Criteria Guide
for the
Texas Prior Authorization Program
PDL Criteria
January 25, 2024

Contents

Document Overview

Purpose

The Texas HHSC Prior Authorization Program Criteria Guide explains the criteria used by the RxPert® 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 RxPert 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-9/10) codes relevant to specific steps in the evaluation
- **Procedure codes** – procedure (CPT; J-) codes relevant to specific steps in the evaluation

PDL Criteria Exceptions

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

Table 1:

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

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

Table 2:

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

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

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

Acne Agents, Oral

Acne Agents, Oral
Prior Authorization Criteria

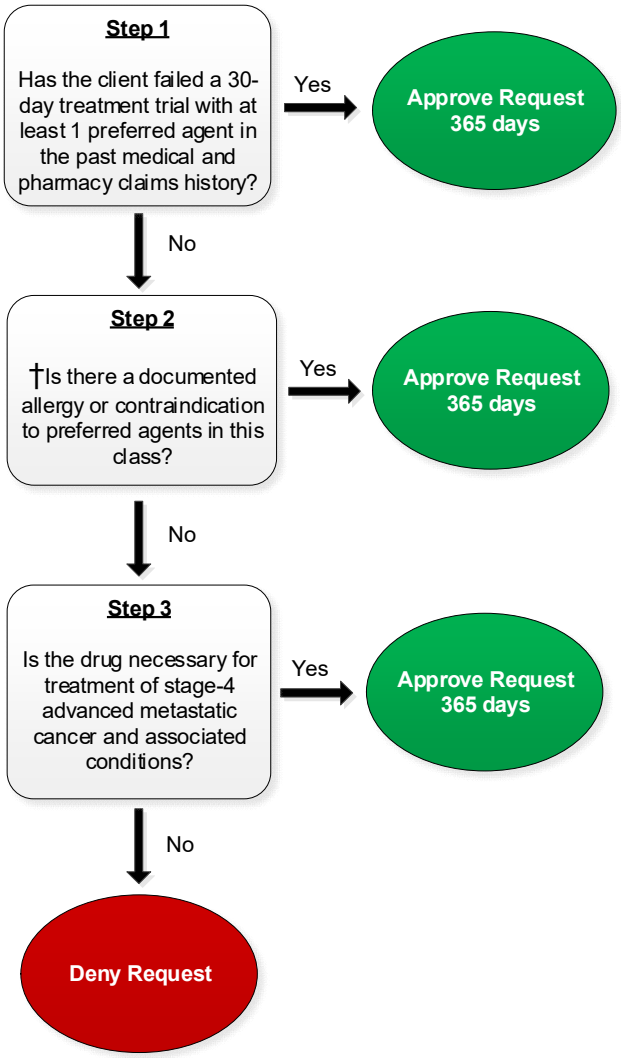
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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 located on page 1 of the PDL Criteria Guide in the Document Overview section.

Acne Agents, Oral Alternate Therapies

Preferred Oral Acne Agents

GCN	Drug Name
59841	AMNESTEEM 10 MG CAPSULE
59842	AMNESTEEM 20 MG CAPSULE
59843	AMNESTEEM 40 MG CAPSULE
59841	CLARAVIS 10 MG CAPSULE
59842	CLARAVIS 20 MG CAPSULE
20383	CLARAVIS 30 MG CAPSULE
59843	CLARAVIS 40 MG CAPSULE
59841	ISOTRETINOIN 10 MG CAPSULE
59842	ISOTRETINOIN 20 MG CAPSULE
20383	ISOTRETINOIN 30 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

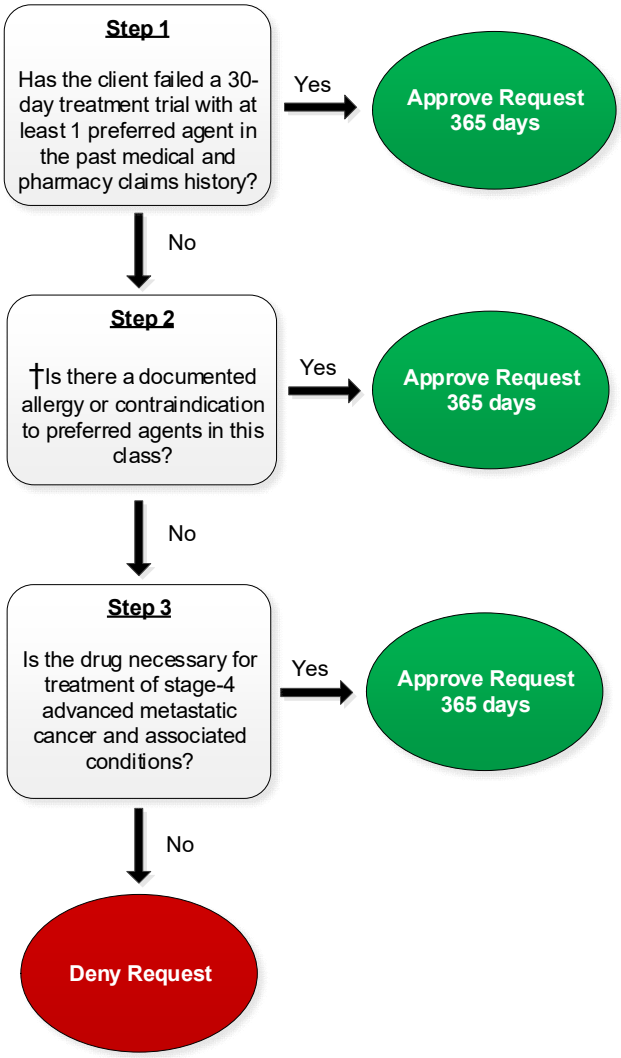
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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
22930	ACNE MEDICATION 10% GEL
22931	ACNE MEDICATION 5% GEL
08205	BENZACLIN GEL
99665	BENZACLIN GEL 35G PUMP
22930	BENZOYL PEROXIDE 10% GEL
22932	BENZOYL PEROXIDE 2.5% GEL
22931	BENZOYL PEROXIDE 5% GEL
28611	BENZOYL PEROXIDE 5% LOTION
28610	BENZOYL PEROXIDE 10% LOTION
24673	BENZOYL PEROXIDE 10% WASH
99676	BENZOYL PEROXIDE 5% WASH
45410	CLINDAMYCIN PHOSPHATE 1% GEL
45411	CLINDAMYCIN PHOSPHATE 1% PLEDGET
31720	CLINDAMYCIN PHOSPHATE 1% SOLUTION
98232	CLIND PH-BENZOYL PEROX 1.2-5%
39163	EPIDUO FORTE 0.3-2.5% GEL PUMP
31710	ERYTHROMYCIN 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

