



**Criteria Guide
for the**

Texas Prior Authorization Program

**Temporary Non-Preferred
(TNP) Prior Authorization
Criteria**

September 1, 2025

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1 Document Overview

Purpose

The Texas HHSC Prior Authorization Program Criteria Guide explains the criteria used by the Gainwell Technologies system to evaluate the prior authorization (PA) requests submitted by Texas Medicaid prescribers. The Temporary Non-Preferred (TNP) Prior Authorization Criteria Guide describes the criteria logic for drugs identified as temporary non-preferred.

Organization

The TNP PA Criteria Guide includes the following information:

Prior authorization criteria logic – a description of how the Gainwell Technologies PA system evaluates the prior authorization request against the TNP criteria rules

Logic diagram – a visual depiction of the criteria logic

TNP Criteria Exceptions

This guide contains the following criteria used for all new to market drugs available on the Texas Medicaid formulary not yet reviewed by the Drug Utilization Review Board. H.B. 3286, 88th Legislature, Regular Session, 2023, amends Section 531.072 of the Texas Government Code to grant temporary non-preferred status to new drugs to the market that are available on the Medicaid formulary but not yet reviewed by the Drug Utilization Review Board. The following TNP criteria information include:

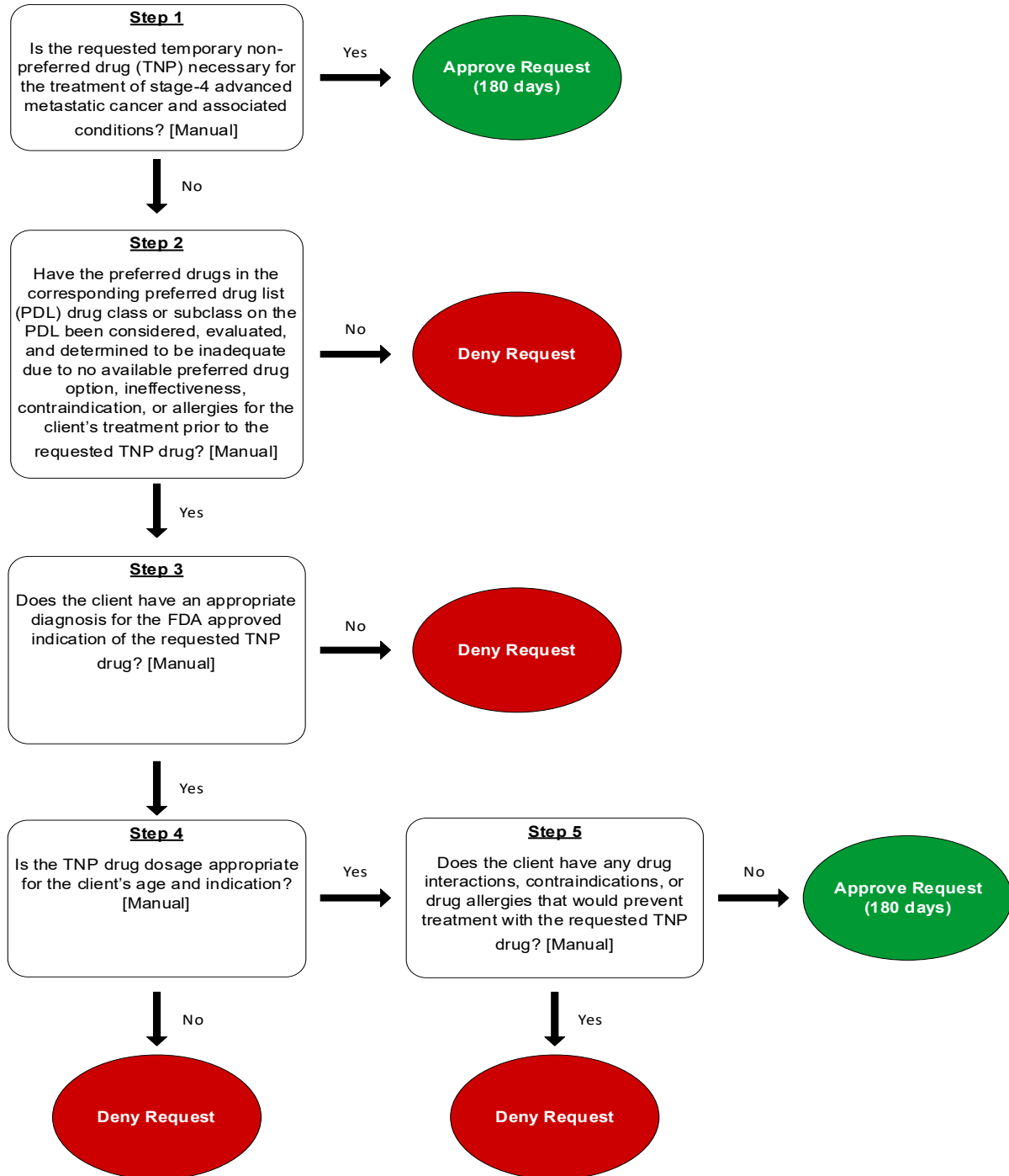
- Treatment of stage-four advanced, metastatic cancer and associated conditions
- Provider consideration, evaluation, and determination of other available treatment options
- Appropriate FDA approved diagnosis
- Appropriate FDA approved age and dosage
- Drug interactions, contraindications, and drug allergies

2 Temporary Non-Preferred Drug (TNP)

Temporary Non-Preferred Drug (TNP) Prior Authorization Criteria

1. Is the requested temporary non-preferred drug (TNP) necessary for the treatment of stage-4 advanced metastatic cancer and associated conditions? [Manual]
☐ Yes (Approve – 180 days)
☐ No (Go to #2)
2. Have the preferred drugs in the corresponding preferred drug list (PDL) drug class or subclass on the PDL been considered, evaluated, and determined to be inadequate due to no available preferred drug option, ineffectiveness, contraindication, or allergies for the client's treatment prior to the requested TNP drug? [Manual]
☐ Yes (Go to #3)
☐ No (Deny)
3. Does the client have an appropriate diagnosis for the FDA approved indication of the requested TNP drug? [Manual]
☐ Yes (Go to #4)
☐ No (Deny)
4. Is the TNP drug dosage appropriate for the client's age and indication? [Manual]
☐ Yes (Go to #5)
☐ No (Deny)
5. Does the client have any drug interactions, contraindications, or drug allergies that would prevent treatment with the requested TNP drug? [Manual]
☐ Yes (Deny)
☐ No (Approve – 180 days)

Temporary Non-Preferred Drug (TNP) Prior Authorization Criteria



3 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
08/06/2025	.01	Changes/edits made to reflect TNP Policy
09/01/2025	.02	Delivery of final draft

4 Change Log

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

Version Number	Chapter/Section	Change
.01	Table of Contents and Document Overview	Changes/edits made to reflect TNP Policy
.02	N/A	N/A