Topical Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Acne Agents, Topical Prior Authorization Criteria



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

## Acne Agents, Topical Alternate Therapies

### Preferred Topical Acne Agents

GCN	Drug Name
24673	ACNE FOAMING 10% WASH
22930	ACNE MEDICATION 10% GEL
28610	ACNE MEDICATION 10% LOTION
22931	ACNE MEDICATION 5% GEL
28611	ACNE MEDICATION 5% LOTION
29300	ADAPALENE 0.1% GEL (OTC)
22984	BENZOYL PEROXIDE 10% WASH
22932	BENZOYL PEROXIDE 2.5% GEL
22982	BENZOYL PEROXIDE 5% WASH
99676	BENZOYL PEROXIDE 5% WASH
98232	CLIND PH-BENZOYL PEROX 1.2-5%
45411	CLINDACIN ETZ 1% PLEDGET
45410	CLINDAMYCIN PH 1% GEL
31720	CLINDAMYCIN PH 1% SOLUTION
39163	EPIDUO FORTE 0.3-2.5% GEL PUMP
31710	ERYGEL 2% GEL
77562	ERYTHROMYCIN 2% SOLUTION
85400	ERYTHROMYCIN-BENZOYL GEL
22870	TRETINOIN 0.01% GEL
22882	TRETINOIN 0.025% CREAM
22871	TRETINOIN 0.025% GEL
22880	TRETINOIN 0.05% CREAM
22881	TRETINOIN 0.1% CREAM

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

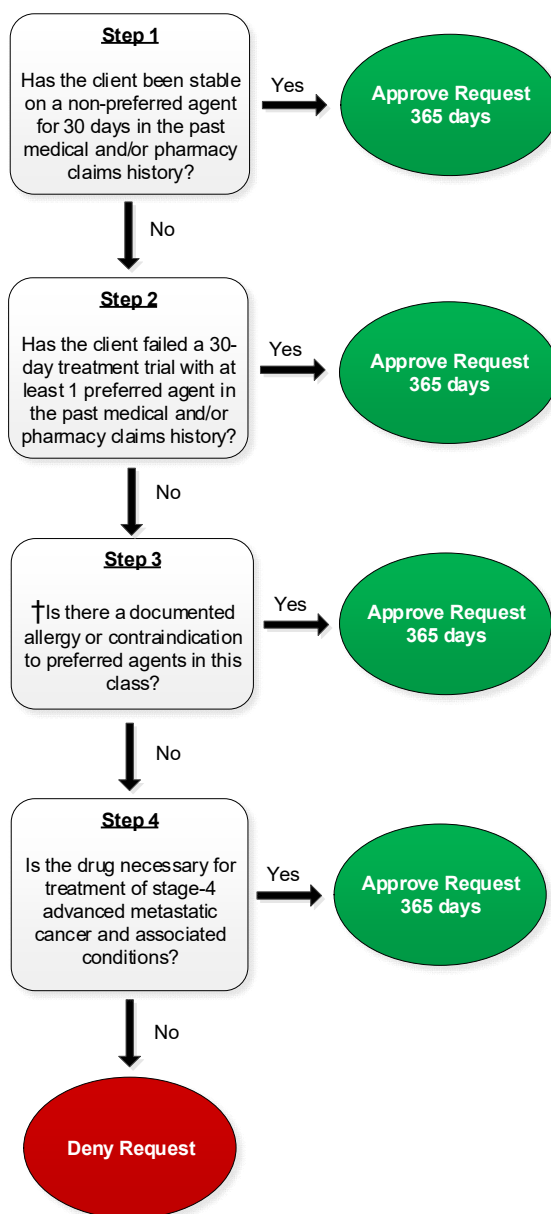
# Alzheimer's Agents

## Alzheimer's Agents Prior Authorization Criteria

1. Has the client been stable on a non-preferred agent for 30 days in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #4)
4. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Alzheimer's Agents Prior Authorization Criteria



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

## Alzheimer's Agents Alternate Therapies

### Preferred Alzheimer's Agents

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

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



## **Analgesics, Narcotic – Long Acting**

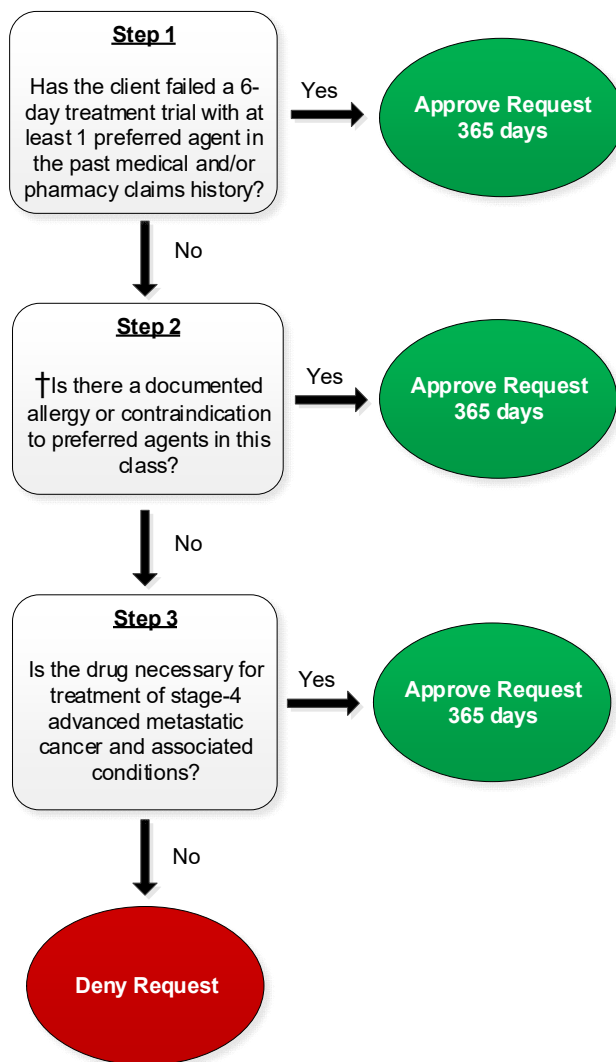
## Analgesics, Narcotic – Long Acting Prior Authorization Criteria

1. Has the client failed a 6-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

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

## Analgesics, Narcotic – Long Acting Prior Authorization Criteria



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

## Analgesics, Narcotic – Long Acting Alternate Therapies

### Preferred Long Acting Narcotics

GCN	Drug Name
25309	BUTRANS 10 MCG/HR PATCH
35214	BUTRANS 15 MCG/HR PATCH
25312	BUTRANS 20 MCG/HR PATCH
25308	BUTRANS 5 MCG/HR PATCH
36946	BUTRANS 7.5 MCG/HR PATCH
19203	FENTANYL 100 MCG/HR PATCH
24635	FENTANYL 12 MCG/HR PATCH
19200	FENTANYL 25 MCG/HR PATCH
19201	FENTANYL 50 MCG/HR PATCH
19202	FENTANYL 75 MCG/HR PATCH
16642	MORPHINE SULF ER 100 MG TABLET
16643	MORPHINE SULF ER 15 MG TABLET
16078	MORPHINE SULF ER 200 MG TABLET
16640	MORPHINE SULF ER 30 MG TABLET
16641	MORPHINE SULF ER 60 MG TABLET
26387	TRAMADOL HCL ER 100 MG TABLET
50417	TRAMADOL HCL ER 200 MG TABLET
50427	TRAMADOL HCL ER 300 MG TABLET
41273	XTAMPZA ER 13.5 MG CAPSULE
41274	XTAMPZA ER 18 MG CAPSULE
41275	XTAMPZA ER 27 MG CAPSULE
41276	XTAMPZA ER 36 MG CAPSULE
41272	XTAMPZA ER 9 MG CAPSULE

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

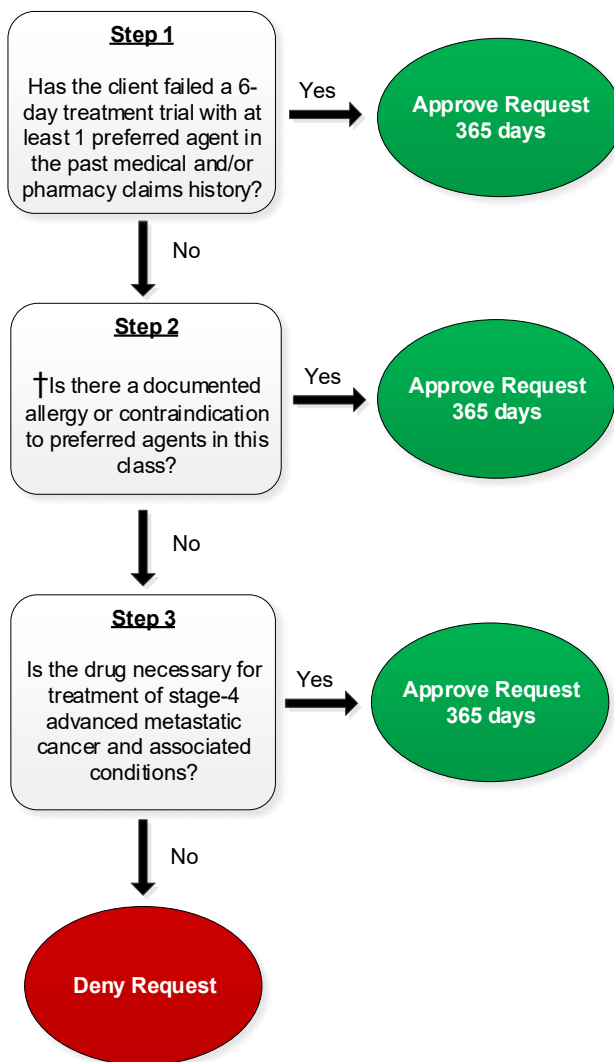
## **Analgesics, Narcotic – Short Acting**

## **Analgesics, Narcotic – Short Acting Prior Authorization Criteria**

1. Has the client failed a 6-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Analgesics, Narcotic – Short Acting Prior Authorization Criteria



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

## Analgesics, Narcotic – Short Acting Alternate Therapies

### Preferred Short Acting Narcotics

GCN	Drug Name
33606	ACETAMIN-CODEIN 300-30 MG/12.5
33604	ACETAMINOP-CODEIN 240-24 MG/10
33589	ACETAMINOP-CODEINE 120-12 MG/5
55402	ACETAMINOP-CODEINE 120-12 MG/5
70131	ACETAMINOPHEN-COD #2 TABLET
70134	ACETAMINOPHEN-COD #3 TABLET
70136	ACETAMINOPHEN-COD #4 TABLET
14966	ENDOCET 10-325 MG TABLET
14966	OXYCODONE HCL/ACETAMINOPHEN 10-325MG TABLET
70491	ENDOCET 5-325 MG TABLET
70491	OXYCODONE/ACETAMINOPHEN 5-325MG TABLET
14965	ENDOCET 7.5-325 MG TABLET
14965	OXYCODONE HCL/ACETAMINOPHEN 7.5-325MG TABLET
22929	HYDROCODONE-ACETAMIN 10-300 MG
70330	HYDROCODONE-ACETAMIN 10-325 MG
70330	LORCET HD 10-325MG TABLET
16227	HYDROCODONE-ACETAMIN 10-325/15
35153	HYDROCODONE-ACETAMIN 2.5-108/5
70337	HYDROCODONE-ACETAMIN 2.5-325
35154	HYDROCODONE-ACETAMIN 5-217/10
26470	HYDROCODONE-ACETAMIN 5-300 MG
12486	HYDROCODONE-ACETAMIN 5-325 MG
12486	LORCET 5-325MG TABLET
26709	HYDROCODONE-ACETAMIN 7.5-300
12488	HYDROCODONE-ACETAMIN 7.5-325
12488	LORCET PLUS 7.5-325MG TABLET
21146	HYDROCODONE-ACETAMN 7.5-325/15
31419	HYDROCODONE-ACETAMN 7.5-325/15
16141	HYDROMORPHONE 2 MG TABLET
16143	HYDROMORPHONE 4 MG TABLET



16144	HYDROMORPHONE 8 MG TABLET
16060	MORPHINE SULF 10 MG/5 ML CUP
16062	MORPHINE SULF 20 MG/5 ML SOLN
16070	MORPHINE SULFATE IR 15 MG TAB
16071	MORPHINE SULFATE IR 30 MG TAB
16291	OXYCODONE HCL (IR) 10 MG TAB
20091	OXYCODONE HCL (IR) 15 MG TAB
21194	OXYCODONE HCL (IR) 20 MG TAB
20092	OXYCODONE HCL (IR) 30 MG TAB
16290	OXYCODONE HCL (IR) 5 MG TABLET
16280	OXYCODONE HCL 5 MG/5 ML CUP
70492	OXYCODONE-ACETAMINOPHN 2.5-325
07221	TRAMADOL HCL 50 MG TABLET
13909	TRAMADOL-ACETAMINOPHN 37.5-325

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

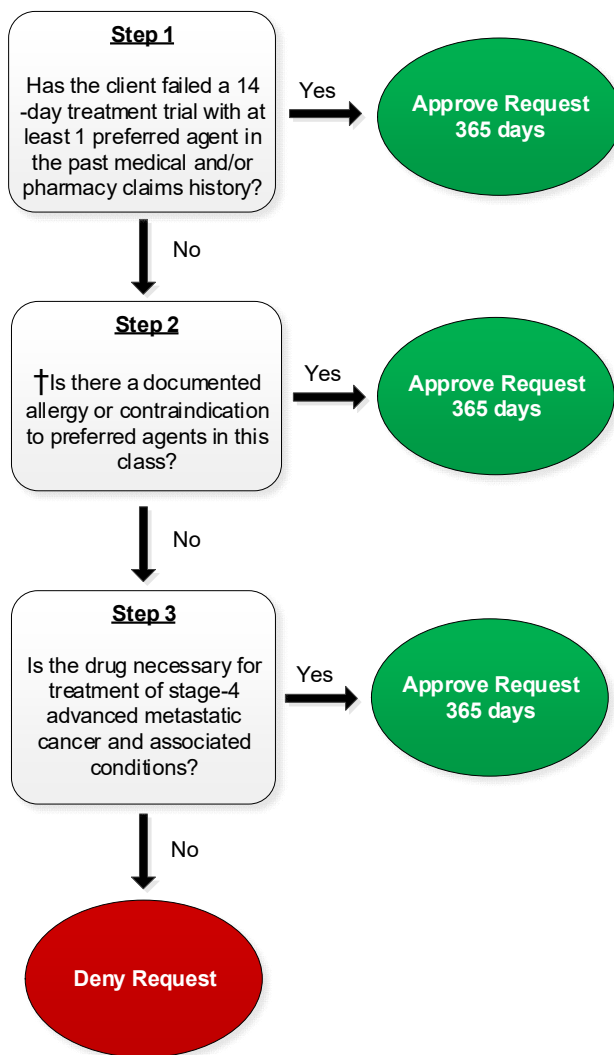
## Androgenic Agents, Topical

## Androgenic Agents, Topical Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Androgenic Agents, Topical Prior Authorization Criteria



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

## Androgenic Agents, Topical Alternate Therapies

### Preferred Androgenic Agents

GCN	Drug Name
30796	ANDRODERM 2 MG/24HR PATCH
29171	ANDRODERM 4 MG/24HR PATCH
29905	ANDROGEL 1.62% GEL PUMP
29905	TESTOSTERONE 1.62% GEL PUMP

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

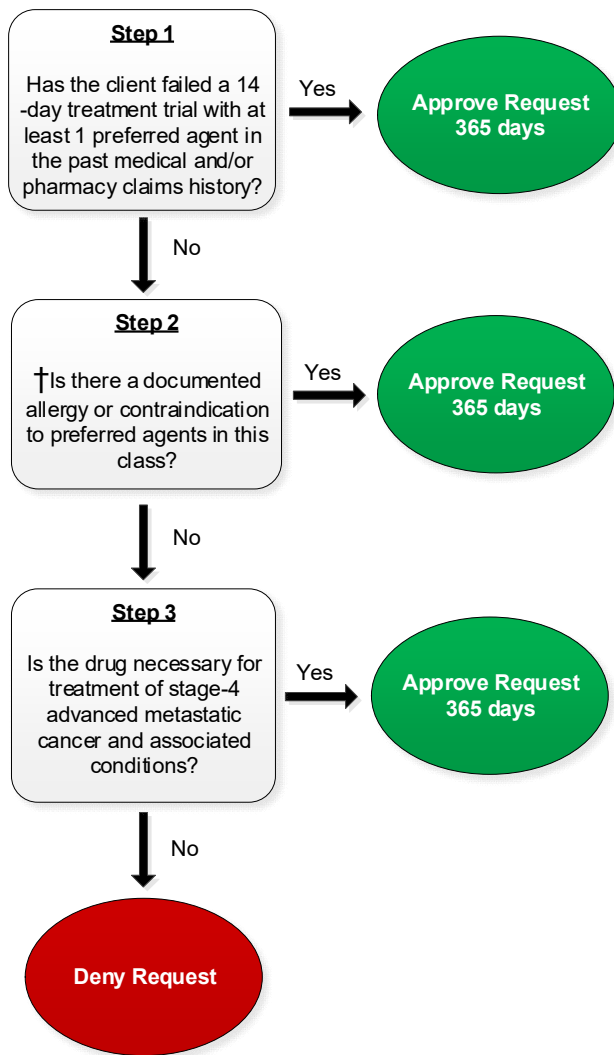
# Angiotensin Modulators

## Angiotensin Modulators Prior Authorization Criteria

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Angiotensin Modulators Prior Authorization Criteria



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



## Angiotensin Modulators Prior Authorization Criteria

### Preferred Angiotensin Modulators

48612	BENAZEPRIL HCL 10 MG TABLET
48613	BENAZEPRIL HCL 20 MG TABLET
48614	BENAZEPRIL HCL 40 MG TABLET
48611	BENAZEPRIL HCL 5 MG TABLET
13844	DIOVAN 160 MG TABLET
13838	DIOVAN 320 MG TABLET
18092	DIOVAN 40 MG TABLET
13846	DIOVAN 80 MG TABLET
42337	ENALAPRIL 1 MG/ML ORAL SOLN
00961	ENALAPRIL MALEATE 10 MG TAB
00963	ENALAPRIL MALEATE 2.5 MG TAB
00962	ENALAPRIL MALEATE 20 MG TAB
00960	ENALAPRIL MALEATE 5 MG TABLET
54860	ENALAPRIL-HCTZ 10-25 MG TABLET
54862	ENALAPRIL-HCTZ 5-12.5 MG TAB
39046	ENTRESTO 24 MG-26 MG TABLET
39047	ENTRESTO 49 MG-51 MG TABLET
39048	ENTRESTO 97 MG-103 MG TABLET
48581	FOSINOPRIL SODIUM 10 MG TAB
48582	FOSINOPRIL SODIUM 20 MG TAB
48580	FOSINOPRIL SODIUM 40 MG TAB
04749	IRBESARTAN 150 MG TABLET
04750	IRBESARTAN 300 MG TABLET
04752	IRBESARTAN 75 MG TABLET
11042	IRBESARTAN-HCTZ 150-12.5 MG TB
11295	IRBESARTAN-HCTZ 300-12.5 MG TB
47261	LISINOPRIL 10 MG TABLET
47264	LISINOPRIL 2.5 MG TABLET
47262	LISINOPRIL 20 MG TABLET
47265	LISINOPRIL 30 MG TABLET
47263	LISINOPRIL 40 MG TABLET

47260	LISINOPRIL 5 MG TABLET
88002	LISINOPRIL-HCTZ 10-12.5 MG TAB
88000	LISINOPRIL-HCTZ 20-12.5 MG TAB
88001	LISINOPRIL-HCTZ 20-25 MG TAB
14853	LOSARTAN POTASSIUM 100 MG TAB
14850	LOSARTAN POTASSIUM 25 MG TAB
14851	LOSARTAN POTASSIUM 50 MG TAB
25851	LOSARTAN-HCTZ 100-12.5 MG TAB
14854	LOSARTAN-HCTZ 100-25 MG TAB
14852	LOSARTAN-HCTZ 50-12.5 MG TAB
27570	QUINAPRIL 10 MG TABLET
27571	QUINAPRIL 20 MG TABLET
27573	QUINAPRIL 40 MG TABLET
27572	QUINAPRIL 5 MG TABLET
48541	RAMIPRIL 1.25 MG CAPSULE
48544	RAMIPRIL 10 MG CAPSULE
48542	RAMIPRIL 2.5 MG CAPSULE
48543	RAMIPRIL 5 MG CAPSULE

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

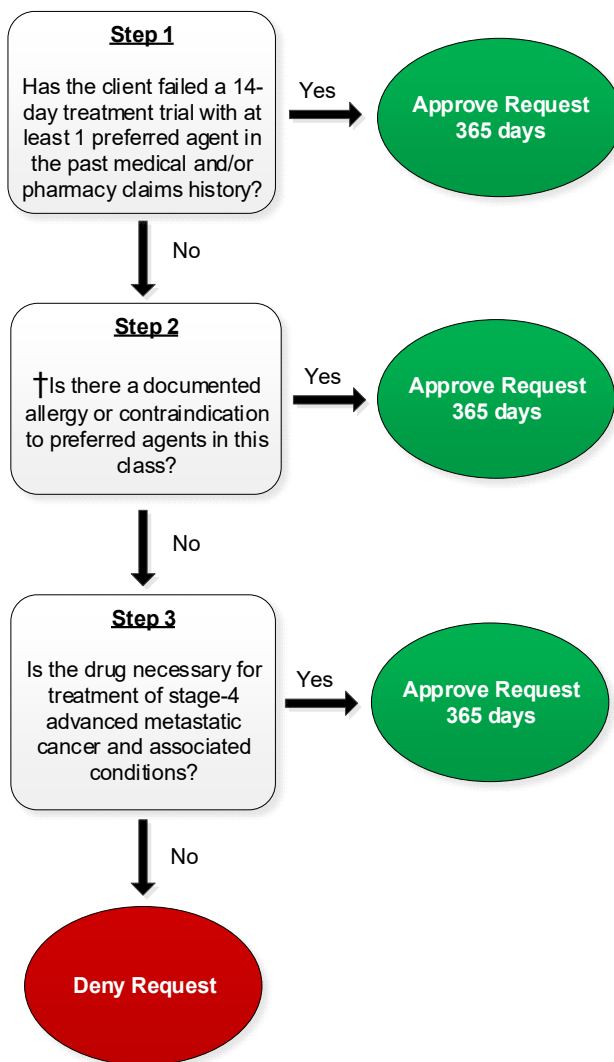
# Angiotensin Modulator Combinations

## Angiotensin Modulator Combinations Prior Authorization Criteria

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Angiotensin Modulator Combinations Prior Authorization Criteria



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

## Angiotensin Modulator Combinations Alternate Therapies

### Preferred Angiotensin Modulators

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

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

## Anti-Allergens, Oral

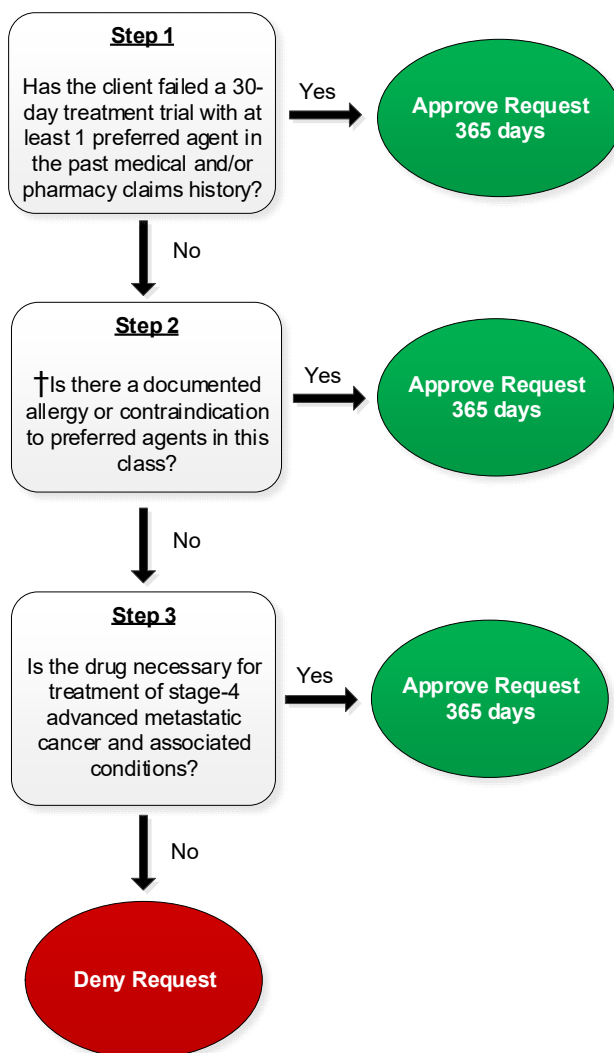
## Anti-Allergens, Oral Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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



## Anti-Allergens, Oral Prior Authorization Criteria



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

## Anti-Allergens, Oral Alternate Therapies

### Preferred Anti-Allergens

GCN	Drug Name
42527	ODACTRA 12 SQ-HDM SL TABLET
33969	ORALAIR 100 IR STARTER PACK
41118	ORALAIR 100-300 IR CHILD SAMPL
33970	ORALAIR 300 IR ADULT SAMPLE KT
33970	ORALAIR 300 IR SUBLINGUAL TAB
47654	PALFORZIA 12 MG (LEVEL 3)
47659	PALFORZIA 120 MG (LEVEL 7)
47664	PALFORZIA 160 MG (LEVEL 8)
47655	PALFORZIA 20 MG (LEVEL 4)
47649	PALFORZIA 200 MG (LEVEL 9)
47652	PALFORZIA 240 MG (LEVEL 10)
47647	PALFORZIA 3 MG (LEVEL 1)
47656	PALFORZIA 40 MG (LEVEL 5)
47648	PALFORZIA 6 MG (LEVEL 2)
47658	PALFORZIA 80 MG (LEVEL 6)
47639	PALFORZIA INITIAL DOSE PACK

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

# Antibiotics, GI

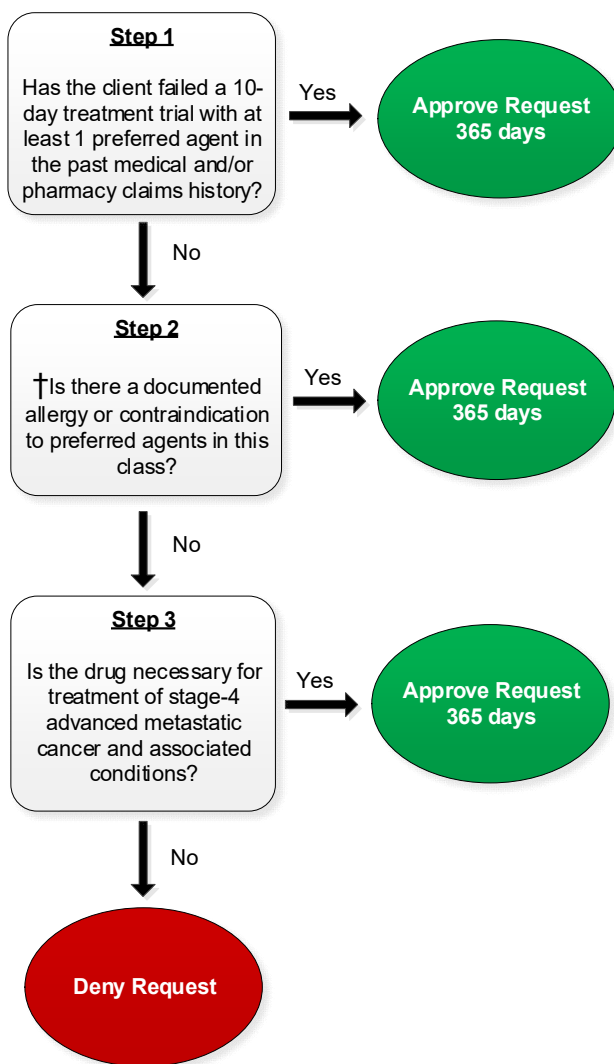
## Antibiotics, GI

### Prior Authorization Criteria

1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Antibiotics, GI Prior Authorization Criteria



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

## Antibiotics, GI Alternate Therapies

### Preferred Gastrointestinal Antibiotics

GCN	Drug Name
44411	FIRVANQ 25 MG/ML SOLUTION
41291	FIRVANQ 50 MG/ML SOLUTION
43031	METRONIDAZOLE 250 MG TABLET
43032	METRONIDAZOLE 500 MG TABLET
41072	NEOMYCIN 500 MG TABLET
22867	TINIDAZOLE 250 MG TABLET
52220	TINIDAZOLE 500 MG TABLET

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

# Antibiotics, Inhaled

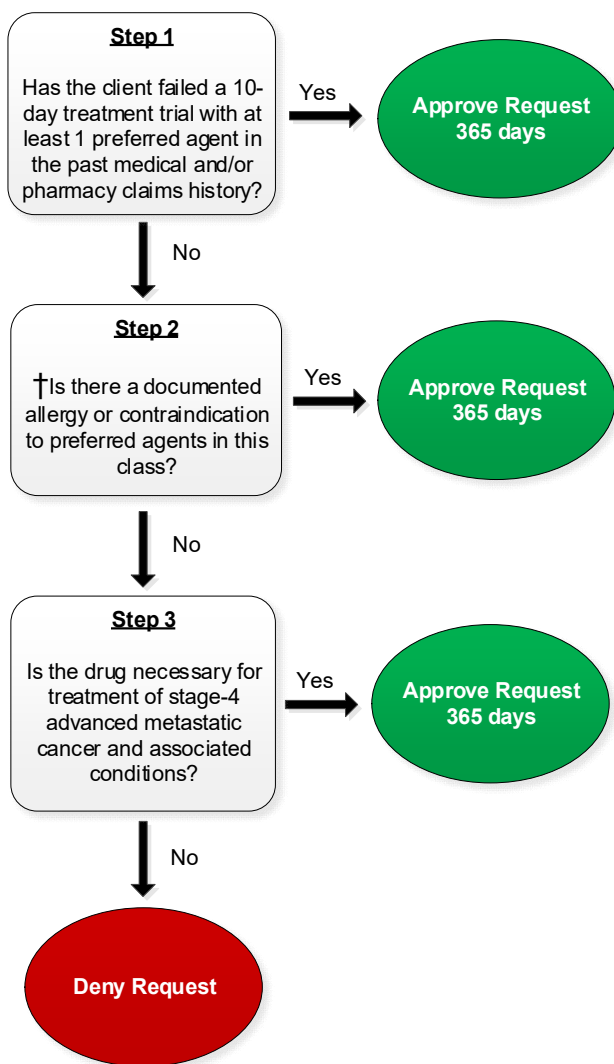
## Antibiotics, Inhaled Prior Authorization Criteria

1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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



## Antibiotics, Inhaled Prior Authorization Criteria



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

## Antibiotics, Inhaled Alternate Therapies

### Preferred Inhaled Antibiotics

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

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

# Antibiotics, Topical

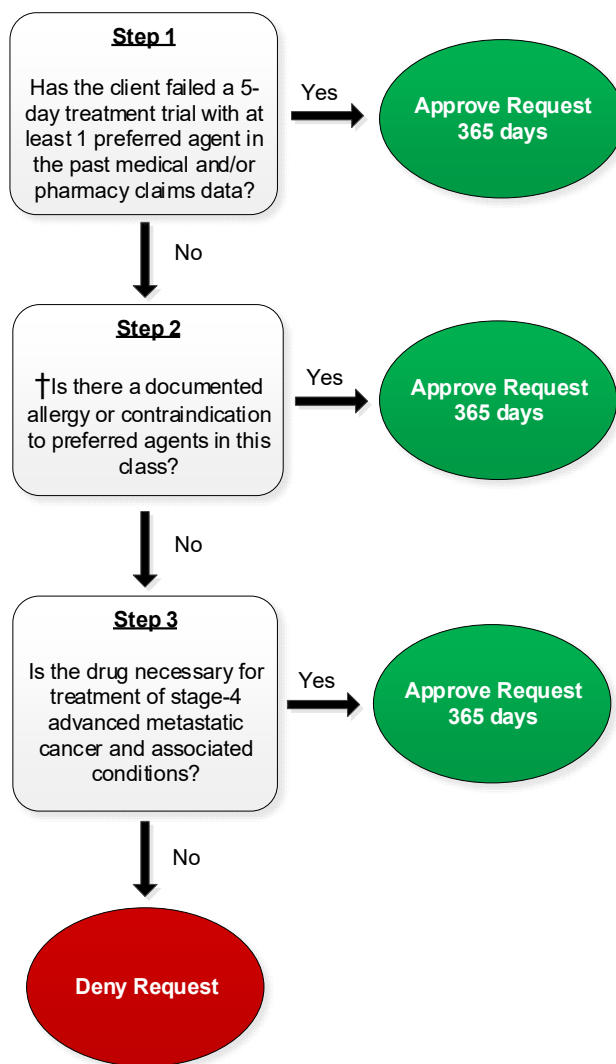
## Antibiotics, Topical

### Prior Authorization Criteria

1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims data?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Antibiotics, Topical Prior Authorization Criteria



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## Antibiotics, Topical Prior Authorization Criteria

### Preferred Topical Antibiotics

GCN	Drug Name
85459	ANTIBIOTIC OINTMENT
31812	BACITRACIN 500 UNIT/GM OINTMNT
31810	BACITRACIN ZN 500 UNIT/GM OINT
97206	CURAD TRIPLE ANTIBIOTIC OINT
98748	FIRST AID ANTIBIOTIC OINTMENT
47450	MUPIROCIN 2% OINTMENT

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

# Antibiotics, Vaginal

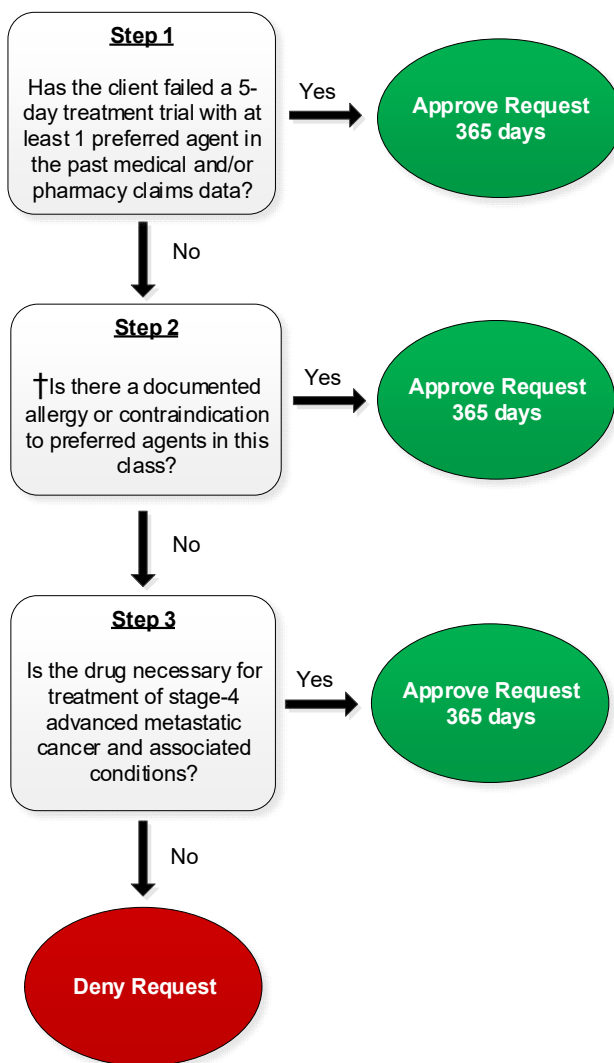
## Antibiotics, Vaginal Prior Authorization Criteria

1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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



## Antibiotics, Vaginal Prior Authorization Criteria



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

## Antibiotics, Vaginal Alternate Therapies

### Preferred Vaginal Antibiotics

GCN	Drug Name
91969	CLEOCIN 100 MG VAGINAL OVULE
23876	CLINDESSE 2% VAGINAL CREAM
49261	METRONIDAZOLE VAGINAL 0.75% GL
36303	NUVESSA VAGINAL 1.3% GEL

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

# Anticoagulants

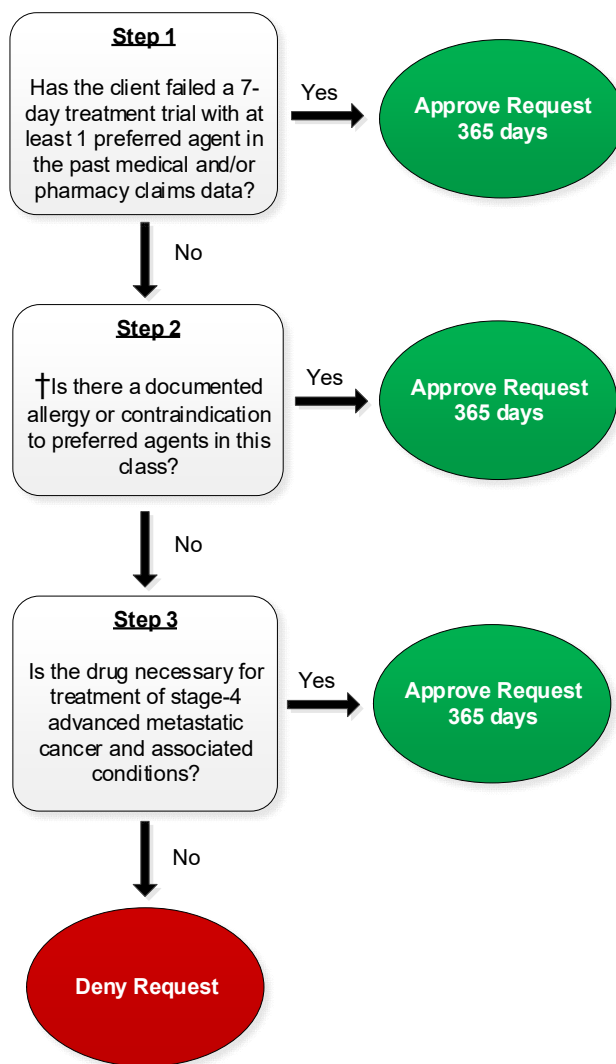
## Anticoagulants

### Prior Authorization Criteria

1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Anticoagulants Prior Authorization Criteria



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

## Anticoagulants Alternate Therapies

### Preferred Anticoagulants

GCN	Drug Name
30239	ELIQUIS 2.5 MG TABLET
33935	ELIQUIS 5 MG TABLET
44357	ELIQUIS DVT-PE TREAT START 5MG
62773	ENOXAPARIN 100 MG/ML SYRINGE
42091	ENOXAPARIN 120 MG/0.8 ML SYR
42071	ENOXAPARIN 150 MG/ML SYRINGE
00420	ENOXAPARIN 30 MG/0.3 ML SYR
96334	ENOXAPARIN 300 MG/3 ML VIAL
70022	ENOXAPARIN 40 MG/0.4 ML SYR
62771	ENOXAPARIN 60 MG/0.6 ML SYR
62772	ENOXAPARIN 80 MG/0.8 ML SYR
25792	JANTOVEN 1 MG TABLET
25790	JANTOVEN 10 MG TABLET
25791	JANTOVEN 2 MG TABLET
25794	JANTOVEN 2.5 MG TABLET
25796	JANTOVEN 3 MG TABLET
25797	JANTOVEN 4 MG TABLET
25793	JANTOVEN 5 MG TABLET
25798	JANTOVEN 6 MG TABLET
25795	JANTOVEN 7.5 MG TABLET
99709	PRADAXA 110 MG CAPSULE
29166	PRADAXA 150 MG CAPSULE
99708	PRADAXA 75 MG CAPSULE
50027	XARELTO 1 MG/ML SUSPENSION
14427	XARELTO 10 MG TABLET
30818	XARELTO 15 MG TABLET
36934	XARELTO 2.5 MG TABLET
30819	XARELTO 20 MG TABLET
37212	XARELTO DVT-PE TREAT START 30D

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# Anticonvulsants

## Anticonvulsants Alternate Therapies

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



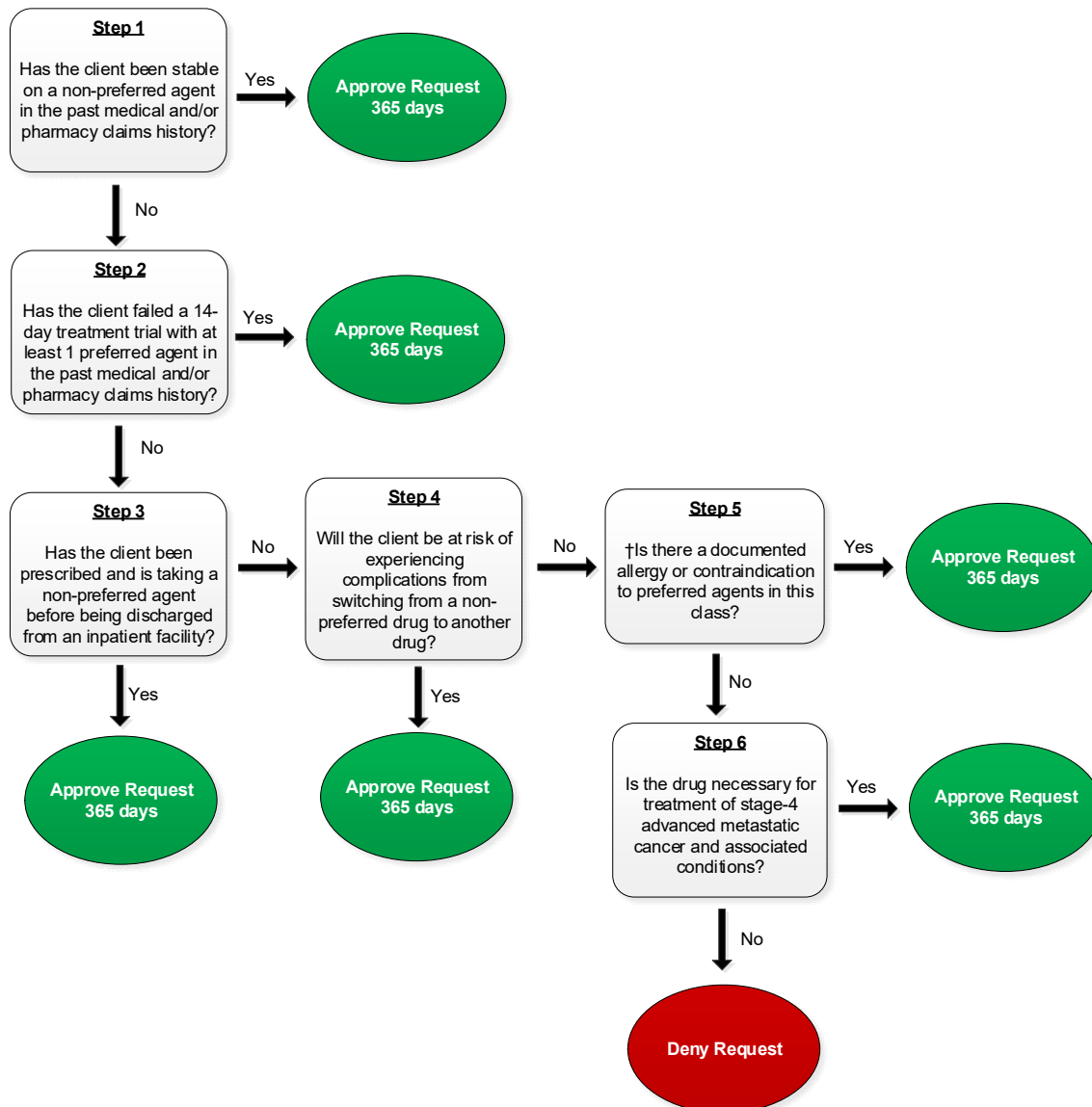
# Antidepressants, Other

## Antidepressants, Other Prior Authorization Criteria

1. Has the client been stable on a non-preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Has the client been prescribed and is taking a non-preferred agent before being discharged from an inpatient facility?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #4)
4. Will the client be at risk of experiencing complications from switching from a non-preferred drug to another drug?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #5)
5. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #6)
6. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Antidepressants, Other Prior Authorization Criteria



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

## Antidepressants, Other Alternate Therapies

### Preferred Other Antidepressants

GCN	Drug Name
16385	BUPROPION HCL 100 MG TABLET
16384	BUPROPION HCL 75 MG TABLET
16387	BUPROPION HCL SR 100 MG TABLET
16386	BUPROPION HCL SR 150 MG TABLET
27901	BUPROPION HCL SR 150MG TABLET
17573	BUPROPION HCL SR 200 MG TABLET
20317	BUPROPION HCL XL 150 MG TABLET
20318	BUPROPION HCL XL 300 MG TABLET
33081	FORFIVO XL 450 MG TABLET
12529	MIRTAZAPINE 15 MG ODT
16732	MIRTAZAPINE 15 MG TABLET
12531	MIRTAZAPINE 30 MG ODT
16733	MIRTAZAPINE 30 MG TABLET
13041	MIRTAZAPINE 45 MG ODT
16734	MIRTAZAPINE 45 MG TABLET
21817	MIRTAZAPINE 7.5 MG TABLET
16417	PHENELZINE SULFATE 15 MG TAB
99452	PRISTIQ ER 100 MG TABLET
38222	PRISTIQ ER 25 MG TABLET
99451	PRISTIQ ER 50 MG TABLET
16392	TRAZODONE 100 MG TABLET
16393	TRAZODONE 150 MG TABLET
16394	TRAZODONE 300 MG TABLET
16391	TRAZODONE 50 MG TABLET
16815	VENLAFAXINE HCL 100 MG TABLET
16811	VENLAFAXINE HCL 25 MG TABLET
16812	VENLAFAXINE HCL 37.5 MG TABLET
16813	VENLAFAXINE HCL 50 MG TABLET
16814	VENLAFAXINE HCL 75 MG TABLET
16818	VENLAFAXINE HCL ER 150 MG CAP
16816	VENLAFAXINE HCL ER 37.5 MG CAP
16817	VENLAFAXINE HCL ER 75 MG CAP
29916	VIIBRYD 10 MG TABLET

GCN	Drug Name
29917	VIIBRYD 20 MG TABLET
29918	VIIBRYD 40 MG TABLET

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

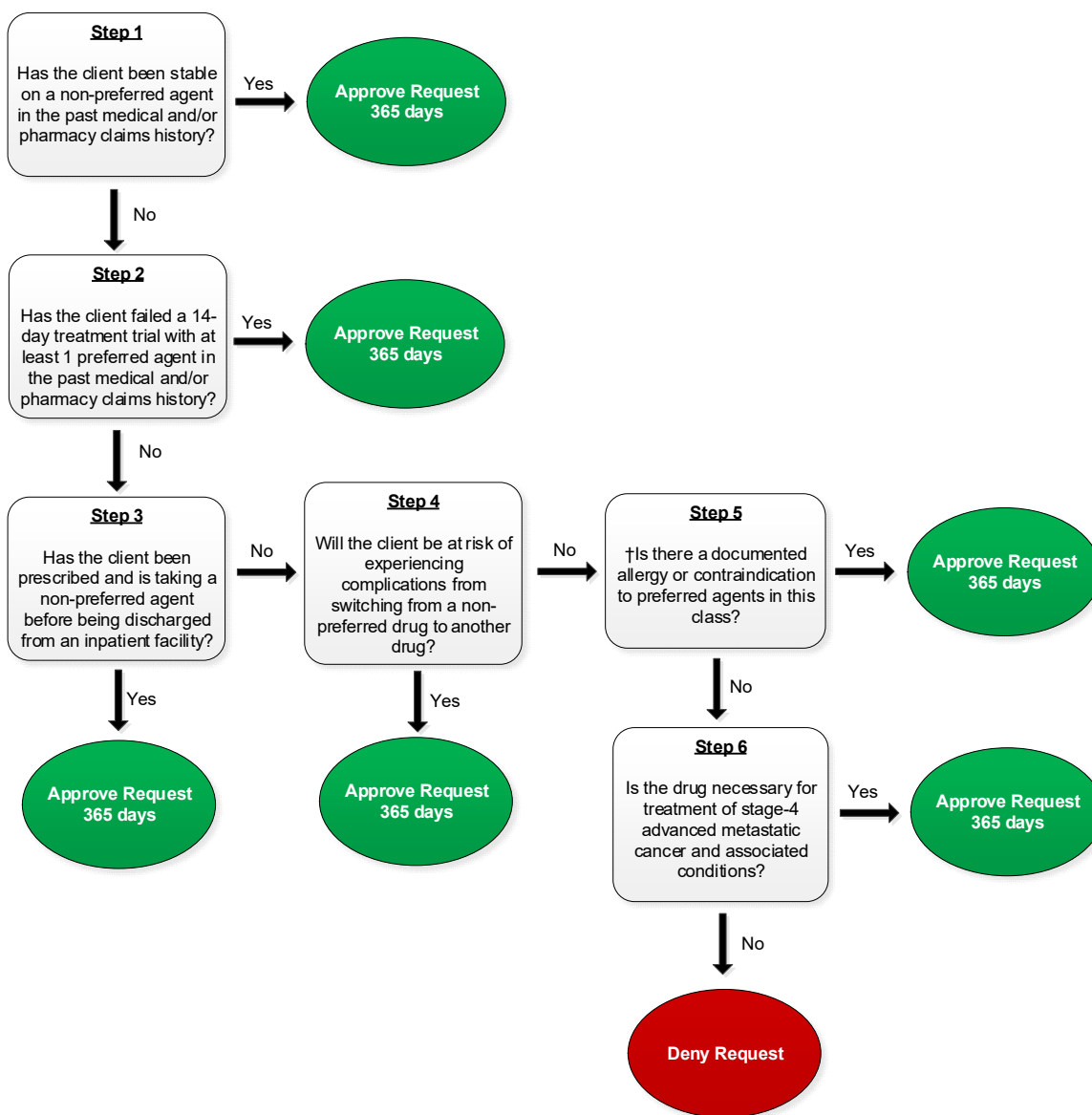
## Antidepressants, SSRI

## Antidepressants, SSRI Prior Authorization Criteria

1. Has the client been stable on a non-preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Has the client been prescribed and is taking a non-preferred agent before being discharged from an inpatient facility?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #4)
4. Will the client be at risk of experiencing complications from switching from a non-preferred drug to another drug?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #5)
5. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #6)
6. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Antidepressants, SSRI Prior Authorization Diagram



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



# Antidepressants, SSRI Alternate Therapies

## Preferred SSRI Antidepressants

GCN	Drug Name
16345	CITALOPRAM HBR 10 MG TABLET
16344	CITALOPRAM HBR 10 MG/5 ML SOLN
16342	CITALOPRAM HBR 20 MG TABLET
16343	CITALOPRAM HBR 40 MG TABLET
17851	ESCITALOPRAM 10 MG TABLET
17987	ESCITALOPRAM 20 MG TABLET
18975	ESCITALOPRAM 5 MG TABLET
16357	FLUOXETINE 20 MG/5 ML SOLN CUP
16353	FLUOXETINE HCL 10 MG CAPSULE
16354	FLUOXETINE HCL 20 MG CAPSULE
16355	FLUOXETINE HCL 40 MG CAPSULE
16349	FLUVOXAMINE MALEATE 100 MG TAB
16347	FLUVOXAMINE MALEATE 25 MG TAB
16348	FLUVOXAMINE MALEATE 50 MG TAB
16364	PAROXETINE HCL 10 MG TABLET
16366	PAROXETINE HCL 20 MG TABLET
16367	PAROXETINE HCL 30 MG TABLET
16368	PAROXETINE HCL 40 MG TABLET
16376	SERTRALINE 20 MG/ML ORAL CONC
16375	SERTRALINE HCL 100 MG TABLET
16373	SERTRALINE HCL 25 MG TABLET
16374	SERTRALINE HCL 50 MG TABLET