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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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

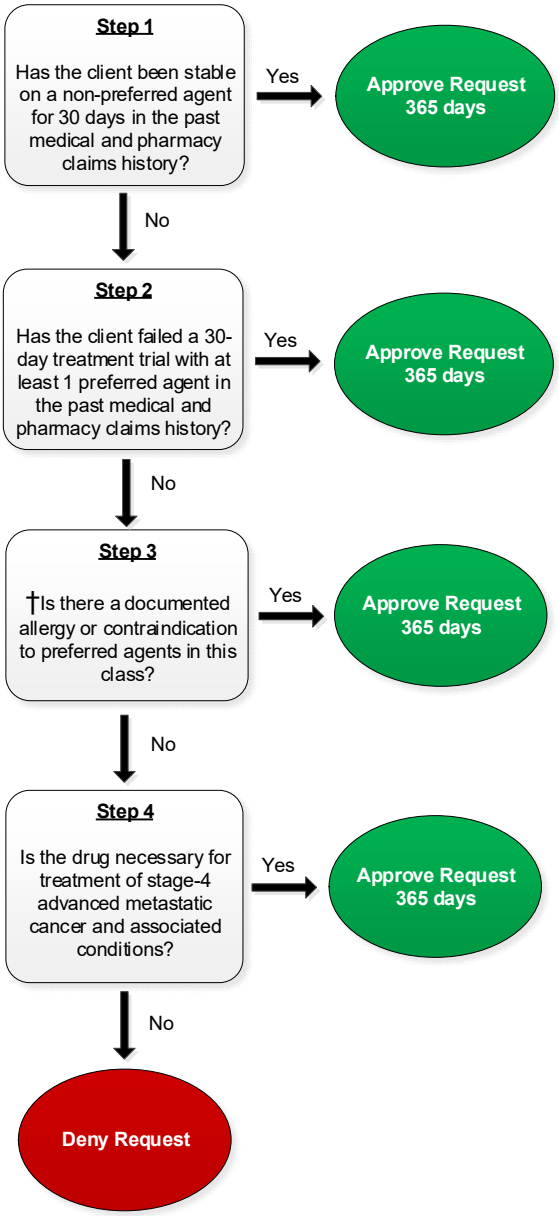
2. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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

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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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

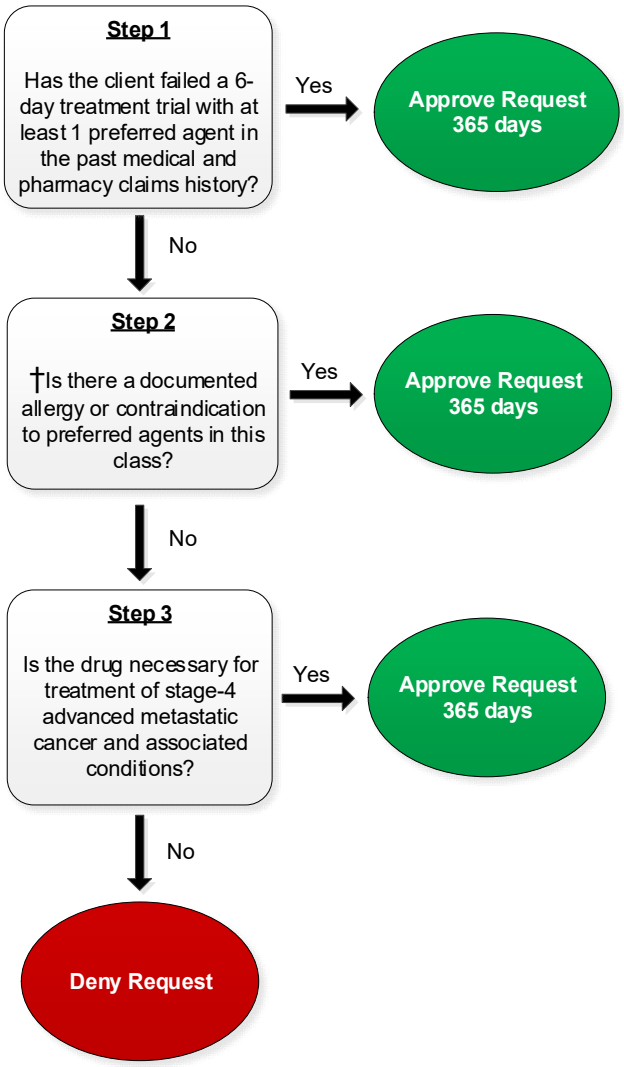
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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