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

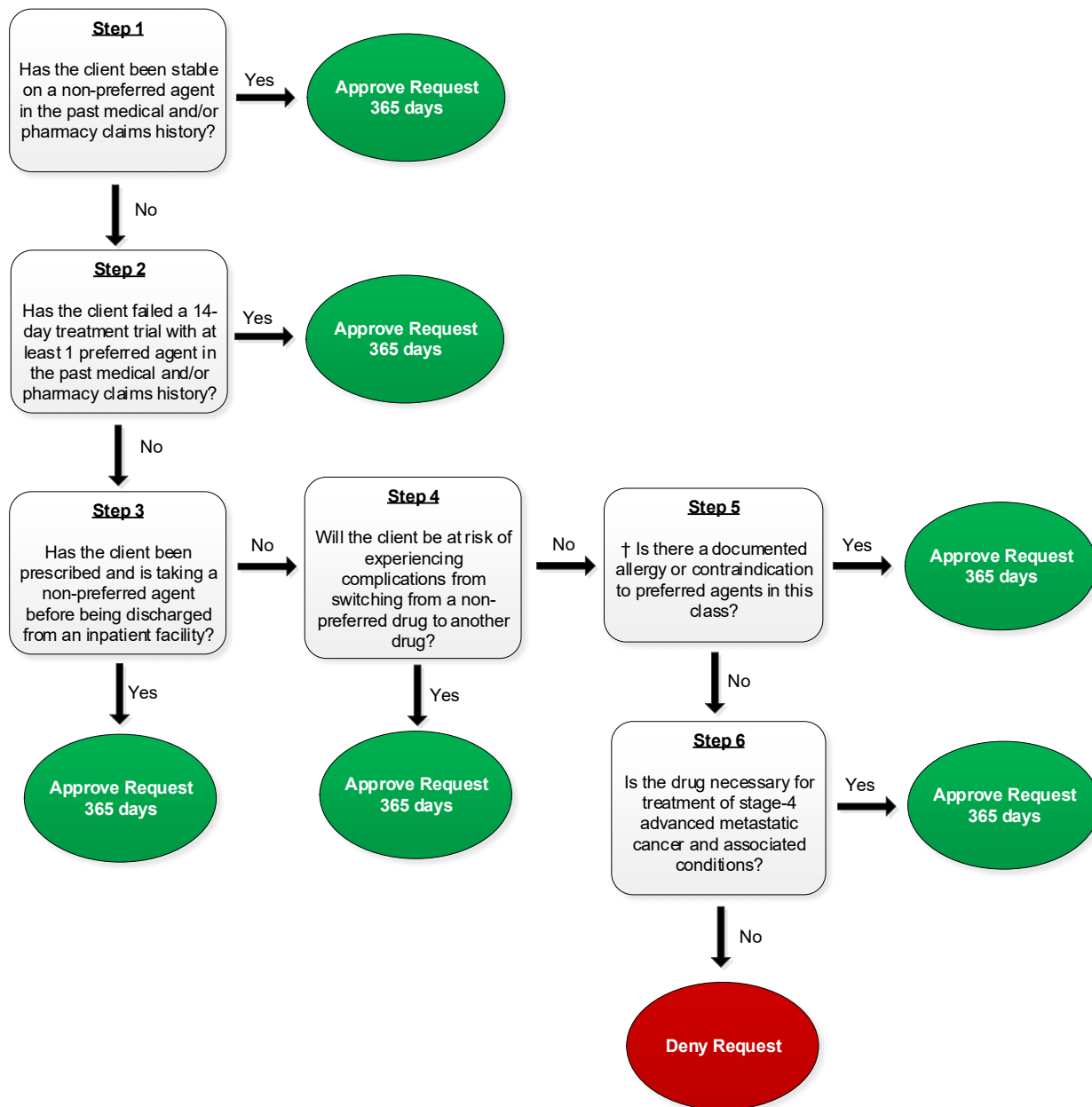
## Antidepressants, Tricyclic

## Antidepressants, Tricyclic Prior Authorization Criteria

1. Has the client been stable on a non-preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Has the client been prescribed and is taking a non-preferred agent before being discharged from an inpatient facility?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #4)
4. Will the client be at risk of experiencing complications from switching from a non-preferred drug to another drug?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #5)
5. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #6)
6. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Antidepressants, Tricyclic Prior Authorization Criteria



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

## Antidepressants, Tricyclic Alternate Therapies

### Preferred Tricyclic Antidepressants

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

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

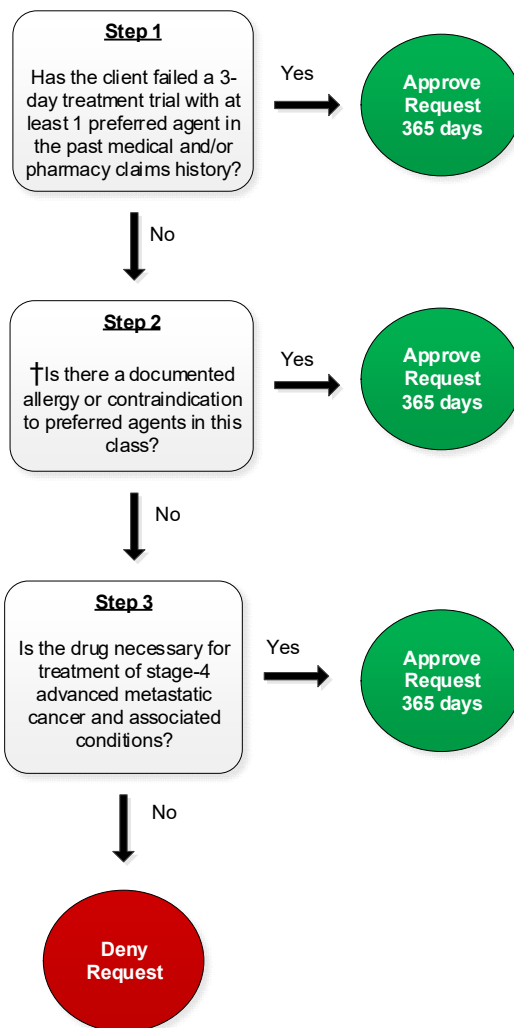
## **Antiemetic-Antivertigo Agents, Oral**

## Antiemetic-Antivertigo Agents, Oral Prior Authorization Criteria

1. Has the client failed a 3-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Antiemetic-Antivertigo Agents, Oral Prior Authorization Criteria



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



## Antiemetic-Antivertigo Agents, Oral

### Alternate Therapies

#### Preferred Antiemetic-Antivertigo Agents

GCN	Label Name
73710	ANTI-NAUSEA LIQUID
18312	BONINE 25 MG CHEWABLE TABLET
18302	CVS MOTION SICKNESS 25 MG TAB
18231	CVS MOTION SICKNESS 50 MG TAB
73860	DICLEGIS DR 10-10 MG TABLET
18301	MECLIZINE 12.5 MG CAPLET
18303	MECLIZINE 50 MG TABLET
21020	METOCLOPRAMIDE 10 MG TABLET
34798	METOCLOPRAMIDE 10 MG/10 ML CUP
21021	METOCLOPRAMIDE 5 MG TABLET
34797	METOCLOPRAMIDE 5 MG/5 ML CUP
03610	METOCLOPRAMIDE 5 MG/5 ML SOLN
20040	ONDANSETRON 1 MG/1.25 ML SYRNGE
20041	ONDANSETRON HCL 4 MG TABLET
20042	ONDANSETRON HCL 8 MG TABLET
20045	ONDANSETRON ODT 4 MG TABLET
20046	ONDANSETRON ODT 8 MG TABLET
14771	PROCHLORPERAZINE 10 MG TAB
14773	PROCHLORPERAZINE 5 MG TABLET
15042	PROMETHAZINE 12.5 MG TABLET
15043	PROMETHAZINE 25 MG TABLET
15044	PROMETHAZINE 50 MG TABLET
15035	PROMETHAZINE 6.25 MG/5 ML CUP
18160	TRANSDERM-SCOP 1 MG/3 DAY PTCH

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

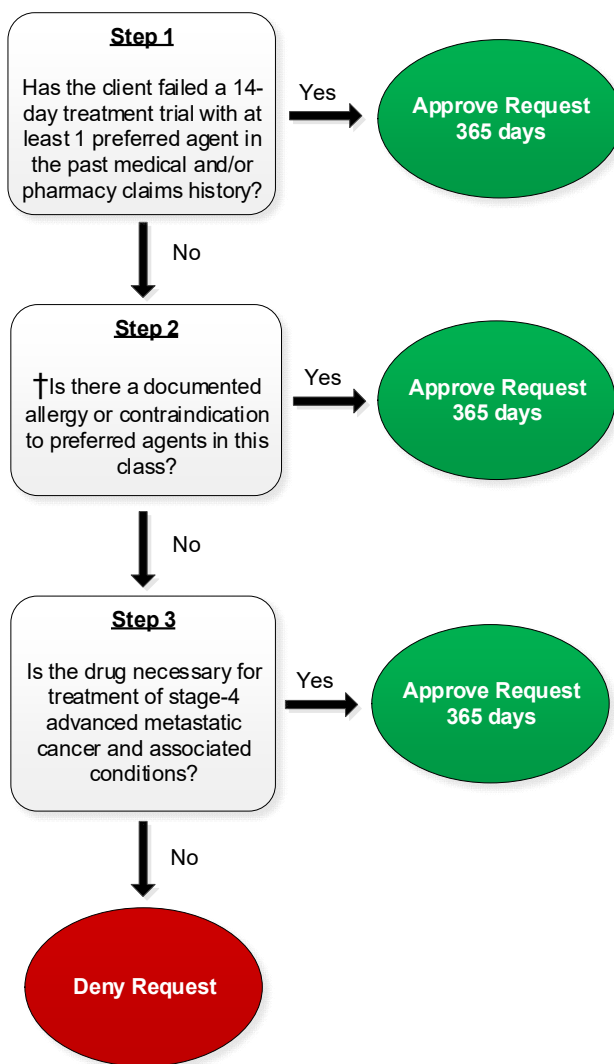
## Antifungals, Oral

## Antifungals, Oral Prior Authorization Criteria

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Antifungals, Oral Prior Authorization Criteria



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

## Antifungals, Oral Alternate Therapies

### Preferred Oral Antifungals

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

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

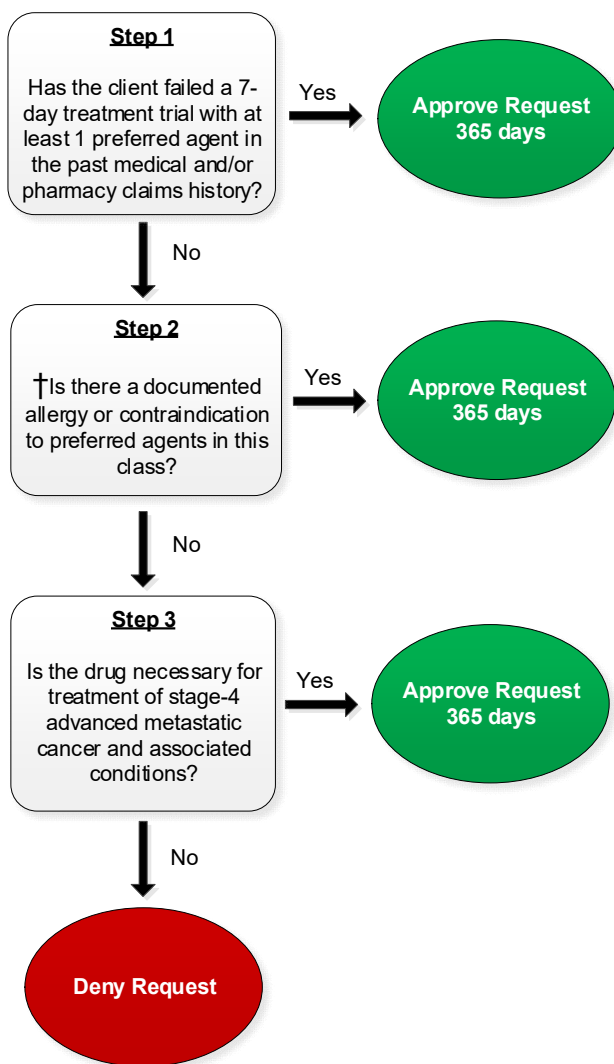
## Antifungals, Topical

## Antifungals, Topical Prior Authorization Criteria

1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Antifungals, Topical Prior Authorization Criteria



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



## Antifungals, Topical Alternate Therapies

### Preferred Topical Antifungals

GCN	Drug Name
30300	ANTIFUNGAL 1% CREAM
30370	ANTIFUNGAL 1% TOPICAL CREAM
30410	ANTIFUNGAL 2% POWDER
30400	ANTIFUNGAL 2% TOPICAL CREAM
62498	ATHLETES FOOT 1% CREAM
94677	CICLOPIROX 0.77% CREAM
30380	CLOTRIMAZOLE 1% SOLUTION
06919	CLOTRIMAZOLE-BETAMETHASONE CREAM
31271	KETOCONAZOLE 2% SHAMPOO
30160	KLAYESTA 100,000 UNIT/GM POWD
30140	NYSTATIN 100,000UNIT/GM CREAM
30150	NYSTATIN 100,000UNIT/GM OINTMENT
30310	TOLNAFTATE 1% POWDER

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

## Antihistamines, First Generation

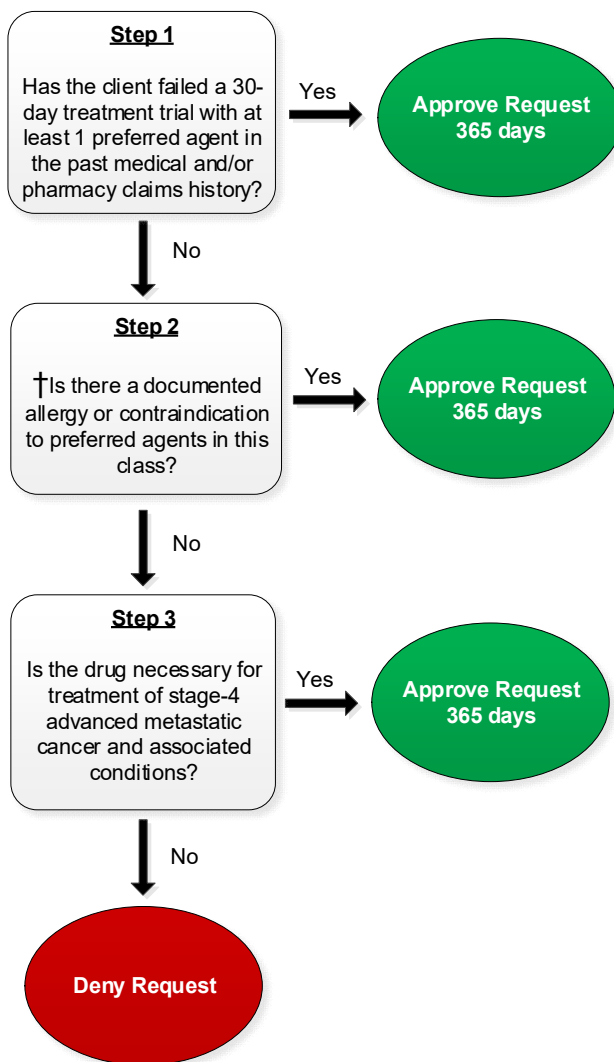
## Antihistamines, First Generation

### Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Antihistamines, First Generation Prior Authorization Criteria



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

## Antihistamines, First Generation Alternate Therapies

### Preferred First Generation Antihistamines

GCN	Drug Name
45971	ALER-CAPS 25 MG CAPSULE
46512	ALLER-CHLOR 4 MG TABLET
46071	ALLER-G-TIME 25 MG CAPLET
48831	ALLERGY 50 MG/20 ML SOLUTION
45971	ALLERGY RELIEF 25 MG SOFTGEL
45972	BANOPEHN 50 MG CAPSULE
45971	BANOPHEN 25 MG CAPSULE
14949	CARBINOXAMINE 4 MG/5 ML LIQUID
46170	CARBINOXAMINE MALEATE 4 MG TAB
43082	CARBINOXAMINE MALEATE 6 MG TAB
48831	CHILD ALLERGY RLF 12.5 MG/5 ML
48831	CHILD ALLERGY RLF 12.5 MG/5 ML
15803	CYPROHEPTADINE 2 MG/5 ML SOLN
15811	CYPROHEPTADINE 4 MG TABLET
45971	DIPHENHIST 25 MG CAPSULE
45971	DIPHENHYDRAMINE 25 MG CAPSULE
45972	DIPHENHYDRAMINE 50 MG CAPSULE
48831	DIPHENYDRAMINE 12.5 MG/5 ML
48831	DIPHENYDRAMINE 12.5 MG/5 ML
36886	HISTEX 2.5 MG/5 ML SYRUP
36284	HISTEX PD 0.938 MG/ML DROP
43586	HISTEX PD 1.25 MG/ML DROP
13932	HYDROXYZINE 10 MG/5 ML CUP
13941	HYDROXYZINE HCL 10 MG TABLET
13943	HYDROXYZINE HCL 25 MG TABLET
13944	HYDROXYZINE HCL 50 MG TABLET
13951	HYDROXYZINE PAM 100 MG CAP
13952	HYDROXYZINE PAM 25 MG CAP
13953	HYDROXYZINE PAM 50 MG CAP
46798	PEDIACLEAR 12.5 MG/15 ML LIQ

31501	PEDIACLEAR PD 0.625 MG/ML DROP
48831	QC CHILD ALLERGY 12.5 MG/5 ML
45971	QC COMPLETE ALLERGY 25 MG CAP
48831	SILADRYL 12.5 MG/5 ML LIQUID
48831	SM ALLERGY RELIEF 12.5 MG/5 ML

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

## Antihistamines, Minimally Sedating

## Antihistamines, Minimally Sedating

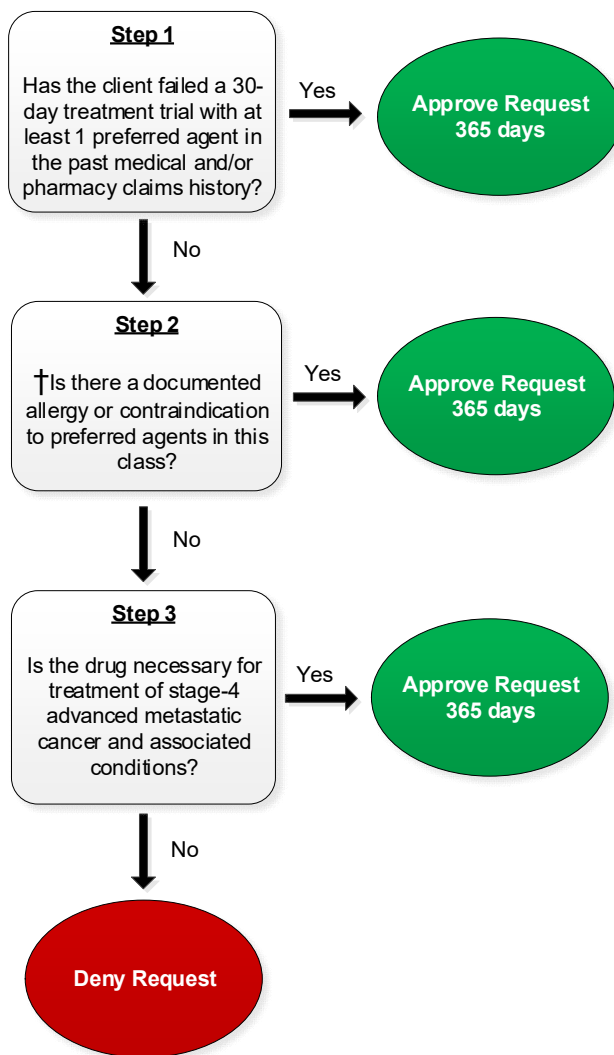
### Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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



## Antihistamines, Minimally Sedating Prior Authorization Criteria



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

## Antihistamines, Minimally Sedating Alternate Therapies

### Preferred Minimally Sedating Antihistamines

GCN	Drug Name
49291	24HOUR ALLERGY 10 MG TABLET
60563	ALLERCLEAR 10 MG TABLET
60563	ALLERGY RELIEF 10 MG TABLET
60562	ALLERGY RELIEF 5 MG/5 ML SOLN
49292	ALLERGY RLF (CETRZN) 5 MG TAB
49290	CETIRIZINE HCL 1 MG/ML SOLN
49291	CETIRIZINE HCL 10MG TABLET
60562	CHILD LORATADINE 5MG/ML SYRUP
60563	GS ALLERGY RELIEF 10 MG TABLET
60563	LORATADINE 10MG TABLET
60562	LORATADINE 5MG/5ML SYRUP
60563	NON-DROWSY ALLERGY 10 MG TAB
60563	QC LORATADINE 10MG TABLET
60562	SM LORATADINE 5MG/5ML SYRUP

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

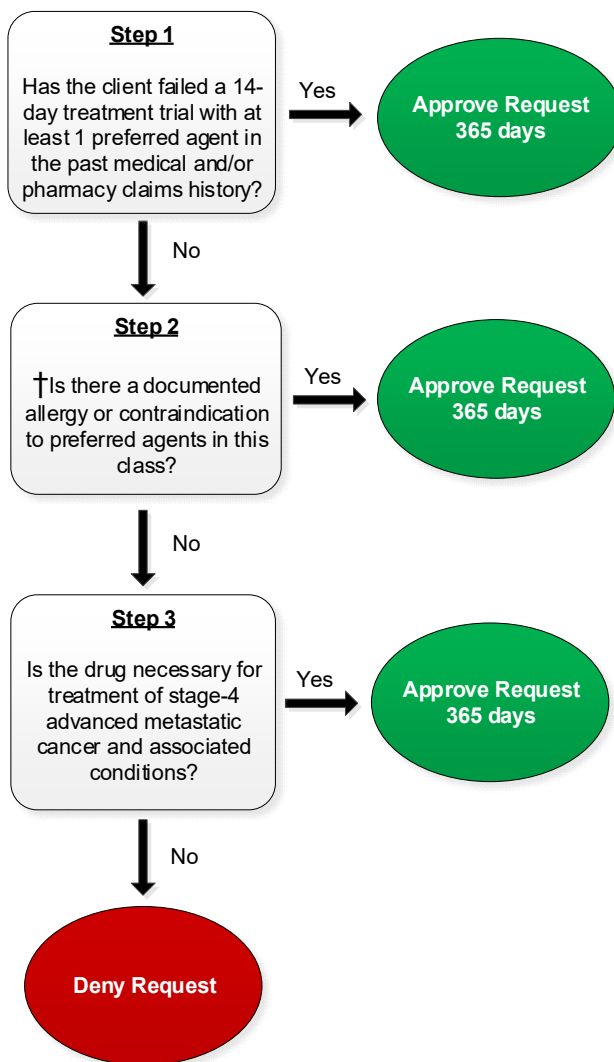
## Antihypertensives, Sympatholytics

## Antihypertensives, Sympatholytics Prior Authorization Criteria

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Antihypertensives, Sympatholytics Prior Authorization Criteria



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

## Antihypertensives, Sympatholytics Alternate Therapies

### Preferred Antihypertensives, Sympatholytics

GCN	Drug Name
23870	CATAPRES-TTS 1 PATCH
23871	CATAPRES-TTS 2 PATCH
23872	CATAPRES-TTS 3 PATCH
23870	CLONIDINE 0.1 MG/DAY PATCH
23871	CLONIDINE 0.2 MG/DAY PATCH
23872	CLONIDINE 0.3 MG/DAY PATCH
01390	CLONIDINE HCL 0.1MG TABLET
01391	CLONIDINE HCL 0.2MG TABLET
01392	CLONIDINE HCL 0.3MG TABLET
32480	GUANFACINE 1MG TABLET
32481	GUANFACINE 2MG TABLET
01431	METHYLDOPA 250MG TABLET
01432	METHYLDOPA 500MG TABLET

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

# Antihyperuricemics

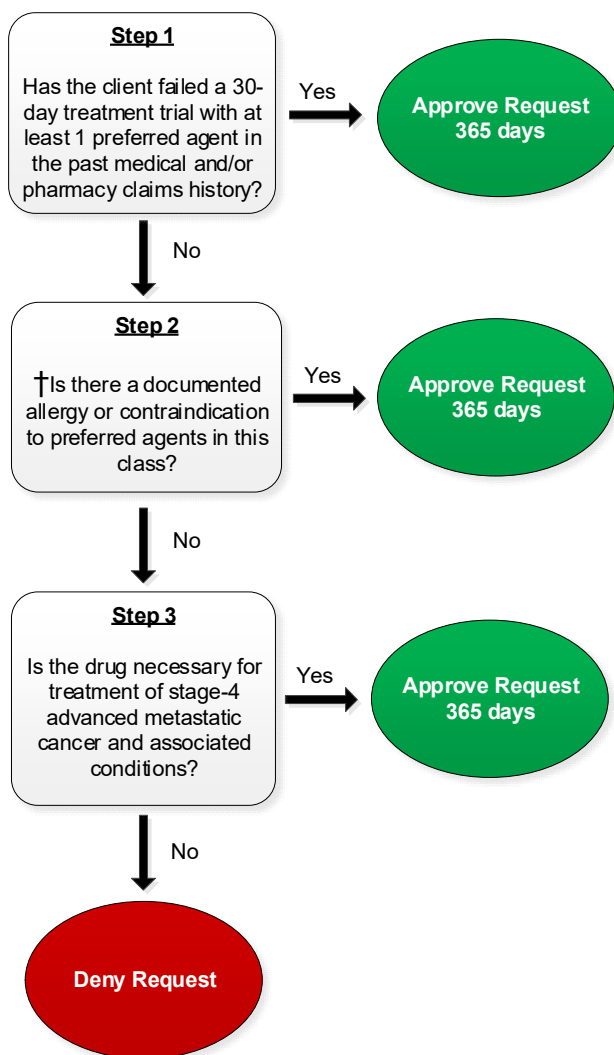
## Antihyperuricemics Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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



## Antihyperuricemics Prior Authorization Criteria



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

## Antihyperuricemics Alternate Therapies

### Preferred Antihyperuricemics

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

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

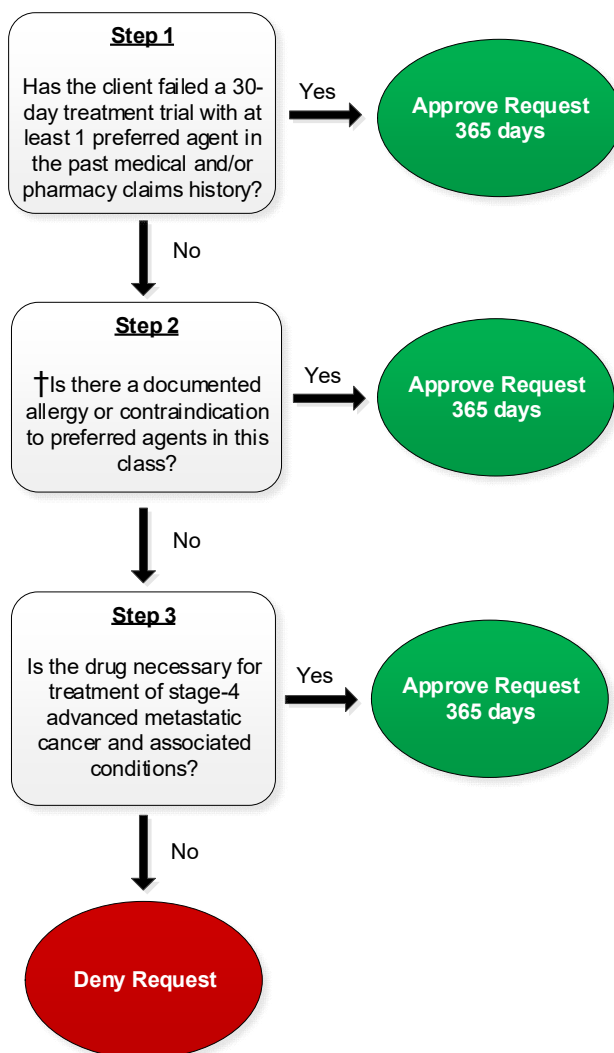
## Antimigraine Agents, Other

## Antimigraine Agents, Other Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Antimigraine Agents Prior Authorization Criteria



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

## Antimigraine Agents, Other Alternate Therapies

### Preferred Antimigraine Agents, Other

GCN	Drug Name
46116	AIMOVIG 140 MG/ML AUTOINJECTOR
44753	AIMOVIG 70 MG/ML AUTOINJECTOR
47862	AJOVY 225 MG/1.5 ML AUTOINJECT
45306	AJOVY 225 MG/1.5 ML SYRINGE
40418	EMGALITY 120 MG/ML PEN
40419	EMGALITY 120 MG/ML SYRINGE
47762	NURTEC ODT 75 MG TABLET
47478	UBRELVY 100 MG TABLET
47477	UBRELVY 50 MG TABLET

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

## Antimigraine Agents, Triptans

## Antimigraine Agents, Triptans

### Prior Authorization Criteria

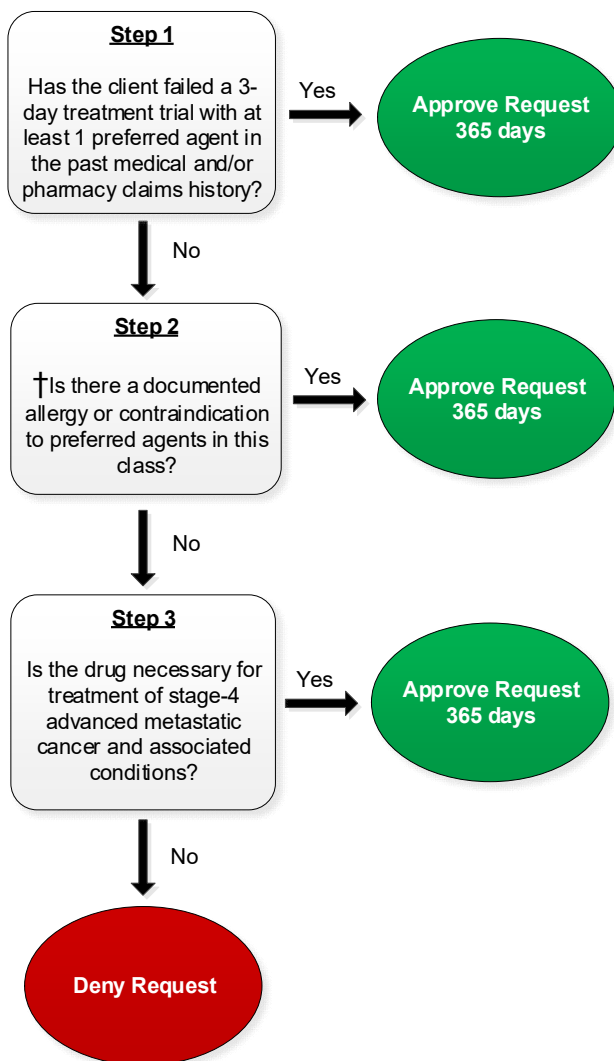
1. Has the client failed a 3-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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



## Antimigraine Agents, Triptans

### Prior Authorization Criteria



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

## Antimigraine Agents, Triptans Alternate Therapies

### Preferred Antimigraine Agents, Triptans

GCN	Drug Name
50744	IMITREX 20 MG NASAL SPRAY
26667	IMITREX 4 MG/0.5 ML CARTRIDGES
26666	IMITREX 4 MG/0.5 ML PEN INJECT
50740	IMITREX 5 MG NASAL SPRAY
24708	IMITREX 6 MG/0.5 ML CARTRIDGES
50741	IMITREX 6 MG/0.5 ML SYRNG KIT
19594	RIZATRIPTAN 10MG ODT
19592	RIZATRIPTAN 10MG TABLET
19593	RIZATRIPTAN 5MG ODT
19591	RIZATRIPTAN 5MG TABLET
50744	SUMATRIPTAN 20MG NASAL SPRAY
50740	SUMATRIPTAN 5MG NASAL SPRAY
05701	SUMATRIPTAN SUCC 100MG TABLET
05702	SUMATRIPTAN SUCC 25MG TABLET
05700	SUMATRIPTAN SUCC 50MG TABLET
18972	ZOMIG 5MG NASAL SPRAY

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

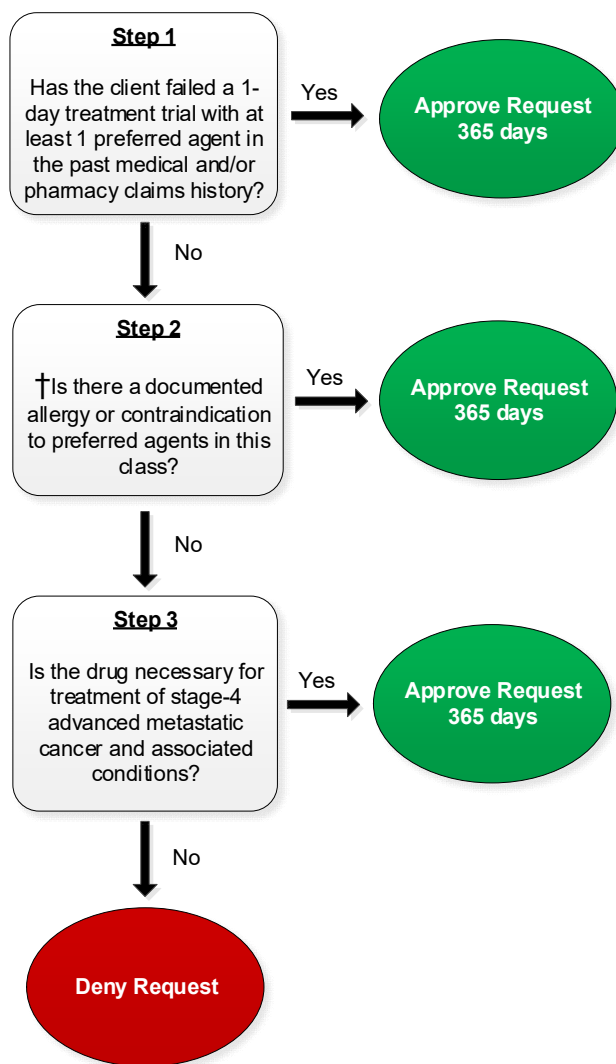
## Antiparasitics, Topical

## Antiparasitics, Topical Prior Authorization Criteria

1. Has the client failed a 1-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Antiparasitics, Topical Prior Authorization Criteria



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

## Antiparasitics, Topical Alternate Therapies

### Preferred Topical Antiparasitics

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

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

## Antiparkinson's Agents

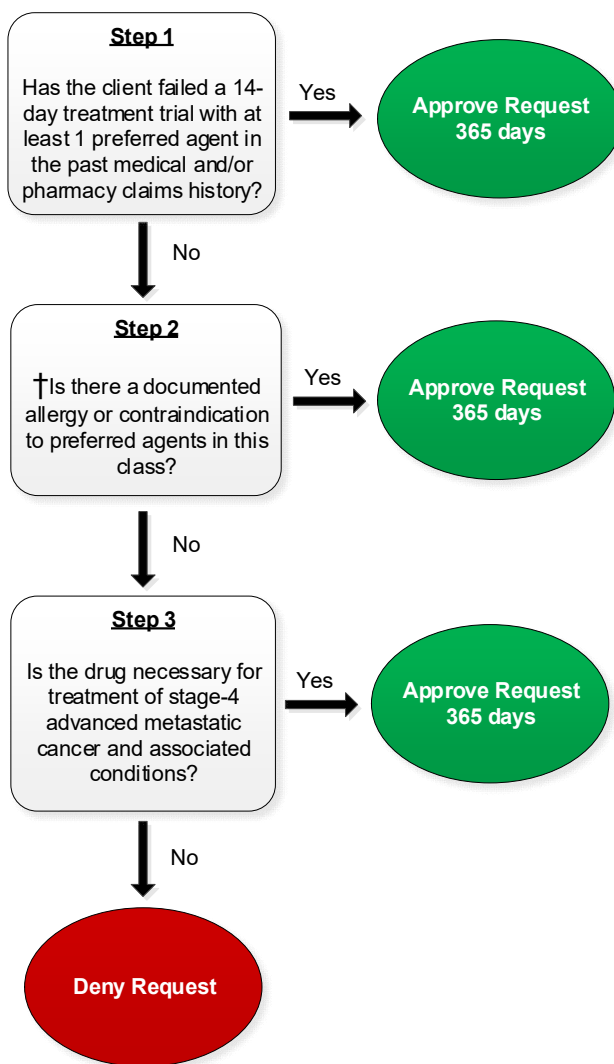
## Antiparkinson's Agents Prior Authorization Criteria

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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



## Antiparkinson's Agents Prior Authorization Criteria



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

## Antiparkinson's Agents Alternate Therapies

### Preferred Antiparkinson's Agents

GCN	Drug Name
17520	AMANTADINE 100 MG CAPSULE
17521	AMANTADINE 100 MG TABLET
17530	AMANTADINE 100 MG/10 ML CUP
17620	BENZTROPINE MES 0.5 MG TAB
17621	BENZTROPINE MES 1 MG TABLET
17622	BENZTROPINE MES 2 MG TABLET
62592	CARBIDOPA-LEVO ER 25-100 TAB
62591	CARBIDOPA-LEVO ER 50-200 TAB
20146	CARBIDOPA-LEVODOPA 100 MG-ENTA
62740	CARBIDOPA-LEVODOPA 10-100 TAB
14474	CARBIDOPA-LEVODOPA 125 MG-ENTA
20145	CARBIDOPA-LEVODOPA 150 MG-ENTA
98948	CARBIDOPA-LEVODOPA 200 MG-ENTA
62741	CARBIDOPA-LEVODOPA 25-100 TAB
62742	CARBIDOPA-LEVODOPA 25-250 TAB
20150	CARBIDOPA-LEVODOPA 50 MG-ENTA
14473	CARBIDOPA-LEVODOPA 75 MG-ENTA
19873	PRAMIPEXOLE 0.125 MG TABLET
19874	PRAMIPEXOLE 0.25 MG TABLET
19875	PRAMIPEXOLE 0.5 MG TABLET
98973	PRAMIPEXOLE 0.75 MG TABLET
19871	PRAMIPEXOLE 1 MG TABLET
19872	PRAMIPEXOLE 1.5 MG TABLET
34100	ROPINIROLE HCL 0.25 MG TABLET
34104	ROPINIROLE HCL 0.5 MG TABLET
34101	ROPINIROLE HCL 1 MG TABLET
34102	ROPINIROLE HCL 2 MG TABLET
93048	ROPINIROLE HCL 3 MG TABLET
93038	ROPINIROLE HCL 4 MG TABLET
34103	ROPINIROLE HCL 5 MG TABLET
17561	TRIHXYPHENIDYL 2 MG TABLET
17550	TRIHXYPHENIDYL 2 MG/5 ML SOLN

GCN	Drug Name
17563	TRIHEXYPHENIDYL 5 MG TABLET

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

# Antipsychotics

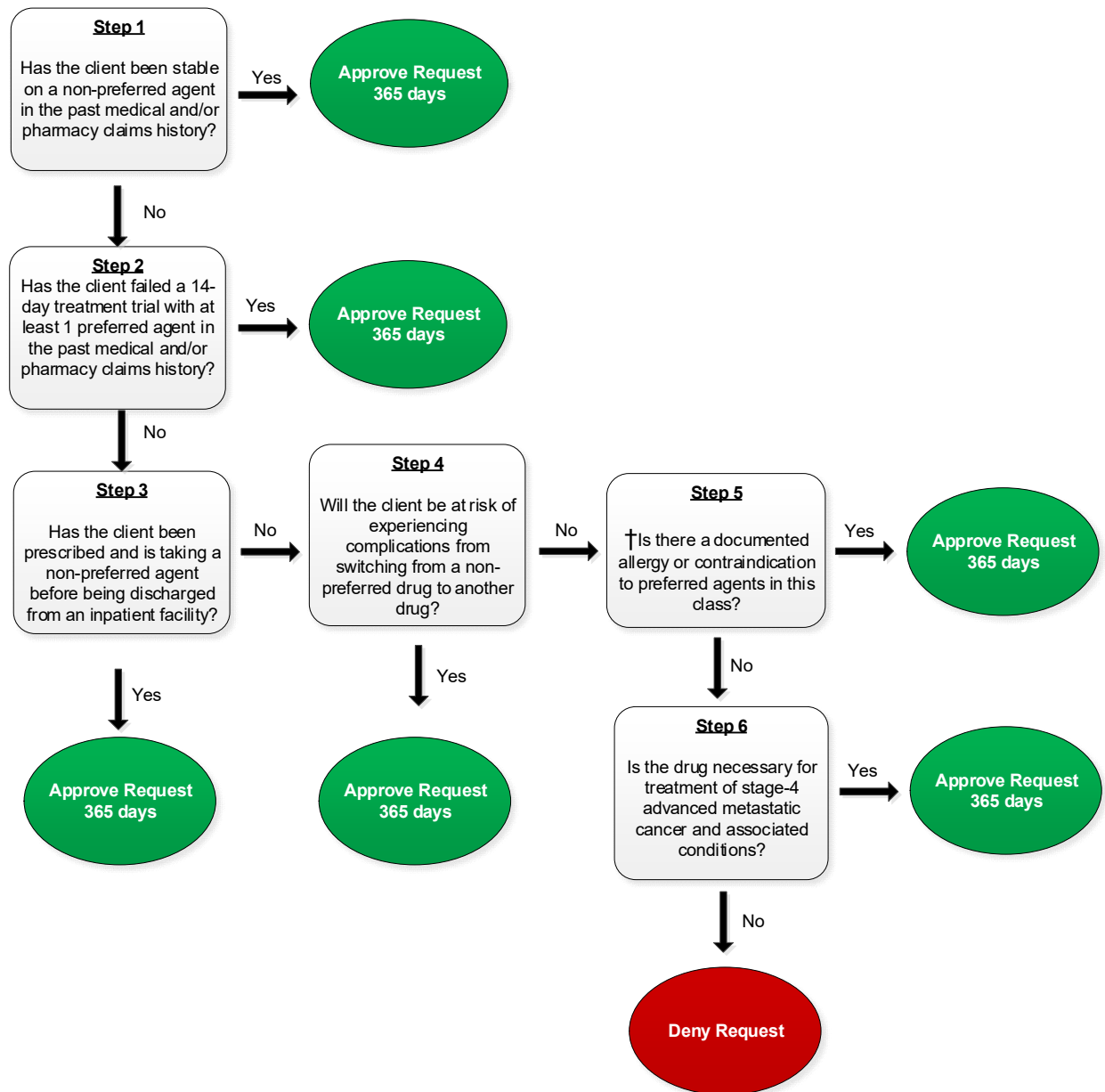
## Antipsychotics Prior Authorization Criteria

1. Has the client been stable on a non-preferred in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Has the client been prescribed and is taking a non-preferred agent before being discharged from an inpatient facility?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #4)
4. Will the client be at risk of experiencing complications from switching from a non-preferred drug to another drug?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #5)
5. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #6)
6. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

# Antipsychotics

## Prior Authorization Criteria



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

## Antipsychotics Alternate Therapies

### Preferred Antipsychotics

GCN	Drug Name
54058	ABILIFY ASIMTUFII 720MG/2.4ML
54059	ABILIFY ASIMTUFII 960MG/3.2ML
37681	ABILIFY MAINTENA ER 300MG SYR
34284	ABILIFY MAINTENA ER 300MG VL
37682	ABILIFY MAINTENA ER 400MG SYR
34285	ABILIFY MAINTENA ER 400MG VL
18537	ARIPIPRAZOLE 10MG TABLET
18538	ARIPIPRAZOLE 15MG TABLET
18539	ARIPIPRAZOLE 20MG TABLET
26305	ARIPIPRAZOLE 2MG TABLET
18541	ARIPIPRAZOLE 30MG TABLET
20173	ARIPIPRAZOLE 5MG TABLET
43488	ARISTADA ER 1064MG/3.9ML SYR
39726	ARISTADA ER 440MG/1.6ML SYRN
39727	ARISTADA ER 662MG/2.4ML SYRN
39728	ARISTADA ER 882MG/3.2ML SYRN
44941	ARISTADA INITIO ER 675MG/2.4
52616	CAPLYTA 10.5MG CAPSULE
52617	CAPLYTA 21MG CAPSULE
47492	CAPLYTA 42MG CAPSULE
14434	CHLORPROMAZINE 100MG TABLET
14431	CHLORPROMAZINE 10MG TABLET
14435	CHLORPROMAZINE 200MG TABLET
14432	CHLORPROMAZINE 25MG TABLET
14433	CHLORPROMAZINE 50MG TABLET
14390	CHLORPROMAZINE 100 MG/ML CONC
14331	CHLORPROMAZINE 25 MG/ML AMP
14391	CHLORPROMAZINE 30 MG/ML CONC
31672	CLOZAPINE 200MG TABLET
18141	CLOZAPINE 25MG TABLET
18143	CLOZAPINE 50MG TABLET

18142	CLOZAPINE100MG TABLET
14603	FLUPHENAZINE 10MG TABLET
14602	FLUPHENAZINE 1MG TABLET
14604	FLUPHENAZINE 2.5MG TABLET
14580	FLUPHENAZINE 25MG/5ML ELIXIR
14605	FLUPHENAZINE 5MG TABLET
14590	FLUPHENAZINE 5MG/ML CONCENTRATE
14571	FLUPHENAZINE 2.5 MG/ML VIAL
15530	HALOPERIDOL 0.5MG TABLET
15532	HALOPERIDOL 10MG TABLET
15531	HALOPERIDOL 1MG TABLET
15534	HALOPERIDOL 20MG TABLET
15533	HALOPERIDOL 2MG TABLET
15535	HALOPERIDOL 5MG TABLET
15520	HALOPERIDOL LAC 2 MG/ML CONC
15520	HALOPERIDOL LAC 10 MG/5 ML CUP
50889	INVEGA HAFYERA 1,092MG/3.5ML
50891	INVEGA HAFYERA 1,560MG/5ML
27416	INVEGA SUSTENNA 117MG/0.75ML
27417	INVEGA SUSTENNA 156MG/ML SYRG
27418	INVEGA SUSTENNA 234MG/1.5ML
27414	INVEGA SUSTENNA 39MG/0.25ML
27415	INVEGA SUSTENNA 78MG/0.5ML
38697	INVEGA TRINZA 273MG/0.88ML
38698	INVEGA TRINZA 410MG/1.32ML
38699	INVEGA TRINZA 546MG/1.75ML
38702	INVEGA TRINZA 819MG/2.63ML
33147	LURASIDONE HCL 120MG TABLET
31226	LURASIDONE HCL 20MG TABLET
29366	LURASIDONE HCL 40MG TABLET
35192	LURASIDONE HCL 60MG TABLET
29367	LURASIDONE HCL 80MG TABLET
44963	NUPLAZID 34MG CAPSULE
15082	OLANZAPINE 10MG TABLET
15085	OLANZAPINE 15MG TABLET
15084	OLANZAPINE 2.5MG TABLET
15086	OLANZAPINE 20MG TABLET
15083	OLANZAPINE 5MG TABLET



15081	OLANZAPINE 7.5MG TABLET
92008	OLANZAPINE ODT 10MG TABLET
34022	OLANZAPINE ODT 15MG TABLET
34023	OLANZAPINE ODT 20MG TABLET
92007	OLANZAPINE ODT 5MG TABLET
14650	PERPHENAZINE 16MG TABLET
14651	PERPHENAZINE 2MG TABLET
14652	PERPHENAZINE 4MG TABLET
14653	PERPHENAZINE 8MG TABLET
16678	PERPHENAZINE/AMITRIPTYLINE 4-50MG TABLET
16674	PERPHENAZINE/AMITRIPTYLINE HCL 2-10MG TABLET
16676	PERPHENAZINE/AMITRIPTYLINE HCL 2-25MG TABLET
16675	PERPHENAZINE/AMITRIPTYLINE HCL 4-10MG TABLET
16677	PERPHENAZINE/AMITRIPTYLINE HCL 4-25MG TABLET
45128	PERSERIS ER 120MG SYRINGE KIT
45127	PERSERIS ER 90MG SYRINGE KIT
26409	QUETIAPINE 50MG TABLET
67662	QUETIAPINE FUMARATE 100MG TABLET
93088	QUETIAPINE 150 MG TABLET
67663	QUETIAPINE FUMARATE 200MG TABLET
67661	QUETIAPINE FUMARATE 25MG TABLET
67665	QUETIAPINE FUMARATE 300MG TABLET
26411	QUETIAPINE FUMARATE 400MG TABLET
38278	REXULTI 0.25 MG TABLET
38476	REXULTI 0.5 MG TABLET
38589	REXULTI 1 MG TABLET
38609	REXULTI 2 MG TABLET
38618	REXULTI 3 MG TABLET
38619	REXULTI 4 MG TABLET
92872	RISPERIDONE 0.25MG TABLET
92892	RISPERIDONE 0.5MG TABLET
16136	RISPERIDONE 1MG TABLET
16135	RISPERIDONE 1MG/ML SOLUTION
16137	RISPERIDONE 2MG TABLET
16138	RISPERIDONE 3MG TABLET
16139	RISPERIDONE 4MG TABLET
14883	THIORIDAZINE 100MG TABLET
14882	THIORIDAZINE 10MG TABLET

14880	THIORIDAZINE 25MG TABLET
14881	THIORIDAZINE 50MG TABLET
15691	THIOTHIXENE 10MG CAPSULE
15690	THIOTHIXENE 1MG CAPSULE
15692	THIOTHIXENE 2MG CAPSULE
15694	THIOTHIXENE 5MG CAPSULE
14831	TRIFLUOPERAZINE 10MG TABLET
14830	TRIFLUOPERAZINE 1MG TABLET
14832	TRIFLUOPERAZINE 2MG TABLET
14833	TRIFLUOPERAZINE 5MG TABLET
54107	UZEDY ER 250MG/0.7ML SYRINGE
54098	UZEDY ER 50MG/0.14ML SYRINGE
54099	UZEDY ER 75MG/0.21ML SYRINGE
54104	UZEDY ER 100MG/0.28ML SYRING
51479	UZEDY ER 125MG/0.35ML SYRING
54105	UZEDY ER 150MG/0.42ML SYRING
54106	UZEDY ER 200MG/0.56MML SYRING
39579	VRAYLAR 1.5MG CAPSULE
40683	VRAYLAR 1.5MG-3MG PACK
39582	VRAYLAR 3MG CAPSUE
39583	VRAYLAR 4.5MG CAPSULE
39584	VRAYLAR 6 MG CAPSULE
13331	ZIPRASIDONE HCL 20MG CAPSULE
13332	ZIPRASIDONE HCL 40MG CAPSULE
13333	ZIPRASIDONE HCL 60MG CAPSULE
13334	ZIPRASIDONE HCL 80MG CAPSULE

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

# Antipsychotics, Long-Acting Injectables

## Antipsychotics, Long-Acting Injectables

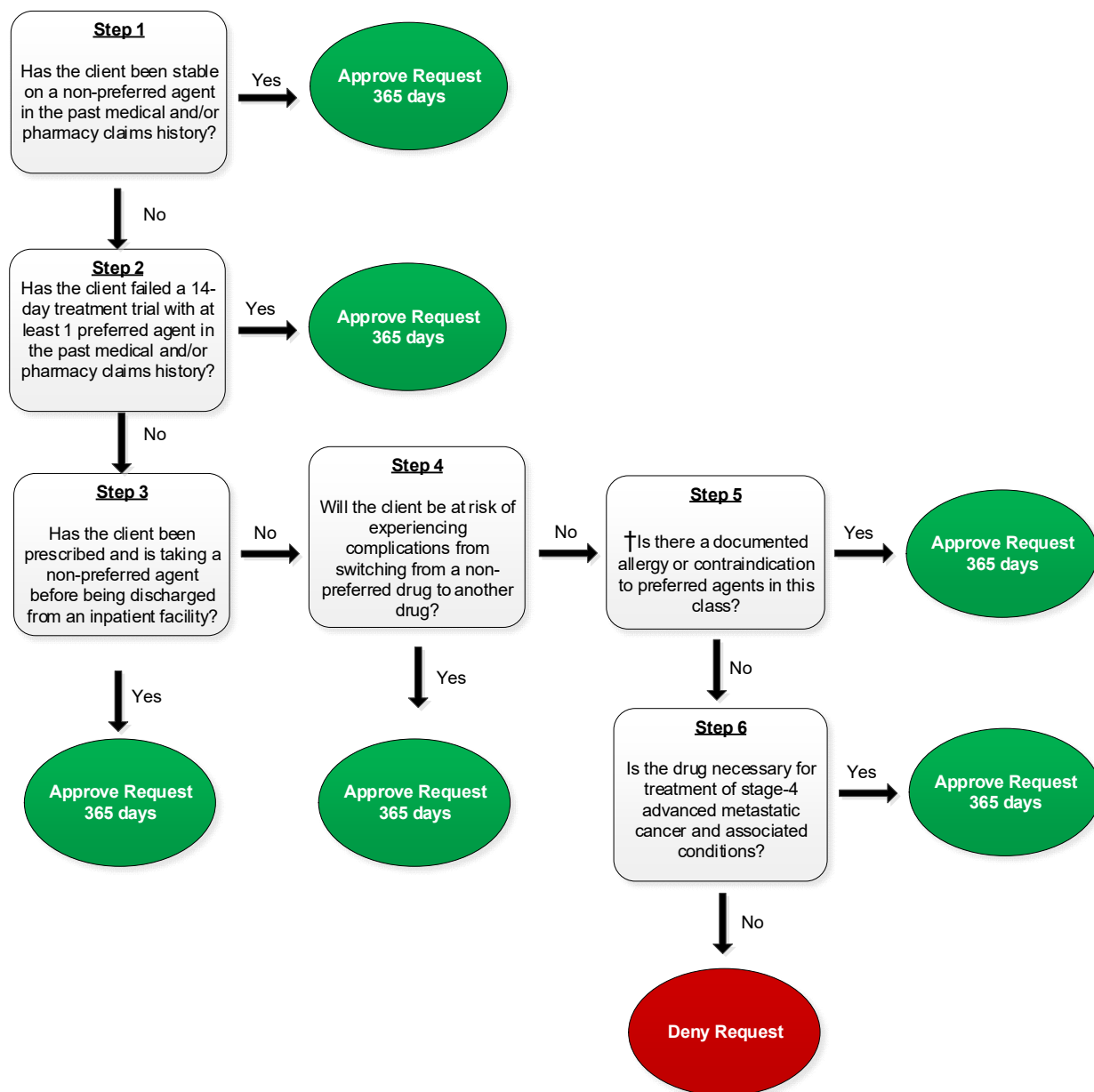
### Prior Authorization Criteria

1. Has the client been stable on 1 non-preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Has the client been prescribed and is taking a non-preferred agent before being discharged from an inpatient facility?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #4)
4. Will the client be at risk of experiencing complications from switching from a non-preferred drug to another drug?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #5)
5. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #6)
6. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

# Antipsychotics, Long-Acting Injectables

## Prior Authorization Criteria



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

## Antipsychotics, Long-Acting Injectables Alternate Therapies

### Preferred Long-Acting Injectable Antipsychotics

GCN	Drug Name
54058	ABILIFY ASIMTUFII 720 MG/2.4ML
54059	ABILIFY ASIMTUFII 960 MG/3.2ML
37681	ABILIFY MAINTENA ER 300MG SYRINGE
34284	ABILIFY MAINTENA ER 300MG VIAL
37682	ABILIFY MAINTENA ER 400MG SYRINGE
34285	ABILIFY MAINTENA ER 400MG VIAL
43488	ARISTADA ER 1064MG/3.9ML SYRN
39726	ARISTADA ER 441MG/1.6ML SYRN
39727	ARISTADA ER 662MG/2.4ML SYRN
39728	ARISTADA ER 882MG/3.2 SYRN
44941	ARISTADA INITIO ER 675MG/2.4ML
14390	CHLORPROMAZINE 100 MG/ML CONC
14331	CHLORPROMAZINE 25 MG/ML AMP
14391	CHLORPROMAZINE 30 MG/ML CONC
14580	FLUPHENAZINE 2.5 MG/5 ML ELIX
14571	FLUPHENAZINE 2.5 MG/ML VIAL
14590	FLUPHENAZINE 5 MG/ML CONC
14801	HALOPERIDOL DEC 100MG/ML AMP
14781	HALOPERIDOL DEC 100MG/ML VIAL
14800	HALOPERIDOL DEC 50MG/ML AMP
14780	HALOPERIDOL DEC 50MG/ML VIAL
15520	HALOPERIDOL LAC 10 MG/5 ML CUP
50889	INVEGA HAFYERA 1,092MG/3.5ML
50891	INVEGA HAFYERA 1,560MG/5ML
27416	INVEGA SUSTENNA 117MG PREFILLED SYRINGE
27417	INVEGA SUSTENNA 156MG PREFILLED SYRINGE
27418	INVEGA SUSTENNA 234MG PREFILLED SYRINGE
27414	INVEGA SUSTENNA 39MG PREFILLED SYRINGE
27415	INVEGA SUSTENNA 78MG PREFILLED SYRINGE
38697	INVEGA TRINZA 273MG/0.875ML
38698	INVEGA TRINZA 410MG/1.315ML
38699	INVEGA TRINZA 546MG/1.75ML

GCN	Drug Name
54058	ABILIFY ASIMTUFII 720 MG/2.4ML
54059	ABILIFY ASIMTUFII 960 MG/3.2ML
38702	INVEGA TRINZA 819MG/2.625ML
45128	PERSERIS ER 120 MG SYRINGE KIT
45127	PERSERIS ER 90 MG POWDER SYRNG
98414	RISPERDAL CONSTA 12.5MG SYRINGE
20217	RISPERDAL CONSTA 25MG SYRINGE
20218	RISPERDAL CONSTA 37.5MG SYRINGE
20219	RISPERDAL CONSTA 50MG SYRINGE
16135	RISPERIDONE 1 MG/ML SOLUTION
54104	UZEDY ER 100 MG/0.28 ML SYRING
54105	UZEDY ER 150 MG/0.42 ML SYRING
54106	UZEDY ER 200 MG/0.56 ML SYRING
54107	UZEDY ER 250 MG/0.7 ML SYRINGE
54098	UZEDY ER 50 MG/0.14 ML SYRINGE
54099	UZEDY ER 75 MG/0.21 ML SYRINGE
51479	UZEDY ER 125 MG/0.35 ML SYRING
40683	VRAYLAR 1.5 MG-3 MG PACK

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

## Antivirals, Oral/Nasal

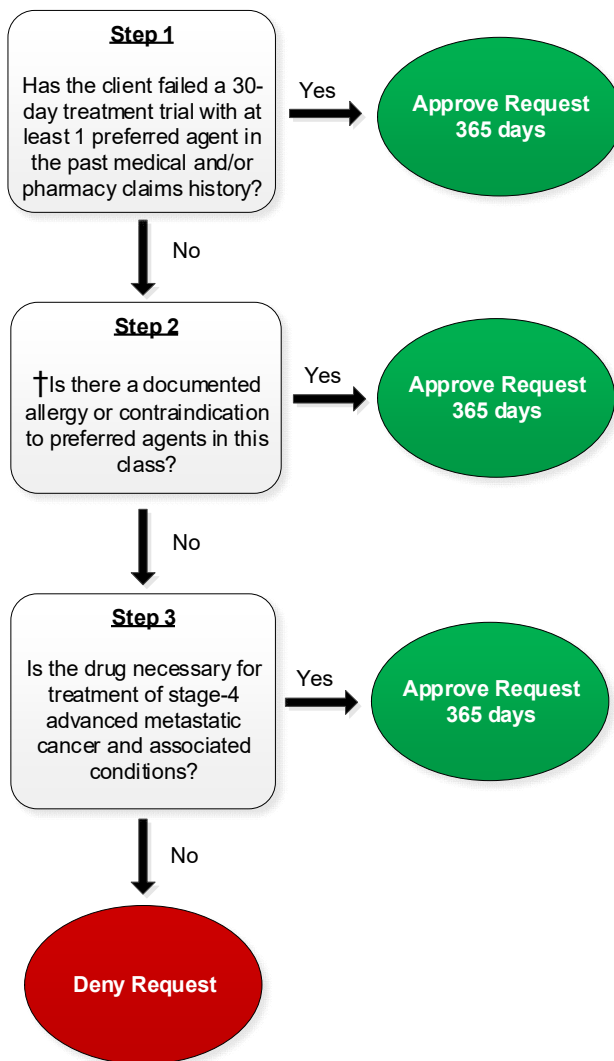


## Antivirals, Oral/Nasal Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Antivirals, Oral/Nasal Prior Authorization Criteria



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

## Antivirals, Oral/Nasal Alternate Therapies

### Preferred Oral/Nasal Antivirals

GCN	Drug Name
43790	ACYCLOVIR 200MG CAPSULE
43731	ACYCLOVIR 200MG/5ML SUSP
33593	ACYCLOVIR 200 MG/5 ML SUSP
13724	ACYCLOVIR 400MG TABLET
13721	ACYCLOVIR 800MG TABLET
14101	FAMCICLOVIR 125MG TABLET
14109	FAMCICLOVIR 250MG TABLET
14108	FAMCICLOVIR 500MG TABLET
29729	OSELTAMIVIR 6 MG/ML SUSPENSION
98980	OSELTAMIVIR PHOS 30 MG CAPSULE
98981	OSELTAMIVIR PHOS 45 MG CAPSULE
73441	OSELTAMIVIR PHOS 75 MG CAPSULE
13742	VALACYCLOVIR HCL 1 GRAM TABLET
13740	VALACYCLOVIR HCL 500MG TABLET
14453	VALCYTE 50MG/ML SOLUTION
13088	VALGANCICLOVIR 450MG TABLET

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

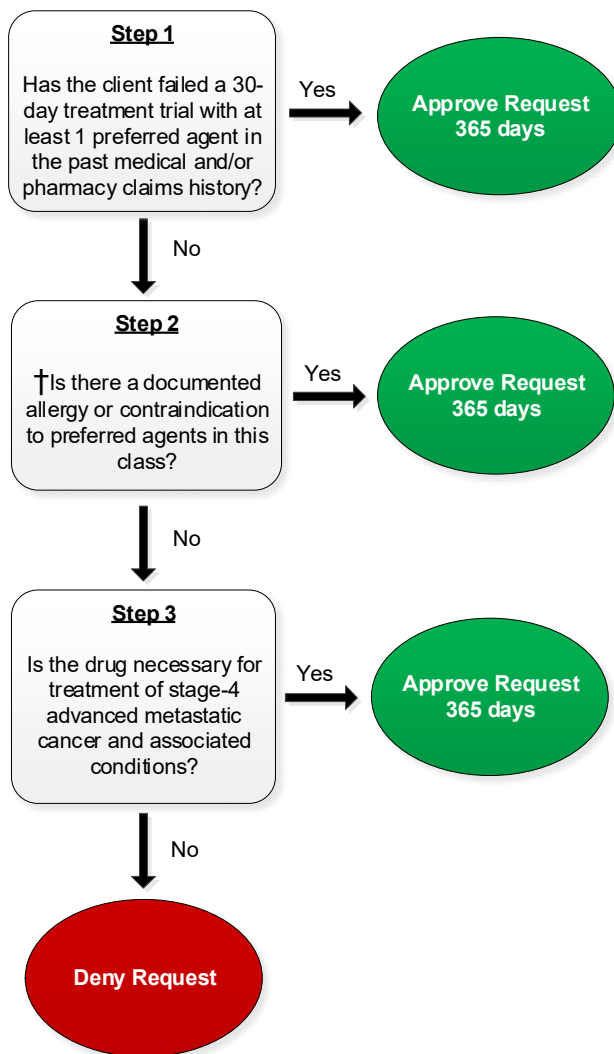
## Antivirals, Topical

## Antivirals, Topical Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Antivirals, Topical Prior Authorization Criteria



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

## Antivirals, Topical Alternate Therapies

### Preferred Topical Antivirals

GCN	Drug Name
37051	DENAVIR 1% CREAM
62420	ZOVIRAX 5% CREAM
31640	ZOVIRAX 5% OINTMENT

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

# Anxiolytics



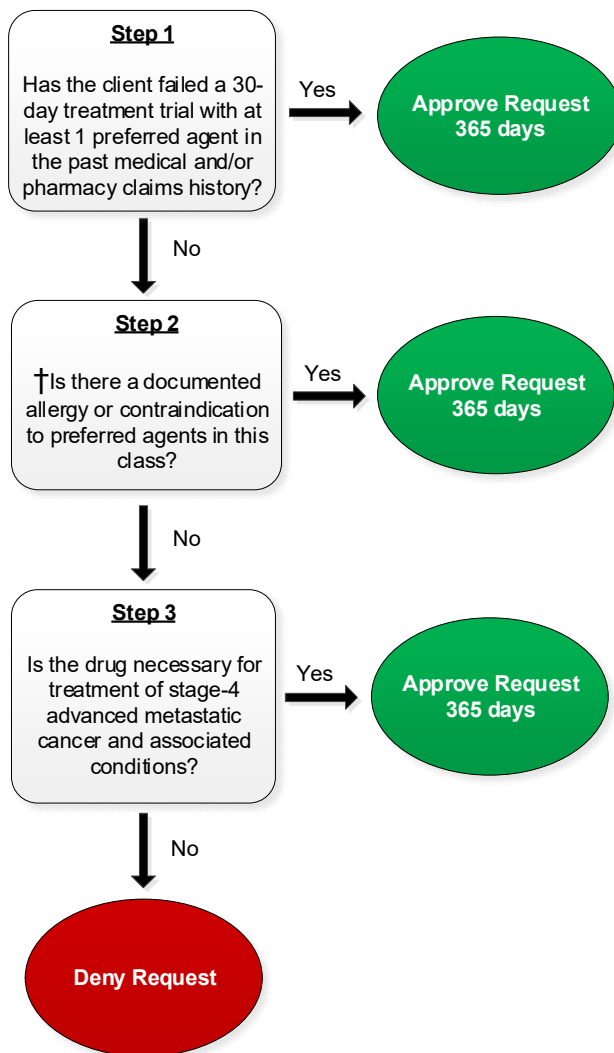
## Anxiolytics

### Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Anxiolytics Prior Authorization Criteria



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

## Anxiolytics Alternate Therapies

### Preferred Anxiolytics

GCN	Drug Name
14260	ALPRAZOLAM 0.25MG TABLET
14261	ALPRAZOLAM 0.5MG TABLET
14262	ALPRAZOLAM 1MG TABLET
14263	ALPRAZOLAM 2MG TABLET
28891	BUSPIRONE HCL 10MG TABLET
28892	BUSPIRONE HCL 15MG TABLET
92121	BUSPIRONE HCL 30MG TABLET
28890	BUSPIRONE HCL 5MG TABLET
13037	BUSPIRONE HCL 7.5MG TABLET
14031	CHLORDIAZEPOXIDE 10MG CAPSULE
14032	CHLORDIAZEPOXIDE 25MG CAPSULE
14033	CHLORDIAZEPOXIDE 5MG CAPSULE
14090	CLORAZEPATE 15MG TABLET
14092	CLORAZEPATE 3.75MG TABLET
14093	CLORAZEPATE 7.5MG TABLET
14220	DIAZEPAM 10MG TABLET
14221	DIAZEPAM 2MG TABLET
14222	DIAZEPAM 5MG TABLET
45560	DIAZEPAM 5MG/5ML SOLUTION
31551	DIAZEPAM 5 MG/5 ML ORAL CUP
14160	LORAZEPAM 0.5MG TABLET
14161	LORAZEPAM 1MG TABLET
14162	LORAZEPAM 2MG TABLET
19601	LORAZEPAM INTENSOL 2MG/ML

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

## Beta Blockers (Oral)

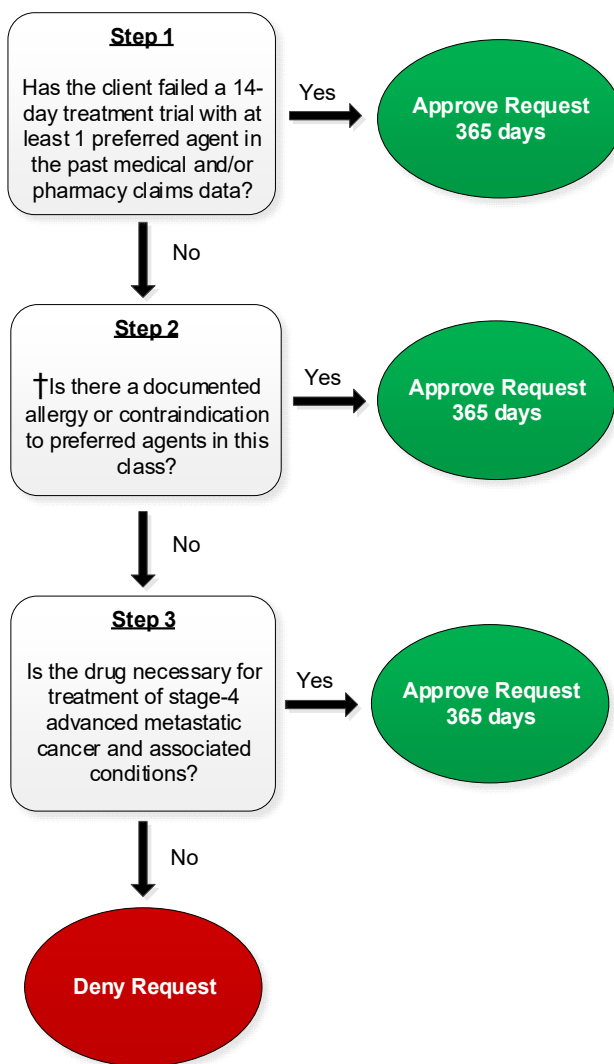
## Beta Blockers

### Prior Authorization Criteria

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Beta Blockers Prior Authorization Criteria



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

## Beta Blockers Alternate Therapies

### Preferred Beta Blockers

GCN	Drug Name
26460	ACEBUTOLOL 200MG CAPSULE
26461	ACEBUTOLOL 400MG CAPSULE
20660	ATENOLOL 100MG TABLET
20662	ATENOLOL 25MG TABLET
20661	ATENOLOL 50MG TABLET
66991	ATENOLOL/CHLORTHALIDONE 100-25MG TABLET
66990	ATENOLOL/CHLORTHALIDONE 50-25MG TABLET
63820	BISOPROLOL FUMARATE 10 MG TAB
63821	BISOPROLOL FUMARATE 5 MG TABLET
45063	BISOPROLOL FUMARATE/HCTZ 10-6.25MG TABLET
45061	BISOPROLOL FUMARATE/HCTZ 2.5-6.25MG TABLET
45062	BISOPROLOL FUMARATE/HCTZ 5-6.25MG TABLET
01552	CARVEDILOL 12.5MG TABLET
01551	CARVEDILOL 25MG TABLET
01553	CARVEDILOL 3.125MG TABLET
01554	CARVEDILOL 6.25MG TABLET
97596	COREG CR 10 MG CAPSULE
97597	COREG CR 20 MG CAPSULE
97598	COREG CR 40 MG CAPSULE
97599	COREG CR 80 MG CAPSULE
36526	HEMANGEOL 4.28MG/ML ORAL SOLN
10342	LABETALOL HCL 100MG TABLET
10341	LABETALOL HCL 200MG TABLET
10340	LABETALOL HCL 300MG TABLET
20742	METOPROLOL SUCCINATE ER 100MG TABLET
20743	METOPROLOL SUCCINATE ER 200MG TABLET
12947	METOPROLOL SUCCINATE ER 25MG TABLET
20741	METOPROLOL SUCCINATE ER 50MG TABLET
20641	METOPROLOL TARTRATE 100MG TABLET
17734	METOPROLOL TARTRATE 25MG TABLET
37653	METOPROLOL TARTRATE 37.5 MG TABLET

20642	METOPROLOL TARTRATE 50MG TABLET
37656	METOPROLOL TARTRATE 75 MG TABLET
20630	PROPRANOLOL 10MG TABLET
20631	PROPRANOLOL 20MG TABLET
45260	PROPRANOLOL 20MG/5ML SOLUTION
20632	PROPRANOLOL 40MG TABLET
45261	PROPRANOLOL 40MG/5ML SOLUTION
20633	PROPRANOLOL 60MG TABLET
20634	PROPRANOLOL 80MG TABLET
39516	SORINE 120 MG TABLET
39511	SORINE 160 MG TABLET
39512	SORINE 80 MG TABLET
39513	SORINE 240 MG TABLET

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



## Bile Salts

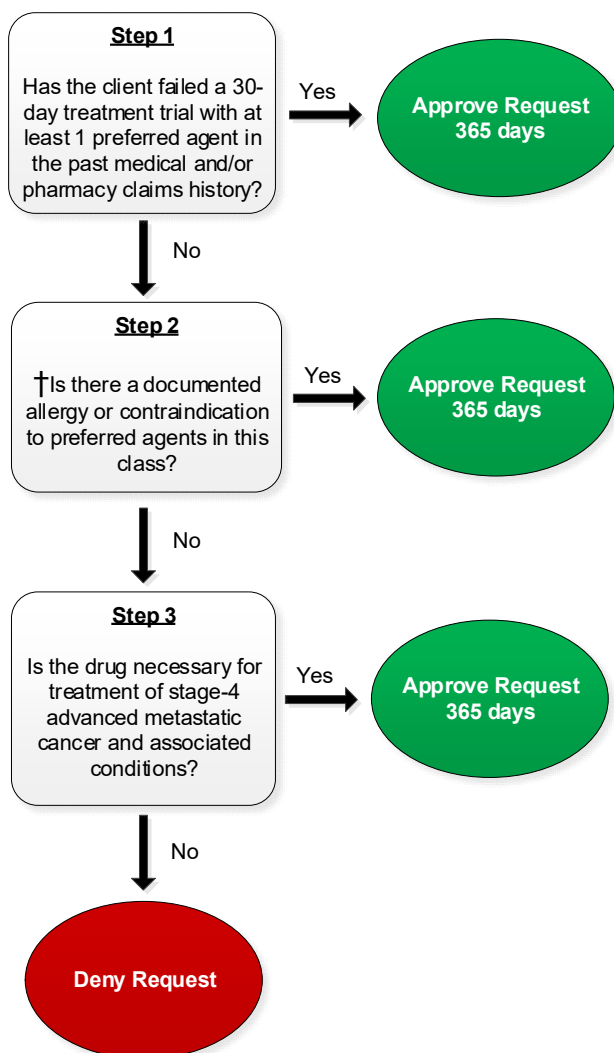
## Bile Salts

### Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Bile Salts Prior Authorization Criteria



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

## Bile Salts Alternate Therapies

### Preferred Bile Salts

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

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

## Bladder Relaxant Preparations

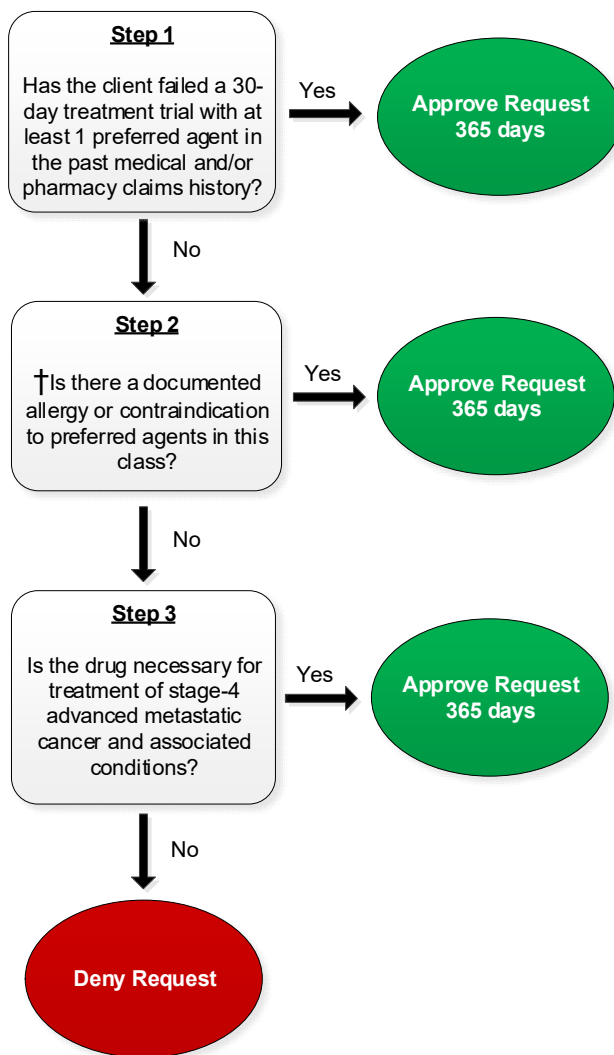
## Bladder Relaxant Preparations

### Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Bladder Relaxant Preparations Prior Authorization Criteria



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

## Bladder Relaxant Preparations Alternate Therapies

### Preferred Bladder Relaxant Preparations

GCN	Drug Name
32766	MYRBETRIQ ER 25 MG TABLET
32767	MYRBETRIQ ER 50 MG TABLET
49454	MYRBETRIQ ER 8 MG/ML SUSP
19380	OXYBUTYNIN 5 MG TABLET
19370	OXYBUTYNIN 5 MG/5 ML SOLUTION
19389	OXYBUTYNIN CL ER 10 MG TABLET
93557	OXYBUTYNIN CL ER 15 MG TABLET
19388	OXYBUTYNIN CL ER 5 MG TABLET
23277	SOLIFENACIN 10 MG TABLET
23276	SOLIFENACIN 5 MG TABLET
99711	TOVIAZ ER 4 MG TABLET
99712	TOVIAZ ER 8 MG TABLET

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



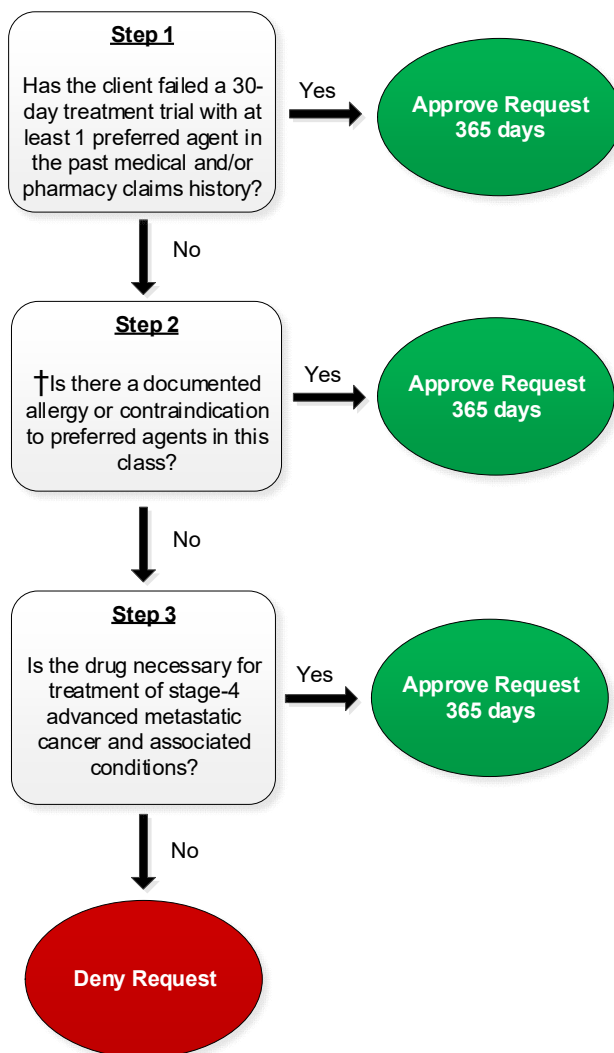
## **Bone Resorption Suppression and Related Agents**

## **Bone Resorption Suppression and Related Agents Prior Authorization Criteria**

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Bone Resorption Suppression and Related Agents Prior Authorization Criteria



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

## Bone Resorption Suppression and Related Agents Alternate Therapies

### Preferred Bone Resorption Suppression and Related Agents

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

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

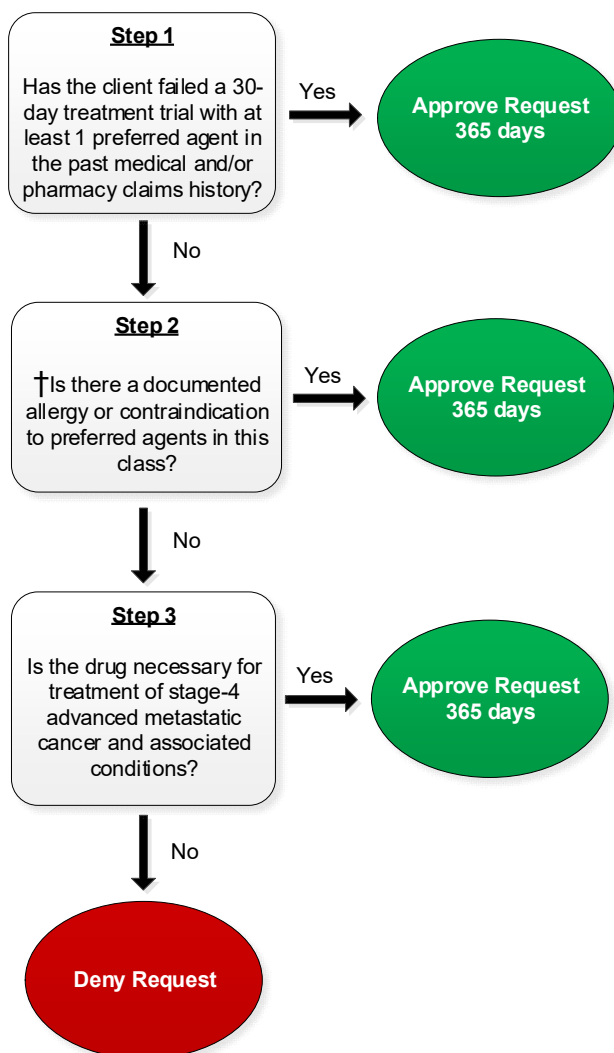
## BPH Agents

## BPH Agents Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## BPH Agents Prior Authorization Criteria



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

## BPH Agents Alternate Therapies

### Preferred BPH Agents

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

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



## Bronchodilators, Beta Agonist

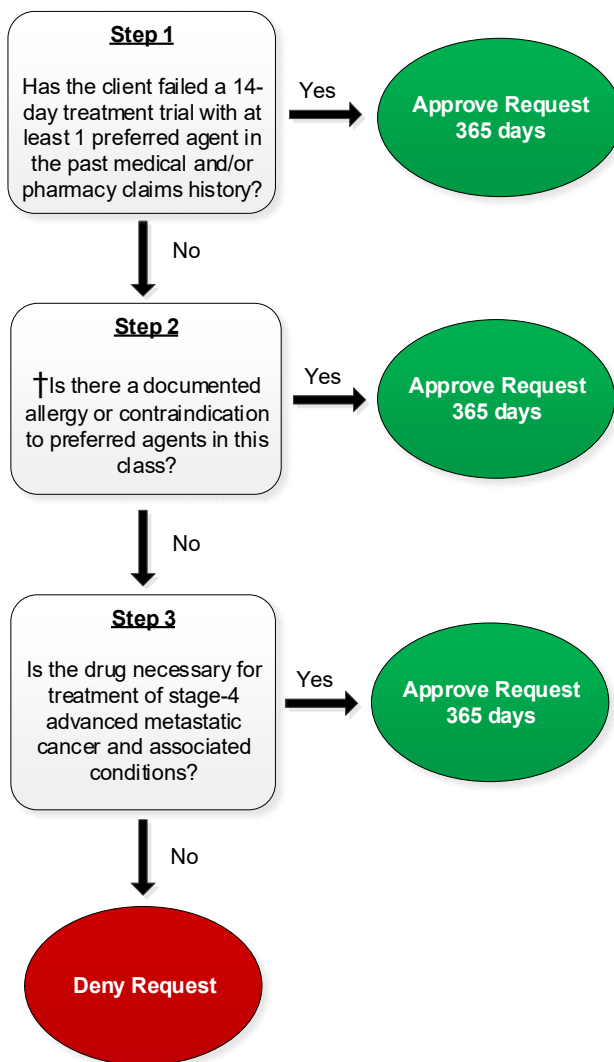
## Bronchodilators, Beta Agonist

### Prior Authorization Criteria

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Bronchodilators, Beta Agonist Prior Authorization Criteria



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

## Bronchodilators, Beta Agonist Alternate Therapies

### Preferred Bronchodilators, Beta Agonist

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

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

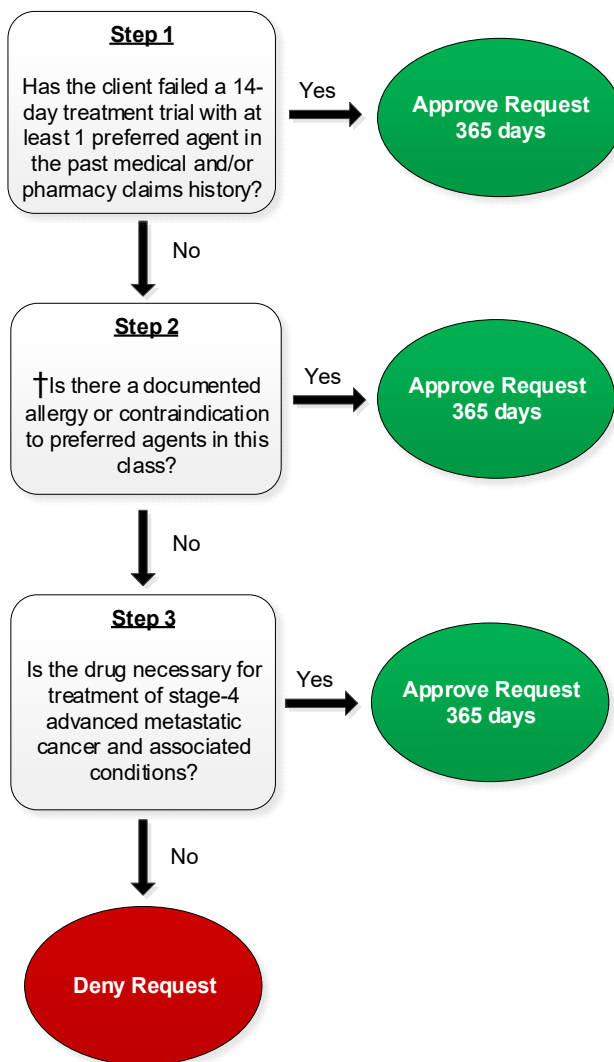
## Calcium Channel Blockers (Oral)

## Calcium Channel Blockers (Oral) Prior Authorization Criteria

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Calcium Channel Blockers (Oral) Prior Authorization Criteria



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

## Calcium Channel Blockers (Oral) Alternate Therapies

### Preferred Calcium Channel Blockers

GCN	Drug Name
02682	AMLODIPINE BESYLATE 10 MG TAB
02681	AMLODIPINE BESYLATE 2.5 MG TAB
02683	AMLODIPINE BESYLATE 5 MG TAB
02326	CARTIA XT 120 MG CAPSULE
02326	DILTIAZEM 24HR ER 120MG CAPSULE
02323	CARTIA XT 180 MG CAPSULE
02323	DILTIAZEM 24HR ER 180MG CAPSULE
02324	CARTIA XT 240 MG CAPSULE
02324	DILTIAZEM 24 HR ER 240MG CAPSULE
02325	CARTIA XT 300 MG CAPSULE
02325	DILTIAZEM 24HR ER 300MG CAPSULE
07463	DILT XR 120 MG CAPSULE
07461	DILT XR 180 MG CAPSULE
07462	DILT XR 240 MG CAPSULE
02363	DILTIAZEM 120 MG TABLET
29354	DILTIAZEM 125MG/125ML-0.9%NACL
02321	DILTIAZEM 12HR ER 120 MG CAP
02322	DILTIAZEM 12HR ER 60 MG CAP
02320	DILTIAZEM 12HR ER 90 MG CAP
07460	DILTIAZEM 24H ER(CD) 360 MG CP
02330	DILTIAZEM 24HR ER 120 MG CAP
02330	TAZTIA XT 120MG CAPSULE
02329	DILTIAZEM 24HR ER 180 MG CAP
02329	TAZTIA XT 180MG CAPSULE
02332	DILTIAZEM 24HR ER 240 MG CAP
02332	TAZTIA XT 240MG CAPSULE
02333	DILTIAZEM 24HR ER 300 MG CAP
02333	TAZTIA XT 300MG CAPSULE
02328	DILTIAZEM 24HR ER 360 MG CAP
02328	TAZTIA XT 360MG CAPSULE
94691	DILTIAZEM 24HR ER 420 MG CAP
02360	DILTIAZEM 30 MG TABLET
02361	DILTIAZEM 60 MG TABLET
02362	DILTIAZEM 90 MG TABLET



GCN	Drug Name
02622	FELODIPINE ER 10 MG TABLET
02620	FELODIPINE ER 2.5 MG TABLET
02621	FELODIPINE ER 5 MG TABLET
46652	KATERZIA 1 MG/ML SUSPENSION
02221	NIFEDIPINE ER 30 MG TABLET
02226	NIFEDIPINE ER 30 MG TABLET
02222	NIFEDIPINE ER 60 MG TABLET
02227	NIFEDIPINE ER 60 MG TABLET
02223	NIFEDIPINE ER 90 MG TABLET
02228	NIFEDIPINE ER 90 MG TABLET
02341	VERAPAMIL 120 MG TABLET
47110	VERAPAMIL 40 MG TABLET
02342	VERAPAMIL 80 MG TABLET
03003	VERAPAMIL ER 120 MG CAPSULE
32472	VERAPAMIL ER 120 MG TABLET
03001	VERAPAMIL ER 180 MG CAPSULE
32471	VERAPAMIL ER 180 MG TABLET
03002	VERAPAMIL ER 240 MG CAPSULE
32470	VERAPAMIL ER 240 MG TABLET

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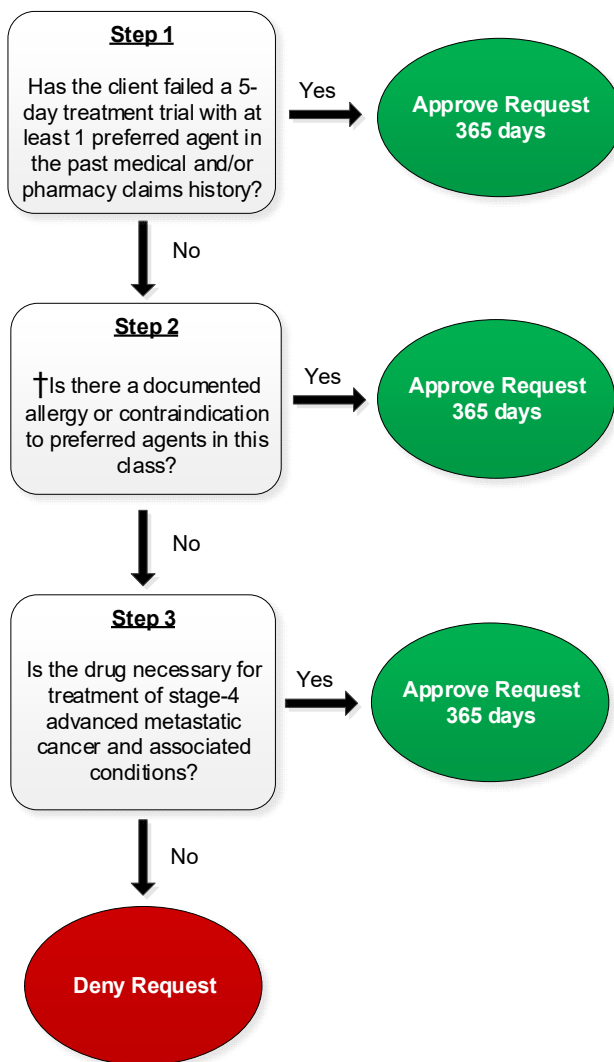
## Cephalosporins and Related Antibiotics

## **Cephalosporins and Related Antibiotics (Oral) Prior Authorization Criteria**

1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Cephalosporins and Related Antibiotics (Oral) Prior Authorization Criteria



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

## Cephalosporins and Related Antibiotics (Oral) Alternate Therapies

### Preferred Cephalosporins and Related Antibiotics

GCN	Drug Name
67154	AMOX-CLAV 200-28.5 MG/5 ML SUS
67070	AMOX-CLAV 250-125 MG TABLET
67151	AMOX-CLAV 250-62.5 MG/5 ML SUS
67153	AMOX-CLAV 400-57 MG/5 ML SUSP
67071	AMOX-CLAV 500-125 MG TABLET
28020	AMOX-CLAV 600-42.9 MG/5 ML SUS
67076	AMOX-CLAV 875-125 MG TABLET
45343	CEFADROXIL 250 MG/5 ML SUSP
45341	CEFADROXIL 500 MG CAPSULE
45344	CEFADROXIL 500 MG/5 ML SUSP
32232	CEFDINIR 125 MG/5 ML SUSP
23308	CEFDINIR 250 MG/5 ML SUSP
32231	CEFDINIR 300 MG CAPSULE
48821	CEFPODOXIME 100 MG TABLET
49302	CEFPODOXIME 100 MG/5 ML SUSP
48822	CEFPODOXIME 200 MG TABLET
49301	CEFPODOXIME 50 MG/5 ML SUSP
29291	CEFPROZIL 125 MG/5 ML SUSP
29271	CEFPROZIL 250 MG TABLET
29292	CEFPROZIL 250 MG/5 ML SUSP
29272	CEFPROZIL 500 MG TABLET
47281	CEFUROXIME AXETIL 250 MG TAB
47282	CEFUROXIME AXETIL 500 MG TAB
39811	CEPHALEXIN 125 MG/5 ML SUSP
39801	CEPHALEXIN 250 MG CAPSULE
39812	CEPHALEXIN 250 MG/5 ML SUSP
39802	CEPHALEXIN 500 MG CAPSULE
27016	CEPHALEXIN 750 MG CAPSULE

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

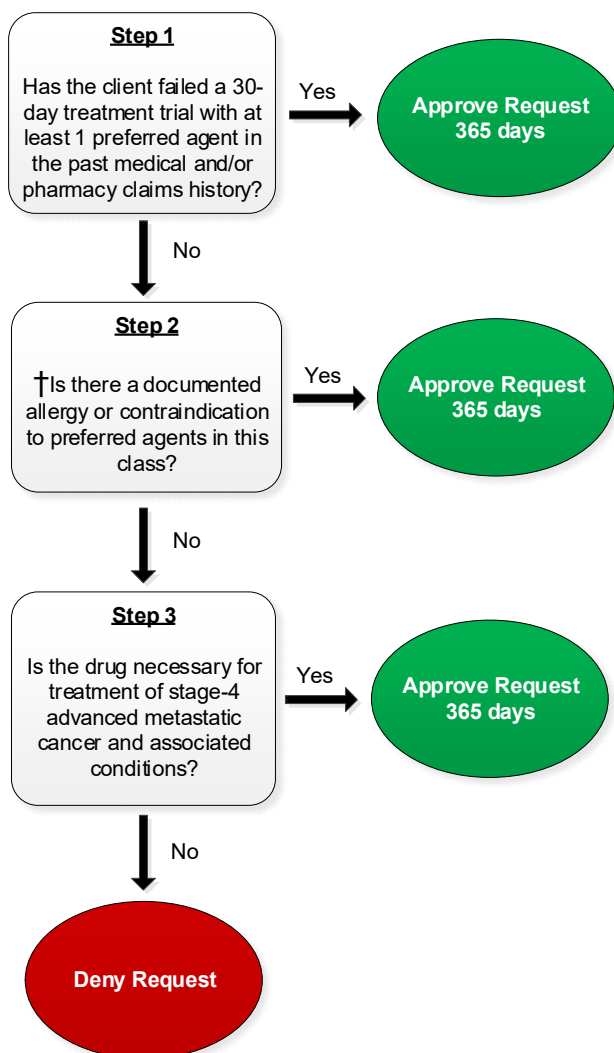
# Colony Stimulating Factors

## Colony Stimulating Factors Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Colony Stimulating Factors Prior Authorization Criteria



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



## Colony Stimulating Factors Alternate Therapies

### Preferred Colony Stimulating Factors

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

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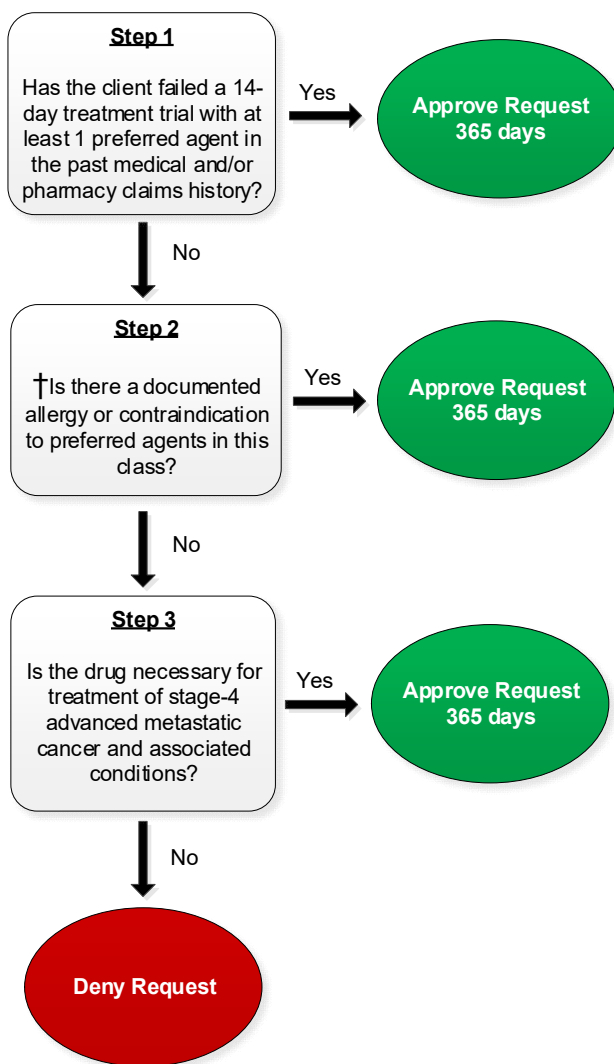
# COPD Agents

## COPD Agents Prior Authorization Criteria

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## COPD Agents Prior Authorization Criteria



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

## COPD Agents Alternate Therapies

### Preferred COPD Agents

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

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

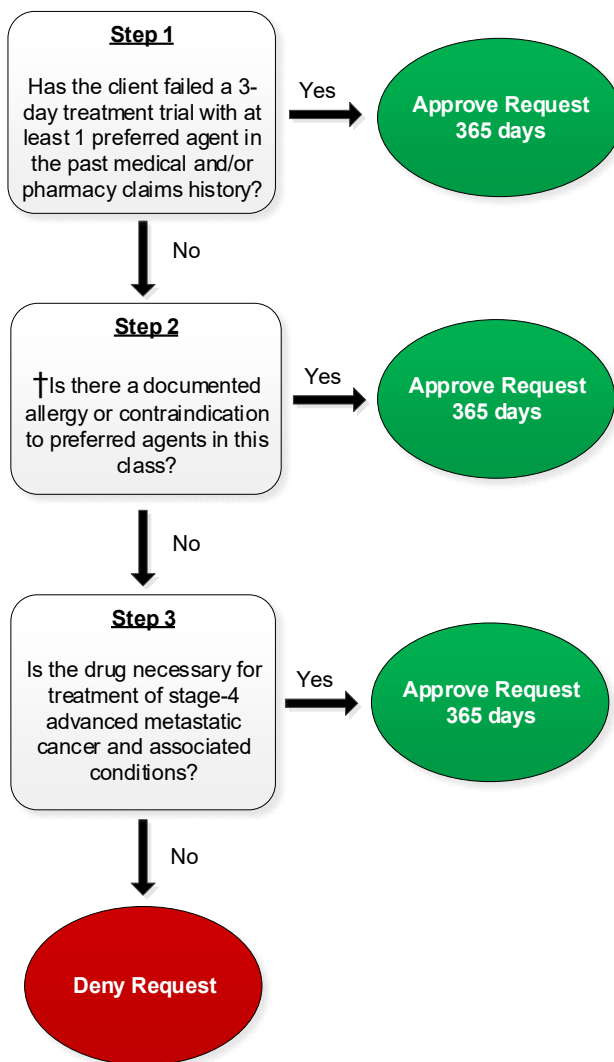
## Cough and Cold Agents

## Cough and Cold Non-Antitussive Prior Authorization Criteria

1. Has the client failed a 3-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Cough and Cold Non-Antitussive Prior Authorization Criteria



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



## Cough and Cold Non-Antitussive Alternate Therapies

### Preferred Cough and Cold Non-Antitussives

GCN	Drug Name
34062	12 HOUR NASAL RELIEF SPRAY
34124	4 WAY 1% NASAL SPRAY
02512	ADULT WAL-TUSSIN LIQUID
46711	ALA-HIST IR 2 MG TABLET
48628	ALAHIST PE 2-7.5 MG TABLET
85915	ALLERGY MULTI-SYMPTOM CAPLET
96445	APRODINE TABLET
18906	CHEST CONGEST RLF 400 MG TAB
27207	CHILD COLD-ALLERGY LIQUID
02512	CHILD MUCINEX CHEST CONGESTION
21827	COLD-SINUS RLF 200-30MG LIQCAP
02512	COUGH SYRUP 200MG/10ML
89731	CVS MUCUS D ER 1,200-120 MG TB
54980	CVS MUCUS D ER 600-60 MG TAB
98863	CVS MUCUS ER 1,200 MG TABLET
35905	CVS MUCUS ER 600 MG TABLET
14359	CVS SEVERE COUGH-COLD POWD PKT
25468	CVS SINUS HEADACHE PE CAPLET
25462	CVS SINUS PE-ALLERGY 4-10MG TB
26743	CVS SINUS RLF PRESS-PAIN CPLT
42022	DECONEX IR 385-10 MG TABLET
27207	DIMAPHEN ELIXIR
54250	ED BRON GP LIQUID
25462	ED-A-HIST 4MG-10MG TABLET
02482	EXPECTORANT 200 MG TABLET
02512	GUAIFENESIN 100MG/5ML SYRUP
54980	GUAIFENESIN-PSE ER 600-60MG TABLET
26743	HEAD CONGESTION-MUCUS CAPLET
98863	MUCINEX ER 1,200MG TABLET
35905	MUCINEX ER 600MG TABLET
26743	MUCINEX FAST-MAX COLD-SINUS TAB

GCN	Drug Name
50018	MUCINEX INSTASOOTH 7%-1% SPRY
26743	MUCINEX SINUS-MAX PRESSURE-PAIN
30574	MUCINEX SINUS-MAX SEVERE LIQ
18906	MUCUS RELIEF 400 MG TABLET
35905	MUCUS RELIEF ER 600MG TABLET
02512	MUCUS-CHEST CONG 200MG/10ML
34062	NASAL DECONGESTANT 0.05% SPRAY
46499	POLY HIST FORTE 10.5-10 MG TAB
02512	ROBAFEN 100MG/5ML LIQUID
27207	RYNEX PE LIQUID
02512	SILTUSSIN SA 100MG/5ML SYR
26743	SINUS CONGST-PAIN 325-200-5MG
34062	SM NASAL SPRAY 0.05%
44023	SUDOGEST COLD AND ALLERGY TAB
02512	TUSSIN 100MG/5ML SYRUP

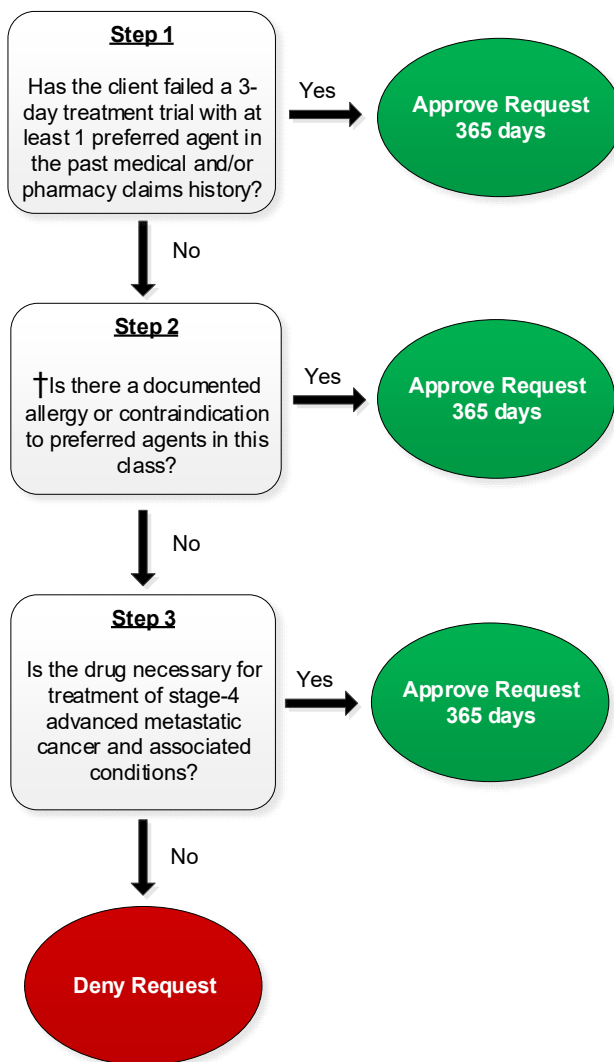
\* The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.

## Cough and Cold Narcotic Antitussive Prior Authorization Criteria

1. Has the client failed a 3-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Cough and Cold Narcotic Antitussive Prior Authorization Criteria



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

## Cough and Cold Narcotic Antitussive Alternate Therapies

### Preferred Cough and Cold, Narcotic Antitussives

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

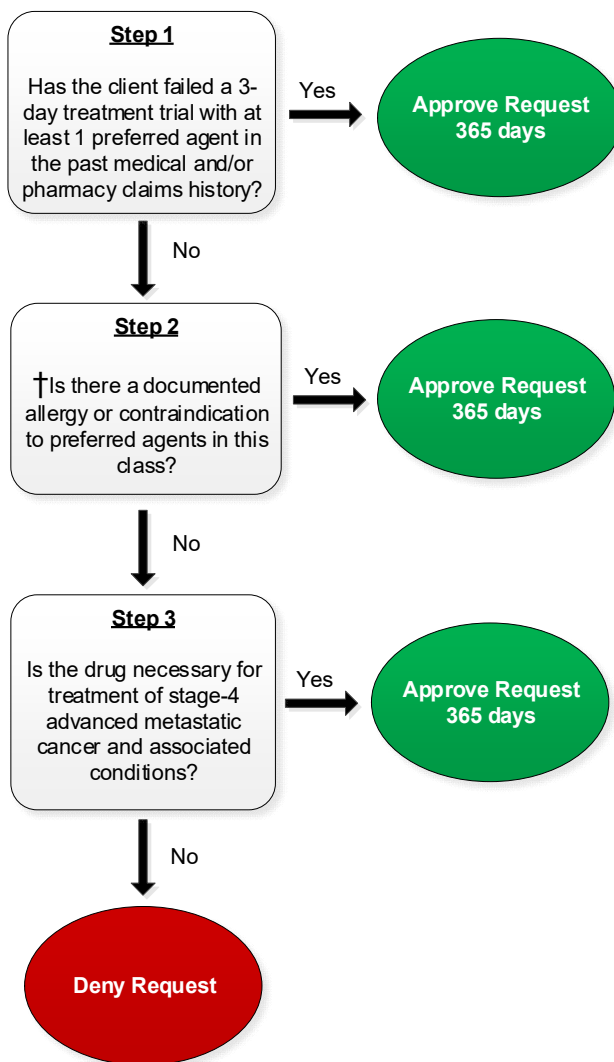
\* The listed GCNs may not be an indication of the current TX Medicaid Formulary Coverage.