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 100MCG/HR PATCH
24635	FENTANYL 12MCG/HR PATCH
19200	FENTANYL 25MCG/HR PATCH
19201	FENTANYL 50MCG/HR PATCH
19202	FENTANYL 75MCG/HR PATCH
16642	MORPHINE SULFATE ER 100MG TABLET
16643	MORPHINE SULFATE ER 15MG TABLET
16078	MORPHINE SULFATE ER 200MG TABLET
16640	MORPHINE SULFATE ER 30MG TABLET
16641	MORPHINE SULFATE ER 60MG TABLET
99151	TRAMADOL ER 100 MG TABLET
99152	TRAMADOL ER 200 MG TABLET
99153	TRAMADOL ER 300 MG TABLET
26387	TRAMADOL HCL ER 100MG TABLET
50417	TRAMADOL HCL ER 200MG TABLET
50427	TRAMADOL HCL ER 300MG TABLET
41273	XTAMPZA ER 13.5MG CAPSULE
41274	XTAMPZA ER 18MG CAPSULE
41275	XTAMPZA ER 27MG CAPSULE
41276	XTAMPZA ER 36MG CAPSULE
41272	XTAMPZA ER 9MG CAPSULE

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Analgesics, Narcotic – Short Acting

Analgesics, Narcotic – Short Acting Prior Authorization Criteria

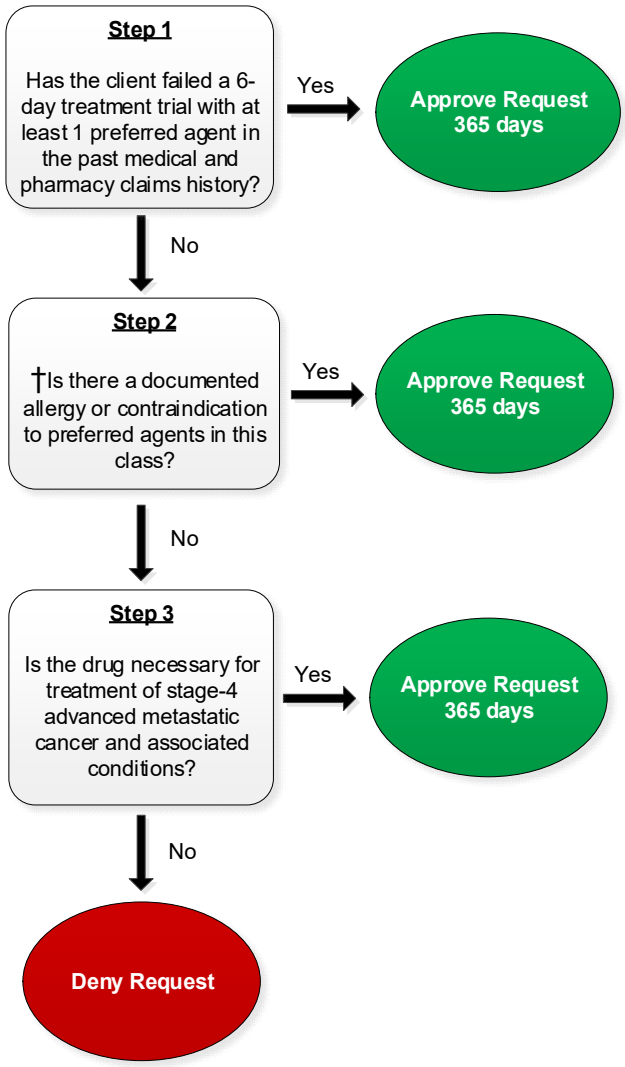
1. Has the client failed a 6-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

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

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

Analgesics, Narcotic – Short Acting Prior Authorization Criteria



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Analgesics, Narcotic – Short Acting Alternate Therapies

Preferred Short Acting Narcotics

GCN	Drug Name
70131	ACETAMINOPHEN/CODEINE #2 TABLET
70134	ACETAMINOPHEN/CODEINE #3 TABLET
70136	ACETAMINOPHEN/CODEINE #4 TABLET
55402	ACETAMINOPHEN/CODEINE 120-12MG/5ML
14966	ENDOCET 10-325MG TABLET
70491	ENDOCET 5-325MG TABLET
14965	ENDOCET 7.5-325MG TABLET
21146	HYDROCODON-ACETAMIN 7.5-325/15 ML
26709	HYDROCODON-ACETAMINOPH 7.5-300
12488	HYDROCODON-ACETAMINOPH 7.5-325
26470	HYDROCODON-ACETAMINOPHEN 5-300
12486	HYDROCODON-ACETAMINOPHEN 5-325
22929	HYDROCODON-ACETAMINOPHN 10-300
70330	HYDROCODON-ACETAMINOPHN 10-325
16141	HYDROMORPHONE HCL 2MG TABLET
16143	HYDROMORPHONE HCL 4MG TABLET
16144	HYDROMORPHONE HCL 8MG TABLET
12486	LORCET 5-325MG TABLET
70330	LORCET HD 10-325MG TABLET
12488	LORCET PLUS 7.5-325MG TABLET
16060	MORPHINE SULFATE 10MG/5ML SOLUTION
16062	MORPHINE SULFATE 20MG/5ML SOLUTION
16070	MORPHINE SULFATE IR 15MG TABLET
16071	MORPHINE SULFATE IR 30MG TABLET
16291	OXYCODONE HCL 10MG TABLET
20091	OXYCODONE HCL 15MG TABLET
21194	OXYCODONE HCL 20MG TABLET
20092	OXYCODONE HCL 30MG TABLET
16290	OXYCODONE HCL 5MG TABLET
16280	OXYCODONE HCL 5MG/5ML SOLUTION
14966	OXYCODONE HCL/ACETAMINOPHEN 10-325MG TABLET