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

1. Has the client failed a 3-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

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



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

## Cough and Cold Non-Narcotic Antitussive Alternate Therapies

### Preferred Cough and Cold, Non-Narcotic Antitussives

GCN	Drug Name
17802	12-HR COUGH RELIEF 30 MG/5 ML
53090	ADLT WAL-TUSSIN COUGH-COLD CF
53495	ADULT WAL-TUSSIN DM SYRUP
43882	ALAHIST CF TABLET
54425	ALAHIST DM 10-12.5-5 MG/5ML LQ
42443	ALAHIST DM 2-15-7.5 MG/5 ML LQ
42443	ALAHIST DM LIQUID
25093	ALKA-SELTZER PLUS DAY CAP
30232	ALL-NITE COLD-FLU RELIEF LIQ
99356	AP-HIST DM LIQUID
29840	BENZONATATE 100 MG CAPSULE
28229	BENZONATATE 150 MG CAPSULE
93007	BENZONATATE 200 MG CAPSULE
53491	BIOCOTRON LIQUID
96136	BROMFED DM 2-30-10 MG/5 ML SYR
23807	CHEST CONG RLF DM 400-20 MG TB
47921	CHILD DELSYM COUGH PLUS DY-NT
53497	CHILD DELSYM COUGH-CHEST DM LQ
30579	CHILD MUCINEX COLD-FLU LIQUID
28875	CHILD MUCINEX COUGH-CONGEST LQ
47825	CHILD MUCINEX FREEFROM NT COLD
37876	CHILD MUCINEX M-S COLD DAY-NTE
26808	CHILDREN'S COLD-COUGH ELIXIR
99788	CHLOPHEDIANOL-DEXCHLORP-PSE LQ
26742	COLD HEAD CONGESTION CAPLET
27135	COLD HEAD CONGESTION CAPLET
20556	COLD-FLU RELIEF LIQUID
17802	COUGH DM 30MG/5ML SUSP
96140	COUGH-COLD HBP TABLET
46697	CVS FLU HBP 325-2-10 MG CAPLET
53550	CVS MUCUS DM ER 600-30 MG TAB
25094	CVS NIGHTTIME COLD-FLU SOFTGEL
26684	CVS NIGHTTIME COUGH LIQUID



GCN	Drug Name
17770	CVS TUSSIN COUGH 15 MG LIQ GEL
44033	DAY MULTI-SYMP FLU-SEVERE COLD
46479	DECONEX DMX 17.5-400-10 MG TAB
42056	DECONEX DMX TABLET
17802	DELSYM 30MG/5ML SUSPENSION
22004	DELSYM COUGH 15 MG CAPLET
53497	DELSYM COUGH+CHEST CNGST DM LQ
47819	DELSYM NIGHTTIME COUGH LIQUID
17802	DEXTROMETHORPHAN ER 30MG/5ML
26808	DIMAPHEN DM ELIXIR
42056	DM-GUAIF-PE 17.5-385-10 MG TAB
34782	DM-GUAIF-PE 18-200-10 MG/15 ML
39986	DURAFLU 325-20-200-60 MG TAB
19347	ED-A-HIST DM LIQUID
26808	ENDACOF-DM LIQUID
14355	GS FLU-SEV COLD-COUGH DAY PKT
36311	HISTEX-DM SYRUP
30577	MUCINEX COLD-FLU-SORETHROAT LQ
38895	MUCINEX FAST-MAX COLD-FLU CAP
36524	MUCINEX FAST-MAX CONGEST-COUGH
53497	MUCINEX FAST-MAX DM MAX LIQUID
49896	MUCINEX FASTMX CLD-NTSHT CPLT
50004	MUCINEX INSTASOOTH COUGH 5-2MG
49573	MUCINEX NIGHTSHT SEVR CLD-FLU
49596	MUCINEX NIGHTSHIFT CLD-FLU CPT
23807	MUCUS RELIEF DM TABLET
30232	NIGHTTIME COLD-FLU LIQUID
19347	NO-HIST DM LIQUID
34835	POLY-HIST DM LIQUID
44218	POLYTUSSIN DM 1-10-5MG/5ML SYR
42443	POLYTUSSIN DM 2-15-7.5 MG/5 ML
54479	POLYTUSSIN DM 7.5-5-12.5MG/5ML
34799	POLY-VENT DM TABLET
13975	PROMETHAZINE-DM 6.25-15 MG/5ML
45903	ROBAFEN DM 200-20 MG/20 ML LIQ
53491	ROBAFEN DM COUGH LIQUID
26808	RYNEX DM LIQUID
23807	SM CHEST CONGEST RLF DM CAPLET
53491	SM TUSSIN DM LIQUID
33223	SUPRESS A DROPS

GCN	Drug Name
55139	VANACOF CP 12.5-25 MG/15 ML LQ
34782	VANACOF DM LIQUID
99788	VANACOF LIQUID
55095	VANACOF XP 18-396 MG/15 ML LIQ
55157	VANACOF-2 12.5-1 MG/5 ML LIQ

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

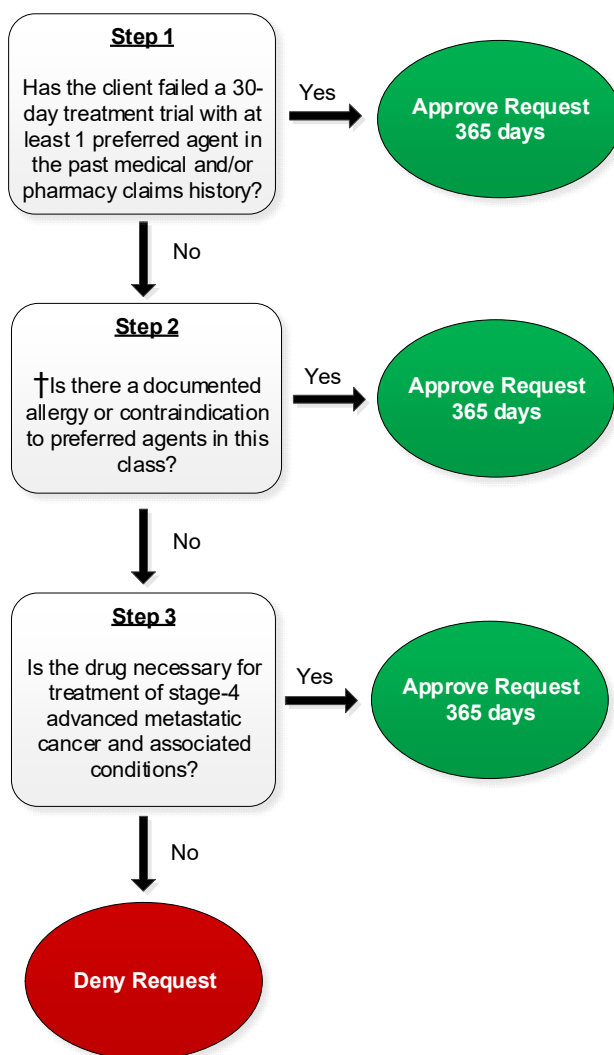
## Cytokine and CAM Antagonists

## **Cytokine and CAM Antagonists (Excluding Rinvoq) Prior Authorization Criteria**

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Cytokine and CAM Antagonists (Excluding Rinvoq) Prior Authorization Criteria



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

## Cytokine and CAM Antagonists (Excluding Rinvoq) Alternate Therapies

### Preferred Cytokine and CAM Antagonists

GCN	Drug Name
98398	ENBREL 25 MG/0.5 ML SYRINGE
48417	ENBREL 25 MG/0.5 ML VIAL
43924	ENBREL 50 MG/ML MINI CARTRIDGE
97724	ENBREL 50 MG/ML SURECLICK
23574	ENBREL 50 MG/ML SYRINGE
18924	HUMIRA 40 MG/0.8 ML SYRINGE
97005	HUMIRA CROHNS-UC-HS 40MG
18924	HUMIRA PEDI CROHN 40MG/0.8ML
97005	HUMIRA PEN 40 MG/0.8 ML
97005	HUMIRA PEN PS-UV-ADOL HS 40MG
44659	HUMIRA(CF) 10 MG/0.1 ML SYRING
44664	HUMIRA(CF) 20 MG/0.2 ML SYRING
43505	HUMIRA(CF) 40 MG/0.4 ML SYRING
44677	HUMIRA(CF) PEDI CROHN 80-40 MG
43904	HUMIRA(CF) PEDI CROHN 80MG/0.8
43506	HUMIRA(CF) PEN 40 MG/0.4 ML
44014	HUMIRA(CF) PEN 80 MG/0.8 ML
44954	HUMIRA(CF) PEN PS-UV-AHS 80-40
37765	OTEZLA 28 DAY STARTER PACK
36172	OTEZLA 30 MG TABLET
36173	OTEZLA STARTER PACK

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

## Cytokine and CAM Antagonists, Rinvoq

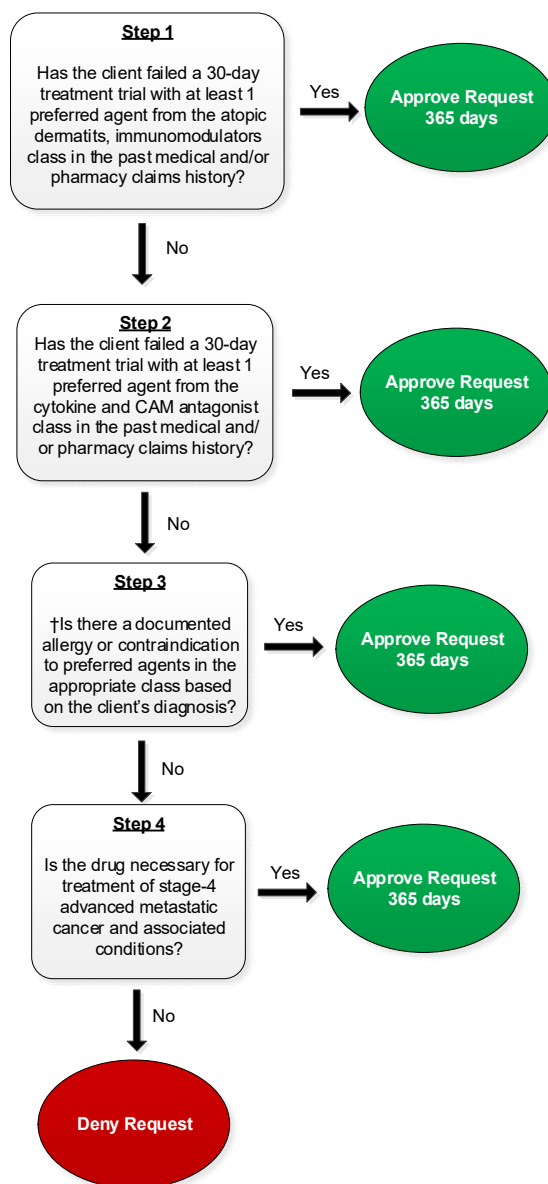
## **Cytokine and CAM Antagonists, Rinvoq Prior Authorization Criteria**

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent from the atopic dermatitis, immunomodulators class in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. Has the client failed a 30-day treatment trial with at least 1 preferred agent from the cytokine and CAM antagonist class in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. †Is there a documented allergy or contraindication to preferred agents in the appropriate class based on the client's diagnosis?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #4)
4. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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



## Cytokine and CAM Antagonists, Rinvoq Prior Authorization Criteria



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

## Cytokine and CAM Antagonists, Rinvog

### Alternate Therapies

#### Preferred Immunomodulators, Atopic Dermatitis

GCN	Drug Name
42792	EUCRISA 2% OINTMENT

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

#### Preferred Cytokine and CAM Antagonists (AS, CD, nr-AxSpA, PsA, RA, UC)

GCN	Drug Name
52651	ENBREL 25MG KIT
48417	ENBREL 25 MG/0.5 ML VIAL
23574	ENBREL 50MG/ML SYRINGE
97724	ENBREL 50MG/ML SURECLICK SYR
98398	ENBREL 25MG/0.5ML SYRING
43924	ENBREL 50MG/ML MINI CARTRIDGE
44677	HUMIRA (CF) PEDI CROHN 80-40MG
44014	HUMIRA (CF) PEN CRHN-UC-HS 80MG
43505	HUMIRA (CF) 40MG/0.4ML SYRINGE
43506	HUMIRA (CF) PEN 40MG/0.4ML
44664	HUMIRA (CF) 20MG/0.2ML SYRINGE
44659	HUMIRA (CF) 10MG/0.1ML SYRINGE
44954	HUMIRA (C F) PEN PSOR-UV-ADOL HS
43904	HUMIRA (CF) PEDI CROHN 80MG/0.8
18924	HUMIRA 40MG/0.8ML SYRINGE
18924	HUMIRA PEDI CROHN 40MG/0.8ML
37262	HUMIRA 10MG/0.2ML SYRINGE
99439	HUMIRA 20MG/0.4ML SYRINGE
97005	HUMIRA 40MG/0.8ML PEN
97005	HUMIRA CROHNS-UC-HS 40MG
97005	HUMIRA PEN PS-UV-ADOL HS 40MG
37765	OTEZLA 28 DAY STARTER PACK
36172	OTEZLA 30MG TABLET

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

# Epinephrine, Self-Injected

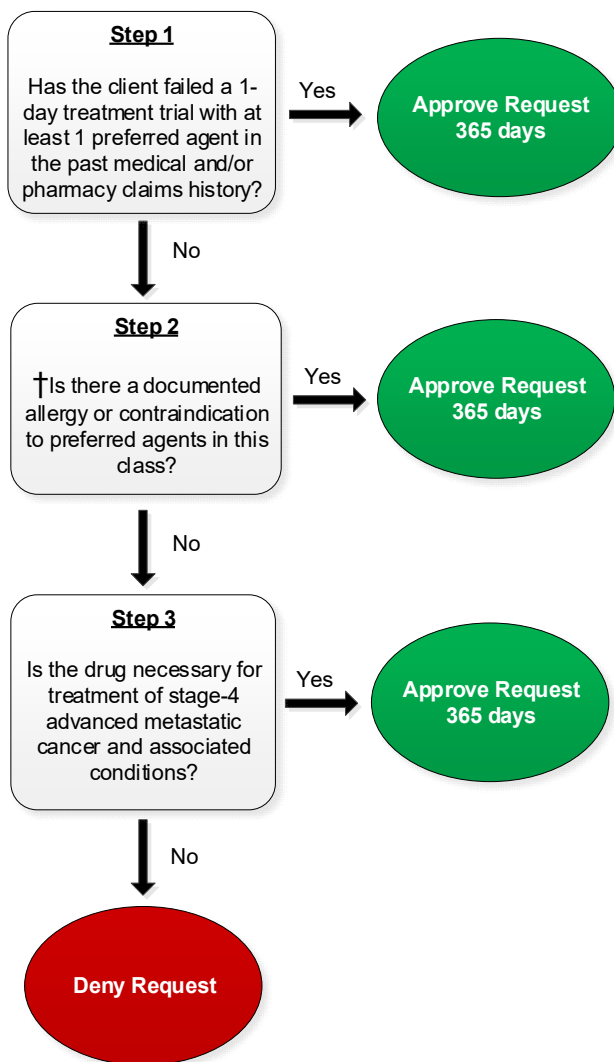
## Epinephrine, Self-Injected

### Prior Authorization Criteria

1. Has the client failed a 1-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Epinephrine, Self-Injected Prior Authorization Criteria



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

## Epinephrine, Self-Injected Alternate Therapies

### Preferred Self-Injected Epinephrine Agents

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

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

# Erythropoiesis Stimulating Proteins

## Erythropoiesis Stimulating Proteins

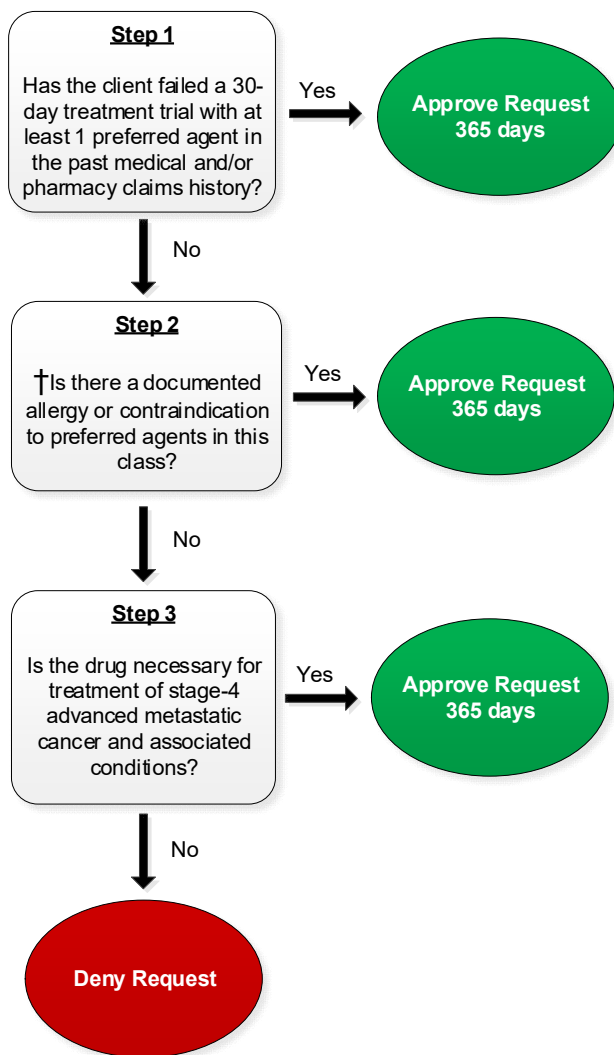
### Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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



## Erythropoiesis Stimulating Proteins Prior Authorization Criteria



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

## Erythropoiesis Stimulating Proteins Alternate Therapies

### Preferred Erythropoiesis Stimulating Proteins

GCN	Drug Name
14877	ARANESP 10 MCG/0.4 ML SYRINGE
14894	ARANESP 100 MCG/0.5 ML SYRINGE
14055	ARANESP 100 MCG/ML VIAL
15202	ARANESP 150 MCG/0.3 ML SYRINGE
97063	ARANESP 200 MCG/0.4 ML SYRINGE
14056	ARANESP 200 MCG/ML VIAL
97064	ARANESP 25 MCG/0.42 ML SYRING
14049	ARANESP 25 MCG/ML VIAL
97065	ARANESP 300 MCG/0.6 ML SYRINGE
14891	ARANESP 40 MCG/0.4 ML SYRINGE
14053	ARANESP 40 MCG/ML VIAL
27164	ARANESP 500 MCG/1 ML SYRINGE
14893	ARANESP 60 MCG/0.3 ML SYRINGE
14054	ARANESP 60 MCG/ML VIAL
25112	EPOGEN 10,000 UNITS/ML VIAL
25110	EPOGEN 2,000 UNITS/ML VIAL
24059	EPOGEN 20,000 UNITS/2 ML VIAL
25114	EPOGEN 20,000 UNITS/ML VIAL
25113	EPOGEN 3,000 UNITS/ML VIAL
25111	EPOGEN 4,000 UNITS/ML VIAL
44767	RETACRIT 10,000 UNIT/ML VIAL
44764	RETACRIT 2,000 UNIT/ML VIAL
48885	RETACRIT 20,000 UNIT/2 ML VIAL
48911	RETACRIT 20,000 UNIT/ML VIAL
44765	RETACRIT 3,000 UNIT/ML VIAL
44766	RETACRIT 4,000 UNIT/ML VIAL
44768	RETACRIT 40,000 UNIT/ML VIAL

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

## Fluoroquinolones, Oral

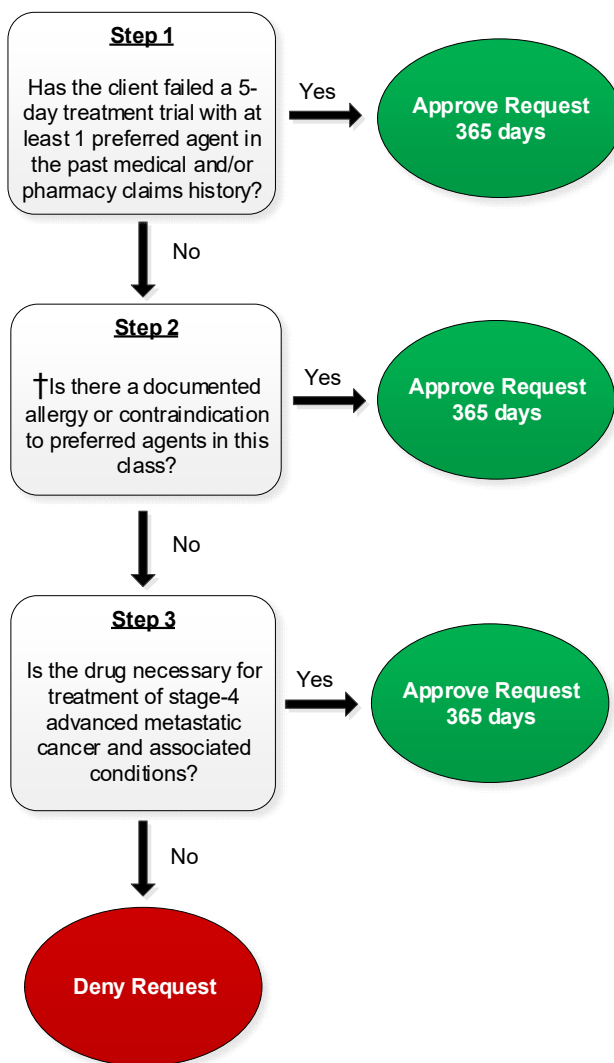
## Fluoroquinolones, Oral

### Prior Authorization Criteria

1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Fluoroquinolones, Oral Prior Authorization Criteria



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

## Fluoroquinolones, Oral Alternate Therapies

### Preferred Oral Fluoroquinolones

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

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## GI Motility, Chronic

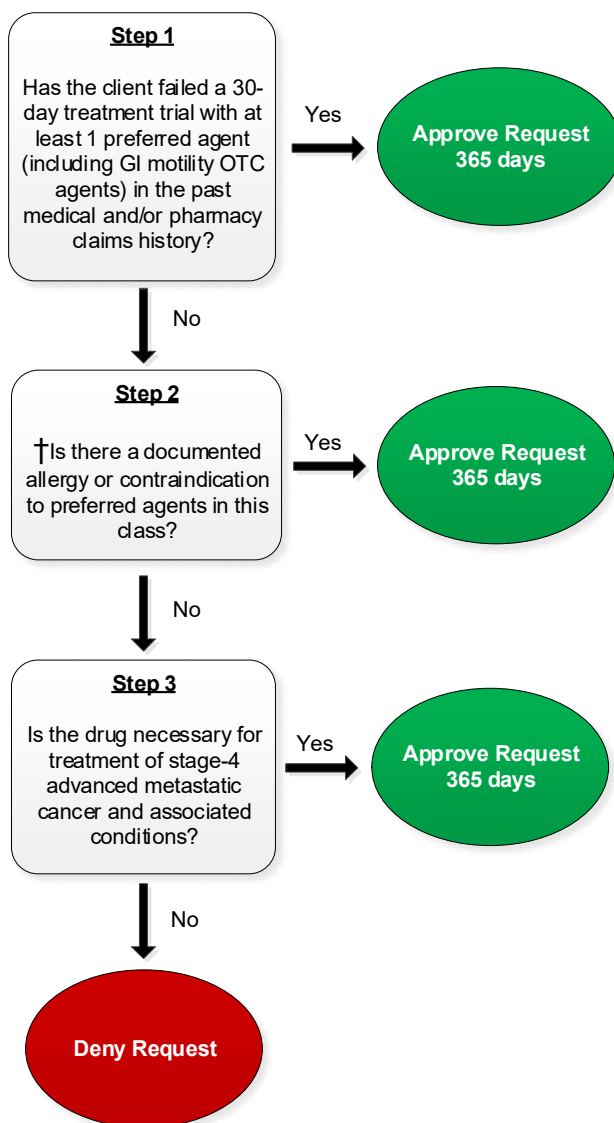
## GI Motility, Chronic Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent (including GI motility OTC products) in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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



## GI Motility, Chronic Prior Authorization Criteria



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

## GI Motility, Chronic Alternate Therapies

### Preferred GI Motility, Chronic Agents

GCN	Drug Name
26473	AMITIZA 24 MCG CAPSULE
99658	AMITIZA 8 MCG CAPSULE
33187	LINZESS 145 MCG CAPSULE
33188	LINZESS 290 MCG CAPSULE
42975	LINZESS 72 MCG CAPSULE
37725	MOVANTIK 12.5 MG TABLET
37726	MOVANTIK 25 MG TABLET
26473	LUBIPROSTONE 24 MCG CAPSULE
99658	LUBIPROSTONE 8 MCG CAPSULE

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

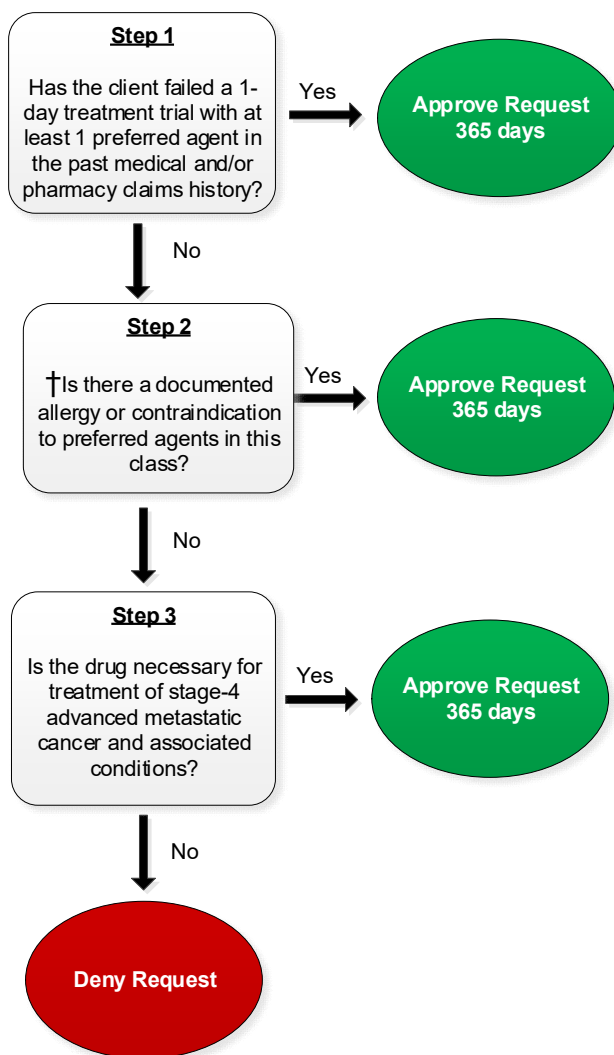
# Glucagon Agents

## Glucagon Agents Prior Authorization Criteria

1. Has the client failed a 1-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Glucagon Agents Prior Authorization Criteria



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

## Glucagon Agents Alternate Therapies

### Preferred Glucagon Agents

GCN	Drug Name
46726	BAQSIMI 3 MG SPRAY
25473	GLUCAGEN 1 MG HYPOKIT
01280	PROGLYCEM 50 MG/ML ORAL SUSP
49402	ZEGALOGUE 0.6 MG/0.6 ML SYRING
49403	ZEGALOGUE 0.6 MG/0.6ML AUTOINJ

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

# Glucocorticoids, Inhaled

## Glucocorticoids, Inhaled

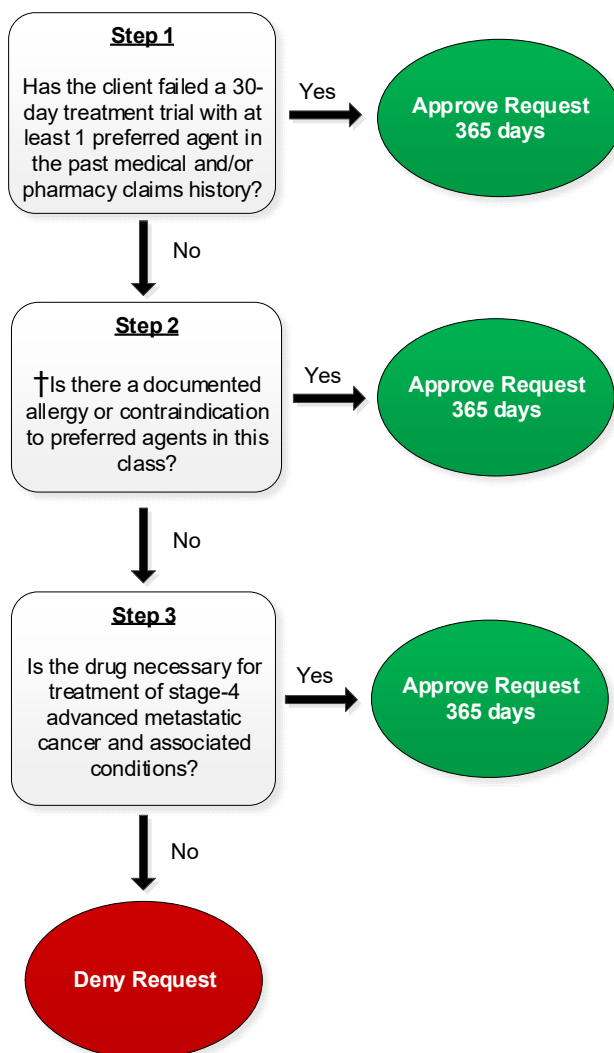
### Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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



## Glucocorticoids, Inhaled Prior Authorization Criteria



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

## Glucocorticoids, Inhaled Alternate Therapies

### Preferred Inhaled Glucocorticoids

GCN	Drug Name
50584	ADVAIR 100-50 DISKUS
50594	ADVAIR 250-50 DISKUS
50604	ADVAIR 500-50 DISKUS
97136	ADVAIR HFA 115-21 MCG INHALER
97137	ADVAIR HFA 230-21 MCG INHALER
97135	ADVAIR HFA 45-21 MCG INHALER
99721	ASMANEX TWISTHALER 110 MCG #30
24927	ASMANEX TWISTHALER 220 MCG #14
24928	ASMANEX TWISTHALER 220 MCG #30
24929	ASMANEX TWISTHALER 220 MCG #60
18987	ASMANEX TWISTHALR 220 MCG #120
17957	BUDESONIDE 0.25 MG/2 ML SUSP
17958	BUDESONIDE 0.5 MG/2 ML SUSP
62980	BUDESONIDE 1 MG/2 ML INH SUSP
28766	DULERA 100 MCG-5 MCG INHALER
28767	DULERA 200 MCG-5 MCG INHALER
30139	DULERA 50 MCG-5 MCG INHALER
53633	FLOVENT 100 MCG DISKUS
53634	FLOVENT 250 MCG DISKUS
53635	FLOVENT 50 MCG DISKUS
53636	FLOVENT HFA 110 MCG INHALER
53639	FLOVENT HFA 220 MCG INHALER
53638	FLOVENT HFA 44 MCG INHALER
98025	PULMICORT 180 MCG FLEXHALER
98024	PULMICORT 90 MCG FLEXHALER
98500	SYMBICORT 160-4.5 MCG INHALER
98499	SYMBICORT 80-4.5 MCG INHALER

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

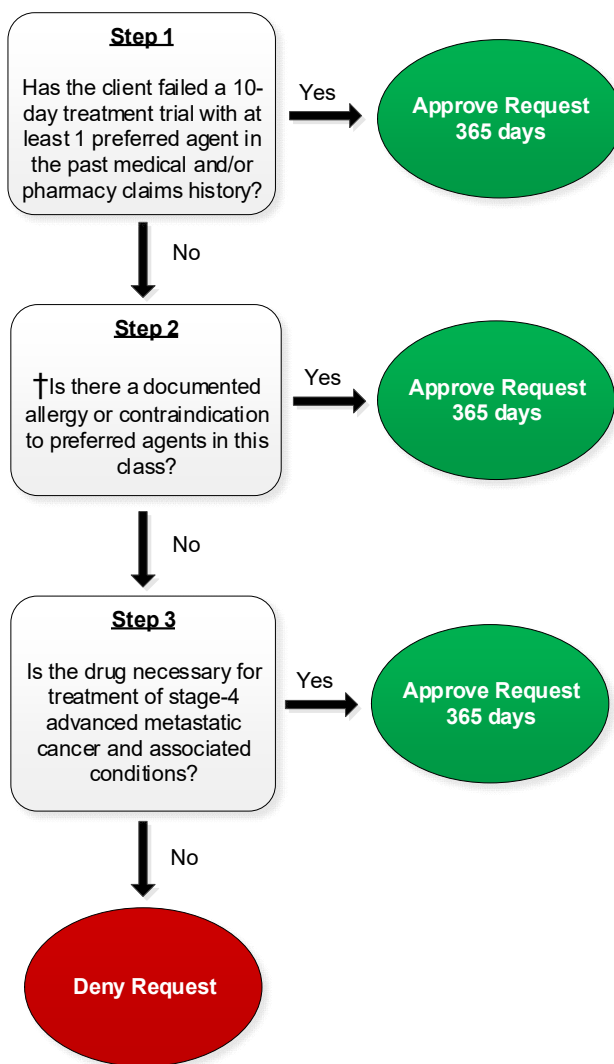
## Glucocorticoids, Oral

## Glucocorticoids, Oral Prior Authorization Criteria

1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Glucocorticoids, Oral Prior Authorization Criteria



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

## Glucocorticoids, Oral Alternate Therapies

### Preferred Oral Glucocorticoids

GCN	Drug Name
28680	BUDESONIDE DR 3 MG CAPSULE
27422	DEXAMETHASONE 0.5 MG TABLET
27400	DEXAMETHASONE 0.5 MG/5 ML ELX
27411	DEXAMETHASONE 0.5 MG/5 ML LIQ
27425	DEXAMETHASONE 0.75 MG TABLET
27424	DEXAMETHASONE 1 MG TABLET
27427	DEXAMETHASONE 1.5 MG TABLET
27426	DEXAMETHASONE 2 MG TABLET
27428	DEXAMETHASONE 4 MG TABLET
27429	DEXAMETHASONE 6 MG TABLET
26781	HYDROCORTISONE 10 MG TABLET
26782	HYDROCORTISONE 20 MG TABLET
26783	HYDROCORTISONE 5 MG TABLET
37499	METHYLPRED DP 4 MG DOSEPAK
26800	PREDNISOLONE 15 MG/5 ML SOLN
33806	PREDNISOLONE 15 MG/5 ML SOLN
33348	PREDNISOLONE 15MG/5ML SOLN CUP
09115	PREDNISOLONE 5 MG/5 ML SOLN
93945	PREDNISOLONE SOD PH 25 MG/5 ML
27171	PREDNISONE 1 MG TABLET
27172	PREDNISONE 10 MG TABLET
27173	PREDNISONE 2.5 MG TABLET
27174	PREDNISONE 20 MG TABLET
27176	PREDNISONE 5 MG TABLET
27160	PREDNISONE 5 MG/5 ML SOLN CUP
27177	PREDNISONE 50 MG TABLET

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

# Growth Hormone

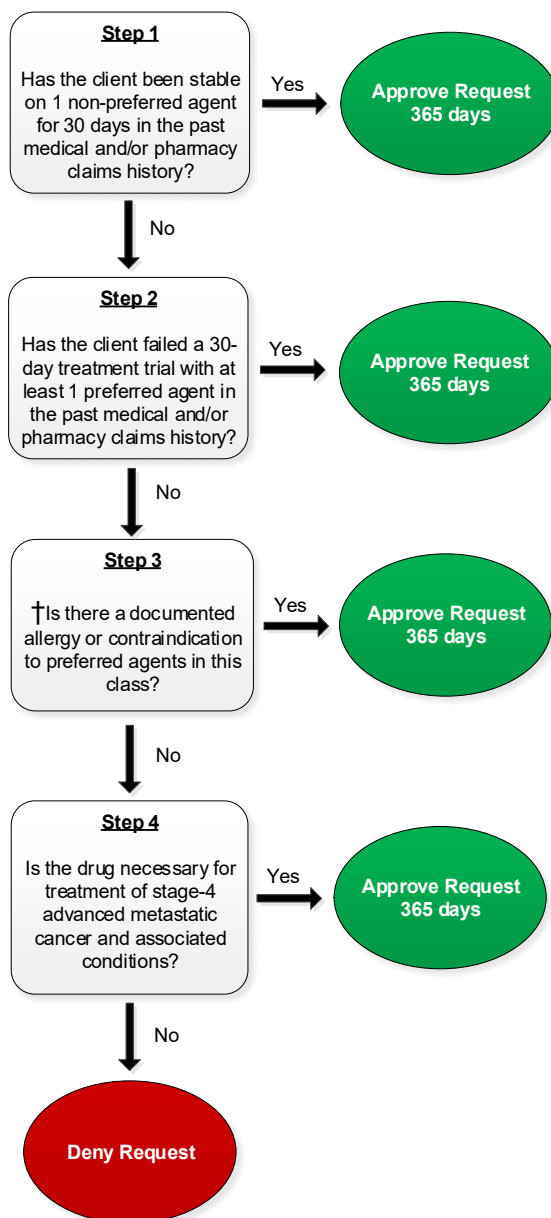
## Growth Hormone Prior Authorization Criteria

1. Has the client been stable on 1 non-preferred agent for 30-days in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #4)
4. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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



## Growth Hormone Prior Authorization Criteria



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

## Growth Hormone Alternate Therapies

### Preferred Growth Hormones

GCN	Drug Name
10554	GENOTROPIN 12 MG CARTRIDGE
63408	GENOTROPIN 5 MG CARTRIDGE
50177	GENOTROPIN MINQUICK 0.2 MG
50187	GENOTROPIN MINQUICK 0.4 MG
50197	GENOTROPIN MINQUICK 0.6 MG
50207	GENOTROPIN MINQUICK 0.8 MG
50217	GENOTROPIN MINQUICK 1 MG
21450	GENOTROPIN MINQUICK 1.2 MG
21451	GENOTROPIN MINQUICK 1.4 MG
21452	GENOTROPIN MINQUICK 1.6 MG
21453	GENOTROPIN MINQUICK 1.8 MG
21454	GENOTROPIN MINQUICK 2 MG
24146	NORDITROPIN FLEXPOR 10 MG/1.5
24147	NORDITROPIN FLEXPOR 15 MG/1.5
25816	NORDITROPIN FLEXPOR 30 MG/3 ML
24145	NORDITROPIN FLEXPOR 5 MG/1.5
50235	SKYTROFA 11 MG CARTRIDGE
50245	SKYTROFA 13.3 MG CARTRIDGE
50164	SKYTROFA 3 MG CARTRIDGE
50174	SKYTROFA 3.6 MG CARTRIDGE
50184	SKYTROFA 4.3 MG CARTRIDGE
50194	SKYTROFA 5.2 MG CARTRIDGE
50204	SKYTROFA 6.3 MG CARTRIDGE
50215	SKYTROFA 7.6 MG CARTRIDGE
50225	SKYTROFA 9.1 MG CARTRIDGE

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

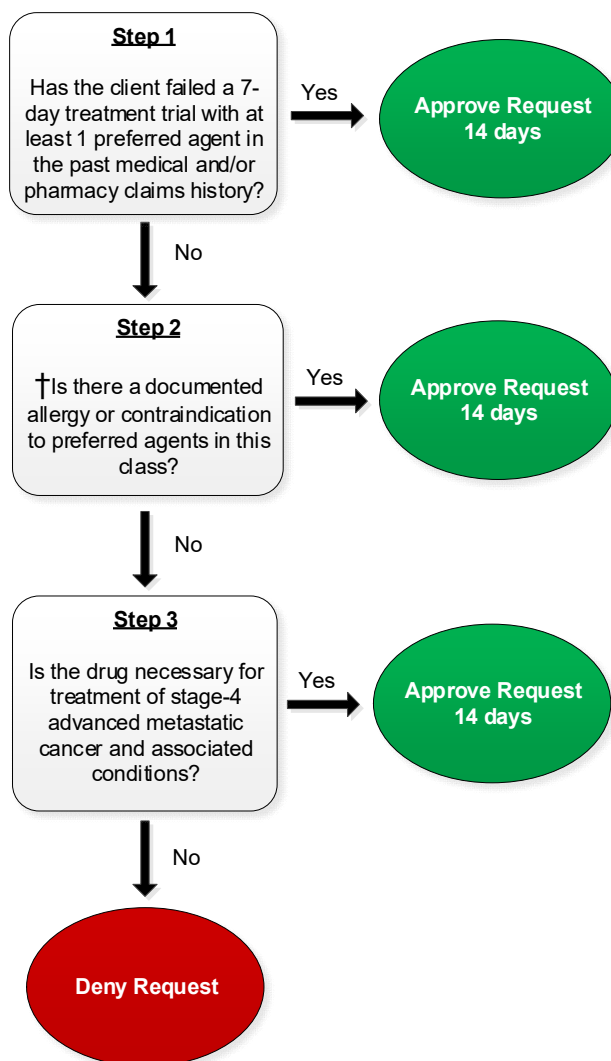
# H.Pylori Treatment

## H.Pylori Treatment Prior Authorization Criteria

1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 14 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 14 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 14 days)  
☐ No (Deny)

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

## H.Pylori Treatment Prior Authorization Criteria



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

# H.Pylori Treatment Alternate Therapies

## Preferred H.Pylori Treatment

GCN	Drug Name
98238	PYLERA CAPSULE

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

# Hemophilia Treatment

## Hemophilia Treatment Alternate Therapies

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



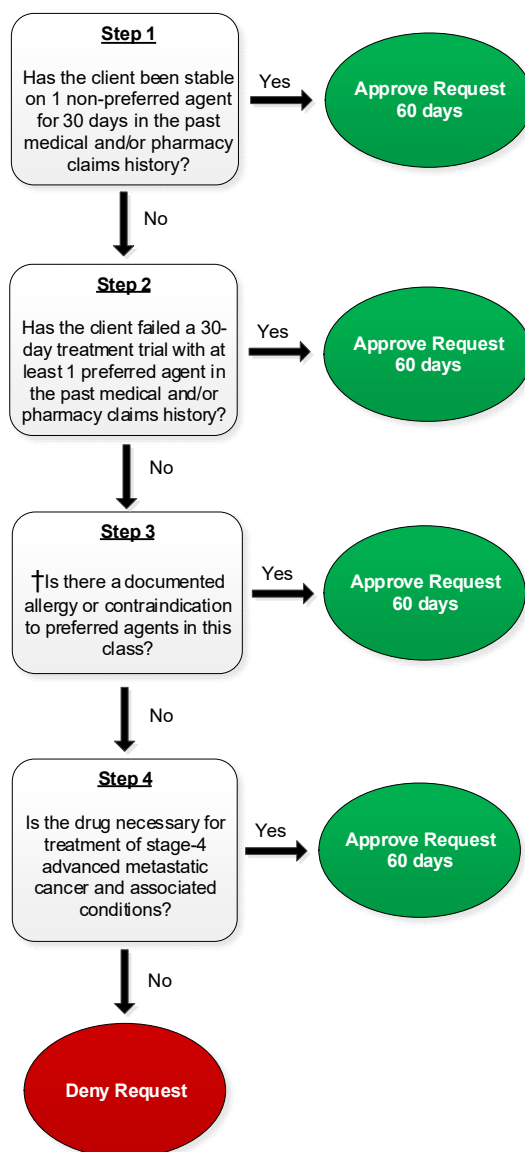
## Hepatitis C Agents

## Hepatitis C Agents Prior Authorization Criteria

1. Has the client been stable on 1 non-preferred agent for 30-days in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 60 days)  
☐ No (Go to #2)
2. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 60 days)  
☐ No (Go to #3)
3. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 60 days)  
☐ No (Go to #4)
4. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 60 days)  
☐ No (Deny)

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

## Hepatitis C Agents Prior Authorization Criteria



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

## Hepatitis C Agents Alternate Therapies

### Preferred Hepatitis C Therapies

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

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

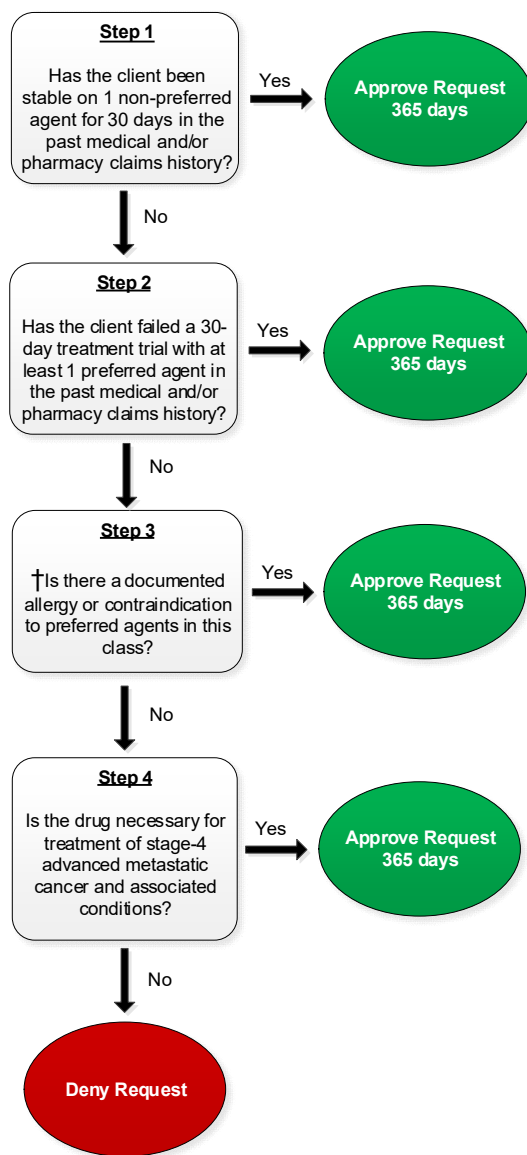
# Hereditary Angioedema Agents

## Hereditary Angioedema Agents Prior Authorization Criteria

1. Has the client been stable on 1 non-preferred agent for 30-days in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #4)
4. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Hereditary Angioedema Agents Prior Authorization Criteria



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

## Hereditary Angioedema Agents Alternate Therapies

### Preferred Hereditary Angioedema Therapies

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

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



# HIV/AIDS

## HIV/AIDS Alternate Therapies

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

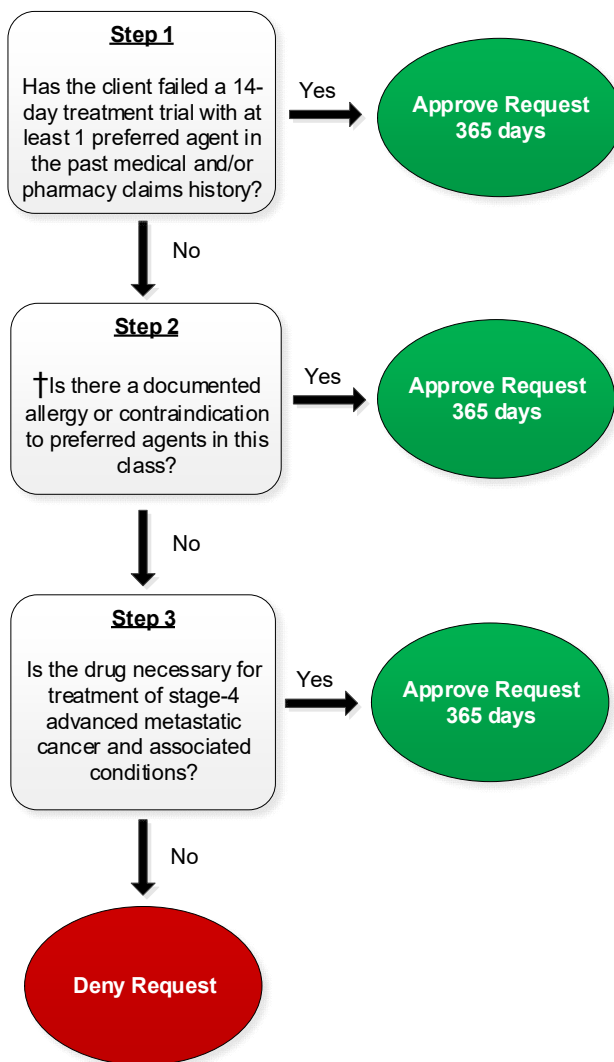
## Hypoglycemics, Incretin Mimetics/Enhancers

## Hypoglycemics, Incretin Mimetics/Enhancers Prior Authorization Criteria

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Hypoglycemics, Incretin Mimetics/Enhancers Prior Authorization Criteria



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

## Hypoglycemics, Incretin Mimetics/Enhancers Alternate Therapies

### Preferred Incretin Hypoglycemic Therapies

GCN	Drug Name
24614	BYETTA 10 MCG DOSE PEN INJ
24613	BYETTA 5 MCG DOSE PEN INJ
37832	GLYXAMBI 10 MG-5 MG TABLET
37833	GLYXAMBI 25 MG-5 MG TABLET
98307	JANUMET 50-1,000 MG TABLET
98306	JANUMET 50-500 MG TABLET
31348	JANUMET XR 100-1,000 MG TABLET
31340	JANUMET XR 50-1,000 MG TABLET
31339	JANUMET XR 50-500 MG TABLET
97400	JANUVIA 100 MG TABLET
97398	JANUVIA 25 MG TABLET
97399	JANUVIA 50 MG TABLET
31317	JENTADUETO 2.5 MG-1000 MG TAB
31315	JENTADUETO 2.5 MG-500 MG TAB
31316	JENTADUETO 2.5 MG-850 MG TAB
41637	JENTADUETO XR 2.5 MG-1,000 MG
41639	JENTADUETO XR 5 MG-1,000 MG TB
29225	KOMBIGLYZE XR 2.5-1,000 MG TAB
29224	KOMBIGLYZE XR 5-1,000 MG TAB
29118	KOMBIGLYZE XR 5-500 MG TABLET
27393	ONGLYZA 2.5 MG TABLET
27394	ONGLYZA 5 MG TABLET
44163	OZEMPIC 0.25-0.5 MG/DOSE PEN
53536	OZEMPIC 0.25-0.5 MG/DOSE PEN
48208	OZEMPIC 1 MG/DOSE (4 MG/3 ML)
52125	OZEMPIC 2 MG/DOSE (8 MG/3 ML)
99450	SYMLINPEN 120 PEN INJECTOR
99514	SYMLINPEN 60 PEN INJECTOR
29890	TRADJENTA 5 MG TABLET
47672	TRIJARDY XR 10-5-1,000 MG TAB
47671	TRIJARDY XR 12.5-2.5-1,000 MG

GCN	Drug Name
47673	TRIJARDY XR 25-5-1,000 MG TAB
47669	TRIJARDY XR 5-2.5-1,000 MG TAB
37169	TRULICITY 0.75 MG/0.5 ML PEN
37171	TRULICITY 1.5 MG/0.5 ML PEN
48574	TRULICITY 3 MG/0.5 ML PEN
48573	TRULICITY 4.5 MG/0.5 ML PEN
26189	VICTOZA 2-PAK 18 MG/3 ML PEN
26189	VICTOZA 3-PAK 18MG/3ML PEN

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

## Hypoglycemics, Insulin

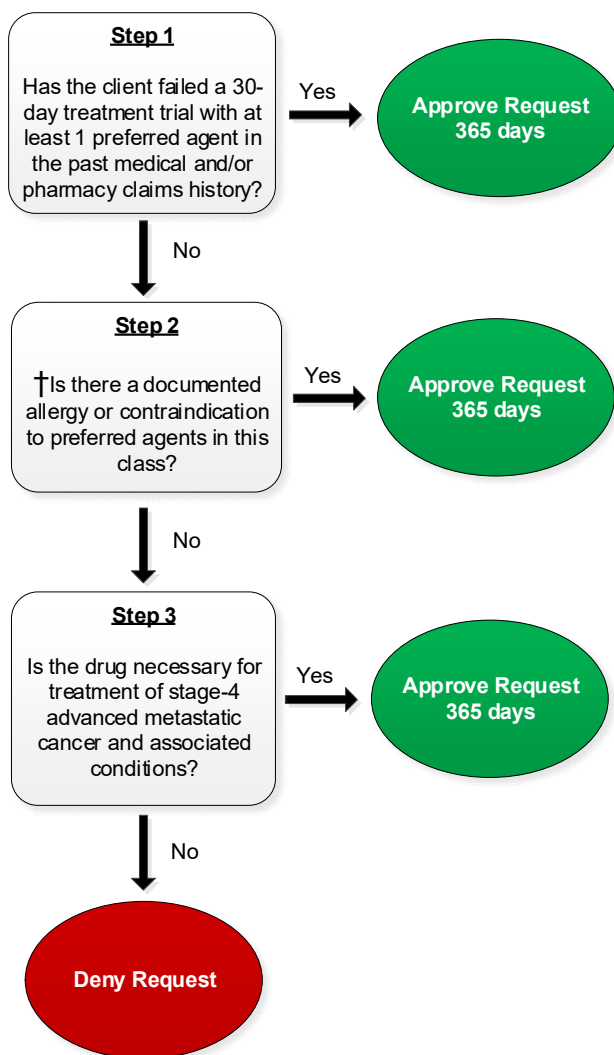


## Hypoglycemics, Insulin Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Hypoglycemics, Insulin Prior Authorization Criteria



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

## Hypoglycemics, Insulin Alternate Therapies

### Preferred Insulins

GCN	Drug Name
05678	HUMALOG 100 UNIT/ML CARTRIDGE
96719	HUMALOG 100 UNIT/ML KWIKPEN
05679	HUMALOG 100 UNIT/ML VIAL
43753	HUMALOG JR 100 UNIT/ML KWIKPEN
50461	HUMALOG MIX 50-50 KWIKPEN
93717	HUMALOG MIX 75-25 KWIKPEN
22681	HUMALOG MIX 75-25 VIAL
54975	HUMALOG TEMPO PEN 100 UNIT/ML
24486	HUMULIN 70/30 KWIKPEN
50001	HUMULIN 70-30 VIAL
11660	HUMULIN N 100 UNIT/ML VIAL
11642	HUMULIN R 100 UNIT/ML VIAL
40542	HUMULIN R 500 UNIT/ML KWIKPEN
09633	HUMULIN R 500 UNIT/ML VIAL
92886	INSULIN ASPART 100 UNIT/ML CRT
92336	INSULIN ASPART 100 UNIT/ML PEN
92326	INSULIN ASPART 100 UNIT/ML VL
17075	INSULIN ASPART PRO MIX70-30 PN
19057	INSULIN ASPART PRO MIX70-30 VL
96719	INSULIN LISPRO 100UNITS/ML PEN
05679	INSULIN LISPRO 100UNITS/ML VL
43753	INSULIN LISPRO JR 100 UNITS/ML
13072	LANTUS 100 UNIT/ML VIAL
17075	NOVOLOG MIX 70-30 FLEXPEN SYRINGE
19057	NOVOLOG MIX 70-30 VIAL

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

## Hypoglycemics, Meglitinides

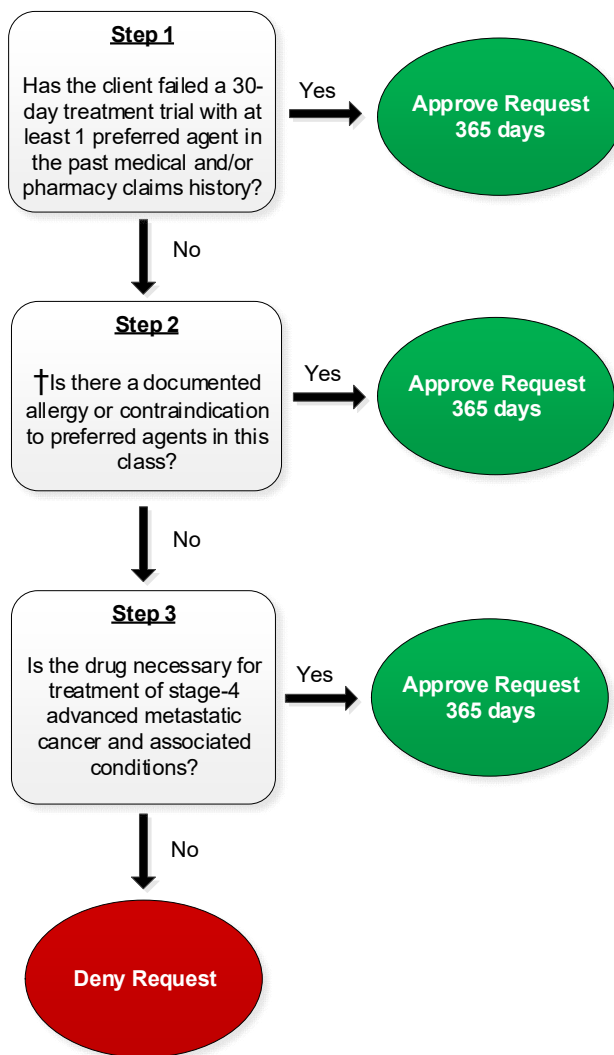
## Hypoglycemics, Meglitinides

### Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Hypoglycemics, Meglitinides Prior Authorization Criteria



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

## Hypoglycemics, Meglitinides Alternate Therapies

### Preferred Meglitinides

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

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

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

## Hypoglycemics, Metformin

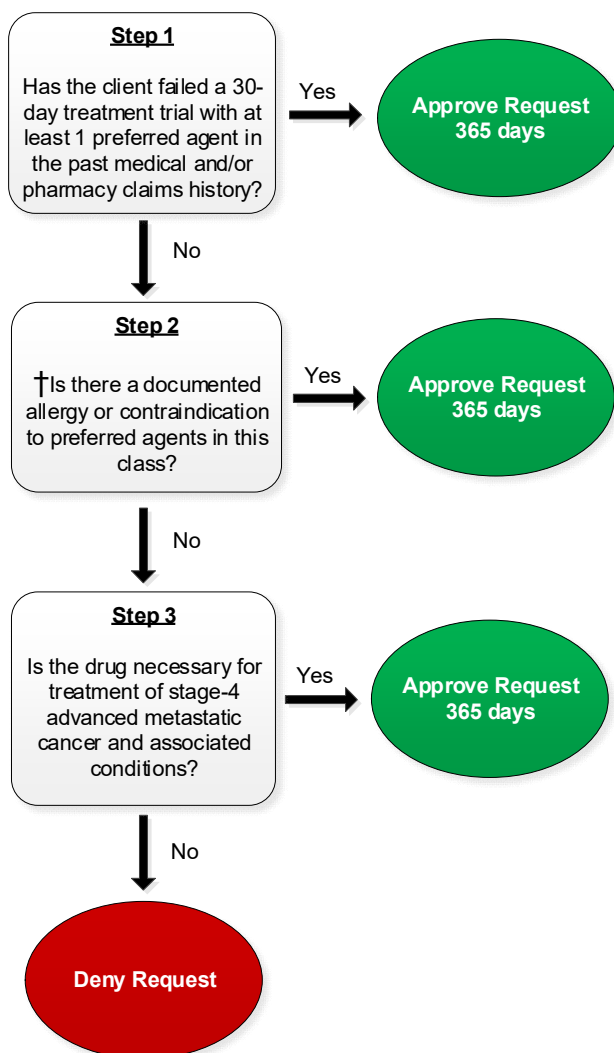


## Hypoglycemics, Metformin Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Hypoglycemics, Metformin Prior Authorization Criteria



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

## Hypoglycemics, Metformin Alternate Therapies

### Preferred Metformin Agents

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

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

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

# Hypoglycemics, SGLT2 Inhibitors

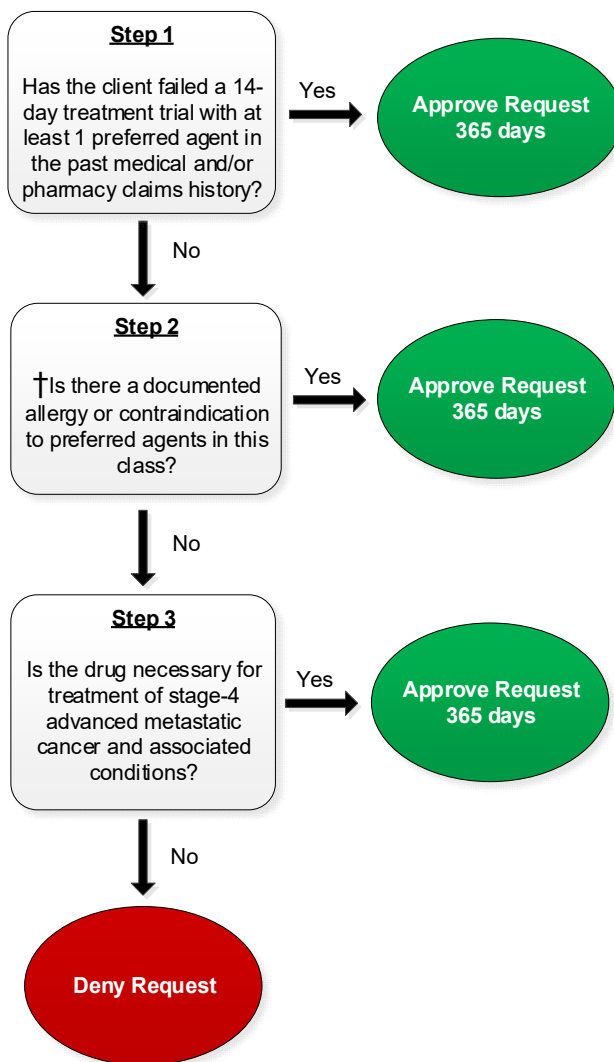
## Hypoglycemics, SGLT2 Inhibitors

### Prior Authorization Criteria

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Hypoglycemics, SGLT2 Inhibitors Prior Authorization Criteria



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

## Hypoglycemics, SGLT2 Inhibitors Alternate Therapies

### Preferred SGLT2 Inhibitors

GCN	Drug Name
34394	FARXIGA 10 MG TABLET
35698	FARXIGA 5 MG TABLET
36859	INVOKAMET 150-1,000 MG TABLET
36953	INVOKAMET 150-500 MG TABLET
36857	INVOKAMET 50-1,000 MG TABLET
36954	INVOKAMET 50-500 MG TABLET
42315	INVOKAMET XR 150-1,000 MG TAB
42314	INVOKAMET XR 150-500 MG TABLET
42313	INVOKAMET XR 50-1,000 MG TAB
42312	INVOKAMET XR 50-500 MG TABLET
34439	INVOKANA 100 MG TABLET
34441	INVOKANA 300 MG TABLET
36716	JARDIANCE 10 MG TABLET
36723	JARDIANCE 25 MG TABLET
38932	SYNJARDY 12.5-1,000 MG TABLET
39378	SYNJARDY 12.5-500 MG TABLET
38929	SYNJARDY 5-1,000 MG TABLET
39377	SYNJARDY 5-500 MG TABLET
37344	XIGDUO XR 10 MG-1,000 MG TAB
37342	XIGDUO XR 10 MG-500 MG TABLET
44304	XIGDUO XR 2.5 MG-1,000 MG TAB
37343	XIGDUO XR 5 MG-1,000 MG TABLET
37339	XIGDUO XR 5 MG-500 MG TABLET

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

## Hypoglycemics, TZD



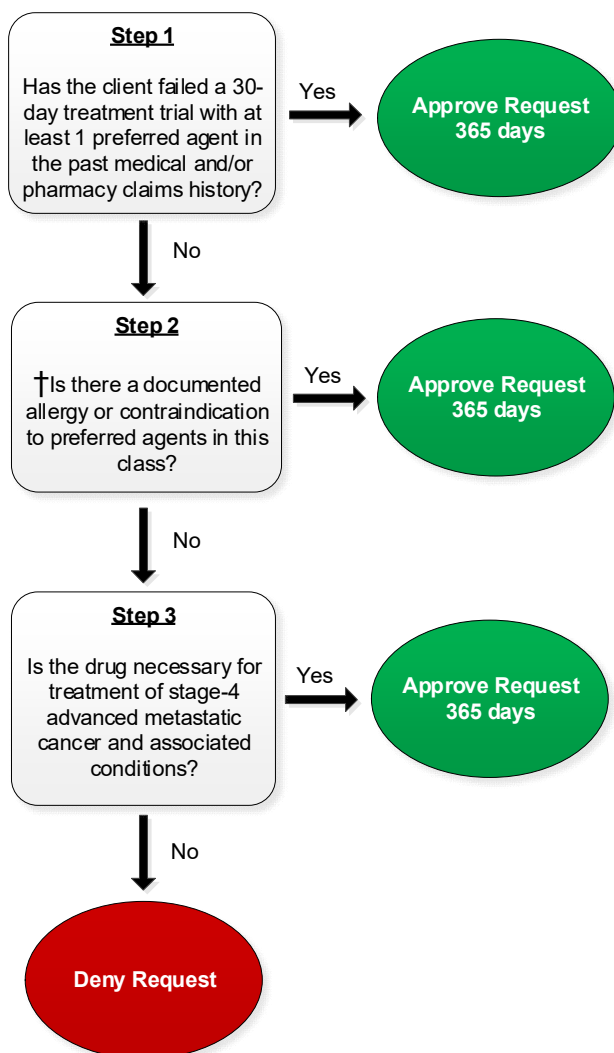
## Hypoglycemics, TZD

### Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Hypoglycemics, TZD Prior Authorization Criteria



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

## Hypoglycemics, TZD Alternate Therapies

### Preferred TZD Agents

GCN	Drug Name
92991	PIOGLITAZONE HCL 15 MG TABLET
93001	PIOGLITAZONE HCL 30 MG TABLET
93011	PIOGLITAZONE HCL 45 MG TABLET

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

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

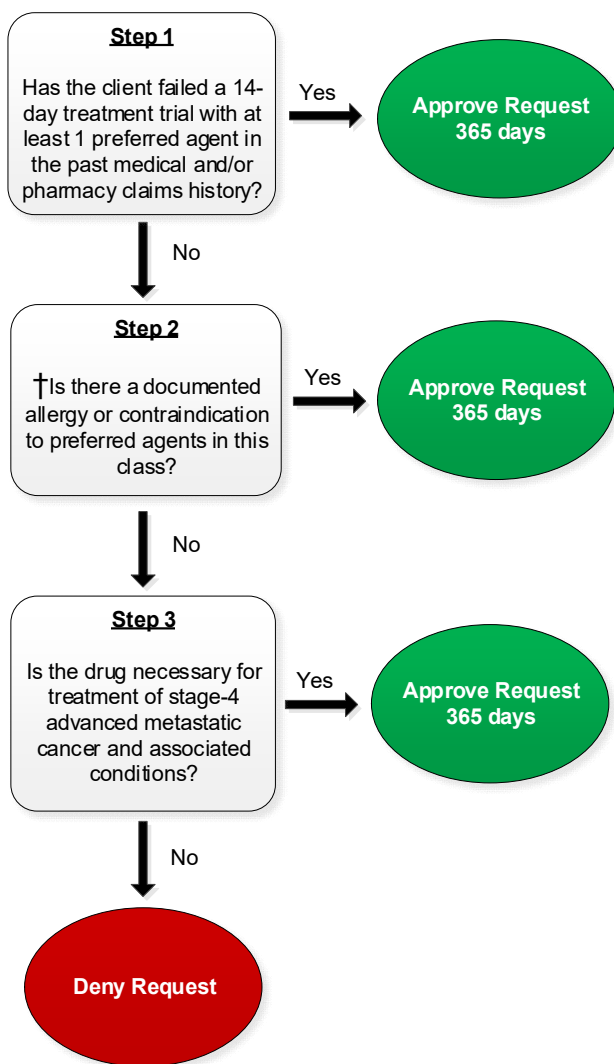
# Immune Globulins

## Immune Globulins Prior Authorization Criteria

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Immune Globulins Prior Authorization Criteria



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

## Immune Globulins Alternate Therapies

### Preferred Immune Globulins

GCN	Drug Name
38016	GAMMAGARD LIQUID 10% VIAL
07392	GAMMAGARD S-D 10 G (IGA<1) SOL
06951	GAMMAGARD S-D 5 G (IGA<1) SOLN
29305	GAMMAKED 1 GRAM/10 ML VIAL
29308	GAMMAKED 10 GRAM/100 ML VIAL
29309	GAMMAKED 20 GRAM/200 ML VIAL
29307	GAMMAKED 5 GRAM/50 ML VIAL
29308	GAMUNEX-C 10GRAM/100ML VIAL
29305	GAMUNEX-C 1GRAM/10ML VIAL
29306	GAMUNEX-C 2.5 GRAM/25 ML VIAL
29309	GAMUNEX-C 20GRAM/200ML VIAL
37322	GAMUNEX-C 40 GRAM/400 ML VIAL
29307	GAMUNEX-C 5GRAM/50ML VIAL
44679	HIZENTRA 1 GRAM/5 ML SYRINGE
28385	HIZENTRA 1 GRAM/5 ML VIAL
55066	HIZENTRA 10 GRAM/50 ML SYRINGE
35316	HIZENTRA 10 GRAM/50 ML VIAL
44686	HIZENTRA 2 GRAM/10 ML SYRINGE
28386	HIZENTRA 2 GRAM/10 ML VIAL
47882	HIZENTRA 4 GRAM/20 ML SYRINGE
28387	HIZENTRA 4 GRAM/20 ML VIAL

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

# Immunomodulators, Asthma



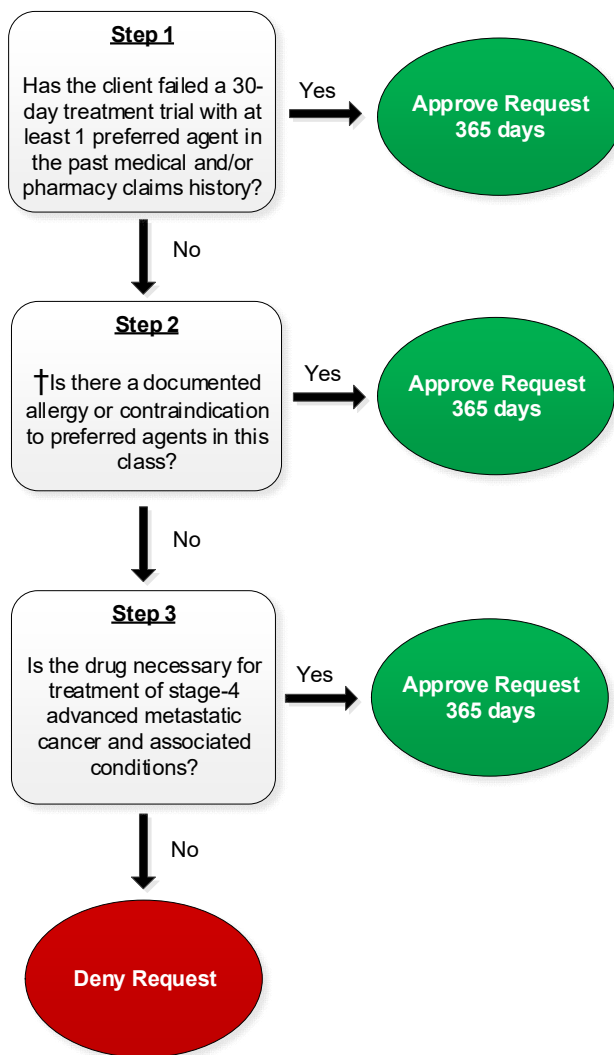
## Immunomodulators, Asthma Prior Authorization Criteria

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

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Immunomodulators, Asthma Prior Authorization Criteria



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

## Immunomodulators, Asthma Alternate Therapies

### Preferred Immunomodulators, Asthma

GCN	Drug Name
47019	FASENRA PEN 30 MG/ML
30556	XOLAIR 150 MG/ML SYRINGE
55224	XOLAIR 300 MG/2 ML SYRINGE
30555	XOLAIR 75 MG/0.5 ML SYRINGE

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

## Immunomodulators, Atopic Dermatitis

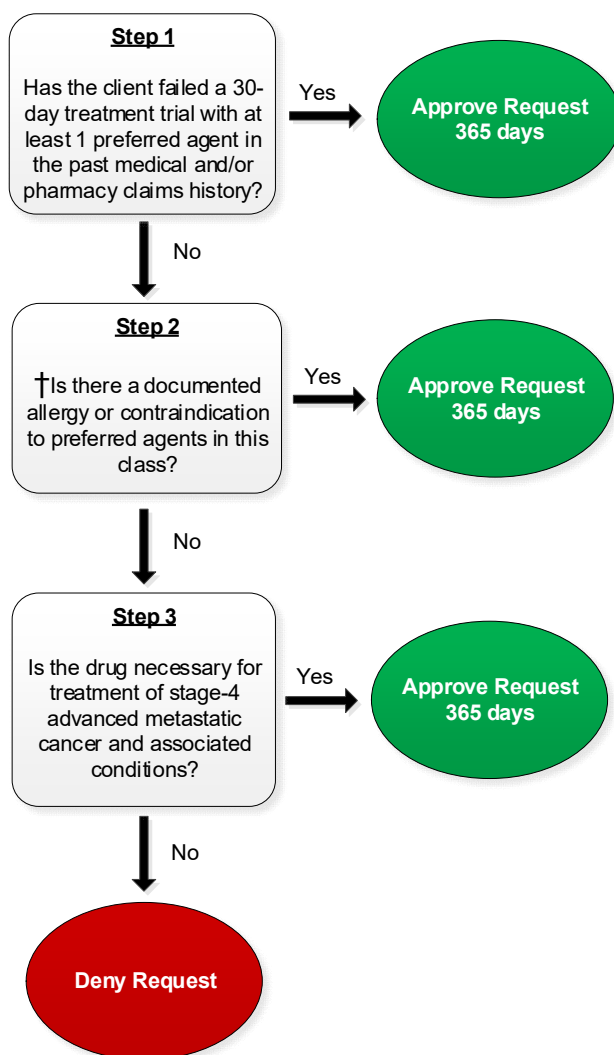
## Immunomodulators, Atopic Dermatitis (Excluding Dupixent) Prior Authorization Criteria

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

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

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



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

## Immunomodulators, Atopic Dermatitis (Excluding Dupixent) Alternate Therapies

### Preferred Immunomodulators, Atopic Dermatitis

GCN	Drug Name
15348	ELIDEL 1% CREAM
42792	EUCRISA 2% OINTMENT
12289	TACROLIMUS 0.03% OINTMENT
12302	TACROLIMUS 0.1% OINTMENT

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

## Immunomodulators, Dupixent

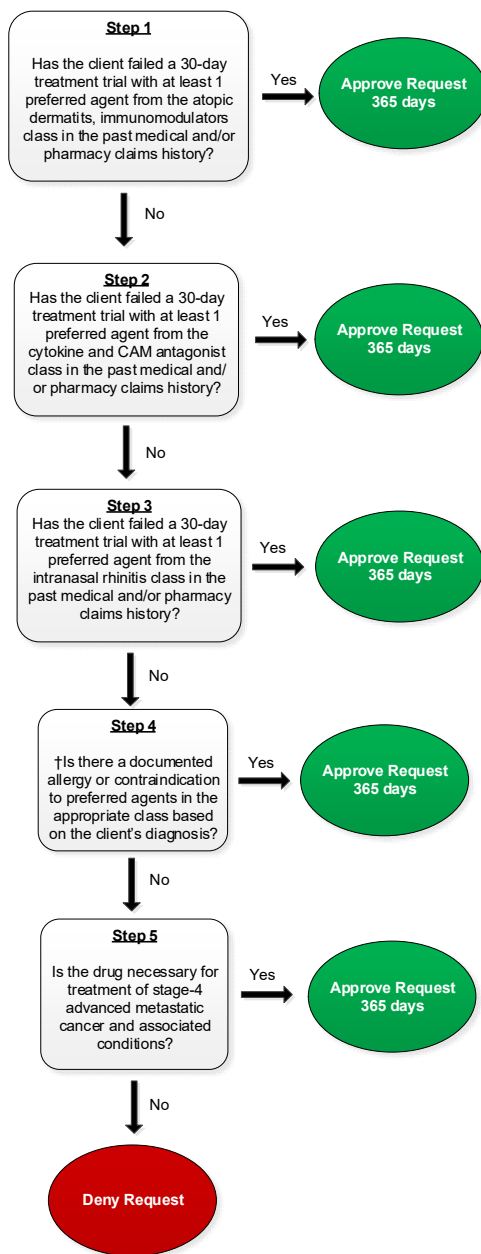


## Immunomodulators, Dupixent Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent from the atopic dermatitis, immunomodulators class in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. Has the client failed a 30-day treatment trial with at least 1 preferred agent from the asthma immunomodulators class in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Has the client had a 30-day treatment trial with at least 1 preferred agent from the intranasal rhinitis class in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #4)
4. †Is there a documented allergy or contraindication to preferred agents in the appropriate class based on the client's diagnosis?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #5)
5. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

# Immunomodulators, Dupixent Prior Authorization Criteria



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

## Immunomodulators, Dupixent Prior Authorization Criteria

### Preferred Immunomodulators, Dupixent

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

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

## Immunomodulators, Dupixent Alternate Therapies

### Preferred Immunomodulators, Atopic Dermatitis

GCN	Drug Name
15438	ELIDEL 1% CREAM
42792	EUCRISA 2% OINTMENT
12289	TACROLIMUS 0.03% OINTMENT
12302	TACROLIMUS 0.1% OINTMENT

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

### Preferred Immunomodulators, Asthma

GCN	Drug Name
47019	FASENRA PEN 30 MG/ML
30556	XOLAIR 150MG/ML SYRINGE
30555	XOLAIR 75MG/0.5ML SYRINGE

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

### Preferred Intranasal Rhinitis Agents

GCN	Drug Name
60544	AZELASTINE 0.1% (137 MCG) SPRY
62263	FLUTICASONE PROP 50MCG SPRAY

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

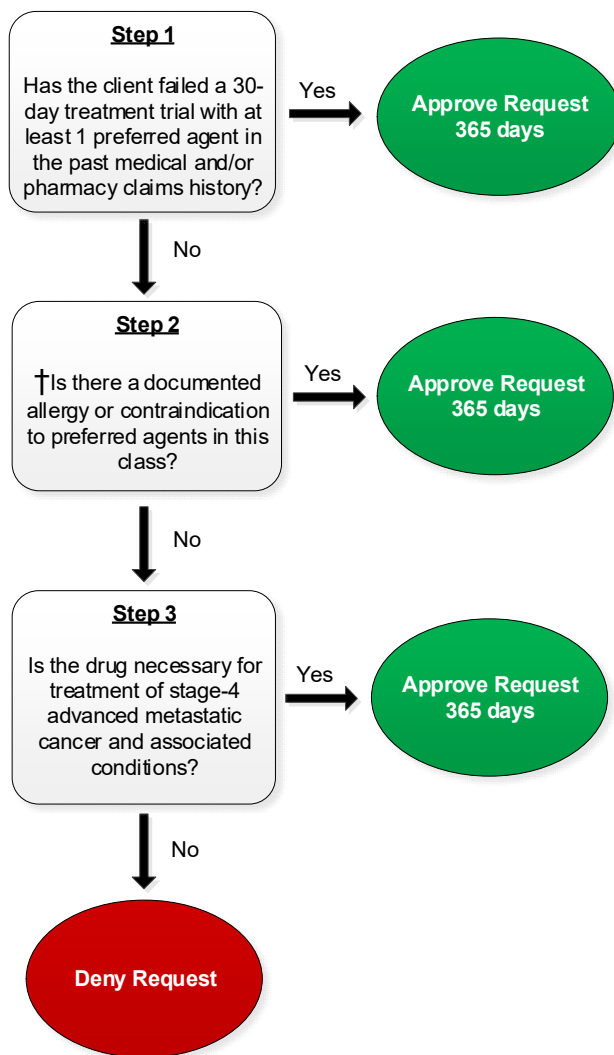
## Immunosuppressives, Oral/SQ

## Immunosuppressives, Oral/SQ Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Immunosuppressives, Oral/SQ Prior Authorization Criteria



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

## Immunosuppressives, Oral/SQ Alternate Therapies

### Preferred Oral Immunosuppressives

GCN	Drug Name
19173	AZATHIOPRINE 100 MG TABLET
46771	AZATHIOPRINE 50 MG TABLET
19170	AZATHIOPRINE 75 MG TABLET
13919	CYCLOSPORINE MODIFIED 100 MG
13917	CYCLOSPORINE MODIFIED 100MG/ML
13918	CYCLOSPORINE MODIFIED 25 MG
13919	GENGRAF 100MG CAPSULE
13918	GENGRAF 25 MG CAPSULE
47560	MYCOPHENOLATE 250 MG CAPSULE
47561	MYCOPHENOLATE 500 MG TABLET
13919	NEORAL 100MG GELATIN CAPSULE
13918	NEORAL 25MG GELATIN CAPSULE
28502	RAPAMUNE 0.5 MG TABLET
13696	RAPAMUNE 1 MG TABLET
50356	RAPAMUNE 1 MG/ML ORAL SOLN
19299	RAPAMUNE 2 MG TABLET
28495	TACROLIMUS 0.5 MG CAPSULE (IR)
28491	TACROLIMUS 1 MG CAPSULE (IR)
28492	TACROLIMUS 5 MG CAPSULE (IR)

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



## Intranasal Rhinitis Agents

## Intranasal Rhinitis Agents Prior Authorization Criteria

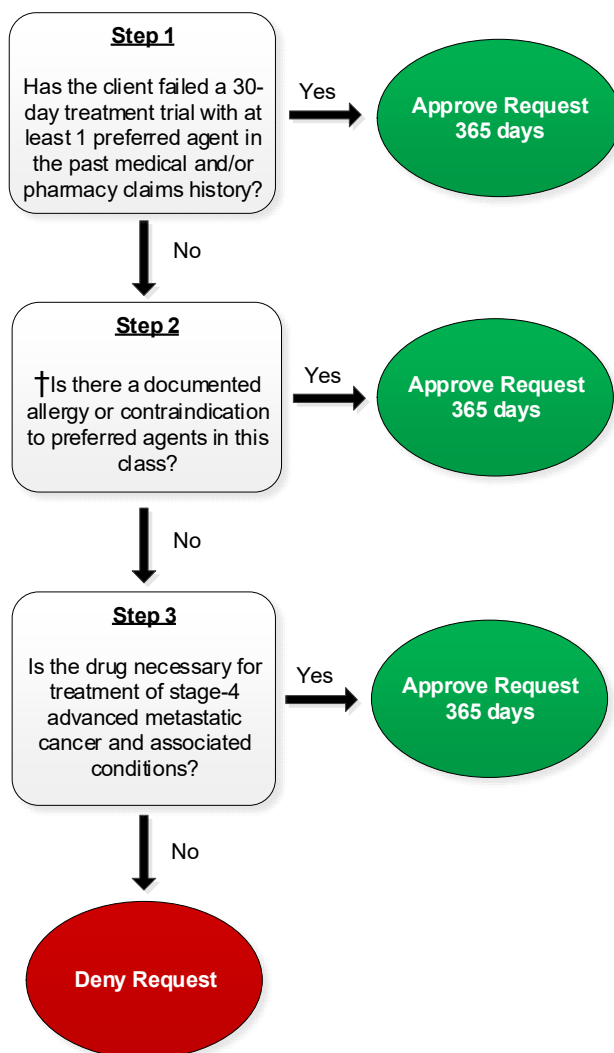
*\*Note: if the request is for Dupixent, please see Immunomodulators, Dupixent section*

*\*\*For treatment of rhinosinusitis with nasal polyposis, Dupixent must be prescribed as adjunct therapy to an intranasal glucocorticoid. Any intranasal glucocorticoid may be used as adjunct therapy as long as a preferred intranasal glucocorticoid has been tried.*

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Intranasal Rhinitis Agents Prior Authorization Criteria



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

## Intranasal Rhinitis Agents Alternate Therapies

### Preferred Intranasal Rhinitis Agents

GCN	Drug Name
52083	ALLERGY NASAL 50 MCG SPRAY
60544	AZELASTINE 0.1% (137 MCG) SPRY
62263	FLUTICASONE PROP 50 MCG SPRAY
42239	IPRATROPIUM 0.03% SPRAY
42238	IPRATROPIUM 0.06% SPRAY

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

## Iron, Oral

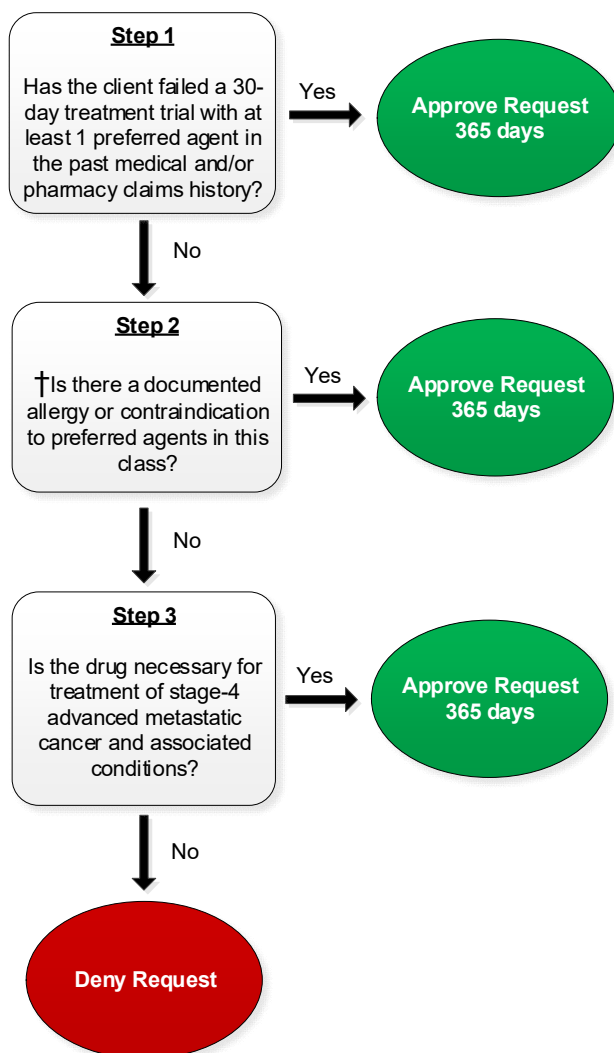
## Iron, Oral

### Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Iron, Oral Prior Authorization Criteria



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

## Iron, Oral

### Alternate Therapies

#### Preferred Oral Iron Agents

GCN	Drug Name
13277	CENTRATEX CAPSULE
97721	CHILD FERROUS SULFATE 15 MG/ML
10510	CVS IRON 27 MG TABLET
04695	CVS IRON 65 MG TABLET
95145	FE C TABLET
04695	FEOSOL 65MG TABLET
04695	FEROSUL 325MG TABLET
04580	FERREX 150 CAPSULE
04515	FERROCITE TABLET
04695	FERRO-TIME 325MG TABLET
97503	FERROUS GLUCONATE 324 MG TAB
99233	FERROUS SULF 220 MG/5 ML CUP
41529	FERROUS SULF 220 MG/5 ML ELIX
04663	FERROUS SULF 300 MG/5 ML CUP
99233	FERROUS SULF 44MG IRON/5ML LQ
98527	FERROUS SULF EC 324 MG TABLET
04701	FERROUS SULF EC 325 MG TABLET
04695	FERROUS SULFATE 325MG TABLET
04695	FERROUSUL 325MG TABLET
29957	GNP IRON 45 MG TABLET
13277	HEMOCYTE PLUS CAPSULE
04580	POLYSACCHARIDE IRON 150MG CAP
26937	PUREVIT DUALFE PLUS CAPSULE
26937	SE-TAN PLUS CAPSULE
26937	TANDEM PLUS CAPSULE

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



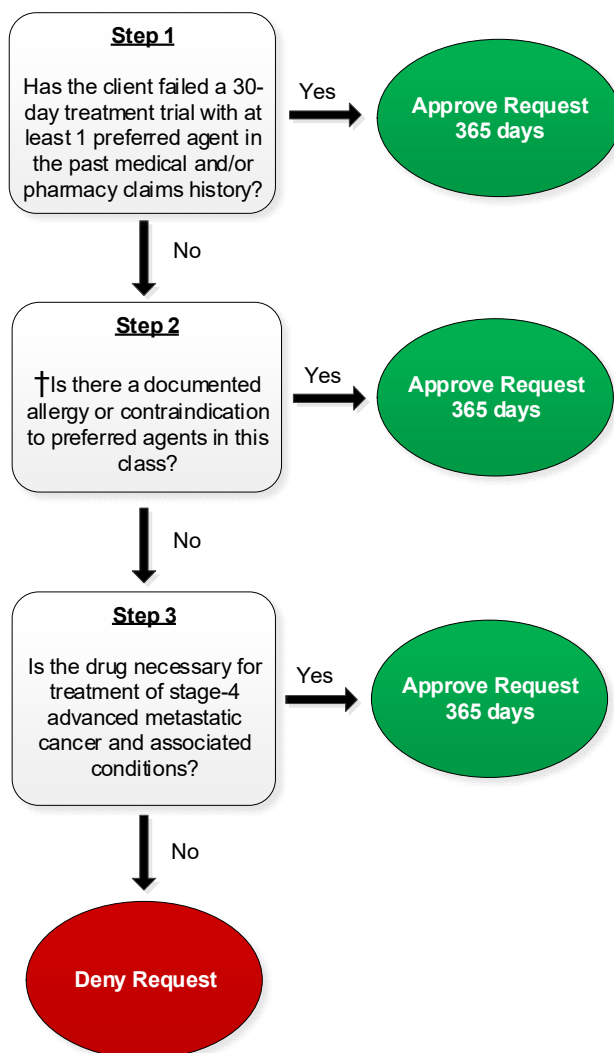
# Leukotriene Modifiers

## Leukotriene Modifiers Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Leukotriene Modifiers Prior Authorization Criteria



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

## Leukotriene Modifiers Alternate Therapies

### Preferred Leukotriene Modifiers

GCN	Drug Name
42373	MONTELUKAST SOD 4 MG TAB CHEW
94440	MONTELUKAST SOD 5 MG TAB CHEW
94444	MONTELUKAST SOD 10 MG TABLET

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

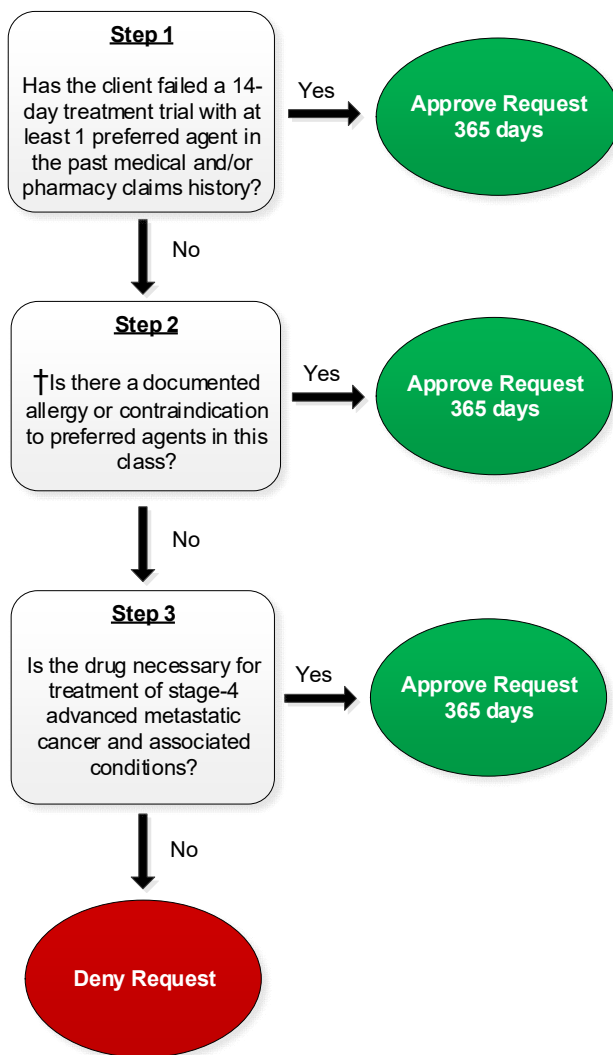
# Lincosamides/Oxazolidinones/Streptogramins

## **Lincosamides/Oxazolidinones/ Streptogramins Prior Authorization Criteria**

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Lincosamides/Oxazolidinones/ Streptogramins Prior Authorization Criteria



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

## Lincosamides/Oxazolidinones/ Streptogramins Alternate Therapies

### Preferred Lincosamides/Oxazolidinones/Streptogramins

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

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



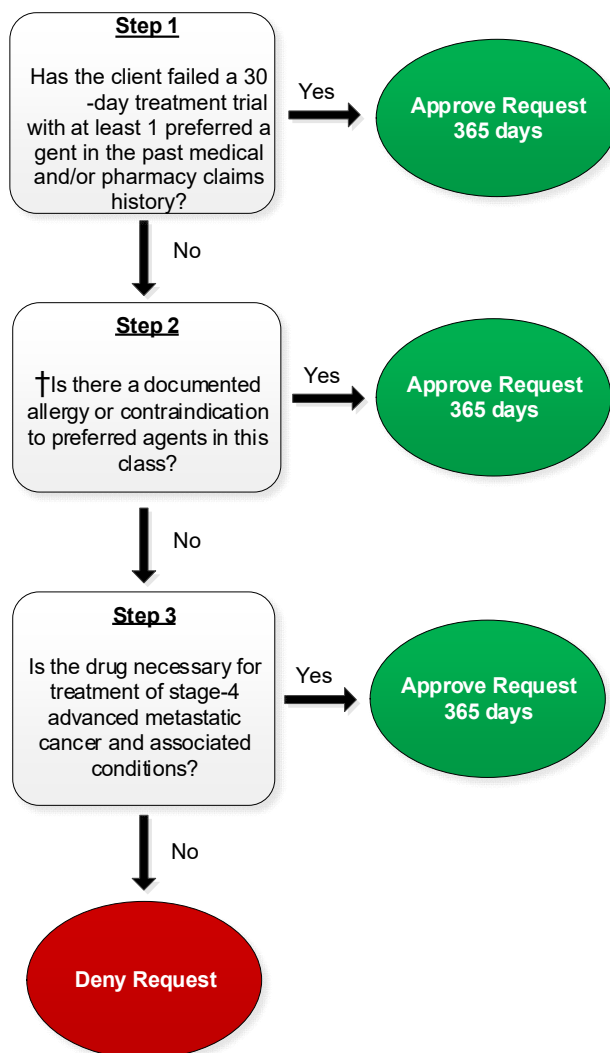
## Lipotropics, Other

## Lipotropics, Other Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Lipotropics, Other Prior Authorization Criteria



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

## Lipotropics, Other Prior Authorization Criteria

### Preferred Other Lipotropics

GCN	Drug Name
09850	CHOLESTYRAMINE LIGHT PACKET
98654	CHOLESTYRAMINE LIGHT POWDER
09920	CHOLESTYRAMINE PACKET
14295	CHOLESTYRAMINE POWDER
25442	COLESTID 1 GM TABLET
94891	ENDUR-ACIN ER 500 MG TABLET
18387	EZETIMIBE 10 MG TABLET
92504	FENOFIBRATE 134 MG CAPSULE
97003	FENOFIBRATE 145 MG TABLET
12595	FENOFIBRATE 160 MG TABLET
93437	FENOFIBRATE 200 MG CAPSULE
97002	FENOFIBRATE 48 MG TABLET
13266	FENOFIBRATE 54 MG TABLET
93446	FENOFIBRATE 67 MG CAPSULE
28126	FISH OIL 1,000 MG SOFTGEL
46508	FISH OIL 1,000 MG SOFTGEL
31469	FISH OIL 500 MG SOFTGEL
29589	FISH OIL EC 1,000 MG SOFTGEL
25540	GEMFIBROZIL 600 MG TABLET
94884	NIACIN 100 MG TABLET
94872	NIACIN 500 MG CAPSULE SA
94881	NIACIN 500 MG TABLET
94874	NIACIN SA 250 MG CAPSULE
23929	OMEGA-3 ETHYL ESTERS 1 GM CAP
39184	PRALUENT 150 MG/ML PEN
39182	PRALUENT 75 MG/ML PEN
38178	REPATHA 140 MG/ML SURECLICK
39363	REPATHA 140 MG/ML SYRINGE
41834	REPATHA 420 MG/3.5ML PUSHTRONX
42365	VASCEPA 0.5 GM CAPSULE
33238	VASCEPA 1 GM CAPSULE
28064	WELCHOL 3.75G PACKET

GCN	Drug Name
16300	WELCHOL 625 MG TABLET

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

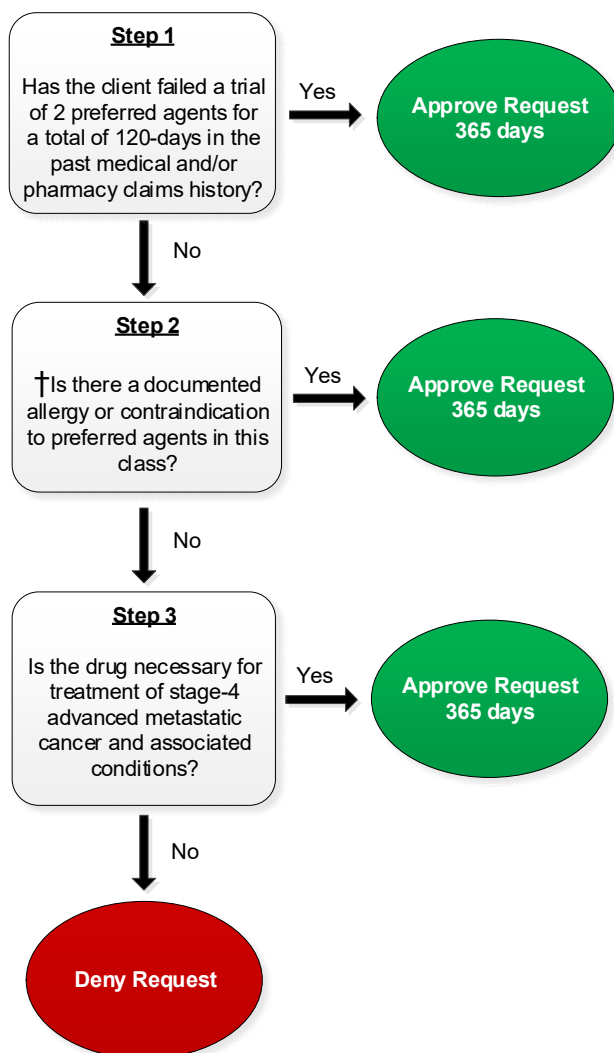
## Lipotropics, Statins

## Lipotropics, Statins Prior Authorization Criteria

1. Has the client failed at least 2 preferred agent(s) for a total of 120 days in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Lipotropics, Statins Prior Authorization Criteria



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



## Lipotropics, Statins Alternate Therapies

### Preferred Statins

GCN	Drug Name
43720	ATORVASTATIN 10 MG TABLET
43721	ATORVASTATIN 20 MG TABLET
43722	ATORVASTATIN 40 MG TABLET
43723	ATORVASTATIN 80 MG TABLET
43720	LIPITOR 10MG TABLET
43721	LIPITOR 20MG TABLET
43722	LIPITOR 40MG TABLET
43723	LIPITOR 80MG TABLET
47042	LOVASTATIN 10 MG TABLET
47040	LOVASTATIN 20 MG TABLET
47041	LOVASTATIN 40 MG TABLET
48671	PRAVASTATIN SODIUM 10 MG TAB
48672	PRAVASTATIN SODIUM 20 MG TAB
48673	PRAVASTATIN SODIUM 40 MG TAB
15412	PRAVASTATIN SODIUM 80 MG TAB
19153	ROSUVASTATIN CALCIUM 10 MG TAB
19154	ROSUVASTATIN CALCIUM 20 MG TAB
19155	ROSUVASTATIN CALCIUM 40 MG TAB
20229	ROSUVASTATIN CALCIUM 5 MG TAB
26532	SIMVASTATIN 10 MG TABLET
26533	SIMVASTATIN 20 MG TABLET
26534	SIMVASTATIN 40 MG TABLET
26531	SIMVASTATIN 5 MG TABLET
26535	SIMVASTATIN 80 MG TABLET

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

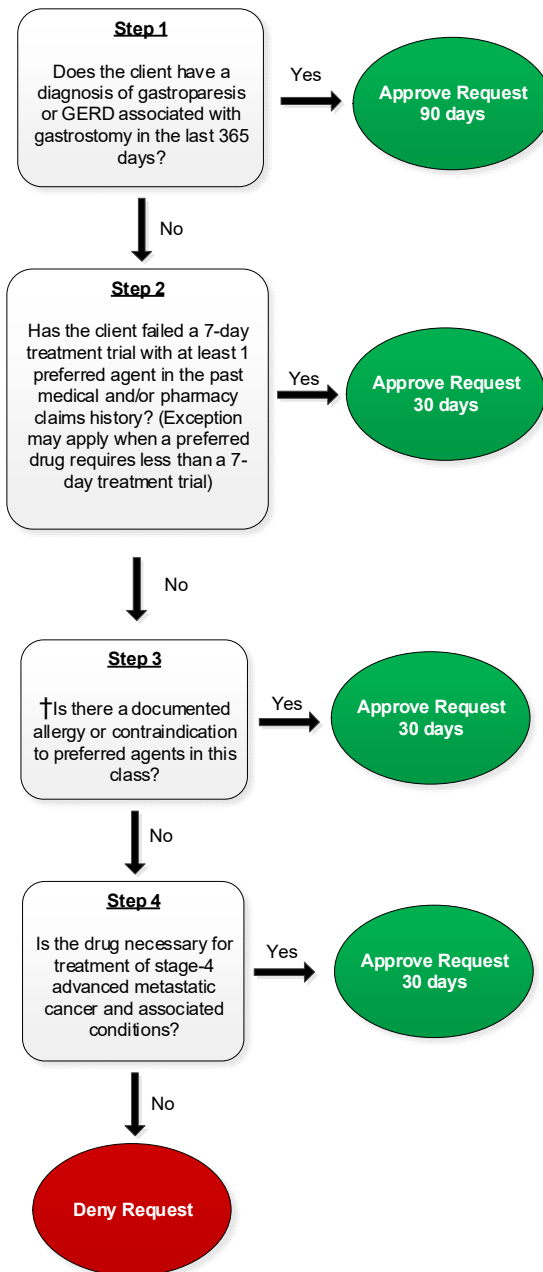
## Macrolides/Ketolides

## Macrolides/Ketolides Prior Authorization Criteria

1. Does the client have a diagnosis of gastroparesis or gastroesophageal reflux disease (GERD) associated with gastrostomy in the last 365 days?  
☐ Yes (Approve – 90 days)  
☐ No (Go to #2)
2. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history? (Exception may apply when a preferred drug requires less than a 7-day treatment trial)  
☐ Yes (Approve – 30 days)  
☐ No (Go to #3)
3. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 30 days)  
☐ No (Go to #4)
4. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 30 days)  
☐ No (Deny)

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

## Macrolides/Ketolides Prior Authorization Criteria



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

## Macrolides/Ketolides Alternate Therapies

### Preferred Macrolides/Ketolides

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

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

## Macrolides/Ketolides Supporting Table

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

# Movement Disorders

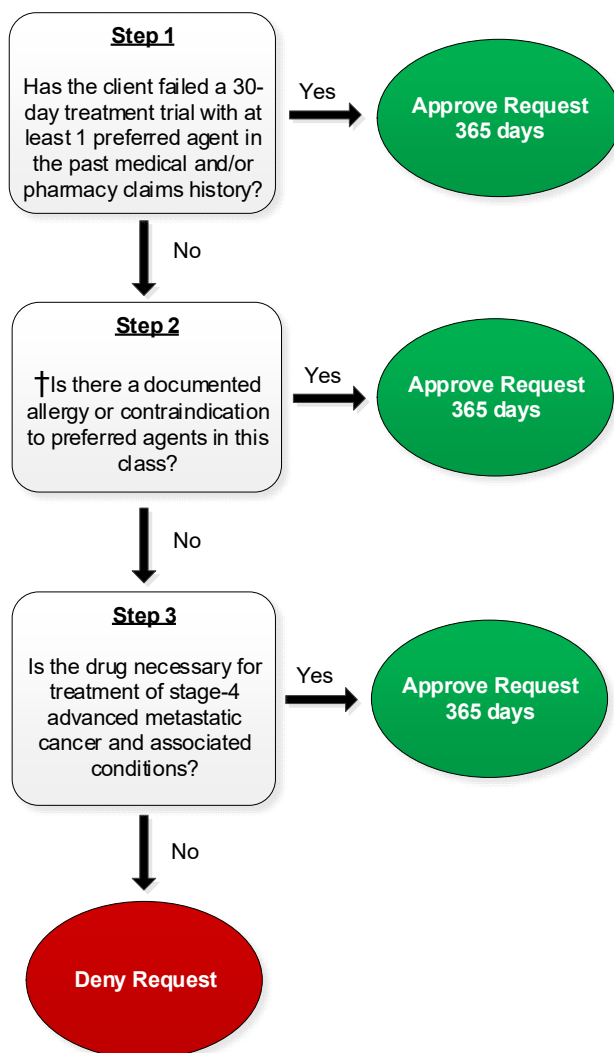
## Movement Disorders Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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



## Movement Disorders Prior Authorization Criteria



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

## Movement Disorders Alternate Therapies

### Preferred Movement Disorder Agents

GCN	Drug Name
43237	AUSTEDO 12 MG TABLET
43228	AUSTEDO 6 MG TABLET
43236	AUSTEDO 9 MG TABLET
53737	AUSTEDO XR 12 MG TABLET
53738	AUSTEDO XR 24 MG TABLET
55819	AUSTEDO XR 30 MG TABLET
55824	AUSTEDO XR 36 MG TABLET
55823	AUSTEDO XR 42 MG TABLET
55822	AUSTEDO XR 48 MG TABLET
53736	AUSTEDO XR 6 MG TABLET
53741	AUSTEDO XR TITRATION KT(WK1-4)
43266	INGREZZA 40 MG CAPSULE
49577	INGREZZA 60 MG CAPSULE
43934	INGREZZA 80 MG CAPSULE
46216	INGREZZA INITIATION PK(TARDIV)
15508	TETRABENAZINE 12.5 MG TABLET
49900	TETRABENAZINE 25 MG TABLET