GCN	Drug Name
14965	OXYCODONE HCL/ACETAMINOPHEN 7.5-325MG TABLET
70492	OXYCODONE/ACETAMINOPHEN 2.5-325MG TABLET
70491	OXYCODONE/ACETAMINOPHEN 5-325MG TABLET
07221	TRAMADOL HCL 50MG TABLET
13909	TRAMADOL HCL/ACETAMINOPHEN 37.5-325MG TABLET

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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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

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

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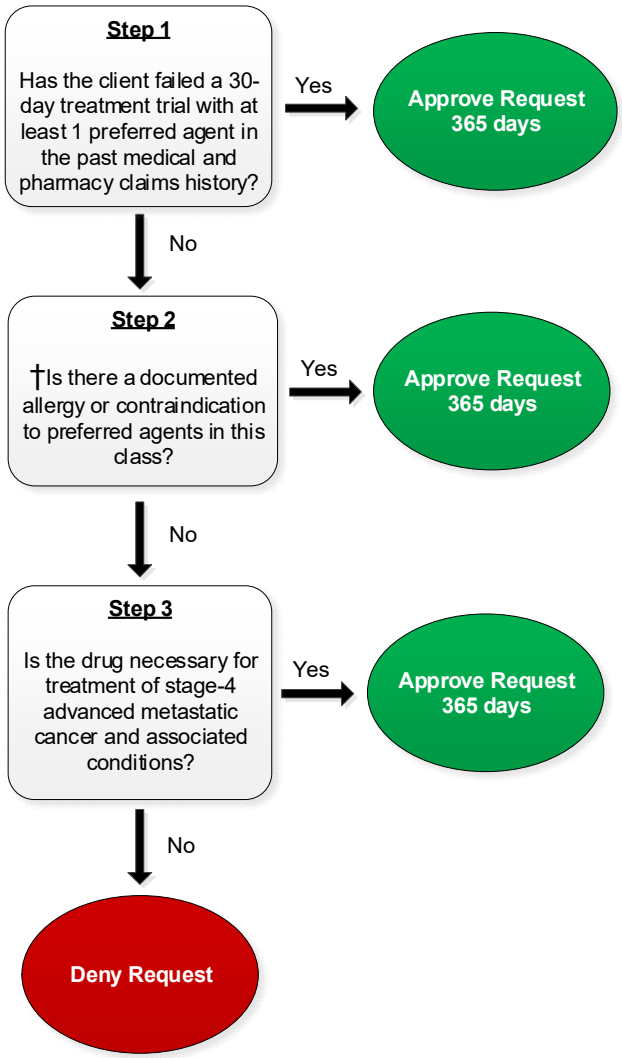
Androgenic Agents, Topical
Prior Authorization Criteria



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Androgenic Agents, Topical
Alternate Therapies

Preferred Androgenic Agents

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

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Angiotensin Modulators

Angiotensin Modulators Prior Authorization Criteria

1. Is the requested medication Epaned?
   [ ] Yes (Go to #2)
   [ ] No (Go to #3)

2. Is the client less than or equal to (≤) 6 years of age?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

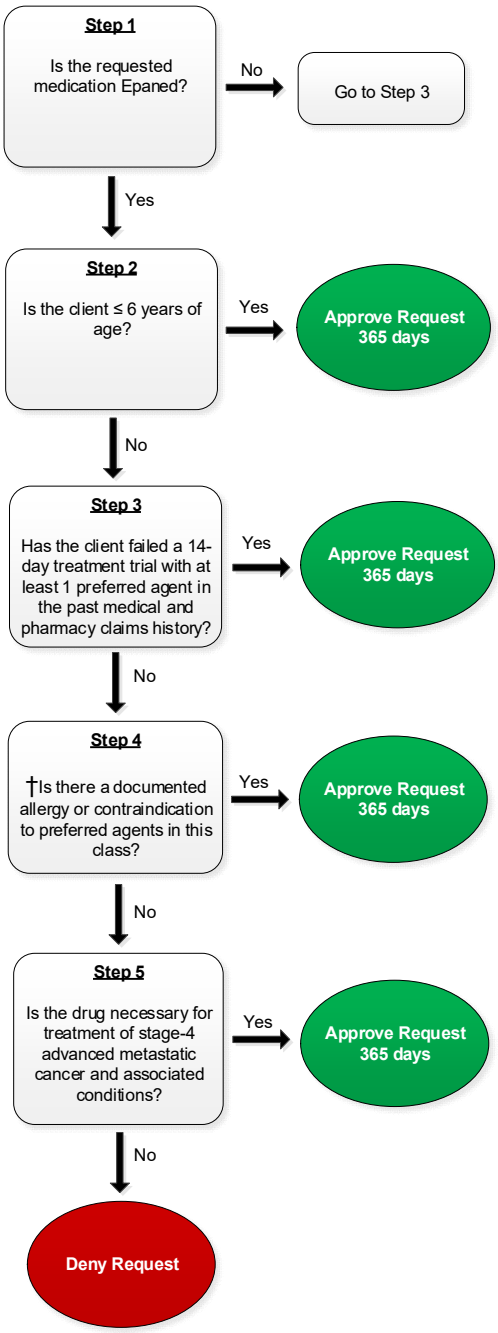
3. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #4)

4. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] 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.

Angiotensin Modulators Prior Authorization Criteria



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Angiotensin Modulators

Alternate Therapies

Preferred Angiotensin Modulators

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

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

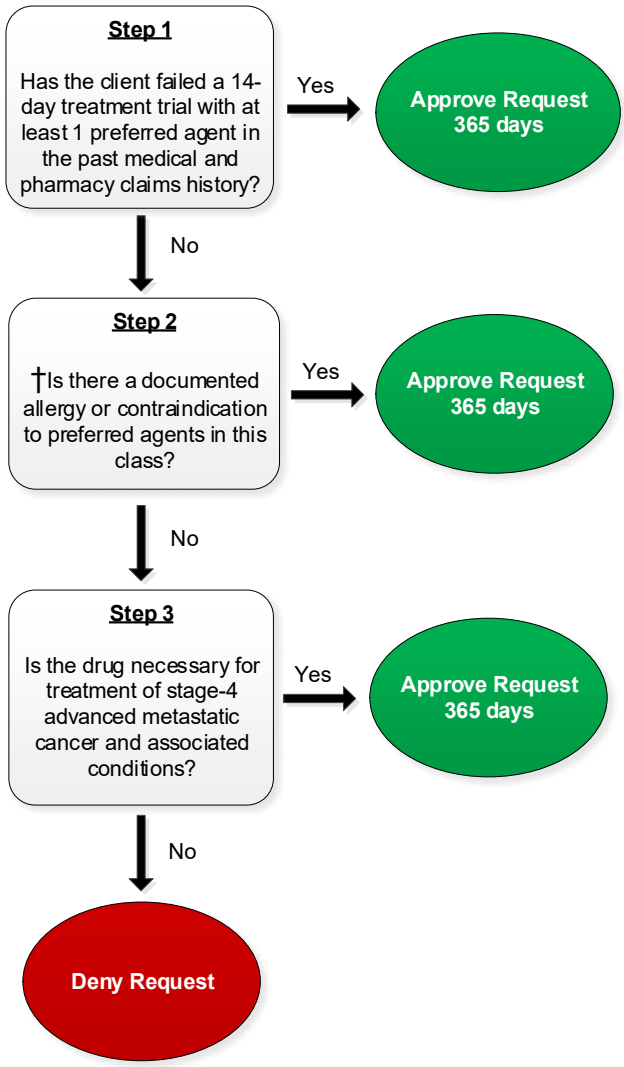
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

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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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

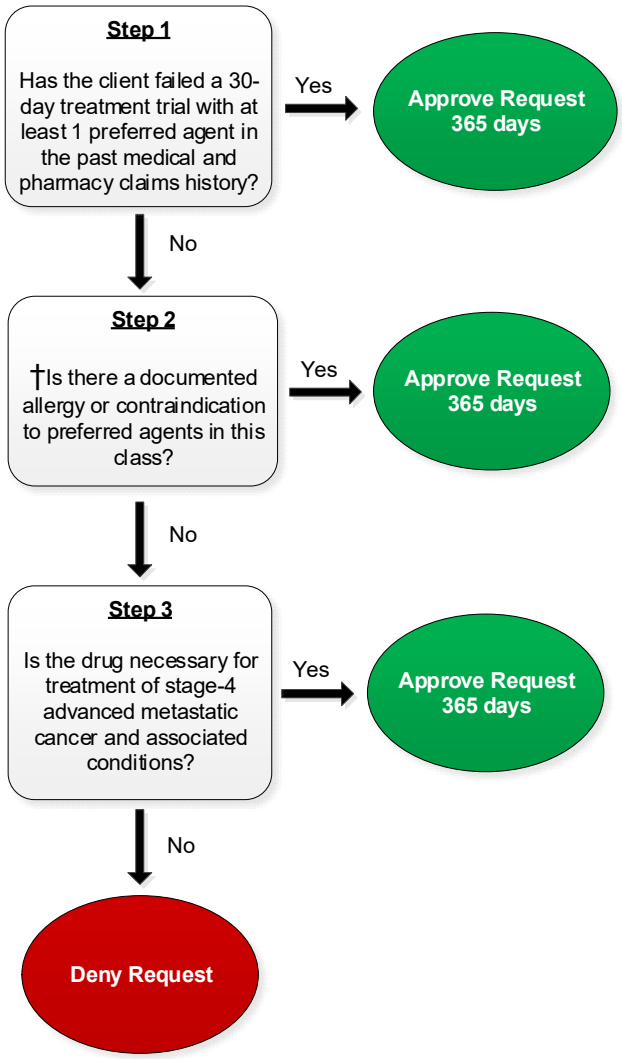
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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
33969	ORALAIR 100 IR STARTER PACK
33970	ORALAIR 300 IR STARTER PACK
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 (excluding Xifaxan 550mg)