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

# Multiple Sclerosis Agents

## Multiple Sclerosis Agents Alternate Therapies

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

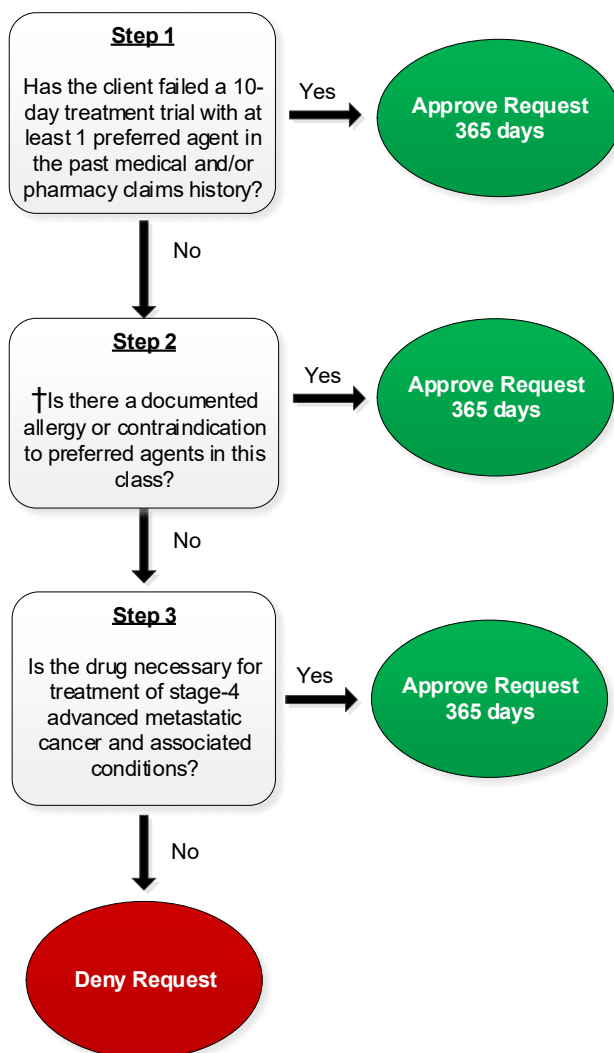
# Neuropathic Pain

## Neuropathic Pain Prior Authorization Criteria

1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Neuropathic Pain Prior Authorization Criteria



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

## Neuropathic Pain Alternate Therapies

### Preferred Agents for Neuropathic Pain

GCN	Drug Name
23373	ARTHRITIS PAIN RELIEF 0.1% CRM
33561	ARTHRITIS PAIN RLF 0.075% CRM
33560	CAPSAICIN 0.025% CREAM
99466	CAPSAICIN 0.15% LIQUID
23161	DULOXETINE HCL DR 20 MG CAP
23162	DULOXETINE HCL DR 30 MG CAP
23164	DULOXETINE HCL DR 60 MG CAP
00780	GABAPENTIN 100 MG CAPSULE
13235	GABAPENTIN 250 MG/5 ML SOLN
33065	GABAPENTIN 250 MG/5 ML SOLN
00781	GABAPENTIN 300 MG CAPSULE
33066	GABAPENTIN 300 MG/6 ML SOLN
00782	GABAPENTIN 400 MG CAPSULE
94624	GABAPENTIN 600 MG TABLET
94447	GABAPENTIN 800 MG TABLET
50272	LIDOCAINE 5% PATCH
50272	LIDODERM 5% PATCH
23048	LYRICA 100 MG CAPSULE
23049	LYRICA 150 MG CAPSULE
23051	LYRICA 200 MG CAPSULE
25019	LYRICA 225 MG CAPSULE
23039	LYRICA 25 MG CAPSULE
23052	LYRICA 300 MG CAPSULE
23046	LYRICA 50 MG CAPSULE
23047	LYRICA 75 MG CAPSULE

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



# NSAIDS

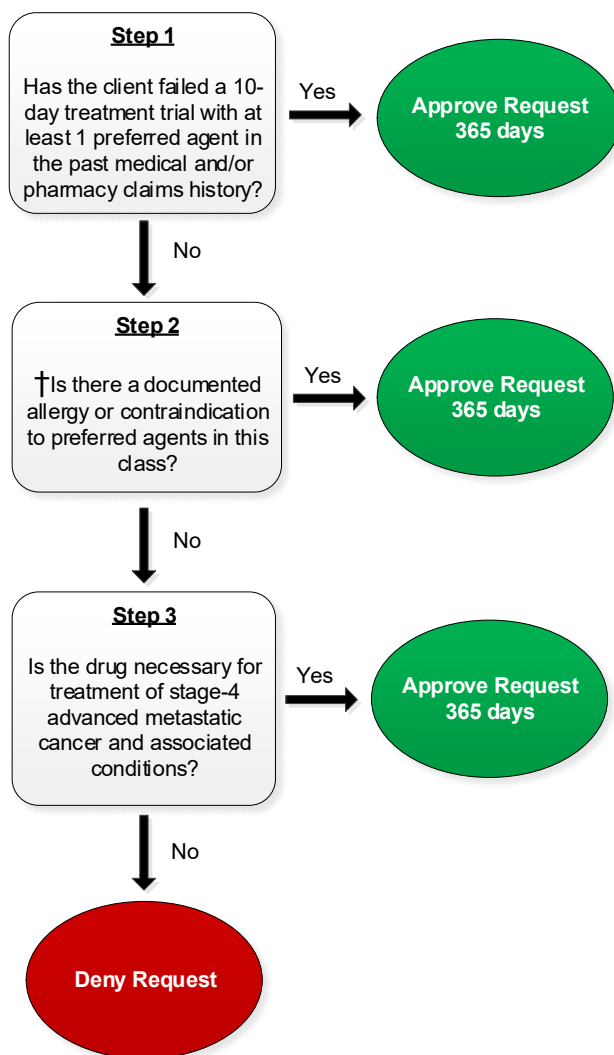
## NSAIDS

### Prior Authorization Criteria

1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## NSAIDS Prior Authorization Criteria



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

## NSAIDS

### Alternate Therapies

#### Preferred Generic NSAIDs

GCN	Drug Name
35743	ADDAPRIN 200 MG TABLET
35749	ADVIL JR STR 100 MG TAB CHEW
45680	ALEVE ARTHRITIS PAIN 1% GEL
47132	ALL DAY PAIN RELIEF 220 MG TAB
42001	CELECOXIB 100 MG CAPSULE
42002	CELECOXIB 200 MG CAPSULE
18127	CELECOXIB 400 MG CAPSULE
97785	CELECOXIB 50 MG CAPSULE
35930	CHILD IBUPROFEN 100 MG/5ML CUP
35431	CVS IBUPROFEN 200 MG CAPSULE
35931	CVS INF IBUPROFEN 50 MG/1.25ML
29254	CVS NAPROXEN SODIUM 220 MG CAP
13967	DICLOFENAC POT 25 MG TABLET
13960	DICLOFENAC POT 50 MG TABLET
35850	DICLOFENAC SOD DR 25 MG TAB
35851	DICLOFENAC SOD DR 50 MG TAB
35852	DICLOFENAC SOD DR 75 MG TAB
35743	GS IBUPROFEN 200MG TABLET
35741	IBU 400 MG TABLET
35742	IBU 600 MG TABLET
35744	IBU 800 MG TABLET
35743	IBU-200 200MG TABLET
35930	IBUPROFEN 100MG/5ML SUSP
35741	IBUPROFEN 400MG TABLET
35742	IBUPROFEN 600MG TABLET
35744	IBUPROFEN 800MG TABLET
35680	INDOMETHACIN 25 MG CAPSULE
35681	INDOMETHACIN 50 MG CAPSULE
32531	KETOROLAC 10 MG TABLET
31662	MELOXICAM 15 MG TABLET
31661	MELOXICAM 7.5 MG TABLET
35790	NAPROXEN 250 MG TABLET
35792	NAPROXEN 375 MG TABLET

GCN	Drug Name
35793	NAPROXEN 500 MG KIT
61850	NAPROXEN DR 375 MG TABLET
61851	NAPROXEN DR 500 MG TABLET
47132	NAPROXEN SODIUM 220MG TABLET
35431	QC IBUPROFEN 200MG SOFTGEL
47132	QC NAPROXEN SOD 220 MG TABLET
35743	SM IBUPROFEN 200MG TABLET
35800	SULINDAC 150 MG TABLET
35801	SULINDAC 200 MG TABLET

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

## Oncology, Oral - Breast

## Oncology, Oral - Breast Alternate Therapies

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

## Oncology, Oral - Hematologic



## **Oncology, Oral - Hematologic Alternate Therapies**

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

## Oncology, Oral - Lung

## Oncology, Oral – Lung Alternate Therapies

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

## Oncology, Oral - Other

## Oncology, Oral – Other Alternate Therapies

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

## Oncology, Oral - Prostate

## Oncology, Oral - Prostate Alternate Therapies

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

## Oncology, Oral – Renal Cell



## **Oncology, Oral – Renal Cell Alternate Therapies**

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

## Oncology, Oral - Skin

## Oncology, Oral - Skin Alternate Therapies

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

# Ophthalmics, Antibiotic - Steroid Combinations

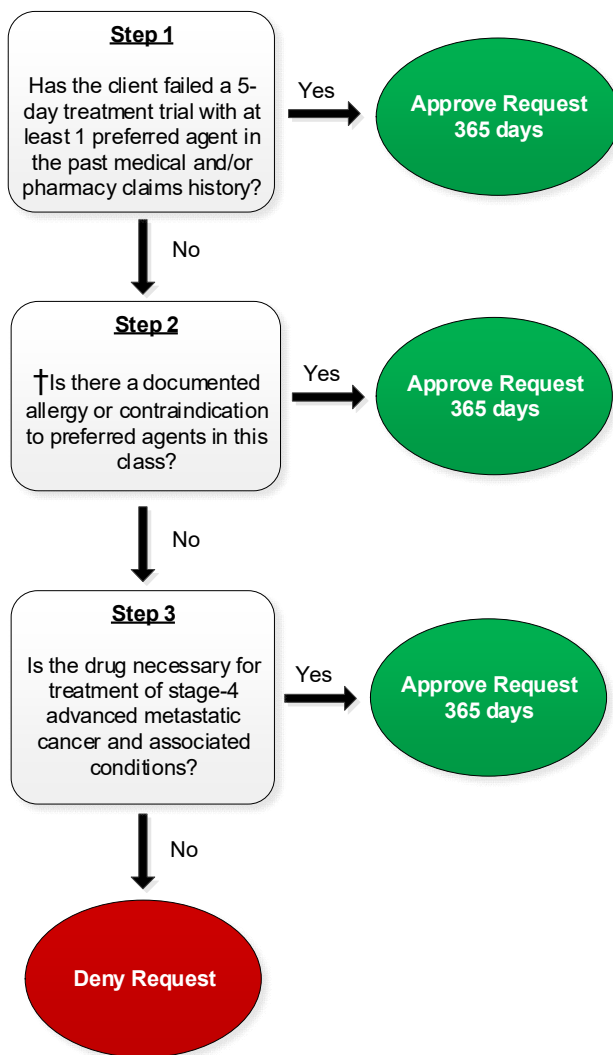
## Ophthalmics, Antibiotic - Steroid Combinations

### Prior Authorization Criteria

1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Ophthalmics, Antibiotic-Steroid Combinations Prior Authorization Criteria



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

## Ophthalmics, Antibiotic- Steroid Combinations Alternate Therapies

### Preferred Ophthalmic Antibiotic/Steroid Agents

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

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

## Ophthalmics, Antibiotic

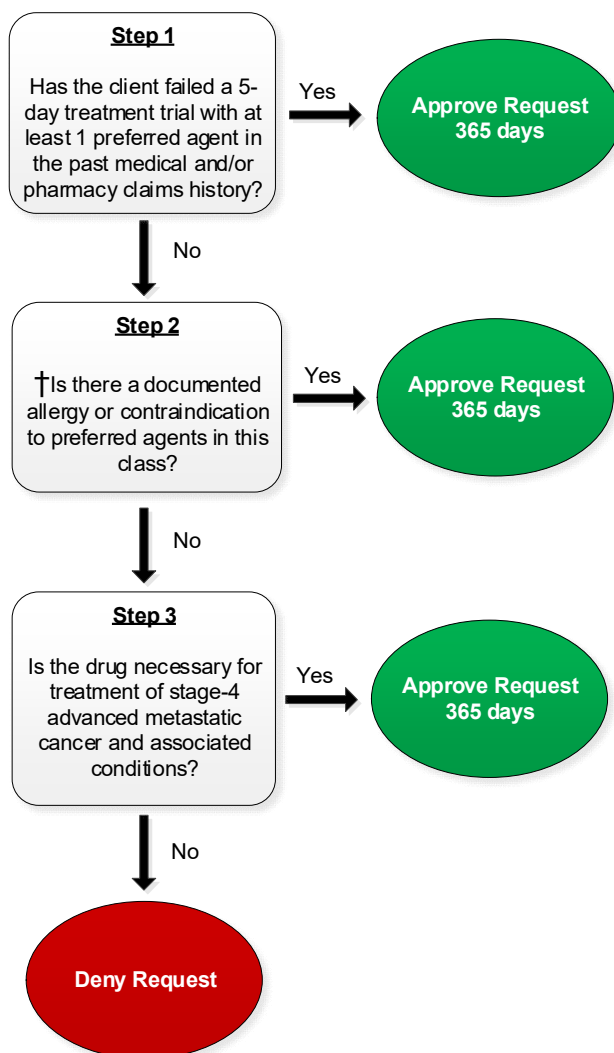


## Ophthalmics, Antibiotic Prior Authorization Criteria

1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Ophthalmics, Antibiotic Prior Authorization Criteria



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

## Ophthalmics, Antibiotic Alternate Therapies

### Preferred Ophthalmic Antibiotics

GCN	Drug Name
25486	AK-POLY-BAC EYE OINTMENT
33580	CIPROFLOXACIN 0.3% EYE DROP
33540	ERYTHROMYCIN 0.5% EYE OINTMENT
33590	GENTAK 0.3 % EYE OINTMENT
33600	GENTAMICIN 0.3% EYE DROP
19542	MOXIFLOXACIN 0.5% EYE DROPS
36600	OFLOXACIN 0.3% EYE DROPS
25486	POLYCIN EYE OINTMENT
14294	POLYMYXIN B-TMP EYE DROPS
09384	TOBRAMYCIN 0.3% EYE DROP
09383	TOBREX 0.3% EYE OINTMENT

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

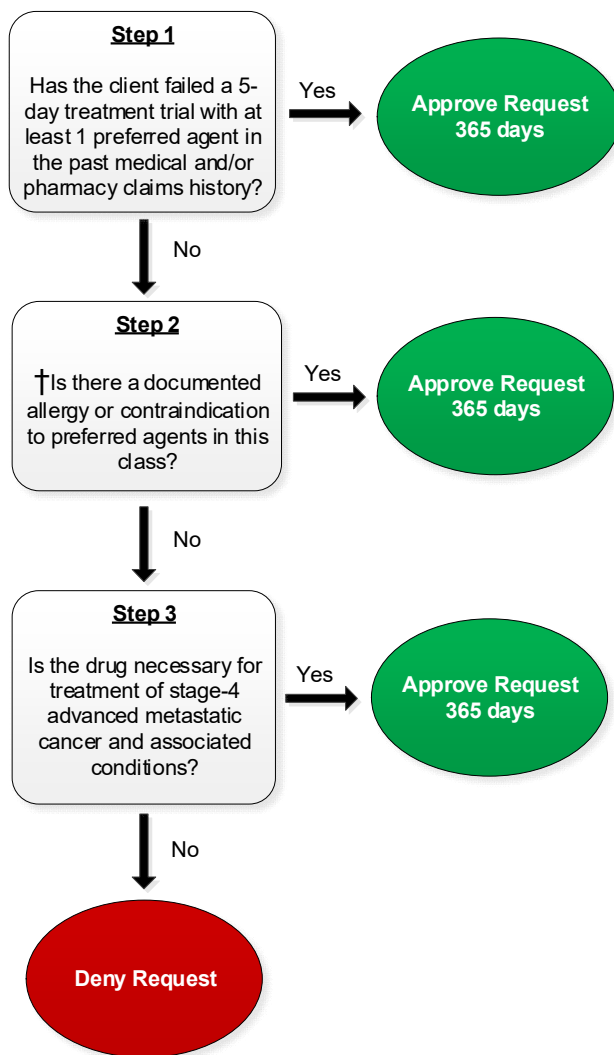
## Ophthalmics, Allergic Conjunctivitis

## Ophthalmics, Allergic Conjunctivitis Prior Authorization Criteria

1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Ophthalmics, Allergic Conjunctivitis Prior Authorization Criteria



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

## Ophthalmics, Allergic Conjunctivitis Alternate Therapies

### Preferred Ophthalmic Allergic Conjunctivitis Agents

GCN	Drug Name
69069	CROMOLYN 4% EYE DROPS
68321	CVS OLOPATADINE 0.1% EYE DROPS
97848	EYE ALLERGY ITCH RLF 0.2% DROP
37855	PATADAY ONCE DAILY 0.7% DROPS

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

## Ophthalmics, Anti-Inflammatories

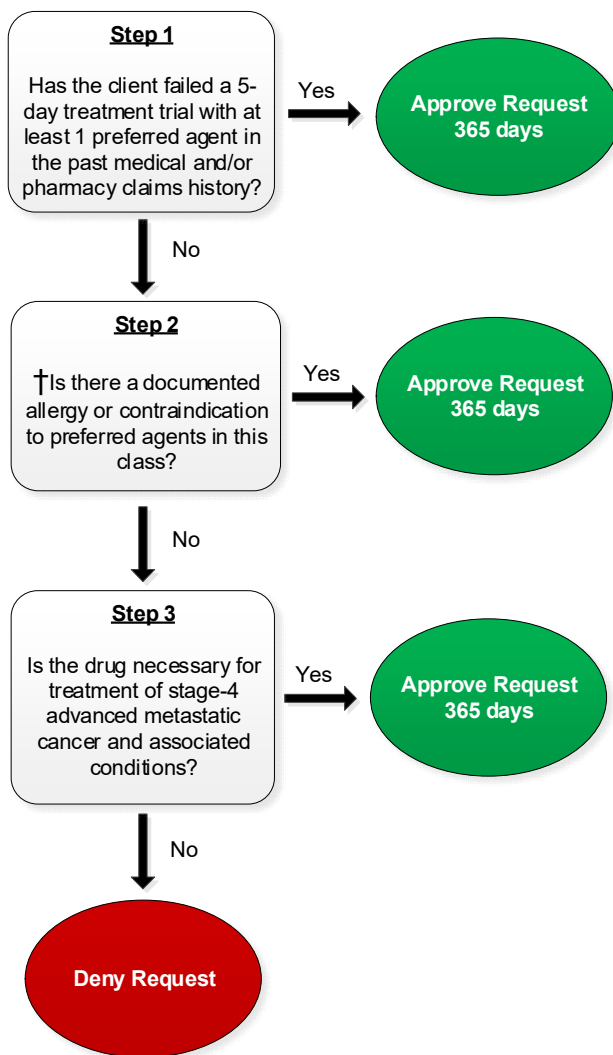


## **Ophthalmics, Anti-Inflammatories Prior Authorization Criteria**

1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Ophthalmics, Anti-Inflammatories Prior Authorization Criteria



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

## Ophthalmics, Anti-Inflammatories Alternate Therapies

### Preferred Ophthalmic Anti-Inflammatory Agents

GCN	Drug Name
33831	DICLOFENAC 0.1% EYE DROPS
13635	DUREZOL 0.05% EYE DROPS
52700	KETOROLAC 0.5% OPTH SOLUTION
95464	LOTEMAX 0.5% EYE DROPS
95464	LOTEMAX 0.5% EYE DROPS 10 ML (NDC 24208029910 only)
95464	LOTEMAX 0.5% EYE DROPS 15 ML (NDC 24208029915 only)
95464	LOTEMAX 0.5% EYE DROPS 5 ML (NDC 24208029905 only)
30304	LOTEMAX 0.5% EYE OINTMENT
33153	PREDNISOLONE AC 1% EYE DROP
44855	PREDNISOLONE ACET 1% EYE DROP

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

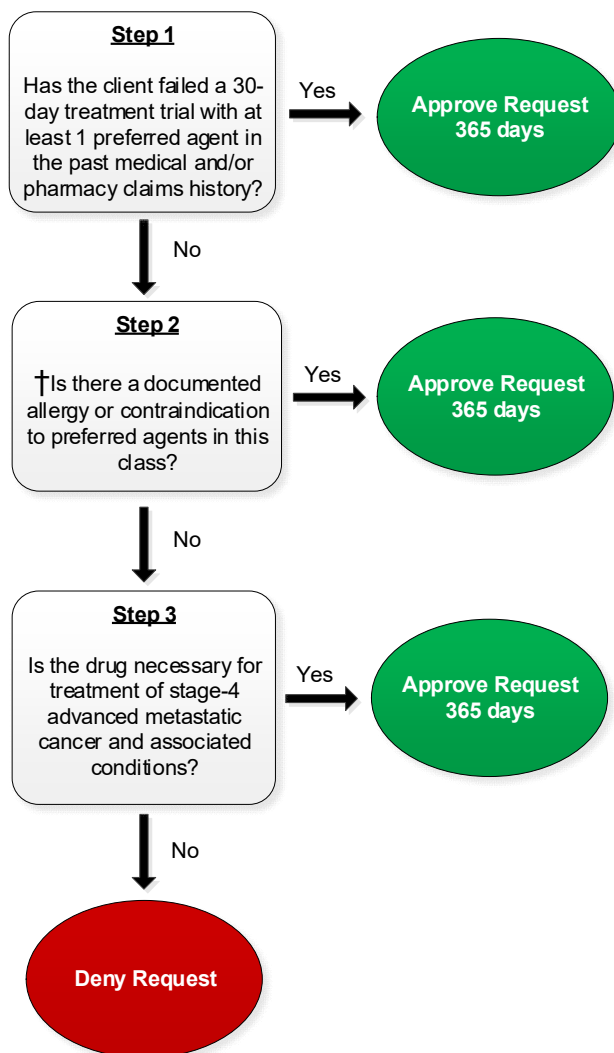
# Ophthalmics, Anti-Inflammatory/Immunomodulators

## **Ophthalmics, Anti-Inflammatory / Immunomodulators Prior Authorization Criteria**

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Ophthalmics, Anti-Inflammatory / Immunomodulators Prior Authorization Criteria



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

## Ophthalmics, Anti-Inflammatory / Immunomodulator Alternate Therapies

### Preferred Ophthalmic Anti-Inflammatory/Immunomodulator Agents

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

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

## Ophthalmics, Glaucoma Agents

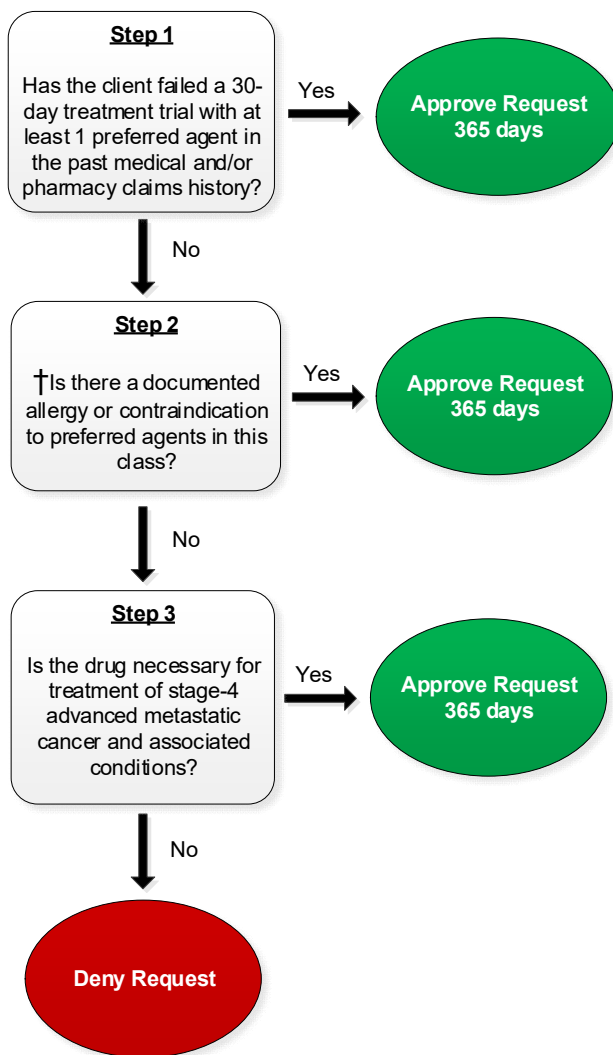


## Ophthalmics, Glaucoma Agents Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Ophthalmics, Glaucoma Agents Prior Authorization Criteria



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

## Ophthalmics, Glaucoma Agents Alternate Therapies

### Preferred Ophthalmic Glaucoma Agents

GCN	Drug Name
95773	AZOPT 1% EYE DROPS
36281	BRIMONIDINE 0.2% EYE DROP
32261	CARTEOLOL HCL 1% EYE DROPS
20876	COMBIGAN 0.2%-0.5% EYE DROPS
33380	DORZOLAMIDE HCL 2% EYE DROPS
95919	DORZOLAMIDE-TIMOLOL EYE DROPS
32749	LATANOPROST 0.005% EYE DROPS
33310	LEVOBUNOLOL 0.5% EYE DROPS
32704	PILOCARPINE 1% EYE DROPS
32706	PILOCARPINE 2% EYE DROPS
32752	PILOCARPINE 4% EYE DROPS
44308	RHOPRESSA 0.02% OPTH SOLUTION
46097	ROCKLATAN 0.02%-0.005% EYE DRP
34579	SIMBRINZA 1%-0.2% EYE DROP
32822	TIMOLOL 0.25% GEL-SOLUTION
32823	TIMOLOL 0.5% GEL-SOLUTION
32820	TIMOLOL MALEATE 0.25% EYE DROP
32821	TIMOLOL MALEATE 0.5% EYE DROPS
13002	TRAVATAN Z 0.004% EYE DROP

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

# Opiate Dependence Treatments

## **Opiate Dependence Treatments Prior Authorization Criteria**

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

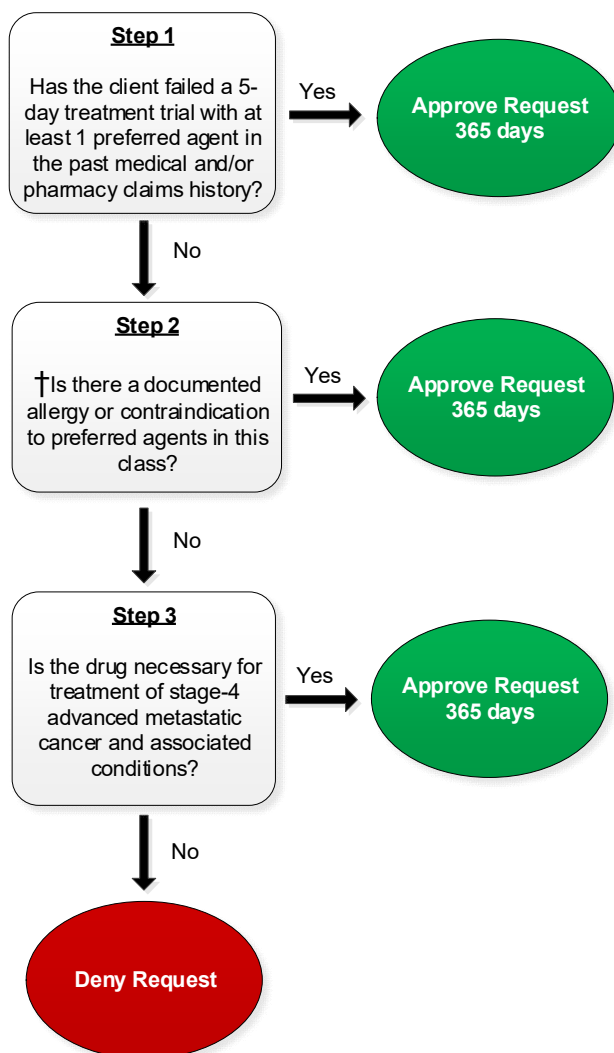
## Otic Antibiotics

## Otic Antibiotics Prior Authorization Criteria

1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Otic Antibiotics Prior Authorization Criteria



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



## Otic Antibiotics Alternate Therapies

### Preferred Otic Antibiotics

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

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

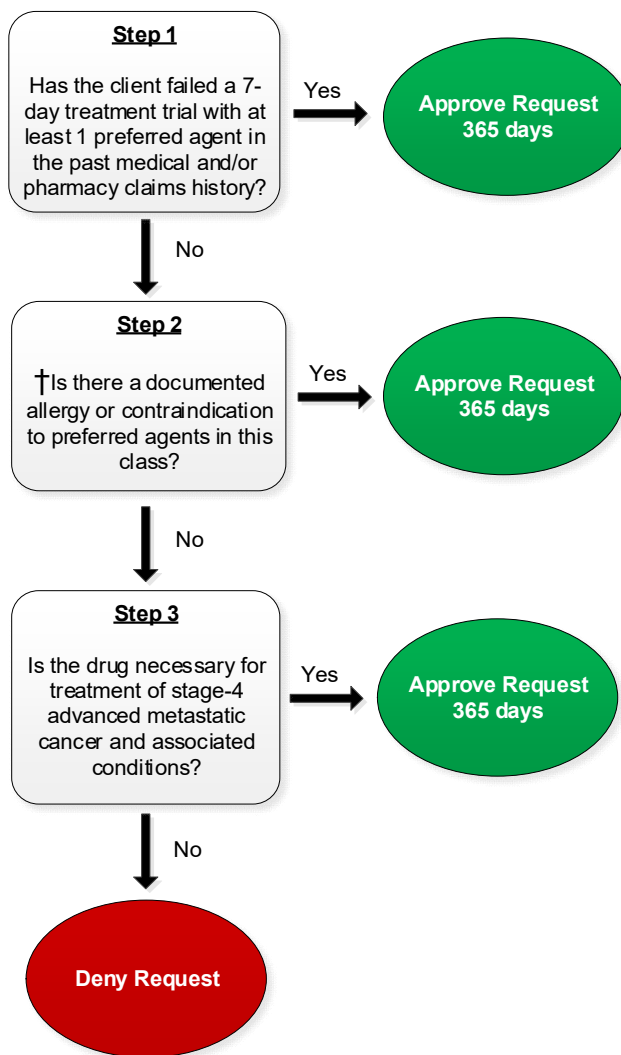
## Otic Anti-Infectives/Anesthetics

## Otic Anti-Infectives/Anesthetics Prior Authorization Criteria

1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Otic Anti-Infectives/Anesthetics Prior Authorization Criteria



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

## Otic Anti-Infectives/Anesthetics Alternate Therapies

### Preferred Otic Anti-Infectives/Anesthetics

GCN	Drug Name
34341	ACETIC ACID 2% EAR SOLUTION

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

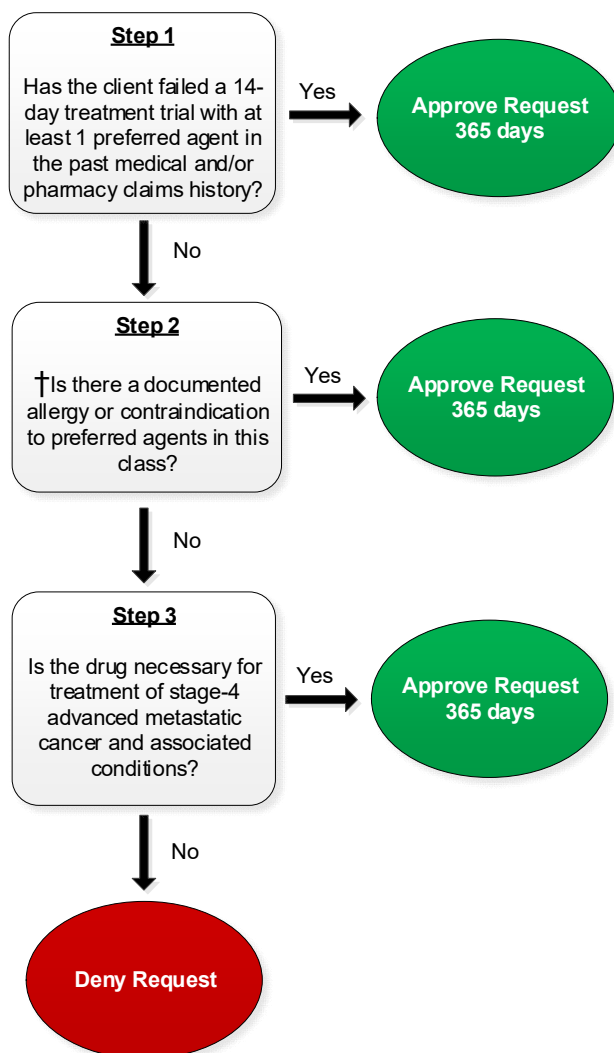
## PAH Agents, Oral

## PAH Agents Prior Authorization Criteria

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## PAH Agents Prior Authorization Criteria



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



## PAH Agents Alternate Therapies

### Preferred PAH Agents

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

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

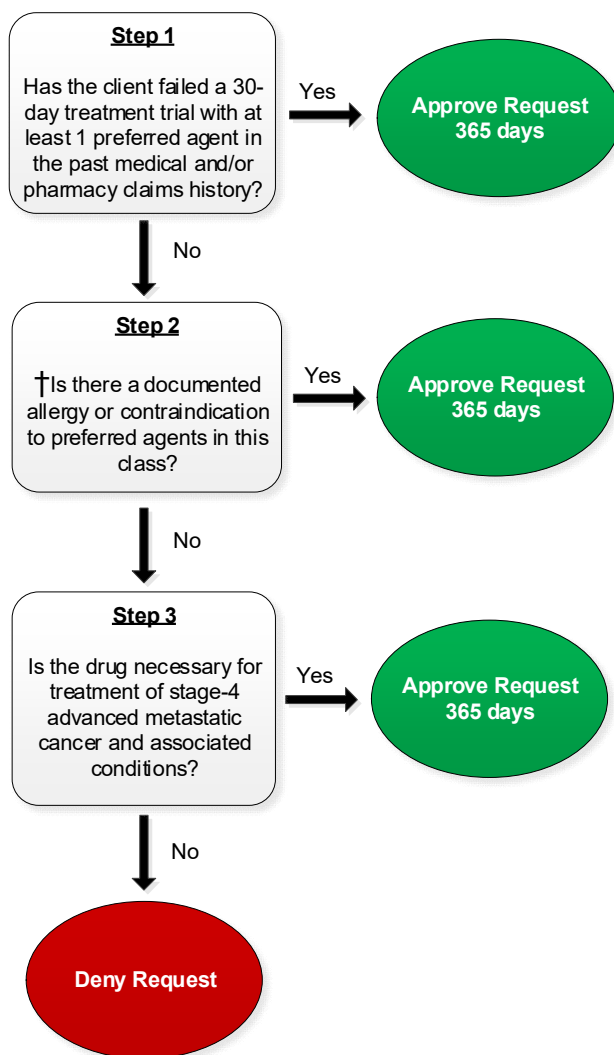
# Pancreatic Enzymes

## Pancreatic Enzymes Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Pancreatic Enzymes Prior Authorization Criteria



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

## Pancreatic Enzymes Alternate Therapies

### Preferred Pancreatic Enzymes

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

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

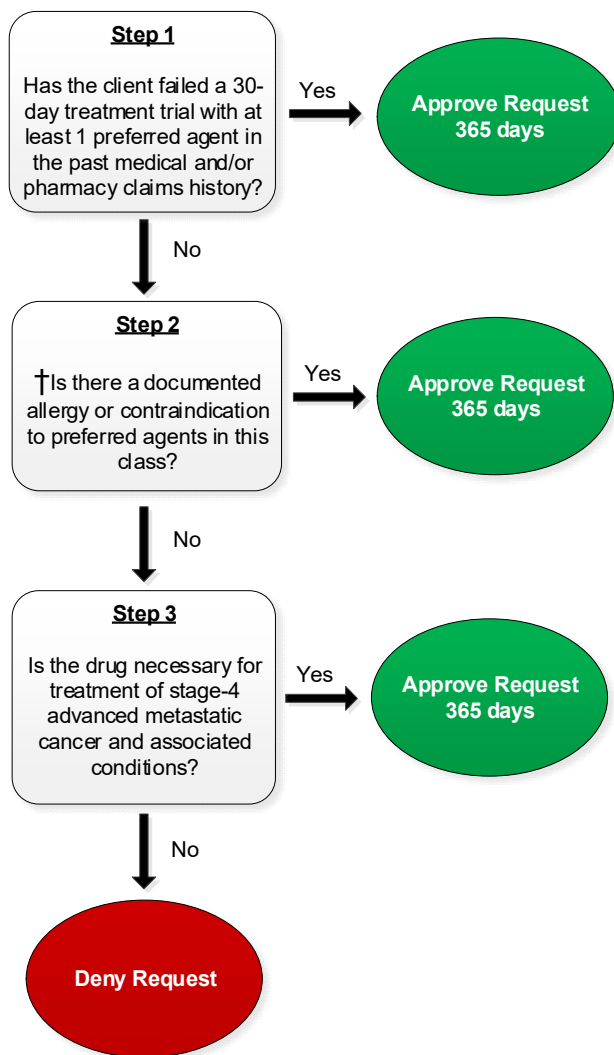
# Pediatric Vitamin Preparations

## Pediatric Vitamin Preparations Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Pediatric Vitamin Preparations Prior Authorization Criteria



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



## Pediatric Vitamin Preparations Alternate Therapies

### Preferred Pediatric Vitamin Preparations

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

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

# Penicillins

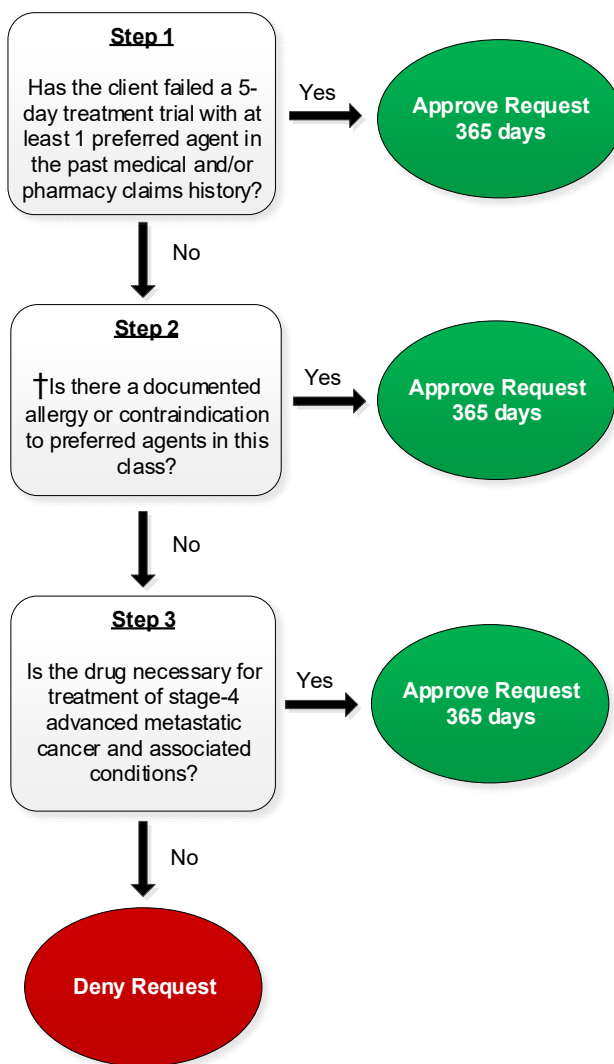
## Penicillins

### Prior Authorization Criteria

1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Penicillins Prior Authorization Criteria



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

## Penicillins

### Alternate Therapies

#### Preferred Penicillins

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

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

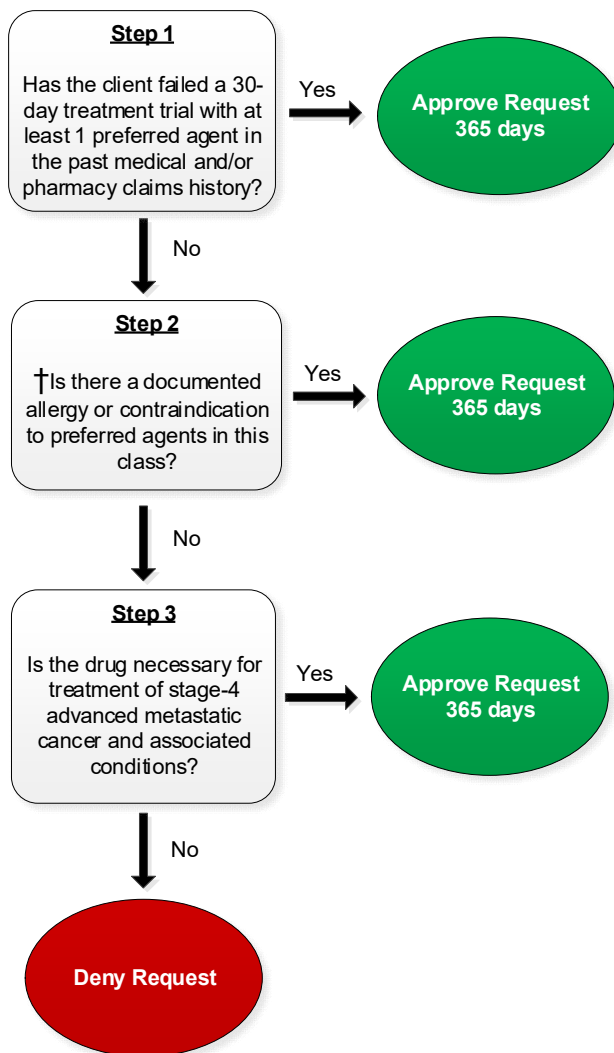
# Phosphate Binders

## Phosphate Binders Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Phosphate Binders Prior Authorization Criteria



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



## Phosphate Binders Alternate Therapies

### Preferred Phosphate Binders

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

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

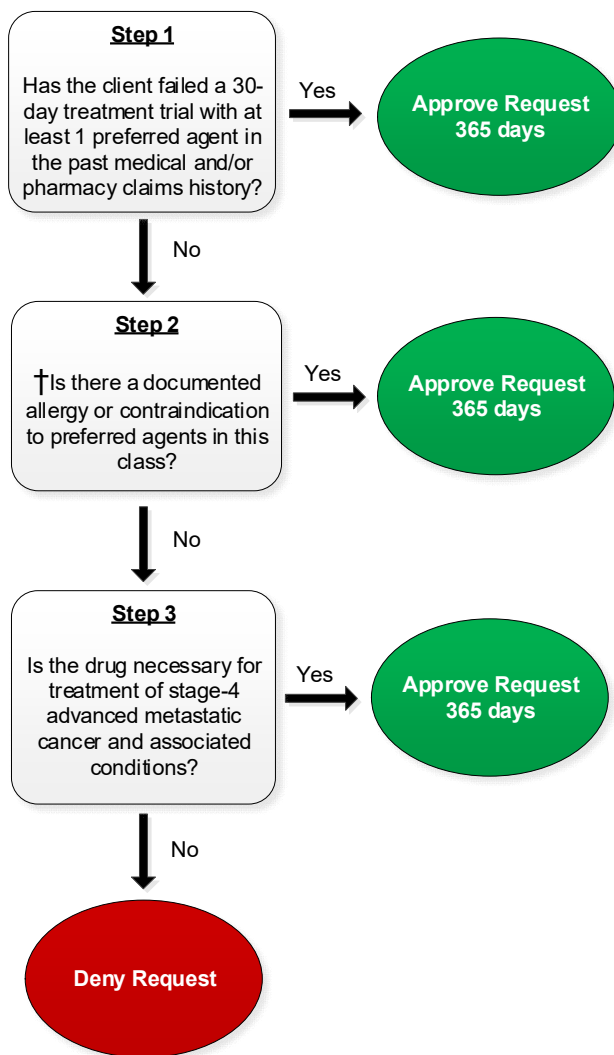
## Platelet Aggregation Inhibitors

## Platelet Aggregation Inhibitors Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Platelet Aggregation Inhibitors Prior Authorization Criteria



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

## Platelet Aggregation Inhibitors Alternate Therapies

### Preferred PAIs

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

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

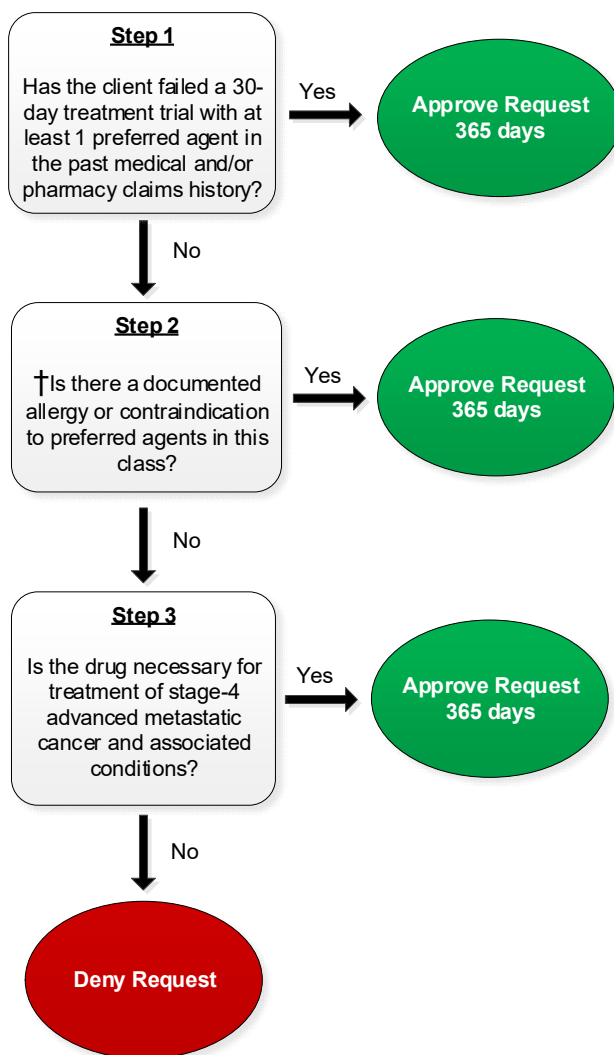
# Potassium Binders

## Potassium Binders Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Potassium Binders Prior Authorization Criteria



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



## Potassium Binders Alternate Therapies

### Preferred Potassium Binders

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

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

# Prenatal Vitamins

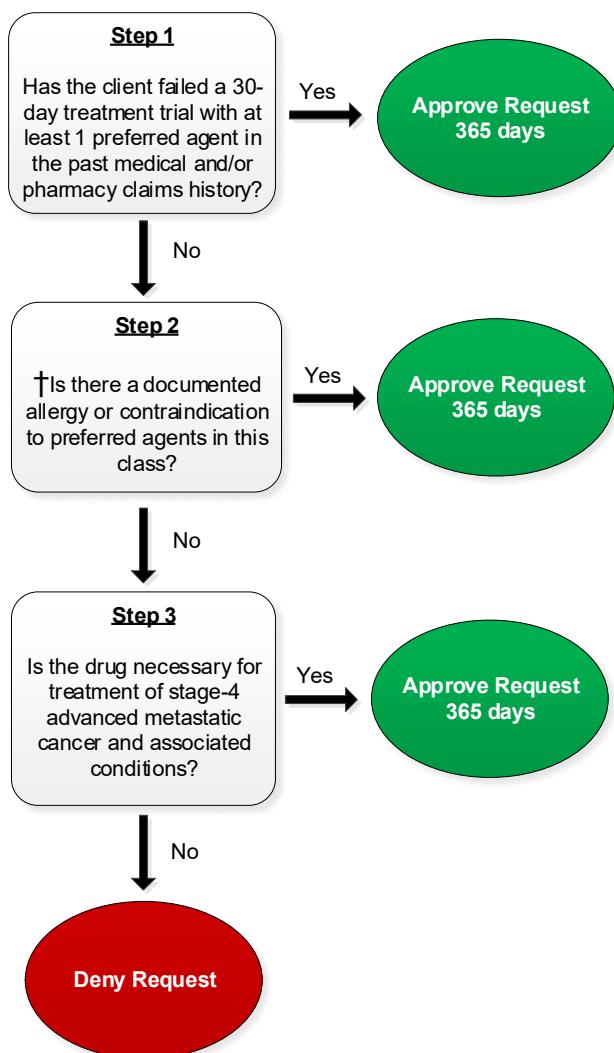
## Prenatal Vitamins Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

*\*Prenatal vitamins are covered only for females less than 50 years of age.*

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

## Prenatal Vitamins Prior Authorization Criteria



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

## Prenatal Vitamins Alternate Therapies

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

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

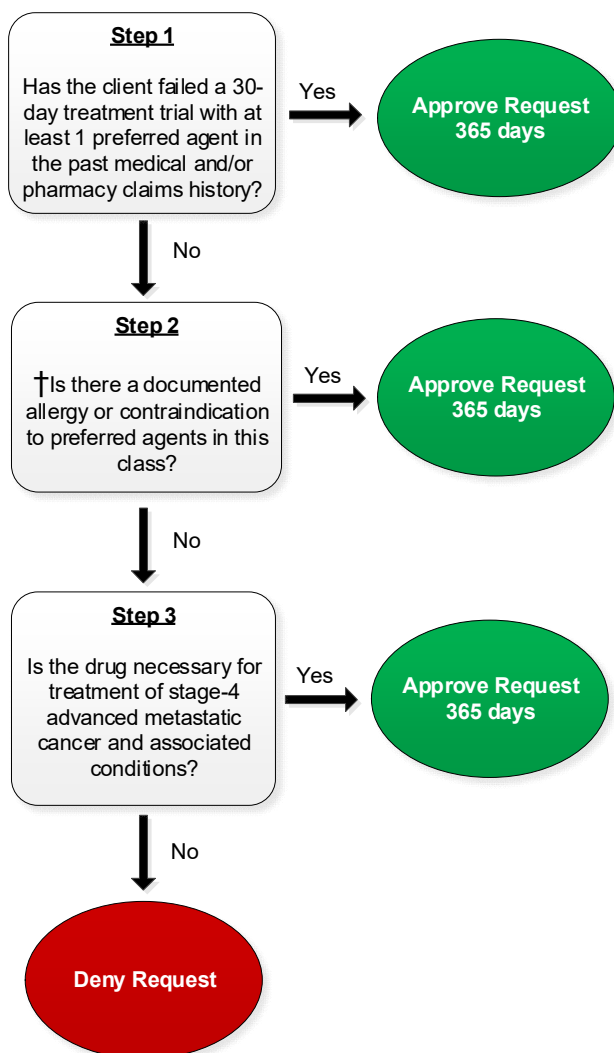
# Progestins for Cachexia

## Progestins for Cachexia Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Progestins for Cachexia Prior Authorization Criteria



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



## Progestins for Cachexia Alternate Therapies

### Preferred Progestins

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

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

# Proton Pump Inhibitors

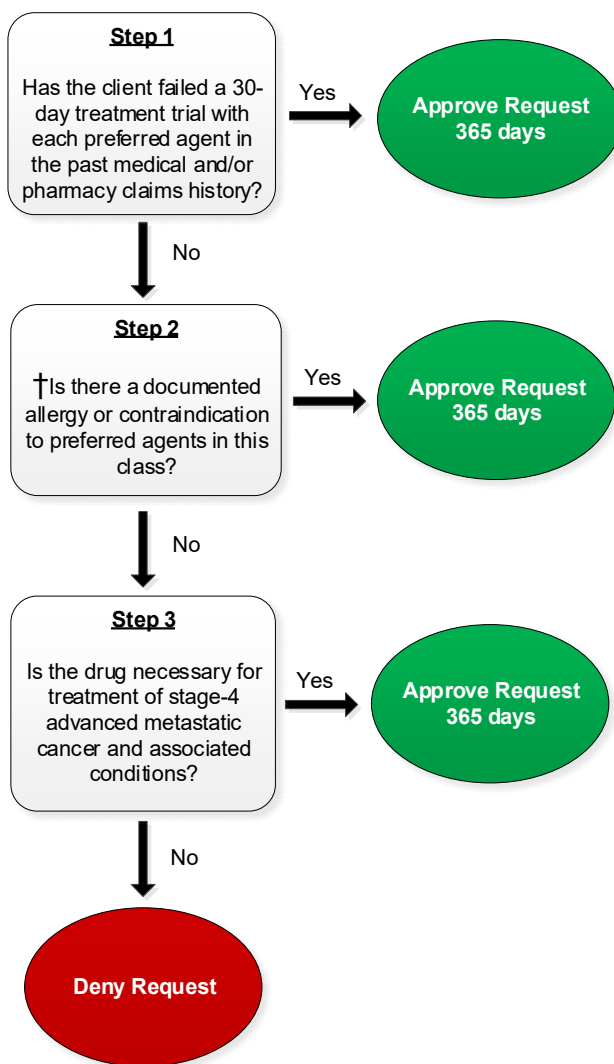
## Proton Pump Inhibitors Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with each\* preferred agent within the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