Antibiotics, GI (excluding Xifaxan 550mg) Prior Authorization Criteria

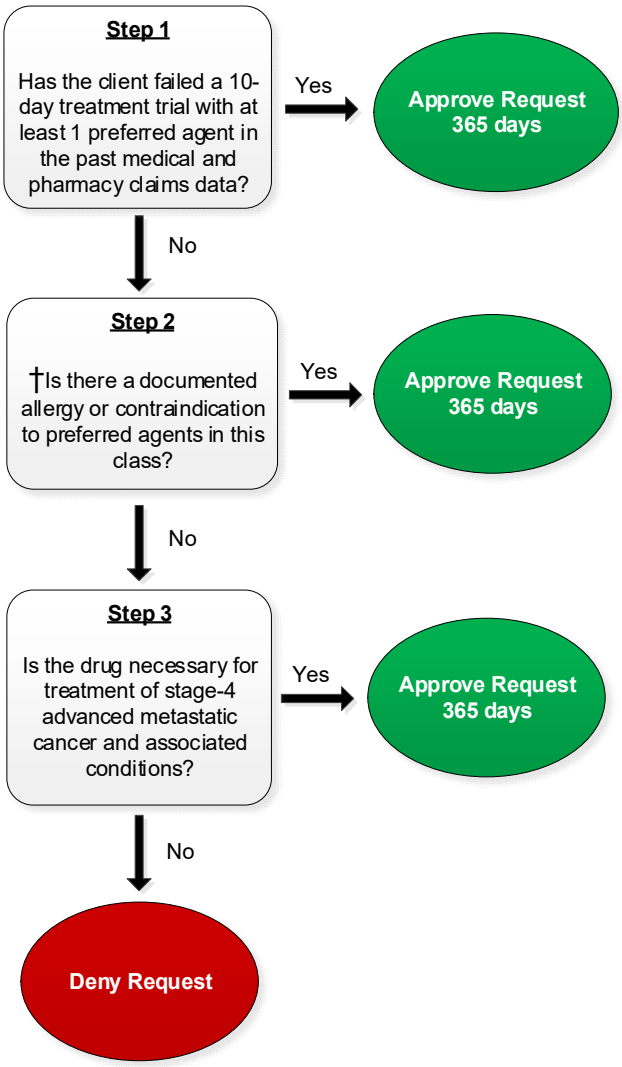
1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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 (excluding Xifaxan 550mg) 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 (excluding Xifaxan 550mg) Alternate Therapies

Preferred Gastrointestinal Antibiotics

GCN	Drug Name
44411	FIRVANQ 25MG/ML SOLUTION
41291	FIRVANQ 50MG/ML SOLUTION
43031	METRONIDAZOLE 250MG TABLET
43032	METRONIDAZOLE 500MG TABLET
414072	NEOMYCIN 500MG TABLET
22867	TINIDAZOLE 250MG TABLET
52220	TINIDAZOLE 500MG TABLET

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

Antibiotics, Gastrointestinal (Xifaxan 550mg only)

Antibiotics, GI (Xifaxan 550mg only) Prior Authorization Criteria

1. Does the client have a diagnosis of hepatic encephalopathy in the last 730 days?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

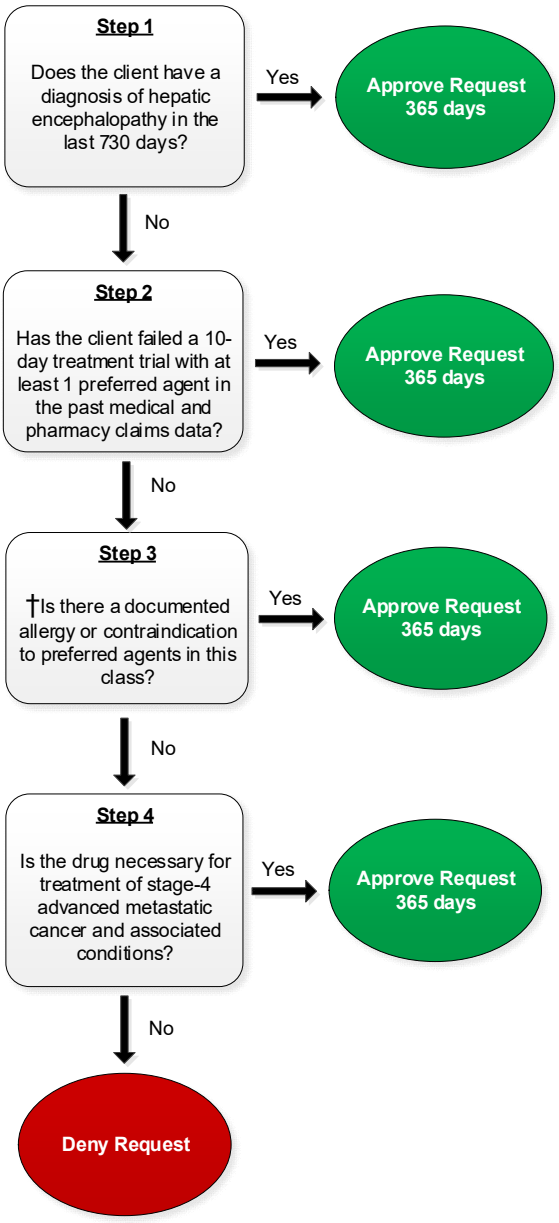
2. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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.