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

## Proton Pump Inhibitors Prior Authorization Criteria



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

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

## Proton Pump Inhibitors Alternate Therapies

### Preferred PPIs

GCN	Drug Name
16305	DEXILANT DR 30 MG CAPSULE
16306	DEXILANT DR 60 MG CAPSULE
99389	NEXIUM DR 10 MG PACKET
33128	NEXIUM DR 2.5 MG PACKET
98030	NEXIUM DR 20 MG PACKET
98031	NEXIUM DR 40 MG PACKET
33135	NEXIUM DR 5 MG PACKET
92989	OMEPRAZOLE DR 10 MG CAPSULE
04348	OMEPRAZOLE DR 20 MG CAPSULE
92999	OMEPRAZOLE DR 40 MG CAPSULE
95976	PANTOPRAZOLE SOD DR 20 MG TAB
40120	PANTOPRAZOLE SOD DR 40 MG TAB
99418	PROTONIX 40 MG SUSPENSION

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

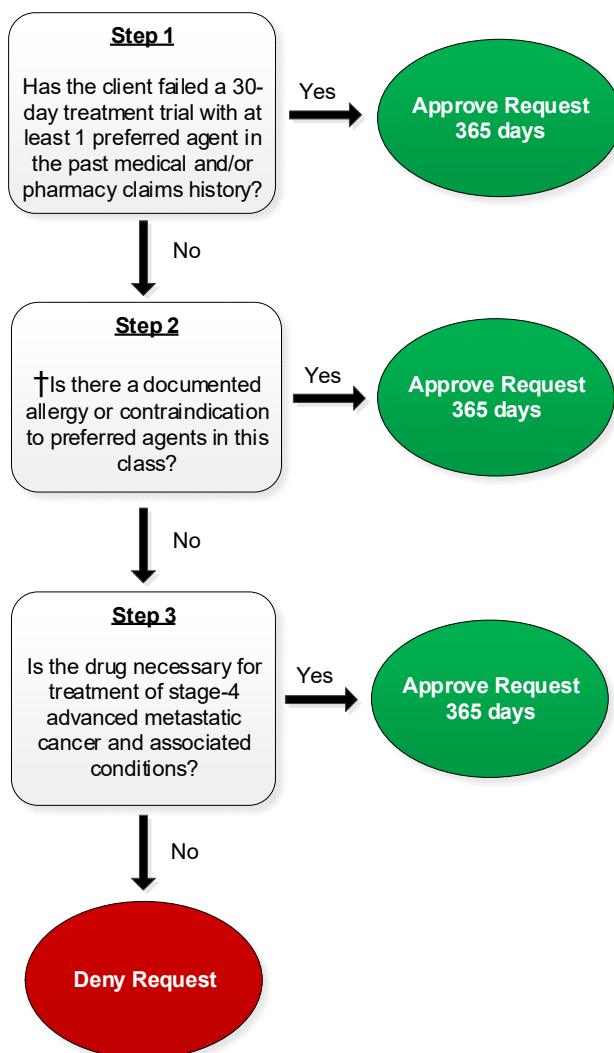
## Rosacea Agents, Topical

## Rosacea Agents, Topical Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with a preferred agent within the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Rosacea Agents, Topical Prior Authorization Criteria



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



## Rosacea Agents, Topical Alternate Therapies

### Preferred Topical Rosacea Agents

GCN	Drug Name
43203	METRONIDAZOLE 0.75% CREAM
31774	METRONIDAZOLE TOP 1% GEL PUMP
43202	METRONIDAZOLE TOPICAL 0.75% GL
24926	METRONIDAZOLE TOPICAL 1% GEL

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

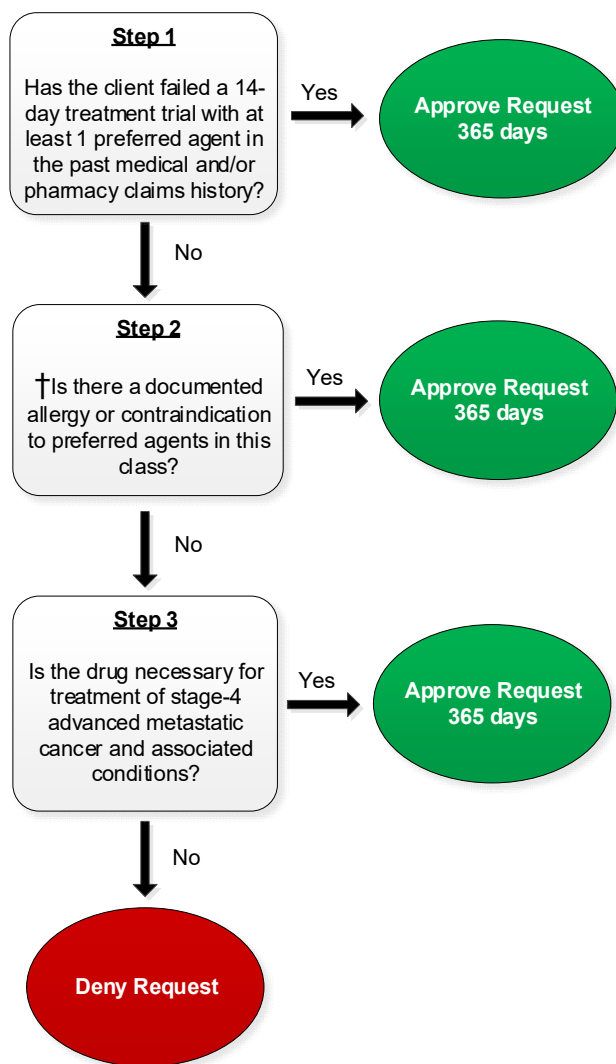
# Sedatives and Hypnotics

## Sedatives and Hypnotics Prior Authorization Criteria

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Sedatives and Hypnotics Prior Authorization Criteria



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

## Sedatives and Hypnotics Alternate Therapies

### Preferred Sedatives and Hypnotics

GCN	Drug Name
23927	ESZOPICLONE 1 MG TABLET
23926	ESZOPICLONE 2 MG TABLET
23925	ESZOPICLONE 3 MG TABLET
13840	TEMAZEPAM 15 MG CAPSULE
13841	TEMAZEPAM 30 MG CAPSULE
14282	TRIAZOLAM 0.125 MG TABLET
14280	TRIAZOLAM 0.25 MG TABLET
92723	ZALEPLON 10 MG CAPSULE
92713	ZALEPLON 5 MG CAPSULE
00871	ZOLPIDEM TARTRATE 10 MG TABLET
00870	ZOLPIDEM TARTRATE 5 MG TABLET

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

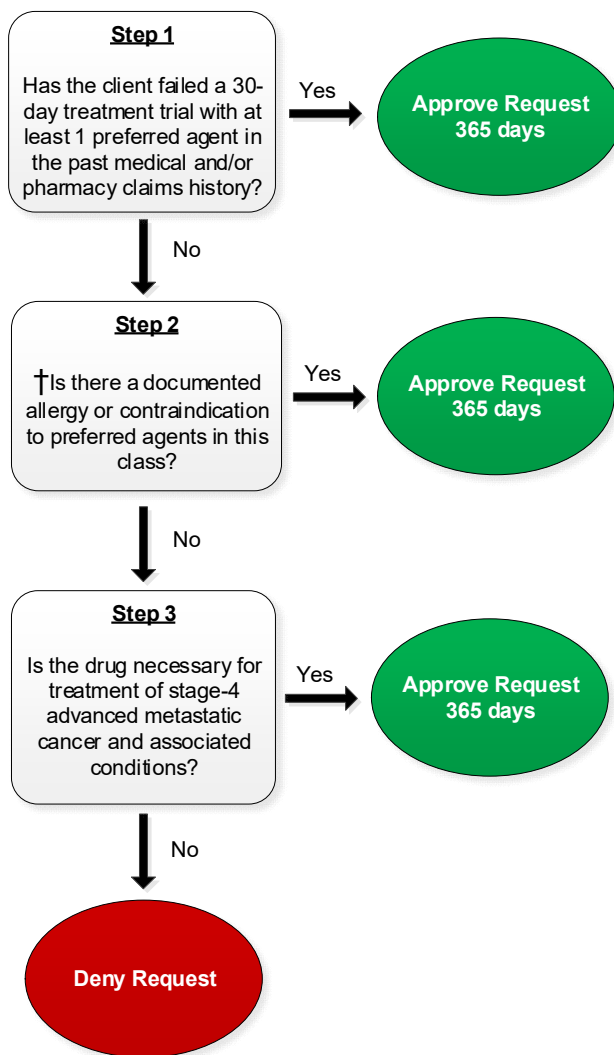
# Sickle Cell Anemia Treatments

## Sickle Cell Anemia Treatments Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Sickle Cell Anemia Treatments Prior Authorization Criteria



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



## Sickle Cell Anemia Treatments Alternate Therapies

### Preferred Sickle Cell Anemia Treatments

GCN	Drug Name
38402	DROXIA 200 MG CAPSULE
38403	DROXIA 300 MG CAPSULE
38404	DROXIA 400 MG CAPSULE
44283	ENDARI 5 GRAM POWDER PACKET
53456	OXBRYTA 300 MG TABLET
51717	OXBRYTA 300 MG TABLET FOR SUSP
47372	OXBRYTA 500 MG TABLET
44626	SIKLOS 1,000 MG TABLET

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

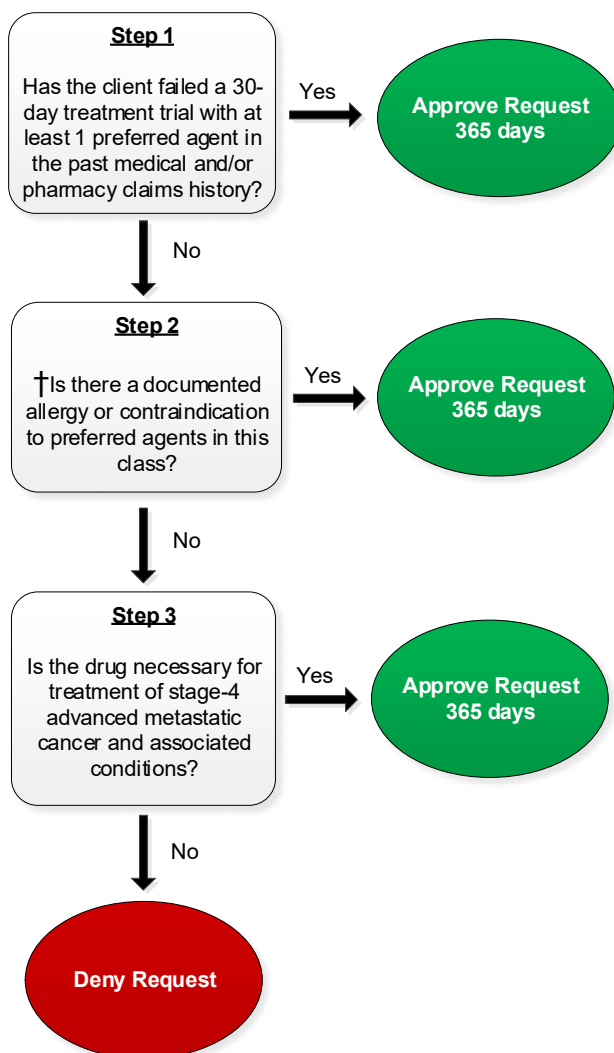
## Skeletal Muscle Relaxants

## Skeletal Muscle Relaxants Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Skeletal Muscle Relaxants Prior Authorization Criteria



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

## Skeletal Muscle Relaxants Alternate Therapies

### Preferred Skeletal Muscle Relaxants

GCN	Drug Name
18010	BACLOFEN 10 MG TABLET
18011	BACLOFEN 20 MG TABLET
18012	BACLOFEN 5 MG TABLET
98857	CARISOPRODOL 250 MG TABLET
17912	CARISOPRODOL 350 MG TABLET
18020	CYCLOBENZAPRINE 10 MG TABLET
12805	CYCLOBENZAPRINE 5 MG TABLET
98299	CYCLOBENZAPRINE 7.5 MG TABLET
17892	METHOCARBAMOL 500 MG TABLET
17893	METHOCARBAMOL 750 MG TABLET
14690	TIZANIDINE HCL 2 MG TABLET
14693	TIZANIDINE HCL 4 MG TABLET

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

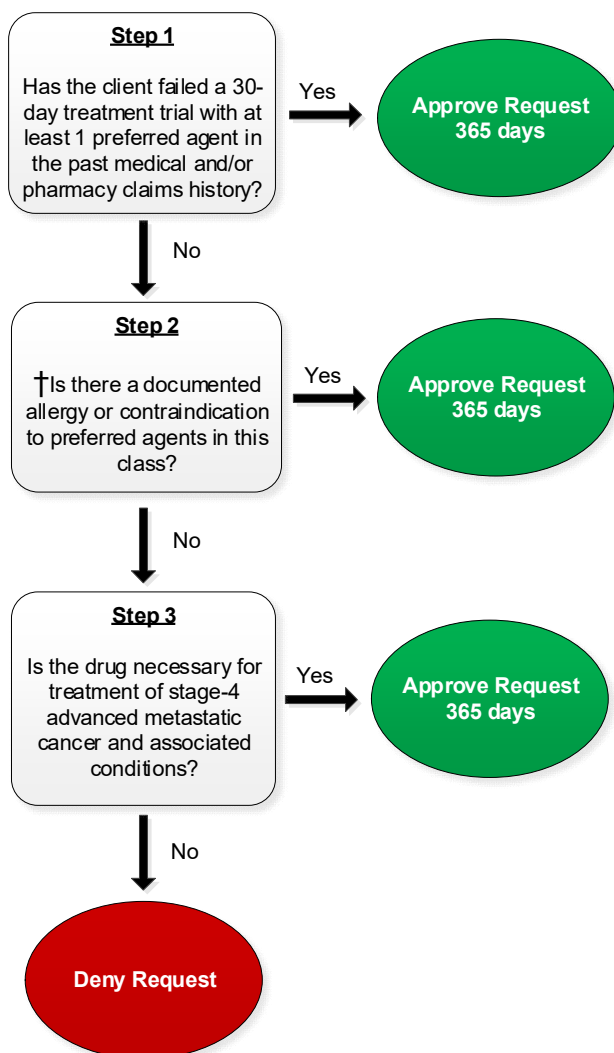
# Smoking Cessation

## Smoking Cessation Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 120 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 120 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 120 days)  
☐ No (Deny)

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

## Smoking Cessation Prior Authorization Criteria



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



## Smoking Cessation Alternate Therapies

### Preferred Smoking Cessation Agents

GCN	Drug Name
27046	APO-VARENICLINE 0.5 MG TABLET
27047	APO-VARENICLINE 1 MG TABLET
27901	BUPROPION HCL SR 150 MG TABLET
27046	CHANTIX 0.5MG TABLET
27047	CHANTIX 1MG TABLET
27048	CHANTIX STARTING MONTH BOX
27048	CHANTIX STARTING MONTH BOX
03422	CVS NICOTINE 14 MG/24HR PATCH
03200	CVS NICOTINE 2 MG CHEWING GUM
14689	CVS NICOTINE 2 MG LOZENGE
43057	CVS NICOTINE 2 MG MINI LOZENGE
03423	CVS NICOTINE 21 MG/24HR PATCH
03201	CVS NICOTINE 4 MG CHEWING GUM
14688	CVS NICOTINE 4 MG LOZENGE
43056	CVS NICOTINE 4 MG MINI LOZENGE
03421	CVS NICOTINE 7 MG/24HR PATCH
43057	GS NICOTINE 2 MG MINI LOZENGE
43057	NICOTINE 2 MG MINI LOZENGE
18772	NICOTINE TRANSDERMAL SYSTEM
27046	VARENICLINE 0.5 MG TABLET
27047	VARENICLINE 1 MG TABLET
27048	VARENICLINE STARTING MONTH BOX

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

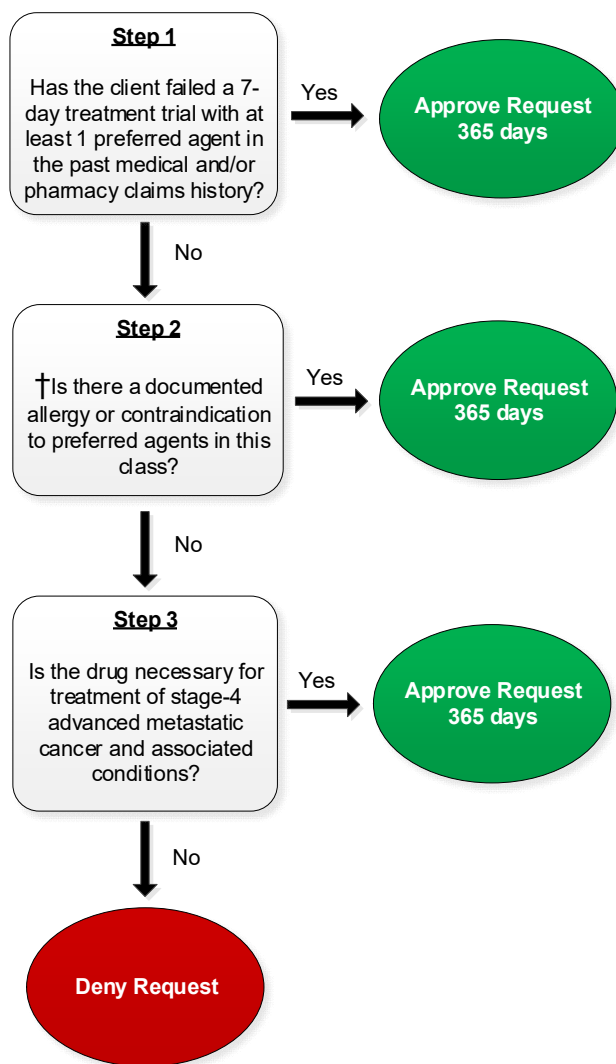
## Steroids, Topical

## Steroids, Topical Prior Authorization Criteria

1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Steroids, Topical Prior Authorization Criteria



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

## Steroids, Topical Alternate Therapies

### Preferred Topical Steroids, Low

GCN	Drug Name
30942	ALA-CORT 1% CREAM
28850	ANUSOL-HC 2.5% CREAM
30951	AQUAPHOR ITCH RELIEF 1% OINT
92421	CORTIZONE-10 FEM ITCH 1% CREME
85080	DERMA-SMOOTHIE-FS BODY OIL
24484	DERMA-SMOOTHIE-FS SCALP OIL
30841	GNP HYDROCORT ACETATE 1% CR
30842	GNP HYDROCORTISONE 0.5% CRM
30941	HYDROCORTISONE 0.5% CREAM
30946	HYDROCORTISONE 1% CREAM PACKET
30851	HYDROCORTISONE 1% OINTMENT
30943	HYDROCORTISONE 2.5% CREAM
28850	HYDROCORTISONE 2.5% CREAM
28850	HYDROCORTISONE 2.5% CREAM
30952	HYDROCORTISONE 2.5% OINTMENT
28850	PROCTO-MED HC 2.5% CREAM
28850	PROCTOSOL-HC 2.5% CREAM
28850	PROCTOZONE-HC 2.5% CREAM

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

### Preferred Topical Steroids, Medium

GCN	Drug Name
48641	FLUTICASONE PROP 0.005% OINT
43951	FLUTICASONE PROP 0.05% CREAM
45850	MOMETASONE FUROATE 0.1% CREAM
45930	MOMETASONE FUROATE 0.1% OINT
06034	MOMETASONE FUROATE 0.1% SOLN

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

### Preferred Topical Steroids, High

GCN	Drug Name
31080	BETAMETHASONE DP 0.05% LOT

31890	BETAMETHASONE DP AUG 0.05% CRM
31101	BETAMETHASONE VA 0.1% CREAM
31110	BETAMETHASONE VALER 0.1% OINTM
31231	TRIAMCINOLONE 0.025% CREAM
31260	TRIAMCINOLONE 0.025% LOTION
31241	TRIAMCINOLONE 0.025% OINT
31243	TRIAMCINOLONE 0.05% OINTMENT
31232	TRIAMCINOLONE 0.1% CREAM
31261	TRIAMCINOLONE 0.1% LOTION
31242	TRIAMCINOLONE 0.1% OINTMENT
31233	TRIAMCINOLONE 0.5% CREAM
31244	TRIAMCINOLONE 0.5% OINTMENT

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

### Preferred Topical Steroids, Very High

GCN	Drug Name
32140	CLOBETASOL 0.05% CREAM
15892	CLOBETASOL 0.05% GEL
32130	CLOBETASOL 0.05% OINTMENT
15891	CLOBETASOL 0.05% SOLUTION
34141	CLOBETASOL EMOLLIENT 0.05% CRM
31251	HALOBETASOL PROP 0.05% CREAM
31211	HALOBETASOL PROP 0.05% OINTMNT

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

# Stimulants and Related Agents

## Stimulants and Related Agents

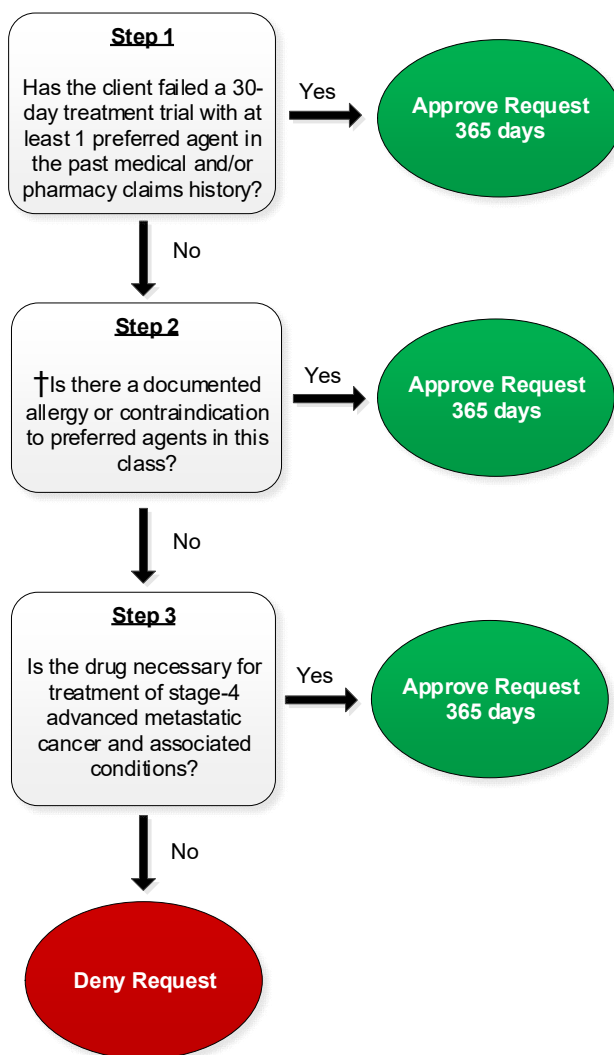
### Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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



## Stimulants and Related Agents Prior Authorization Criteria



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

## Stimulants and Related Agents

### Alternate Therapies

#### Preferred Stimulants

GCN	Drug Name
56971	ADDERALL 10 MG TABLET
29008	ADDERALL 12.5 MG TABLET
29009	ADDERALL 15 MG TABLET
56973	ADDERALL 20 MG TABLET
56972	ADDERALL 30 MG TABLET
56970	ADDERALL 5 MG TABLET
29007	ADDERALL 7.5 MG TABLET
14635	ADDERALL XR 10 MG CAPSULE
17468	ADDERALL XR 15 MG CAPSULE
14636	ADDERALL XR 20 MG CAPSULE
17469	ADDERALL XR 25 MG CAPSULE
14637	ADDERALL XR 30 MG CAPSULE
17459	ADDERALL XR 5 MG CAPSULE
18776	ATOMOXETINE HCL 10 MG CAPSULE
26539	ATOMOXETINE HCL 100 MG CAPSULE
18777	ATOMOXETINE HCL 18 MG CAPSULE
18778	ATOMOXETINE HCL 25 MG CAPSULE
18779	ATOMOXETINE HCL 40 MG CAPSULE
18781	ATOMOXETINE HCL 60 MG CAPSULE
26538	ATOMOXETINE HCL 80 MG CAPSULE
12567	CONCERTA ER 18 MG TABLET
17123	CONCERTA ER 27 MG TABLET
12568	CONCERTA ER 36 MG TABLET
12248	CONCERTA ER 54 MG TABLET
26801	DAYTRANA 10 MG/9 HR PATCH
26802	DAYTRANA 15 MG/9 HR PATCH
26803	DAYTRANA 20 MG/9 HOUR PATCH
26804	DAYTRANA 30 MG/9 HOUR PATCH
14975	DESMETHYLPHENIDATE 10 MG TAB
14973	DESMETHYLPHENIDATE 2.5 MG TAB
14974	DESMETHYLPHENIDATE 5 MG TAB
19880	DEXTROAMPHETAMINE 10 MG TAB

GCN	Drug Name
19885	DEXTROAMPHETAMINE 15 MG TAB
34734	DEXTROAMPHETAMINE 2.5 MG TAB
36463	DEXTROAMPHETAMINE 20 MG TAB
36464	DEXTROAMPHETAMINE 30 MG TAB
19881	DEXTROAMPHETAMINE 5 MG TAB
34735	DEXTROAMPHETAMINE 7.5 MG TAB
39686	DYANAVEL XR 2.5 MG/ML SUSP
24734	FOCALIN XR 10 MG CAPSULE
97111	FOCALIN XR 15 MG CAPSULE
24735	FOCALIN XR 20 MG CAPSULE
30305	FOCALIN XR 25 MG CAPSULE
28035	FOCALIN XR 30 MG CAPSULE
30306	FOCALIN XR 35 MG CAPSULE
28933	FOCALIN XR 40 MG CAPSULE
24733	FOCALIN XR 5 MG CAPSULE
27576	GUANFACINE HCL ER 1 MG TABLET
27578	GUANFACINE HCL ER 2 MG TABLET
27579	GUANFACINE HCL ER 3 MG TABLET
27582	GUANFACINE HCL ER 4 MG TABLET
45110	JORNAY PM 100 MG CAPSULE
45106	JORNAY PM 20 MG CAPSULE
45107	JORNAY PM 40 MG CAPSULE
45108	JORNAY PM 60 MG CAPSULE
45109	JORNAY PM 80 MG CAPSULE
22686	METHYLIN 10 MG/5 ML SOLUTION
22685	METHYLIN 5 MG/5 ML SOLUTION
15911	METHYLPHENIDATE 10 MG TABLET
15920	METHYLPHENIDATE 20 MG TABLET
15913	METHYLPHENIDATE 5 MG TABLET
49447	QELBREE ER 100 MG CAPSULE
49449	QELBREE ER 150 MG CAPSULE
49452	QELBREE ER 200 MG CAPSULE
33887	QUILLIVANT XR 25 MG/5 ML SUSP
37674	VYVANSE 10 MG CAPSULE
42969	VYVANSE 10 MG CHEWABLE TABLET
99366	VYVANSE 20 MG CAPSULE
43058	VYVANSE 20 MG CHEWABLE TABLET
98071	VYVANSE 30 MG CAPSULE
43059	VYVANSE 30 MG CHEWABLE TABLET

GCN	Drug Name
99367	VYVANSE 40 MG CAPSULE
43063	VYVANSE 40 MG CHEWABLE TABLET
98072	VYVANSE 50 MG CAPSULE
43064	VYVANSE 50 MG CHEWABLE TABLET
99368	VYVANSE 60 MG CAPSULE
43065	VYVANSE 60 MG CHEWABLE TABLET
98073	VYVANSE 70 MG CAPSULE

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

# Tetracyclines

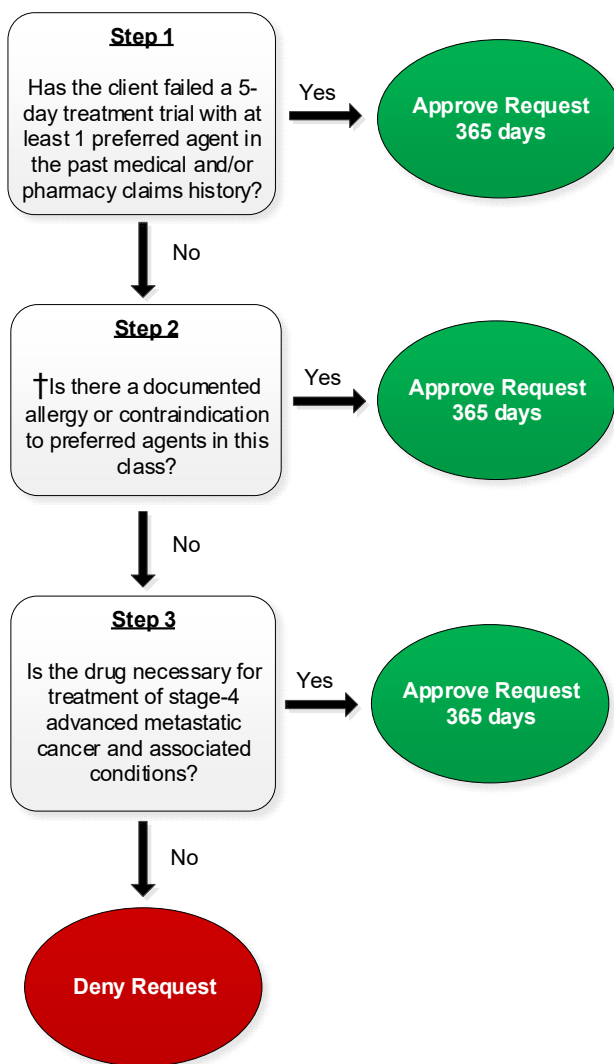
## Tetracyclines

### Prior Authorization Criteria

1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Tetracyclines Prior Authorization Criteria



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

## Tetracyclines Alternate Therapies

### Preferred Tetracyclines

GCN	Drug Name
40370	DOXYCYCLINE 25 MG/5 ML SUSP
40331	DOXYCYCLINE HYCLATE 100 MG CAP
40333	DOXYCYCLINE HYCLATE 50 MG CAP
40651	DOXYCYCLINE MONO 100 MG CAP
40652	DOXYCYCLINE MONO 50 MG CAP
40410	MINOCYCLINE 100 MG CAPSULE
40411	MINOCYCLINE 50 MG CAPSULE
93387	MINOCYCLINE 75 MG CAPSULE
40370	VIBRAMYCIN 25MG/5ML SUSP

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



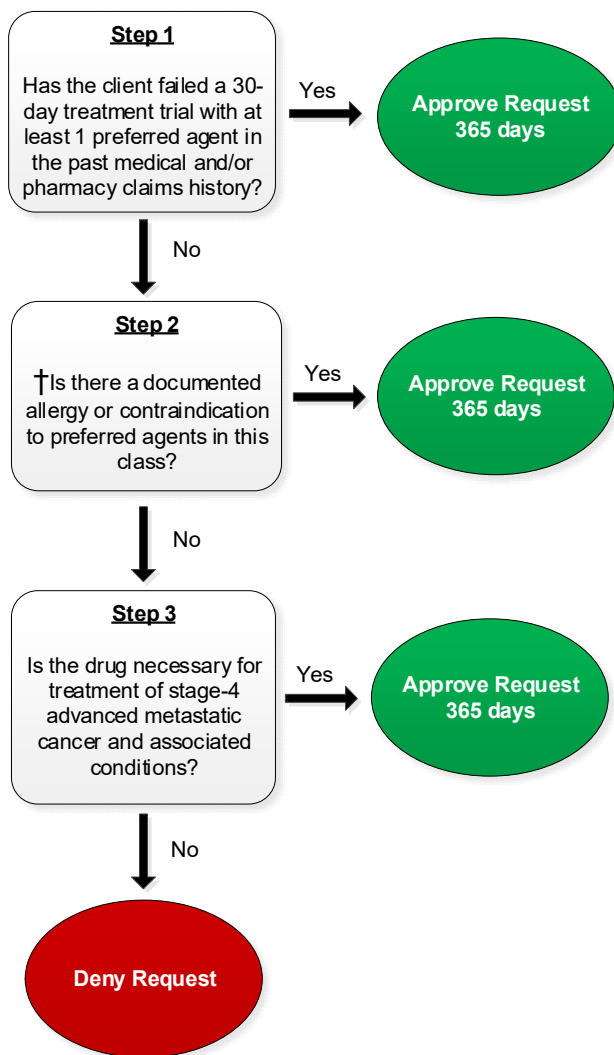
# Thrombopoiesis Stimulating Proteins

## Thrombopoiesis Stimulating Proteins Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Thrombopoiesis Stimulating Proteins Prior Authorization Criteria



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

## Thrombopoiesis Stimulating Proteins Alternate Therapies

### Preferred Thrombopoiesis Stimulating Proteins

GCN	Drug Name
31176	PROMACTA 12.5 MG TABLET
15994	PROMACTA 25 MG TABLET
15995	PROMACTA 50 MG TABLET
28344	PROMACTA 75 MG TABLET

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

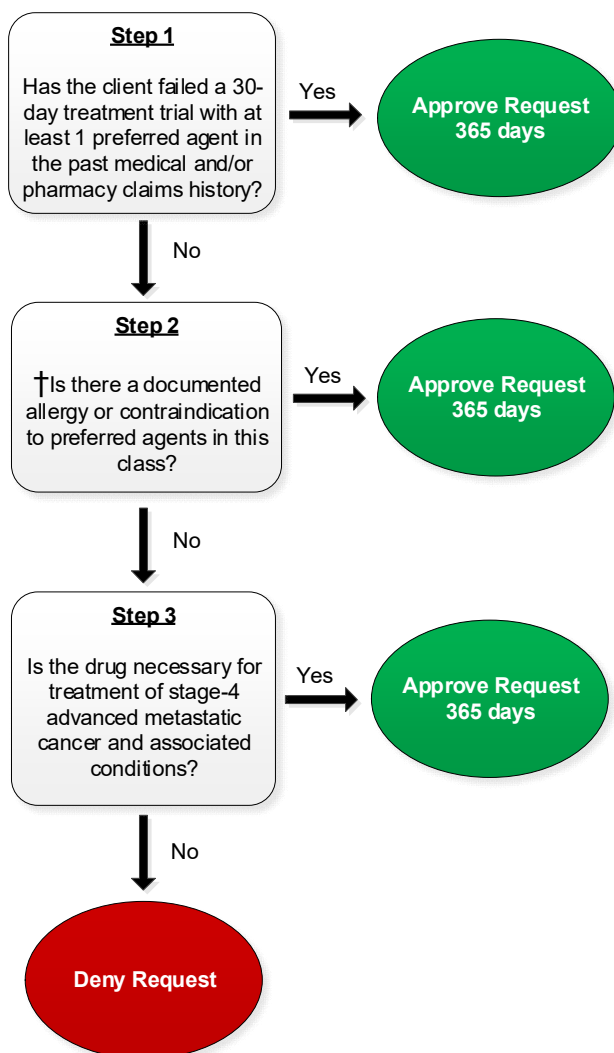
## Ulcerative Colitis Agents

## Ulcerative Colitis Agents Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Ulcerative Colitis Agents Prior Authorization Criteria



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

## Ulcerative Colitis Agents Alternate Therapies

### Preferred UC Agents

GCN	Drug Name
48490	CANASA 1,000 MG SUPPOSITORY
41428	DELZICOL DR 400 MG CAPSULE
97842	LIALDA DR 1.2 GM TABLET
30220	PENTASA 250 MG CAPSULE
23422	PENTASA 500 MG CAPSULE
41611	SULFASALAZINE 500 MG TABLET
41620	SULFASALAZINE DR 500 MG TAB

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



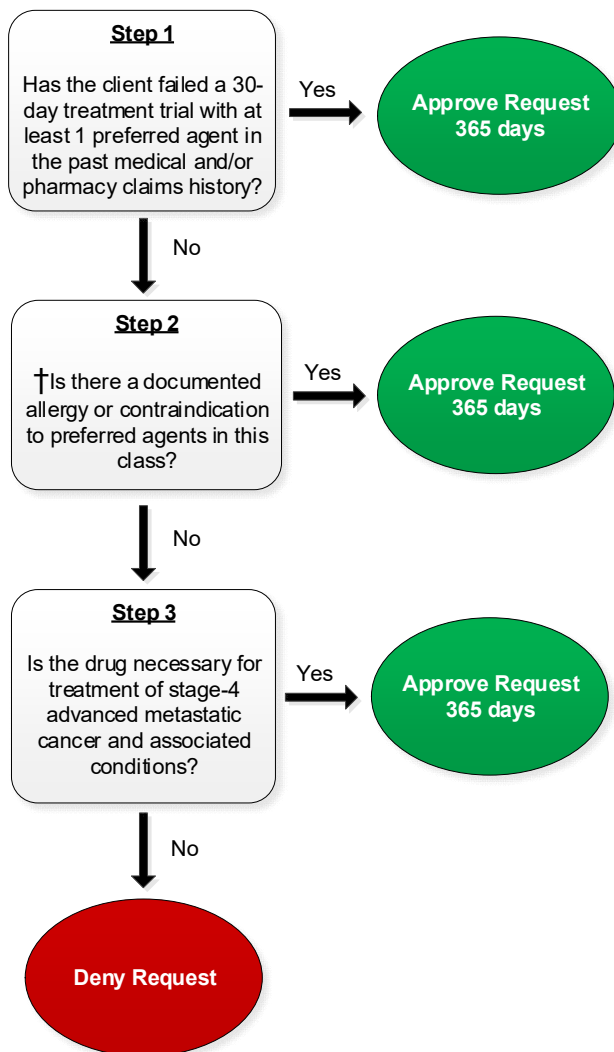
## Uterine Disorder Treatments

## Uterine Disorder Treatments Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Uterine Disorder Treatments Prior Authorization Criteria



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

## Uterine Disorder Treatments Alternate Therapies

### Preferred Uterine Disorder Treatments

GCN	Drug Name
49699	MYFEMBREE 40 MG-1 MG-0.5 MG TB
48158	ORIAHNN 300-1-0.5MG/300MG CAPS
45026	ORILISSA 150 MG TABLET
45028	ORILISSA 200 MG TABLET

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

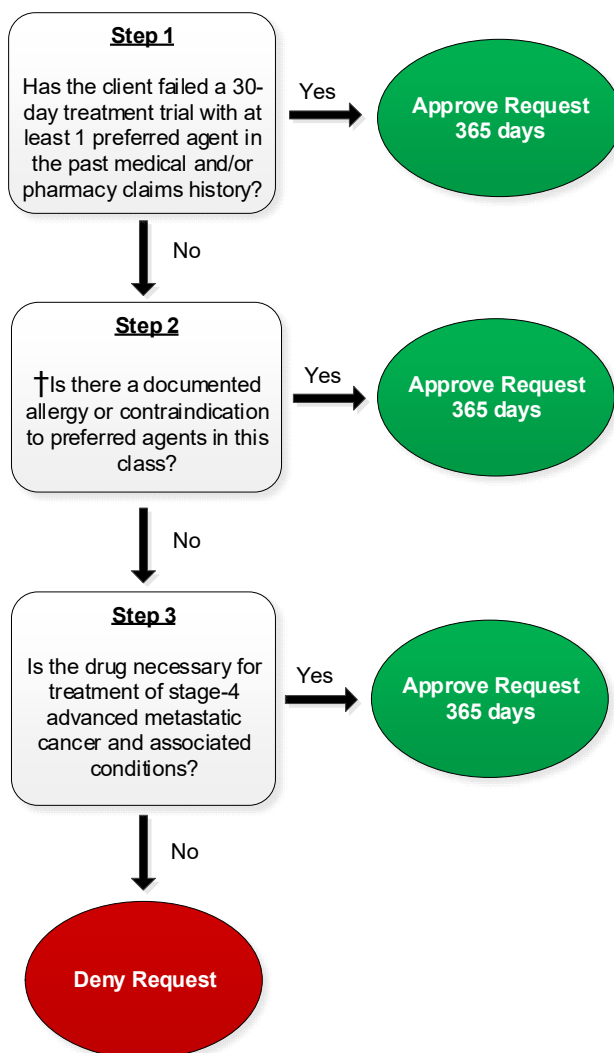
## Urea Cycle Disorders, Oral

## Urea Cycle Disorders, Oral Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #2)
2. †Is there a documented allergy or contraindication to preferred agents in this class?  
☐ Yes (Approve – 365 days)  
☐ No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
☐ Yes (Approve – 365 days)  
☐ No (Deny)

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

## Urea Cycle Disorders, Oral Prior Authorization Criteria



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

## Urea Cycle Disorders, Oral Alternate Therapies

### Preferred Urea Cycle Disorders Agents

GCN	Drug Name
20522	CARBAGLU 200 MG TAB FOR SUSP
36733	PHEBURANE PELLET
43370	BUPHENYL POWDER
43371	BUPHENYL 500 MG TABLET

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



## Version History

The Version History records the publication history of this document. See the Change Log for more details regarding the changes and enhancements included in each version.

Publication Date	Version Number	Comments
09/22/2010	.01	Delivery of final draft
11/11/2010	.02	Revised per comment log received from HHSC and to improve navigation and usability
03/03/2014	.03	Updated PDL classes and GCNs
01/22/2015	.04	Updated PDL classes and GCNs
07/23/2015	.05	Updated PDL classes and GCNs
10/06/2015	.06	Updated Stimulant and Related Agents criteria
01/28/2016	.07	Updated PDL classes and GCNs
07/21/2016	.08	Updated PDL classes and GCNs
01/26/2017	.09	Updated PDL classes and GCNs
07/27/2017	.10	Updated PDL classes and GCNs
08/29/2017	.11	Updated Ophthalmics, Anti-Inflammatory/Immunomodulator criteria
02/01/2018	.12	Updated PDL classes and GCNs
03/09/2018	.13	Updated PDL classes and GCNs
07/25/2018	.14	Updated PDL classes and GCNs
01/31/2019	.15	Updated PDL classes and GCNs
05/15/2019	.16	Verified GCNs for all preferred agents
07/25/2019	.17	Updated PDL classes and GCNs
08/06/2019	.18	Updated PPI criteria
11/22/2019	.19	Removed references to Part I: PDL Criteria on title page and on purpose of document, page 1
01/30/2020	.20	Added question for advanced cancer to all criteria and updated PDL classes and GCNs
07/30/2020	.21	Updated PDL classes and GCNs
08/14/2020	.22	Updated Macrolide criteria and approval duration
10/08/2020	.23	Updated Immunomodulators, Dupixent lookback timeframe for preferred agents
12/15/2020	.24	Removed criteria logic and logic diagram for Methylin – medication is currently preferred
12/21/2020	.25	Rearranged criteria logic and logic diagram for Macrolides
12/29/2020	.26	Removed duloxetine 40mg from preferred agent table in Neuropathic Pain Agents
01/28/2021	.27	Added new classes and updated preferred drug lists and GCNs
02/23/2021	.28	Removed exemption criteria for ondansetron solution because it is currently a preferred agent

Publication Date	Version Number	Comments
		<p>Removed GCNs for clemastine fum 2.68mg, methylphenidate ER, metronidazole 0.75% vaginal gel and Granix</p> <p>Added the following statement to Hypoglycemics, TZD: Separate prescriptions for the individual components should be used instead of the combination drugs</p> <p>Added subsection for PCSK9 inhibitors under Lipotropics, Other</p> <p>Added the following statement to Anti-Allergens: For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization</p> <p>Added the following statement to Prenatal Vitamins: Prenatal vitamins are covered only for females less than 50 years of age.</p> <p>Removed diagnosis check of CVD and intolerable side effects for Inhaled Bronchodilators</p>
04/13/2021	.29	For Macrolides criteria: revised prior therapy question to read: Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history? (Exception may apply when a preferred drug requires less than a 7-day treatment trial)
07/29/2021	.30	<p>Updated PDL classes and GCNs</p> <p>Updated criteria for Phosphate Binders – removed checks for lab values and diagnosis</p>
08/13/2021	.31	Revised lookback time frame for Ophthalmics, Anti-Inflammatory/Immunomodulators from 180 days therapy with a preferred agent in the last 200 days to 30 days therapy in the last 180 days
10/12/2021	.32	Added GCN for Lotemax 0.5% drops to preferred agents
12/20/2021	.33	Updated logic diagram for Topical antibiotics, question 1, to look for a 5-days supply of a preferred agent in the last 60 days
12/21/2021	.34	Updated PDL classes and GCNs
04/05/2022	.35	Updated Phosphate Binders criteria
06/22/2022	.36	<p>Moved criteria for Rinvoq to Cytokine and CAM class section.</p> <p>Added diagnoses of ankylosing spondylitis and ulcerative colitis for Rinvoq – for clients with these diagnoses, preferred therapy is from the Cytokine and CAM class</p>
07/28/2022	.37	Updated PDL classes and GCNs
08/10/2022	.38	Added diagnosis of eosinophilic esophagitis for Dupixent
09/16/2022	.39	Updated lookback for a preferred agent to 14 days supply in the last 180 days for Bronchodilators, Beta Agonists and 1 day supply in the last 180 days for Glucagon agents
01/01/2023	.40	Updated the preferred Hepatitis C Agents
01/26/2023	.41	<p>Added criteria for Uterine Disorder Treatments</p> <p>Updated PDL classes and GCNs</p>
07/27/2023	.42	Updated PDL classes and GCNs

Publication Date	Version Number	Comments
08/04/2023	.43	Updated Rinvoq and Dupixent criteria Added ribavirin GCNs to Hepatitis C preferred agents
01/25/2024	.44	Updated PDL classes and GCNs Added information detailed in HB 3286, Section 2, 88 <sup>th</sup> Legislature, Regular Session, 2023
07/25/2024	.45	Updated PDL classes and GCNs Added information to Antidepressant criteria logic regarding discharge from an inpatient facility or risk of experiencing complications if switched from a non-preferred agent to a preferred agent Removed age exemption from Epaned Removed Criteria for Xifaxan, Progestational Agents, and PCSK9 Inhibitors Removed diagnosis question from Rinvoq and Dupixent criteria logic Rephrased PA system from RxPert to Gainwell Technologies PA System Updated and/or reviewed all preferred drug tables

## Change Log

The Change Log records the changes and enhancements included in each version.