Antibiotics, GI (Xifaxan 550mg only) 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 (Xifaxan 550mg only) Prior Authorization Criteria

ICD-10 Code	Description
K72.90	HEPATIC FAULURE, UNSPECIFIED WITHOUT COMA
K72.91	HEPATIC FAILURE, UNSPECIFIED WITH COMA

Antibiotics, GI (Xifaxan 550mg only) Alternate Therapy

Preferred Gastrointestinal Antibiotics

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

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

Antibiotics, Inhaled

Antibiotics, Inhaled
Prior Authorization Criteria

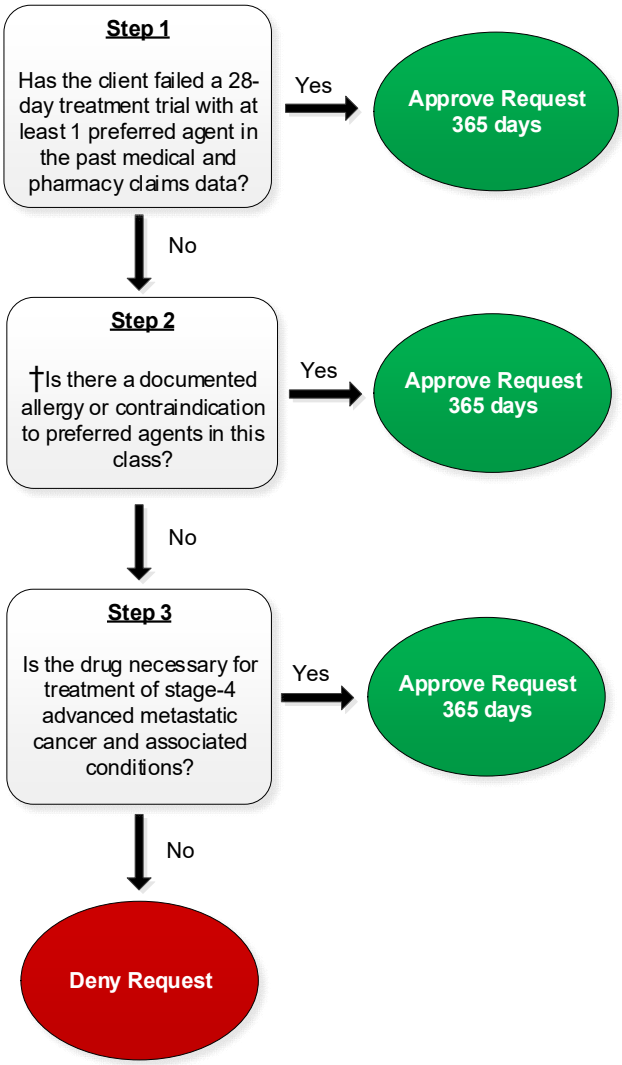
1. Has the client failed a 28-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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 300MG/4ML AMPULE
28039	CAYSTON 75MG INHALATION SOLUTION
37569	KITABIS PAK 300MG/5ML
30025	TOBI PODHALER 28MG INHALTION CAPSULE

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

Antibiotics, Topical

Antibiotics, Topical
Prior Authorization Criteria

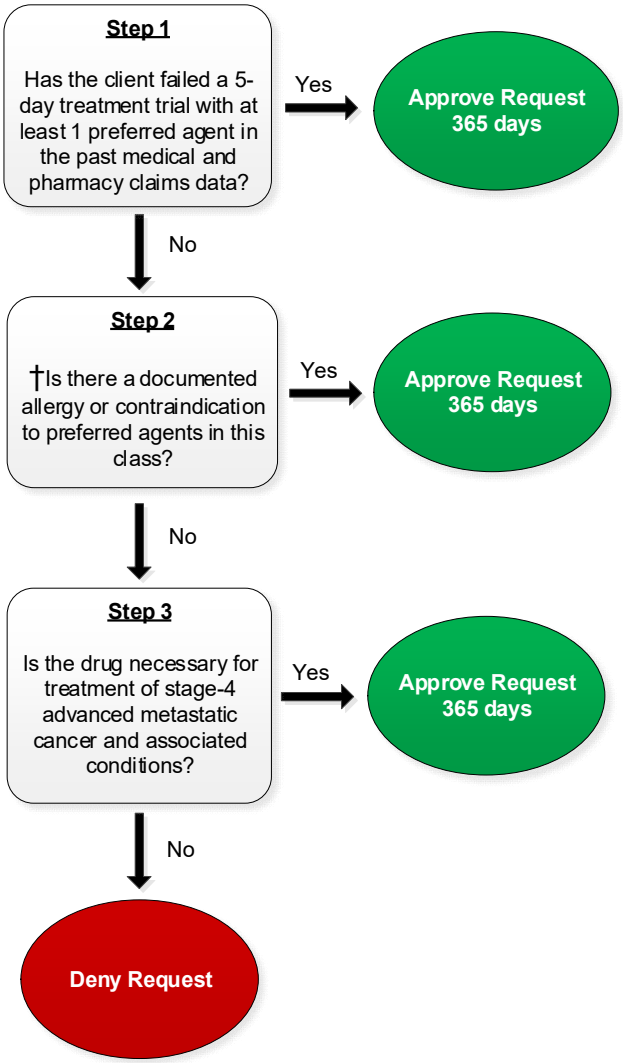
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims data?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