Version Number	Chapter/Section	Change
.01	N/A	N/A
.02	Purpose	Updated paragraph to explain the division of the criteria guide
	Organization	Added descriptions for diagnosis codes, procedure codes
	Organization	Removed note at end of section
	All sections	Revised formatting to support consecutive page numbering
	All sections	Replaced all occurrences of patient with client
	All checklist pages	Removed the approval duration note at the end of a checklist
	All checklist pages	Added the approval duration for all actions of a rule that results in approval
	All flowchart pages	Added the approval duration to all Approve Request ovals
	All list pages	Updated table format to be consistent with previous documents
	All list titles	Added the RxPert form code in title
	All checklists and flowcharts	Updated the RxPert form code in title where necessary
	Checklists and flowchart for: <ul style="list-style-type: none"> <li>Alzheimer's Agents</li> <li>Antidepressants, Other</li> <li>Antidepressants, SSRI</li> <li>Antipsychotics, Oral</li> <li>Growth Hormones</li> <li>Hepatitis C Agents</li> </ul>	Added missing stable therapy step
	<ul style="list-style-type: none"> <li>Analgesics, Narcotic – Long Acting</li> <li>Analgesics, Narcotic – Short Acting</li> </ul>	Updated titles for checklist, flowchart and list to correspond with the section title
	<ul style="list-style-type: none"> <li>Analgesics, Narcotic – Long Acting</li> <li>Analgesics, Narcotic – Short Acting</li> </ul>	Updated the RxPert form code in title

	Anticoagulants, Injectable	Added allergy and contraindication step to checklist and flowchart
	Antidepressants	Divided section into Antidepressants, Other and Antidepressants, SSRI as shown in the PDL

Version Number	Chapter/Section	Change
	Antiparkinson's Agents	Updated Step 1 in the checklist and flowchart to read "14-day treatment trial"
	Bile Salts	Added checklist, flowchart and list
	Bronchodilators, Beta Agonist	Added step 3 to the checklist and flowchart
	Bronchodilators, Beta Agonist	Added diagnosis code list for step 2
	Fluoroquinolones, Oral – Cipro Suspension	Modified step 1 to read "less than 11 years of age"
	Glucocorticoids, Inhaled	Added checklist, flowchart and list for Pulmicort
	Hypoglycemics, Incretin Mimetics/Enhancers – Symlin	Added sub-section
	Impetigo Agents, Topical	Updated approval duration to 5-days in checklist and flowchart
	Lipotropics, Statins	Updated step 1 in checklist and flowchart to read "Has the client failed at least 2 preferred agent(s) for a total of 120 days within the past 180 days?"
	Macrolides/Ketolides	Updated approval duration to 30 days
	Ophthalmics, Quinolones/Macrolides	Updated step 1 to read "7-day treatment trial"
	PAH Agents, Oral	Added step 2 for allergy and contraindication to checklist and flowchart
	Phosphate Binders	Added checklist, flowchart and lists
	Proton Pump Inhibitors	Added checklist, flowchart and list for Prevacid Solutabs
.03	Bronchodilators, Beta Agonist	Corrected list of diagnosis codes related to step 2
	Hypoglycemics, Incretin Mimetics/Enhancers – Symlin	Corrected list of diagnosis codes related to step 2
	Cover page	Replaced Texas state seal image with higher resolution image
.04	Antimigraine Agents, Other	Added checklist, flowchart and list
	HAE Treatments	Added checklist, flowchart and list
	H.Pylori Treatment	Added checklist, flowchart and list
	Immune Globulins	Added checklist, flowchart and list
	Lincosamides/Oxazolidinones/ Streptogramins	Added checklist, flowchart and list
	Progestins for Cachexia	Added checklist, flowchart and list
	Smoking Cessation	Added checklist, flowchart and list

Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>• Acne Agents, Topical</li> <li>• Analgesics, Narcotics Long</li> <li>• Analgesics, Narcotics Short</li> <li>• Angiotensin Modulators</li> <li>• Bladder Relaxant Preparations</li> <li>• Intranasal Rhinitis Agents</li> <li>• Neuropathic Pain</li> <li>• Platelet Aggregation Inhibitors</li> <li>• Proton Pump Inhibitors</li> <li>• Stimulants and Related Agents</li> <li>• Anticoagulants</li> <li>• Antidepressants, Other</li> <li>• Antiparkinson's Agents</li> <li>• Beta-Blockers</li> <li>• Bronchodilators, Beta Agonist</li> <li>• Glucocorticoids, Inhaled</li> <li>• Lipotropics, Other</li> <li>• Lipotropics, Statins</li> </ul>	Updated list of preferred agents
.05	<ul style="list-style-type: none"> <li>• All PDL Sections</li> </ul>	Reviewed and updated all lists of preferred agents
.06	<ul style="list-style-type: none"> <li>• Stimulants and Related Agents</li> </ul>	Added criteria for Methylin solution

.07	<ul style="list-style-type: none"> <li>• Alzheimer's Agents</li> <li>• Androgenic Agents</li> <li>• Antibiotics, GI</li> <li>• Antibiotics, Topical</li> <li>• Antibiotics, Vaginal</li> <li>• Antiemetic/Antivertigo Agents</li> <li>• Antifungals, Oral</li> <li>• Antifungals, Topical</li> <li>• Antihistamines, Minimally Sedating</li> <li>• Antihypertensives, Sympatholytics</li> <li>• Antiparasitics, Topical</li> <li>• Antipsychotics</li> <li>• Antivirals, Oral</li> <li>• Antivirals, Topical</li> <li>• Bone Resorption Suppression and Related Agents</li> <li>• Calcium Channel Blockers</li> <li>• Cephalosporins and Related Antibiotics</li> <li>• Colony Stimulating Factors</li> <li>• Cytokine and CAM Antagonists</li> <li>• Epinephrine, Self-Injected</li> <li>• Fluoroquinolones, Oral</li> <li>• GI Motility, Chronic</li> <li>• Glucocorticoids, Oral</li> <li>• Growth Hormone</li> <li>• Hypoglycemics, Incretin</li> <li>• Hypoglycemics, Insulin and Related Agents</li> <li>• Hypoglycemics, Meglitinides</li> <li>• Hypoglycemics, TZDs</li> <li>• Immunosuppressives, Oral</li> <li>• Iron, Oral</li> <li>• Leukotriene Modifiers</li> <li>• Macrolides/Ketolides</li> <li>• NSAIDs</li> <li>• Ophthalmic Antibiotics</li> <li>• Ophthalmic Antibiotic-Steroid</li> <li>• Ophthalmics for Allergic Conjunctivitis</li> <li>• Ophthalmics, Anti-Inflammatories</li> </ul>	Updated list of preferred agents
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"><li>• Ophthalmics, Glaucoma Agents</li><li>• Opiate Dependence Treatments</li><li>• Otic Antibiotics</li><li>• Otic Anti-Infectives &amp; Anesthetics</li><li>• Penicillins</li><li>• Prenatal Vitamins</li><li>• Skeletal Muscle Relaxants</li><li>• Steroids, Topical</li><li>• Tetracyclines</li><li>• Ulcerative Colitis Agents</li></ul>	
	Antibiotics, Topical	Changed PDL Class Name from Agents for Impetigo to Topical Antibiotics



Version Number	Chapter/Section	Change
.08	<ul style="list-style-type: none"> <li>• Acne Agents, Oral</li> <li>• Analgesics, Narcotic-Long Acting</li> <li>• Angiotensin Modulator Combinations</li> <li>• Antimigraine Agents</li> <li>• Antiparkinson's Agents, Oral/Transdermal</li> <li>• Antipsychotics</li> <li>• Antivirals, Oral/Nasal</li> <li>• Bile Salts</li> <li>• BPH Agents</li> <li>• COPD Agents</li> <li>• GI Motility, Chronic</li> <li>• Glucocorticoids, Inhaled</li> <li>• Hepatitis C Agents</li> <li>• Hypoglycemics, Insulin</li> <li>• Hypoglycemics, SGLT2</li> <li>• Immune Globulins</li> <li>• Immunomodulators, Atopic Dermatitis</li> <li>• Immunosuppressives, Oral</li> <li>• Iron, Oral</li> <li>• Lincosamides/Oxazolidinones/Streptogramins</li> <li>• Lipotropics, Other</li> <li>• Lipotropics, Statins</li> <li>• Neuropathic Pain</li> <li>• Opiate Dependence Treatments</li> <li>• PAH Agents, Oral/Inhalation</li> <li>• Prenatal Vitamins</li> <li>• Steroids, Topical</li> <li>• Stimulants and Related Agents</li> </ul>	Updated list of preferred agents and GCNs
.09	<ul style="list-style-type: none"> <li>• Hypoglycemics, Metformin</li> </ul>	New class: Added criteria logic, logic diagram and table of preferred agents

	<ul style="list-style-type: none"> <li>• Alzheimer's Agents</li> <li>• Androgenic Agents</li> <li>• Antibiotics, GI</li> <li>• Antibiotics, Topical</li> <li>• Antibiotics, Vaginal</li> <li>• Antiemetic/Antivertigo Agents</li> <li>• Antifungals, Oral</li> <li>• Antifungals, Topical</li> <li>• Antihistamines, Minimally Sedating</li> <li>• Antihypertensives, Sympatholytics</li> <li>• Antiparasitics, Topical</li> <li>• Antipsychotics</li> <li>• Antivirals, Oral</li> <li>• Antivirals, Topical</li> <li>• Bone Resorption Suppression and Related Agents</li> <li>• Calcium Channel Blockers</li> <li>• Cephalosporins and Related Antibiotics</li> <li>• Colony Stimulating Factors</li> <li>• Cytokine and CAM Antagonists</li> <li>• Epinephrine, Self-Injected</li> <li>• Fluoroquinolones, Oral</li> <li>• GI Motility, Chronic</li> <li>• Glucocorticoids, Oral</li> <li>• Growth Hormone</li> <li>• Hypoglycemics, Incretin Mimetics/Enhancers</li> <li>• Hypoglycemics, Insulin and Related Agents</li> <li>• Hypoglycemics, Meglitinides</li> <li>• Hypoglycemics, TZD</li> <li>• Immunosuppressives, Oral</li> <li>• Iron, Oral</li> <li>• Leukotriene Modifiers</li> <li>• Macrolides/Ketolides</li> <li>• NSAIDs</li> <li>• Ophthalmic Antibiotics</li> <li>• Ophthalmic Antibiotic-Steroid Combinations</li> <li>• Ophthalmics for Allergic Conjunctivitis</li> </ul>	Updated list of preferred agents and GCNs
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>• Ophthalmics, Anti-Inflammatories</li> <li>• Ophthalmics, Glaucoma Agents</li> <li>• Opiate Dependence Treatments</li> <li>• Otic Antibiotics</li> <li>• Otic Anti-Infectives &amp; Anesthetics</li> <li>• Penicillins</li> <li>• Prenatal Vitamins</li> <li>• Skeletal Muscle Relaxants</li> <li>• Steroids, Topical</li> <li>• Tetracyclines</li> <li>• Ulcerative Colitis Agents</li> </ul>	
.10	<ul style="list-style-type: none"> <li>• Antidepressants, Tricyclic</li> <li>• Anxiolytics</li> <li>• Ophthalmics, Anti-Inflammatory/Immunomodulators</li> <li>• Urea Cycle Disorders</li> </ul>	New classes: Added criteria logic, logic diagram and table of preferred agents

	<ul style="list-style-type: none"> <li>• Acne Agents, Oral</li> <li>• Acne Agents, Topical</li> <li>• Analgesics, Narcotics Long</li> <li>• Analgesics, Narcotics Short</li> <li>• Angiotensin Modulators</li> <li>• Angiotensin Modulator Combinations</li> <li>• Anti-Allergens, Oral</li> <li>• Antibiotics, Inhaled</li> <li>• Anticoagulants</li> <li>• Antidepressants, Other</li> <li>• Antidepressants, SSRIs</li> <li>• Antihyperuricemics</li> <li>• Antimigraine Agents, Other</li> <li>• Antimigraine Agents, Triptans</li> <li>• Antiparkinson's Agents</li> <li>• Beta-Blockers</li> <li>• Bladder Relaxant Preparations</li> <li>• Bile Salts</li> <li>• BPH Treatments</li> <li>• Bronchodilators, Beta Agonist</li> <li>• COPD Agents</li> <li>• Cough and Cold, Cold</li> <li>• Cough and Cold, Narcotic</li> <li>• Cough and Cold, Non-Narcotic</li> <li>• Erythropoiesis Stimulating Proteins</li> <li>• Glucocorticoids, Inhaled</li> <li>• H. Pylori Treatment</li> <li>• HAE Treatments</li> <li>• Hepatitis C Agents</li> <li>• Hypoglycemics, SGLT2</li> <li>• Immune Globulins</li> <li>• Immunomodulators, Atopic Dermatitis</li> <li>• Intranasal Rhinitis Agents</li> <li>• Lincosamides / Oxazolidinones / Streptogramins</li> <li>• Lipotropics, Other</li> <li>• Lipotropics, Statins</li> <li>• Neuropathic Pain</li> <li>• PAH, Oral and Inhaled</li> <li>• Pancreatic Enzymes</li> </ul>	Updated list of preferred agents and GCNs
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>• Phosphate Binders</li> <li>• Platelet Aggregation Inhibitors</li> <li>• Progestins for Cachexia</li> <li>• Proton Pump Inhibitors</li> <li>• Sedative Hypnotics</li> <li>• Smoking Cessation</li> <li>• Stimulants and Related Agents</li> </ul>	
	<ul style="list-style-type: none"> <li>• Angiotensin Modulators</li> <li>• Antiemetic and Antivertigo Agents</li> </ul>	Updated criteria logic and logic diagram
.11	<ul style="list-style-type: none"> <li>• Ophthalmics, Anti-Inflammatory / Immunomodulators</li> </ul>	Changed prior therapy requirements to 180 day trial of a preferred agent in the last 200 days
.12	<ul style="list-style-type: none"> <li>• Progestational Agents</li> </ul>	New classes: Added criteria logic, logic diagram and table of preferred agents

Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>• Alzheimer's Agents</li> <li>• Antihistamines, Minimally Sedating</li> <li>• Antihypertensives, Sympatholytics</li> <li>• Antivirals, Oral/Nasal</li> <li>• Calcium Channel Blockers</li> <li>• Cephalosporins and Related Antibiotics</li> <li>• Fluoroquinolones, Oral</li> <li>• Glucocorticoids, Oral</li> <li>• Hypoglycemics, SGLT2</li> <li>• Immunosuppressives, Oral</li> <li>• Iron, Oral</li> <li>• Leukotriene Modifiers</li> <li>• NSAIDs</li> <li>• Ophthalmic Antibiotics</li> <li>• Ophthalmic Antibiotic-Steroid Combinations</li> <li>• Ophthalmics for Allergic Conjunctivitis</li> <li>• Ophthalmics, Anti-Inflammatories</li> <li>• Ophthalmics, Glaucoma Agents</li> <li>• Otic Antibiotics</li> <li>• Otic Anti-Infectives and Anesthetics</li> <li>• Prenatal Vitamins</li> <li>• Skeletal Muscle Relaxants</li> <li>• Steroids, Topical</li> <li>• Ulcerative Colitis Agents</li> </ul>	Updated list of preferred agents and GCNs
.13	<ul style="list-style-type: none"> <li>• Antihistamines, First Generation</li> <li>• Pediatric Vitamin Preparations</li> </ul>	New classes: Added criteria logic, logic diagram and table of preferred agents

Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>• Analgesics, Narcotic-Long Acting</li> <li>• Androgenic Agents</li> <li>• Antibiotics, GI</li> <li>• Antibiotics, Topical</li> <li>• Antibiotics, Vaginal</li> <li>• Antiemetic/Antivertigo Agents</li> <li>• Antifungals, Oral</li> <li>• Antifungals, Topical</li> <li>• Antihistamines, Minimally Sedating</li> <li>• Antiparasitics, Topical</li> <li>• Antiparkinson's Agents</li> <li>• Antipsychotics</li> <li>• Antivirals, Oral/Nasal</li> <li>• Antivirals, Topical</li> <li>• Bile Salts</li> <li>• Bone Resorption Suppression and Related Agents</li> <li>• Colony Stimulating Factors</li> <li>• Cytokine and CAM Antagonists</li> <li>• Epinephrine, Self-Injected</li> <li>• GI Motility, Chronic</li> <li>• Growth Hormone</li> <li>• Hepatitis C Agents</li> <li>• Hypoglycemics, Incretin Mimetics/Enhancers</li> <li>• Hypoglycemics, Insulin and Related Agents</li> <li>• Hypoglycemics, Meglitinides</li> <li>• Hypoglycemics, Metformins</li> <li>• Hypoglycemics, TZD</li> <li>• Macrolides/Ketolides</li> <li>• Opiate Dependence Treatments</li> <li>• Penicillins</li> <li>• Stimulants and Related Agents</li> <li>• Tetracyclines</li> </ul>	Updated list of preferred agents and GCNs

.14	<ul style="list-style-type: none"> <li>• Movement Disorders</li> <li>• Acne Agents, Oral</li> <li>• Acne Agents, Topical</li> <li>• Analgesics, Narcotics Long</li> <li>• Analgesics, Narcotics Short</li> <li>• Angiotensin Modulator Combinations</li> <li>• Angiotensin Modulators</li> <li>• Anti-Allergens, Oral</li> <li>• Antibiotics, GI</li> <li>• Antibiotics, Inhaled</li> <li>• Anticoagulants</li> <li>• Antidepressants, Other</li> <li>• Antidepressants, SSRIs</li> <li>• Antidepressants, Tricyclic</li> <li>• Antihyperuricemics</li> <li>• Antimigraine Agents, Other</li> <li>• Antimigraine Agentsm Triptans</li> <li>• Antiparkinson's Agents</li> <li>• Anxiolytics</li> <li>• Beta-Blockers</li> <li>• Bile Salts</li> <li>• Bladder Relaxant Preparations</li> <li>• BPH Treatments</li> <li>• Bronchodilators, Beta Agonist</li> <li>• COPD Agents</li> <li>• Cough and Cold Agents</li> <li>• Cytokine and CAM Antagonists</li> <li>• Erythropoiesis Stimulating Proteins</li> <li>• GI Motility, Chronic</li> <li>• Glucocorticoids, Inhaled</li> <li>• Glucocorticoids, Oral</li> <li>• HAE Treatments</li> <li>• H. Pylori Treatment</li> <li>• Hypoglycemics, Incretin Mimetics/Enhancers</li> <li>• Hypoglycemics, Insulin and Related</li> <li>• Hypoglycemics, SGLT2</li> <li>• Immune Globulins</li> <li>• Immunomodulators, Atopic Dermatitis</li> </ul>	<p>New classes: Added criteria logic, logic diagram and table of preferred agents</p> <p>Updated list of preferred agents and GCNs</p>
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"><li>• Intranasal Rhinitis Agents</li><li>• Lincosamides/ Oxazolidinones/ Streptogramins</li><li>• Lipotropics, Other</li><li>• Lipotropics, Statins</li><li>• Neuropathic Pain</li><li>• Ophthalmics, Glaucoma Agents</li><li>• Ophthalmics, Anti-Inflammatory/ Immunomodulator</li><li>• PAH Agents, Oral and Inhaled</li><li>• Pancreatic Enzymes</li><li>• Phosphate Binders</li><li>• Platelet Aggregation Inhibitors</li><li>• Progestins for Cachexia</li><li>• Proton Pump Inhibitors</li><li>• Sedative Hypnotics</li><li>• Smoking Cessation</li><li>• Stimulants and Related Agents</li><li>• Tetracyclines</li><li>• Urea Cycle Disorders, Oral</li></ul>	

.15	<ul style="list-style-type: none"> <li>• Alzheimer's Agents</li> <li>• Analgesics, Narcotics Short</li> <li>• Androgenic Agents</li> <li>• Antibiotics, GI</li> <li>• Antibiotics, Topical</li> <li>• Antibiotics, Vaginal</li> <li>• Anticoagulants</li> <li>• Antiemetic/Antivertigo Agents</li> <li>• Antifungals, Oral</li> <li>• Antifungals, Topical</li> <li>• Antihistamines, First Generation</li> <li>• Antihistamines, Minimally Sedating</li> <li>• Antihypertensives, Sympatholytics</li> <li>• Antimigraine Agents, Other</li> <li>• Antiparasitics, Topical</li> <li>• Antiparkinson's Agents</li> <li>• Antipsychotics</li> <li>• Antivirals, Oral</li> <li>• Antivirals, Topical</li> <li>• Bone Resorption Suppression and Related Agents</li> <li>• Calcium Channel Blockers</li> <li>• Cephalosporins and Related Antibiotics</li> <li>• Colony Stimulating Factors</li> <li>• COPD Agents</li> <li>• Cytokine and CAM Antagonists</li> <li>• Epinephrine, Self-Injected</li> <li>• Erythropoiesis Stimulating Proteins</li> <li>• Fluoroquinolones, Oral</li> <li>• GI Motility, Chronic</li> <li>• Glucocorticoids, Oral</li> <li>• Growth Hormone</li> <li>• Hepatitis C Agents</li> <li>• Hypoglycemics, Incretin Mimetics/Enhancers</li> <li>• Hypoglycemics, Insulin and Related Agents</li> <li>• Hypoglycemics, Meglitinides</li> </ul>	Updated list of preferred agents and GCNs
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>• Hypoglycemics, Metformins</li> <li>• Hypoglycemics, SGLT2</li> <li>• Hypoglycemics, TZD</li> <li>• Immunomodulators, Atopic Dermatitis</li> <li>• Immunosuppressives, Oral</li> <li>• Iron, Oral</li> <li>• Leukotriene Modifiers</li> <li>• Lipotropics, Statins</li> <li>• Macrolides/Ketolides</li> <li>• NSAIDs</li> <li>• Ophthalmic Antibiotics</li> <li>• Ophthalmic Antibiotic-Steroid Combinations</li> <li>• Ophthalmics for Allergic Conjunctivitis</li> <li>• Ophthalmics, Anti-Inflammatories</li> <li>• Ophthalmics, Glaucoma Agents</li> <li>• Opiate Dependence Treatments</li> <li>• Otic Antibiotics</li> <li>• Otic Anti-Infectives &amp; Anesthetics</li> <li>• Pediatric Vitamin Preparations</li> <li>• Penicillins</li> <li>• Prenatal Vitamins</li> <li>• Progestational Agents</li> <li>• Skeletal Muscle Relaxants</li> <li>• Steroids, Topical</li> <li>• Tetracyclines</li> <li>• Ulcerative Colitis Agents</li> </ul>	
.16	<ul style="list-style-type: none"> <li>• All Classes</li> </ul>	Reviewed and updated GCNs for all preferred agents

.17	<ul style="list-style-type: none"> <li>• Thrombopoiesis Stimulating Proteins</li> <li>• Acne Agents, Oral</li> <li>• Acne Agents, Topical</li> <li>• Analgesics, Narcotics Long</li> <li>• Analgesics, Narcotics Short</li> <li>• Angiotensin Modulator Combinations</li> <li>• Angiotensin Modulators</li> <li>• Anti-Allergens, Oral</li> <li>• Antibiotics, Inhaled</li> <li>• Anticoagulants</li> <li>• Antidepressants, Other</li> <li>• Antidepressants, SSRIs</li> <li>• Antidepressants, Tricyclics</li> <li>• Antifungals, Oral</li> <li>• Antihistamines, First Generation</li> <li>• Antihyperuricemics</li> <li>• Antimigraine Agents, Other</li> <li>• Antimigraine Agents, Triptans</li> <li>• Antiparasitics, Topical</li> <li>• Antiparkinson's Agents</li> <li>• Antivirals, Oral</li> <li>• Anxiolytics</li> <li>• Beta-Blockers</li> <li>• Bile Salts</li> <li>• Bladder Relaxant Preparations</li> <li>• BPH Treatments</li> <li>• Bronchodilators, Beta Agonist</li> <li>• COPD Agents</li> <li>• Colony Stimulating Factors</li> <li>• Cough and Cold Agents</li> <li>• Cytokine and CAM Antagonists</li> <li>• Epinephrine, Self-Injected</li> <li>• Erythropoiesis Stimulating Proteins</li> <li>• Glucocorticoids, Inhaled</li> <li>• H. Pylori Treatment</li> <li>• HAE Treatments</li> <li>• Hypoglycemics, Insulin and Related Agents</li> </ul>	<p>New classes: Added criteria logic, logic diagram and table of preferred agents</p> <p>Updated list of preferred agents and GCNs</p>
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>• Hypoglycemics, SGLT2</li> <li>• Immune Globulins</li> <li>• Immunomodulators, Atopic Dermatitis</li> <li>• Intranasal Rhinitis Agents</li> <li>• Lincosamides/ Oxazolidinones/ Streptogramins</li> <li>• Lipotropics, Other</li> <li>• Lipotropics, Statins</li> <li>• Movement Disorders</li> <li>• Neuropathic Pain</li> <li>• Ophthalmics, Anti-Inflammatories</li> <li>• Ophthalmics, Anti-Inflammatory/ Immunomodulator</li> <li>• Ophthalmics, Glaucoma Agents</li> <li>• PAH Agents, Oral and Inhaled</li> <li>• Pancreatic Enzymes</li> <li>• Pediatric Vitamin Preparations</li> <li>• Prenatal Vitamins</li> <li>• Phosphate Binders</li> <li>• Platelet Aggregation Inhibitors</li> <li>• Progestins for Cachexia</li> <li>• Proton Pump Inhibitors</li> <li>• Sedative-Hypnotics</li> <li>• Smoking Cessation</li> <li>• Steroids, Topical</li> <li>• Stimulants and Related Agents</li> <li>• Tetracyclines</li> <li>• Urea Cycle Disorders, Oral</li> </ul>	
.18	<ul style="list-style-type: none"> <li>• Proton Pump Inhibitors</li> </ul>	Updated criteria to indicate that a minimum of 30-day trial of all preferred agents in the preceding 365 days is required before approval of a non-preferred agent.
.19	<ul style="list-style-type: none"> <li>• Title Page</li> <li>• Document Overview</li> </ul>	Removed references to Part I: PDL Criteria on title page and on purpose of document, page 1
.20	<ul style="list-style-type: none"> <li>• Updated all criteria logic and logic diagrams</li> </ul>	Added the following question to all criteria: Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

.20	<ul style="list-style-type: none"> <li>• Alzheimer's Agents</li> <li>• Analgesics, Narcotic Short</li> <li>• Androgenic Agents</li> <li>• Antibiotics, GI</li> <li>• Antibiotics, Topical</li> <li>• Antibiotics, Vaginal</li> <li>• Antiemetic/Antivertigo Agents</li> <li>• Antifungals, Oral</li> <li>• Antifungals, Topical</li> <li>• Antihistamines, First Generation</li> <li>• Antihistamines, Minimally Sedating</li> <li>• Antihypertensives, Sympatholytics</li> <li>• Antimigraine Agents, Other</li> <li>• Antiparasitics, Topical</li> <li>• Antiparkinson's Agents</li> <li>• Antipsychotic Agents</li> <li>• Antivirals, Topical</li> <li>• Bone Resorption Suppression and Related Agents</li> <li>• BPH Agents</li> <li>• Calcium Channel Blockers</li> <li>• Cephalosporins and Related Antibiotics</li> <li>• Colony Stimulating Factors</li> <li>• Cytokine and CAM Antagonists</li> <li>• Epinephrine Self-Injected</li> <li>• Fluoroquinolones, Oral</li> <li>• GI Motility, Chronic</li> <li>• Glucocorticoids, Oral</li> <li>• Growth Hormone</li> <li>• Hepatitis C Agents</li> <li>• Hypoglycemics, Incretin Mimetics/Enhancers</li> <li>• Hypoglycemics, Insulin and Related Agents</li> <li>• Hypoglycemics, Meglitinides</li> <li>• Hypoglycemics, Metformins</li> <li>• Hypoglycemics, SGLT2</li> <li>• Hypoglycemics, TZD</li> <li>• Immune Globulins</li> </ul>	Updated preferred agents and GCNs
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>• Immunosuppressives, Oral</li> <li>• Iron, Oral</li> <li>• Leukotriene Modifiers</li> <li>• Lipotropics, Statins</li> <li>• Macrolides and Ketolides</li> <li>• Movement Disorders</li> <li>• Neuropathic Pain</li> <li>• NSAIDs</li> <li>• Ophthalmic Antibiotics</li> <li>• Ophthalmic Antibiotic-Steroid Combinations</li> <li>• Ophthalmics for Allergic Conjunctivitis</li> <li>• Ophthalmics, Anti-inflammatory</li> <li>• Ophthalmics, Anti-inflammatory / Immunomodulator</li> <li>• Ophthalmics, Glaucoma Agents</li> <li>• Opiate Dependence Treatments</li> <li>• Otic Antibiotics</li> <li>• Otic Anti-infectives &amp; Anesthetics</li> <li>• Penicillins</li> <li>• Progestational Agents</li> <li>• Skeletal Muscle Relaxants</li> <li>• Steroids, Topical</li> <li>• Stimulants and Related Agents</li> <li>• Tetracyclines</li> <li>• Ulcerative Colitis Agents</li> </ul>	

.21	<ul style="list-style-type: none"> <li>• Glucagon Agents</li> <li>• Immunomodulators, Asthma</li> <li>• Sickle Cell Anemia Treatment</li> <li>• Acne Agents, Oral</li> <li>• Acne Agents, Topical</li> <li>• Analgesics, Narcotics Long</li> <li>• Analgesics, Narcotics Short</li> <li>• Angiotensin Modulator Combinations</li> <li>• Angiotensin Modulators</li> <li>• Anti-Allergens, Oral</li> <li>• Anticoagulants</li> <li>• Antidepressants, Other</li> <li>• Antidepressants, SSRIs</li> <li>• Antidepressants, Tricyclics</li> <li>• Antihyperuricemics</li> <li>• Antimigraine Agents, Other</li> <li>• Antimigraine Agents, Triptans</li> <li>• Antiparkinson's Agents</li> <li>• Antipsychotics</li> <li>• Antivirals, Oral/Nasal</li> <li>• Anxiolytics</li> <li>• Beta-Blockers</li> <li>• Bile Salts</li> <li>• Bladder Relaxant Preparations</li> <li>• BPH Treatments</li> <li>• Bronchodilators, Beta Agonist</li> <li>• Colony Stimulating Factors</li> <li>• COPD Agents</li> <li>• Cough and Cold Agents</li> <li>• Erythropoiesis Stimulating Proteins</li> <li>• Glucocorticoids, Inhaled</li> <li>• HAE Treatments</li> <li>• H. Pylori Treatment</li> <li>• Hypoglycemics, Incretin Mimetics/Enhancers</li> <li>• Hypoglycemics, Insulin and Related Agents</li> <li>• Immune Globulins</li> <li>• Intranasal Rhinitis Agents</li> </ul>	Added new classes and updated preferred drug lists and GCNs
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>• Linconsamides/Oxazolidinones/Streptogramins</li> <li>• Lipotropics, Other</li> <li>• Lipotropics, Statins</li> <li>• Movement Disorders</li> <li>• Neuropathic Pain</li> <li>• PAH Agents, Oral and Inhaled</li> <li>• Pancreatic Enzymes</li> <li>• Pediatric Vitamin Preparations</li> <li>• Phosphate Binders</li> <li>• Platelet Aggregation Inhibitors</li> <li>• Prenatal Vitamins</li> <li>• Progestins for Cachexia</li> <li>• Proton Pump Inhibitors</li> <li>• Sedative Hypnotics</li> <li>• Smoking Cessation</li> <li>• Stimulants and Related Agents</li> <li>• Thrombopoiesis Stimulating Proteins</li> <li>• Urea Cycle Disorders, Oral</li> </ul>	
.22	<ul style="list-style-type: none"> <li>• Macrolides</li> </ul>	Updated criteria and approval duration Updated diagnosis lookback timeframe for Immunomodulators, Dupixent
.23	<ul style="list-style-type: none"> <li>• Immunomodulators, Atopic Dermatitis</li> <li>• Immunomodulators, Dupixent (atopic dermatitis step)</li> </ul>	Updated lookback timeframe for preferred agents
.24	<ul style="list-style-type: none"> <li>• Stimulants and Related Agents</li> </ul>	Removed Methylin criteria logic and logic diagram – medication is currently preferred
.25	<ul style="list-style-type: none"> <li>• Macrolides</li> </ul>	Rearranged criteria logic and logic diagram for Macrolides
.26	<ul style="list-style-type: none"> <li>• Neuropathic Pain</li> </ul>	Removed duloxetine 40mg from the preferred agents table

.27	<ul style="list-style-type: none"><li>• Acne Agents Topical</li><li>• Alzheimer's Agents</li><li>• Androgenic Agents</li><li>• Antiallergens, Oral</li><li>• Antibiotics, GI</li><li>• Antibiotics, Topical</li><li>• Antibiotics, Vaginal</li><li>• Anticonvulsants</li><li>• Antiemetic/Antivertigo Agents</li><li>• Antifungals, Oral</li><li>• Antifungals, Topical</li><li>• Antihistamines, First Generation</li><li>• Antihistamines, Minimally Sedating</li><li>• Antihypertensives, Sympatholytics</li><li>• Antimigraine Agents, Other</li><li>• Antiparasitics, Topical</li><li>• Antipsychotics</li><li>• Antipsychotics, Long-Acting Injectables</li><li>• Antivirals, Topical</li><li>• Bone Resorption Suppression and Related Agents</li><li>• Calcium Channel Blockers</li><li>• Cephalosporins and Related Antibiotics</li><li>• Colony Stimulating Factors</li><li>• Cytokine and CAM Antagonists</li><li>• Epinephrine Self-Injected</li><li>• Fluoroquinolones, Oral</li><li>• GI Motility, Chronic</li><li>• Glucocorticoids, Oral</li><li>• Growth Hormone</li><li>• Hemophilia Treatment</li><li>• Hepatitis C Agents</li><li>• HIV/AIDS</li><li>• Hypoglycemics, Incretin Mimetics/Enhancers</li><li>• Hypoglycemics, Insulin and Related Agents</li><li>• Hypoglycemics, Meglitinides</li><li>• Hypoglycemics, Metformin</li></ul>	Added new classes and updated preferred drug lists and GCNs
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>• Hypoglycemics, SGLT2</li> <li>• Hypoglycemics, TZD</li> <li>• Immune Globulins</li> <li>• Immunomodulators, Atopic Dermatitis</li> <li>• Immunosuppressives, Oral</li> <li>• Iron, Oral</li> <li>• Leukotriene Modifiers</li> <li>• Lipotropics, Other</li> <li>• Macrolides/Ketolides</li> <li>• Multiple Sclerosis Agents</li> <li>• NSAIDs</li> <li>• Oncology, Oral – Breast</li> <li>• Oncology, Oral – Hematologic</li> <li>• Oncology, Oral – Lung</li> <li>• Oncology, Oral – Other</li> <li>• Oncology, Oral – Prostate</li> <li>• Oncology, Oral – Renal Cell</li> <li>• Oncology, Oral - Skin</li> <li>• Ophthalmic Antibiotics</li> <li>• Ophthalmic Antibiotic-Steroid Combinations</li> <li>• Ophthalmics for Allergic Conjunctivitis</li> <li>• Ophthalmics, Anti-Inflammatories</li> <li>• Ophthalmics, Anti-Inflammatory/Immunomodulator</li> <li>• Ophthalmics, Glaucoma Agents</li> <li>• Opiate Dependence Treatments</li> <li>• Otic Antibiotics</li> <li>• Otic Anti-Infectives and Anesthetics</li> <li>• Penicillins</li> <li>• Progestational Agents</li> <li>• Rosacea Agents, Topical</li> <li>• Sedative/Hypnotics</li> <li>• Skeletal Muscle Relaxants</li> <li>• Steroids, Topical</li> <li>• Tetracyclines</li> <li>• Ulcerative Colitis Agents</li> </ul>	

Version Number	Chapter/Section	Change
.28	<ul style="list-style-type: none"> <li>• Anti-Allergen Agents</li> <li>• Antibiotics, Vaginal</li> <li>• Antiemetic-Antivertigo Agents</li> <li>• Bronchodilators, Inhaled</li> <li>• Colony Stimulating Factors</li> <li>• First Generation Antihistamines</li> <li>• Hypoglycemics, TZDs</li> <li>• Lipotropics, Other</li> <li>• Prenatal Vitamins</li> <li>• Stimulants and Related Agents</li> </ul>	<p>Removed exemption criteria for ondansetron solution because it is currently a preferred agent</p> <p>Removed GCNs for clemastine fum 2.68mg, methylphenidate ER, metronidazole 0.75% vaginal gel and Granix</p> <p>Added the following statement to Hypoglycemics, TZD: Separate prescriptions for the individual components should be used instead of the combination drugs</p> <p>Added subsection for PCSK9 inhibitors under Lipotropics, Other</p> <p>Added the following statement to Anti-Allergens: For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization</p> <p>Added the following statement to Prenatal Vitamins: Prenatal vitamins are covered only for females less than 50 years of age.</p> <p>Removed diagnosis check of CVD and intolerable side effects for Inhaled Bronchodilators</p>
.29	<ul style="list-style-type: none"> <li>• Macrolides</li> </ul>	<p>Revised prior therapy question to read: Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and/or pharmacy claims history? (Exception may apply when a preferred drug requires less than a 7-day treatment trial)</p>

.30	<ul style="list-style-type: none"> <li>• Acne Agents, Oral</li> <li>• Acne Agents, Topical</li> <li>• Analgesics, Narcotics Long</li> <li>• Analgesics, Narcotics Short</li> <li>• Angiotensin Modulator Combinations</li> <li>• Angiotensin Modulators</li> <li>• Anti-allergens, Oral</li> <li>• Antibiotics, GI</li> <li>• Antibiotics, Inhaled</li> <li>• Anticoagulants</li> <li>• Antidepressants, Other</li> <li>• Antidepressants, SSRI</li> <li>• Antidepressants, Tricyclic</li> <li>• Antihyperuricemics</li> <li>• Antimigraine Agents, Other</li> <li>• Antimigraine Agents, Triptans</li> <li>• Antiparkinson's Agents</li> <li>• Antivirals, Oral</li> <li>• Anxiolytics</li> <li>• Beta-Blockers</li> <li>• Bile Salts</li> <li>• Bladder Relaxant Preparations</li> <li>• BPH Treatments</li> <li>• Bronchodilators, Beta Agonist</li> <li>• Colony Stimulating Factors</li> <li>• COPD Agents</li> <li>• Cough and Cold</li> <li>• Cytokine and CAM Antagonists</li> <li>• Erythropoiesis Stimulating Proteins</li> <li>• Glucagon Agents</li> <li>• Glucocorticoids, Inhaled</li> <li>• Glucocorticoids, Oral</li> <li>• HAE Treatments</li> <li>• Hemophilia Treatment</li> <li>• H.Pylori Treatment</li> <li>• Hypoglycemics, Incretin Mimetics/Enhancers</li> <li>• Hypoglycemics, Insulin and Related Agents</li> <li>• Immune Globulins</li> <li>• Immunomodulators, Asthma</li> </ul>	Updated preferred drug lists and GCNs
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>Immunomodulators, Atopic Dermatitis</li> <li>Intranasal Rhinitis Agents</li> <li>Lincosamides/ Oxazolidinones/ Streptogramins</li> <li>Lipotropics, Other</li> <li>Lipotropics, Statins</li> <li>Movement Disorders</li> <li>Multiple Sclerosis</li> <li>Neuropathic Pain</li> <li>NSAIDs</li> <li>Oncology, Oral-Breast</li> <li>Oncology, Oral-Hematologic</li> <li>Oncology, Oral-Lung</li> <li>Oncology, Oral-Other</li> <li>Oncology, Oral-Prostate</li> <li>Oncology, Oral-Renal Cell</li> <li>Oncology, Oral-Skin</li> <li>Ophthalmics for Allergic Conjunctivitis</li> <li>Ophthalmics, Anti-Inflammatory/ Immunomodulators</li> <li>PAH Agents, Oral and Inhaled</li> <li>Pancreatic Enzymes</li> <li>Pediatric Vitamin Preparations</li> <li>Phosphate Binder</li> <li>Platelet Aggregation Inhibitors</li> <li>Prenatal Vitamins</li> <li>Progestins for Cachexia</li> <li>Proton Pump Inhibitors</li> <li>Sedative Hypnotics</li> <li>Sickle Cell Anemia Treatments</li> <li>Smoking Cessation</li> <li>Steroids, Topical</li> <li>Stimulants and Related Agents</li> <li>Thrombopoiesis Stimulating Proteins</li> <li>Urea Cycle Disorders, Oral</li> </ul>	

Version Number	Chapter/Section	Change
.31	<ul style="list-style-type: none"><li>Ophthalmics, Anti-Inflammatory / Immunomodulators</li></ul>	Revised lookback timeframe from 180 days therapy with a preferred agent in the last 200 days to 30 days therapy in the last 180 days
.32	<ul style="list-style-type: none"><li>Ophthalmics, Anti-Inflammatory Agents</li></ul>	Added GCN for Lotemax 0.5% drops to preferred agents
.33	<ul style="list-style-type: none"><li>Antibiotics, Topical</li></ul>	Updated logic diagram, question 1, to look for a 5-days supply of a preferred agent in the last 60 days
.34	<ul style="list-style-type: none"><li>Immunomodulators, Rinvoq</li></ul>	Added criteria for atopic dermatitis and check for prior therapy with preferred atopic dermatitis agents
	<ul style="list-style-type: none"><li>Macrolides</li></ul>	Updated heading to Macrolides/Ketolides

	<ul style="list-style-type: none"> <li>• Alzheimer's Agents</li> <li>• Androgenic Agents</li> <li>• Antibiotics, GI</li> <li>• Antibiotics, Topical</li> <li>• Antibiotics, Vaginal</li> <li>• Anticonvulsants</li> <li>• Antiemetic/Antivertigo Agents</li> <li>• Antifungals, Oral</li> <li>• Antifungals, Topical</li> <li>• Antihistamines, First Generation</li> <li>• Antihistamines, Minimally Sedating</li> <li>• Antihypertensives Sympatholytics</li> <li>• Antiparasitics, Topical</li> <li>• Antipsychotics</li> <li>• Antivirals, Topical</li> <li>• Bladder Relaxant Preparations</li> <li>• Bone Resorption Suppression and Related Agents</li> <li>• Calcium Channel Blockers</li> <li>• Cephalosporins and Related Antibiotics</li> <li>• Colony Stimulating Factors</li> <li>• Cytokine and CAM Antagonists</li> <li>• Epinephrine, Self-Injected</li> <li>• Fluoroquinolones, Oral</li> <li>• GI Motility, Chronic</li> <li>• Glucagon Agents</li> <li>• Glucocorticoids, Oral</li> <li>• Growth Hormone</li> <li>• Hepatitis C Agents</li> <li>• HIV/AIDS</li> <li>• Hypoglycemics, Insulin and Related Agents</li> <li>• Hypoglycemics, Meglitinides</li> <li>• Hypoglycemics, Metformins</li> <li>• Hypoglycemics, SGLT2</li> <li>• Hypoglycemics, TZD</li> <li>• Immunosuppressives, Oral</li> <li>• Iron, Oral</li> <li>• Leukotriene Modifiers</li> </ul>	Updated preferred drug lists and GCNs
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>• Macrolides/Ketolides</li> <li>• Multiple Sclerosis Agents</li> <li>• NSAIDs</li> <li>• Oncology, Oral - Hematologic</li> <li>• Oncology, Oral – Lung</li> <li>• Oncology, Oral - Other</li> <li>• Ophthalmic Antibiotics</li> <li>• Ophthalmic Antibiotics-Steroid Combinations</li> <li>• Ophthalmics for Allergic Conjunctivitis</li> <li>• Ophthalmics, Anti-Inflammatories</li> <li>• Ophthalmics, Anti-Inflammatory/Immunomodulator</li> <li>• Ophthalmics, Glaucoma Agents</li> <li>• Opiate Dependence Treatments</li> <li>• Otic Antibiotics</li> <li>• Otic Anti-Infectives &amp; Anesthetics</li> <li>• Penicillins</li> <li>• Platelet Aggregation Inhibitors</li> <li>• Progestational Agents</li> <li>• Rosacea Agents, Topical</li> <li>• Sedative Hypnotics</li> <li>• Skeletal Muscle Relaxants</li> <li>• Steroids, Topical</li> <li>• Stimulants and Related Agents</li> <li>• Tetracyclines</li> <li>• Ulcerative Colitis Agents</li> </ul>	
.35	<ul style="list-style-type: none"> <li>• Phosphate Binders</li> </ul>	Updated criteria
.36	<ul style="list-style-type: none"> <li>• Rinvoq</li> </ul>	Moved Rinvoq criteria to Cytokine and CAM Antagonist class section Added diagnoses of ankylosing spondylitis and ulcerative colitis. Clients with these diagnoses requires preferred therapy from the Cytokine and CAM class.
.37	<ul style="list-style-type: none"> <li>• Potassium Binders</li> </ul>	Added criteria for the new class, Potassium Binders

	<ul style="list-style-type: none"> <li>• Acne Agents, Oral</li> <li>• Acne Agents, Topical</li> <li>• Analgesics, Narcotic Long</li> <li>• Analgesics, Narcotic Short</li> <li>• Angiotensin Modulator Combinations</li> <li>• Angiotensin Modulators</li> <li>• Anti-Allergens, Oral</li> <li>• Anticoagulants</li> <li>• Antidepressants, Other</li> <li>• Antidepressants, SSRIs</li> <li>• Antidepressants, TCAs</li> <li>• Antihyperuricemics</li> <li>• Antimigraine Agents, Other</li> <li>• Antimigraine Agents, Triptans</li> <li>• Antiparkinson's Agents</li> <li>• Antipsychotic Agents</li> <li>• Antivirals, Oral</li> <li>• Anxiolytics</li> <li>• Beta Blockers</li> <li>• Bile Salts</li> <li>• Bladder Relaxant Preparations</li> <li>• BPH Treatments</li> <li>• Bronchodilators, Beta Agonist</li> <li>• COPD Agents</li> <li>• Cough and Cold Agents</li> <li>• Erythropoiesis Stimulating Proteins</li> <li>• Glucagon Agents</li> <li>• Glucocorticoids, Inhaled</li> <li>• HAE Treatments</li> <li>• Hemophilia Treatments</li> <li>• H. Pylori Treatment</li> <li>• Immune Globulins</li> <li>• Immunomodulators, Asthma</li> <li>• Immunomodulators, Atopic Dermatitis</li> <li>• Intranasal Rhinitis Agents</li> <li>• Lincosamides/ Oxazolidinones/ Streptogramins</li> <li>• Lipotropics, Other</li> <li>• Lipotropics, Statins</li> <li>• Movement Disorders</li> </ul>	Updated classes and GCNs
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>• Multiple Sclerosis Agents</li> <li>• Neuropathic Pain</li> <li>• Oncology, Oral-Breast</li> <li>• Oncology, Oral-Hematologic</li> <li>• Oncology, Oral-Lung</li> <li>• Oncology, Oral-Other</li> <li>• Oncology, Oral – Prostate</li> <li>• Oncology, Oral-Renal Cell</li> <li>• Oncology, Oral-Skin</li> <li>• PAH Agents, Oral and Inhaled</li> <li>• Pancreatic Enzymes</li> <li>• Pediatric Vitamin Preparations</li> <li>• Phosphate Binders</li> <li>• Platelet Aggregation Inhibitors</li> <li>• Prenatal Vitamins</li> <li>• Progestins for Cachexia</li> <li>• PPIs</li> <li>• Sedative Hypnotics</li> <li>• Sickle Cell Anemia Treatments</li> <li>• Smoking Cessation</li> <li>• Stimulants and Related Agents</li> <li>• Thrombopoiesis Stimulating Proteins</li> <li>• Urea Cycle Disorders, Oral</li> </ul>	
.38	<ul style="list-style-type: none"> <li>• Immunomodulators, Dupixent</li> </ul>	Added diagnosis of eosinophilic esophagitis for Dupixent
.39	<ul style="list-style-type: none"> <li>• Bronchodilators, Beta Agonists</li> <li>• Glucagon Agents</li> </ul>	Updated lookback for a preferred agent to 14 days supply in the last 180 days for Bronchodilators, Beta Agonists and 1 day supply in the last 180 days for Glucagon agents
.40	<ul style="list-style-type: none"> <li>• Hepatitis C Agents</li> </ul>	Updated preferred agents
.41	<ul style="list-style-type: none"> <li>• Uterine Disorder Treatments</li> </ul>	Added criteria for Uterine Disorder Treatments

	<ul style="list-style-type: none"> <li>• Acne Agents, Topical</li> <li>• Alzheimer's Agents</li> <li>• Analgesics, Narcotic – Short</li> <li>• Androgenic Agents</li> <li>• Antibiotics, Vaginal</li> <li>• Antiemetic/Antivertigo Agents</li> <li>• Antifungals, Oral</li> <li>• Antifungals, Topical</li> <li>• Antihistamines, First Generation</li> <li>• Antipsychotic Agents</li> <li>• Antiviral Agents</li> <li>• Calcium Channel Blockers</li> <li>• Colony Stimulating Factors</li> <li>• Cytokine and CAM Antagonists</li> <li>• Epinephrine, Self-injected</li> <li>• Fluroquinolones, Oral</li> <li>• Glucocorticoids, Oral</li> <li>• GI Motility Agents</li> <li>• HAE Agents</li> <li>• HIV/AIDs</li> <li>• Hypoglycemics, Incretin Mimetics/Enhancers</li> <li>• Hypoglycemics, Insulin and Related Agents</li> <li>• Hypoglycemics, Metformin</li> <li>• Hypoglycemics, SGLT2</li> <li>• Immunosuppressives, Oral</li> <li>• Macrolides/Ketolides</li> <li>• NSAIDs</li> <li>• Ophthalmic Antibiotics</li> <li>• Ophthalmic Antibiotic-Steroid Combinations</li> <li>• Ophthalmics for Allergic Conjunctivitis</li> <li>• Opiate Dependence Treatments</li> <li>• PAH Agents, Oral and Inhaled</li> <li>• Rosacea Agents, Topical</li> <li>• Sedative/Hypnotics</li> <li>• Skeletal Muscle Relaxants</li> <li>• Tetracyclines</li> </ul>	Updated GCNs for preferred and nonpreferred agents
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"><li>• Ulcerative Colitis Agents</li></ul>	

.42	<ul style="list-style-type: none"> <li>• Acne Agents, Oral</li> <li>• Acne Agents, Topical</li> <li>• Analgesics, Narcotic (Long)</li> <li>• Analgesics, Narcotic (Short)</li> <li>• Anti-allergens, Oral</li> <li>• Antibiotics, Inhaled</li> <li>• Anticoagulants</li> <li>• Antidepressants, Other</li> <li>• Antidepressants, SSRIs</li> <li>• Antidepressants, Tricyclic</li> <li>• Antifungals, Oral</li> <li>• Angiotensin Modulator Combinations</li> <li>• Angiotensin Modulators</li> <li>• Antihypertensives, Sympatholytics</li> <li>• Antihyperuricemics</li> <li>• Antimigraine Agents, Other</li> <li>• Antimigraine Agents, Triptans</li> <li>• Antiparkinson's Agents</li> <li>• Antivirals, Oral</li> <li>• Anxiolytics</li> <li>• Beta-Blockers</li> <li>• Bile Salts</li> <li>• Bladder Relaxant Preparations</li> <li>• BPH Treatments</li> <li>• Bronchodilators, Beta Agonist</li> <li>• Colony Stimulating Factors</li> <li>• COPD Agents</li> <li>• Cough and Cold, Cold</li> <li>• Cough and Cold, Narcotic</li> <li>• Cough and Cold, Non-Narcotic</li> <li>• Cytokine and CAM Antagonists</li> <li>• Erythropoiesis Stimulating Proteins</li> <li>• Glucagon Agents</li> <li>• Glucocorticoids, Inhaled</li> <li>• HAE Treatments</li> <li>• Hemophilia Treatments</li> <li>• HIV/AIDS</li> <li>• H. Pylori Treatment</li> </ul>	Updated GCNs for preferred and nonpreferred agents
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>• Hypoglycemics, Insulin and Related Agents</li> <li>• Immune Globulins</li> <li>• Immunomodulators, Asthma</li> <li>• Immunomodulators, Atopic Dermatitis</li> <li>• Intranasal Rhinitis Agents</li> <li>• Lincosamides/Oxazolidinones/Streptogramins</li> <li>• Lipotropics, Other</li> <li>• Lipotropics, Statins</li> <li>• Movement Disorders</li> <li>• MS Agents</li> <li>• Neuropathic Pain</li> <li>• Oncology, Oral-Breast</li> <li>• Oncology, Oral-Hematologic</li> <li>• Oncology, Oral-Lung</li> <li>• Oncology, Oral-Other</li> <li>• Oncology, Oral-Prostate</li> <li>• Oncology, Oral-Renal Cell</li> <li>• Oncology, Oral-Skin</li> <li>• PAH Agents, Oral and Inhaled</li> <li>• Pancreatic Enzymes</li> <li>• Pediatric Vitamin Preparations</li> <li>• Phosphate Binders</li> <li>• Platelet Aggregation Inhibitors</li> <li>• Potassium Binders</li> <li>• Prenatal Vitamins</li> <li>• Progesterones for Cachexia</li> <li>• Proton Pump Inhibitors</li> <li>• Sedative Hypnotics</li> <li>• Sickle Cell Treatments</li> <li>• Smoking Cessation</li> <li>• Stimulants and Related Agents</li> <li>• Thrombopoiesis Stimulating Proteins</li> <li>• Urea Cycle Disorders, Oral</li> </ul>	

Version Number	Chapter/Section	Change
.43	<ul style="list-style-type: none"><li>• Rinvoq</li><li>• Dupixent</li><li>• Hepatitis C Agents</li></ul>	Added diagnosis of prurigo nodularis to Dupixent criteria Added diagnoses of Crohn's disease and non-radiographic axial spondyloarthritis to Rinvoq criteria Added GCNs for ribavirin to preferred Hepatitis C Agents table



.44	<ul style="list-style-type: none"> <li>• Alzheimer's Agents</li> <li>• Androgenic Agents</li> <li>• Antibiotics, GI</li> <li>• Antibiotics, Topical</li> <li>• Antibiotics, Vaginal</li> <li>• Anticonvulsants</li> <li>• Antiemetic/Antivertigo Agents</li> <li>• Antifungals, Oral</li> <li>• Antifungals, Topical</li> <li>• Antihistamines, First Generation</li> <li>• Antihistamines, Minimally Sedating</li> <li>• Antimigraine Agents, Other</li> <li>• Antiparasitics, Topical</li> <li>• Antipsychotics</li> <li>• Antivirals, Topical</li> <li>• Bone Resorption Suppression and Related Agents</li> <li>• Calcium Channel Blockers</li> <li>• Cephalosporins and Related Antibiotics</li> <li>• Colony Stimulating Factors</li> <li>• Cytokine and CAM Antagonists</li> <li>• Epinephrine, Self-injected</li> <li>• Fluoroquinolones, Oral</li> <li>• GI Motility, Chronic</li> <li>• Glucocorticoids, Oral</li> <li>• Growth Hormone</li> <li>• Hemophilia Treatment</li> <li>• HIV/AIDS</li> <li>• Hypoglycemics, Incretin Mimetics/Enhancers</li> <li>• Insulin and Related Agents</li> <li>• Meglitinides</li> <li>• Metformins</li> <li>• SGLT2</li> <li>• TZD</li> <li>• Immunomodulators, Lupus</li> <li>• Immunosuppressives, Oral</li> <li>• Iron, Oral</li> <li>• Leukotriene Modifiers</li> <li>• Macrolides/Ketolides</li> </ul>	<p>Updated GCNs for preferred and nonpreferred agents</p> <p>Added information from HB 3286, Section 2, 88<sup>th</sup> Legislature, Regular Session, 2023, including PDL criteria exceptions and additional criteria for the Antipsychotic PDL class</p>
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>• Movement Disorders</li> <li>• NSAIDs</li> <li>• Oncology, Oral</li> <li>• Ophthalmic Antibiotics</li> <li>• Ophthalmic Antibiotic-Steroid Combinations</li> <li>• Ophthalmics for Allergic Conjunctivitis</li> <li>• Ophthalmics, Anti-Inflammatory</li> <li>• Ophthalmics, Anti-Inflammatory/Immuno modulator</li> <li>• Ophthalmics, Glaucoma Agents</li> <li>• Opiate Dependence Treatments</li> <li>• Otic Antibiotics</li> <li>• Otic Anti-Infectives &amp; Anesthetics</li> <li>• PAH Agents, Oral and Inhaled</li> <li>• Penicillins</li> <li>• Proton Pump Inhibitors</li> <li>• Rosacea Agents, Topical</li> <li>• Sedative Hypnotics</li> <li>• Skeletal Muscle Relaxants</li> <li>• Steroids, Topical</li> <li>• Tetracyclines</li> <li>• Ulcerative Colitis Agents</li> <li>• Uterine Disorder Treatments</li> </ul>	

08/08/2024	<ul style="list-style-type: none"> <li>• Acne Agents, Oral</li> <li>• Acne Agents, Topical</li> <li>• Analgesics, Narcotics Long</li> <li>• Analgesics, Narcotics Short</li> <li>• Angiotensin Modulator Combinations</li> <li>• Angiotensin Modulators</li> <li>• Anti-Allergans</li> <li>• Antibiotics, GI</li> <li>• Antibiotics, Inhaled</li> <li>• Anticoagulants</li> <li>• Antidepressants, Other</li> <li>• Antidepressants, SSRIs</li> <li>• Antidepressants, Tricyclic</li> <li>• Antihypertensives, Sympatholytics</li> <li>• Anticonvulsants</li> <li>• Antihyperuricemics</li> <li>• Antimigraine Agents, Other</li> <li>• Antimigraine Agents, Triptans</li> <li>• Antivirals</li> <li>• Antiparkinson's Agents</li> <li>• Anxiolytics</li> <li>• Beta-Blockers</li> <li>• Bladder Relaxant Preparations</li> <li>• Bile Salts</li> <li>• BPH Agents</li> <li>• Bronchodilators, Beta Agonist</li> <li>• COPD Agents</li> <li>• Cough and Cold, Cold</li> <li>• Cough and Cold, Narcotics</li> <li>• Cough and Cold, Non-Narcotic</li> <li>• Cytokine and CAM Antagonists</li> <li>• Erythropoiesis Stimulating Agents</li> <li>• Glucagon Agents</li> <li>• Glucocorticoids, Inhaled</li> <li>• Hemophilia Treatment</li> <li>• HAE Treatments</li> <li>• H. Pylori Treatment</li> <li>• Immune Globulins</li> <li>• Immunomodulators, Asthma</li> </ul>	<p>Updated PDL classes and GCNs</p> <p>Added information to Antidepressant criteria logic regarding discharge from an inpatient facility or risk of experiencing complications if switched from a non preferred agent to a preferred agent</p> <p>Removed age exemption from Epaned</p> <p>Removed Criteria for Xifaxan, Progestational Agents, and PCSK9 Inhibitors</p> <p>Removed diagnosis question from Rinvoq and Dupixent criteria logic</p> <p>Rephrased PA system from RxPert to GW PA System</p> <p>Updated and/or reviewed all preferred drug tables</p>
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Version Number	Chapter/Section	Change
	<ul style="list-style-type: none"> <li>• Immunomodulators, Atopic Dermatitis</li> <li>• Intranasal Rhinitis Agents</li> <li>• Lincosamides/Oxazolidinones/Streptogramins</li> <li>• Lipotropics, Other</li> <li>• Lipotropics, Statins</li> <li>• Movement Disorders</li> <li>• Multiple Sclerosis Agents</li> <li>• Neuropathic Pain</li> <li>• Oncology, Oral-Breast</li> <li>• Oncology, Oral-Hematologic</li> <li>• Oncology, Oral-Lung</li> <li>• Oncology, Oral-Other</li> <li>• Oncology, Oral-Prostate</li> <li>• Oncology, Oral-Renal Cell</li> <li>• Oncology, Oral-Skin</li> <li>• Opioid Dependence Treatments</li> <li>• Ophthalmics, Anti-Inflammatory Immunomodulators</li> <li>• PAH Agents</li> <li>• Pancreatic Enzymes</li> <li>• Pediatric Vitamin Preparations</li> <li>• Prenatal Vitamins</li> <li>• Phosphate Binders</li> <li>• Platelet Aggregation Inhibitors</li> <li>• Potassium Binders</li> <li>• Progestins for Cachexia</li> <li>• Proton Pump Inhibitors</li> <li>• Sedative Hypnotic</li> <li>• Sickle Cell Anemia Treatments</li> <li>• Smoking Cessation</li> <li>• Stimulants and Related Agents</li> <li>• Thrombopoiesis Stimulating Proteins</li> <li>• Ulcerative Colitis</li> <li>• Urea Cycle Disorder</li> </ul>	