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

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

Antibiotics, Topical
Prior Authorization Criteria



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

Antibiotics, Topical Alternate Therapies

Preferred Topical Antibiotics

GCN	Drug Name
31812	BACITRACIN 500 UNITS/GM OINTMENT
31810	BACITRACIN ZINC 500 UNIT/GM OINTMENT NDC 00536-1263-28 only
47450	MUPIROCIN 2% OINTMENT
85459	TRIPLE ANTIBIOTIC OINTMENT
97206	TRIPLE ANTIBIOTIC OINTMENT
12623	TRIPLE ANTIBIOTIC PLUS OINTMENT

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

Antibiotics, Vaginal

Antibiotics, Vaginal
Prior Authorization Criteria

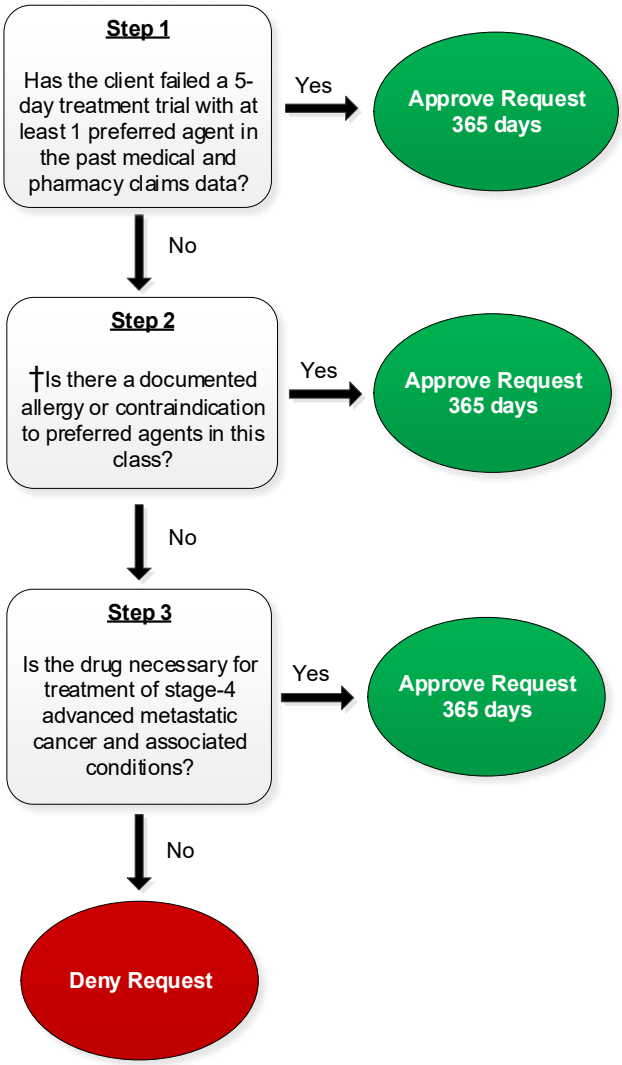
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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 100MG 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

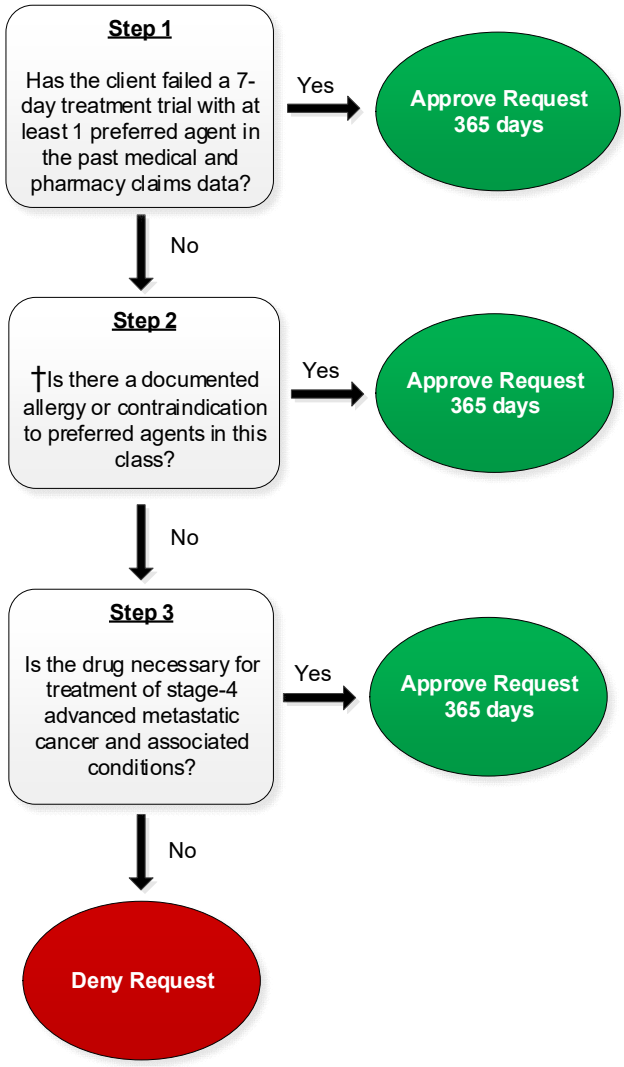
1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

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

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 1 non-preferred agent for 30-days in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

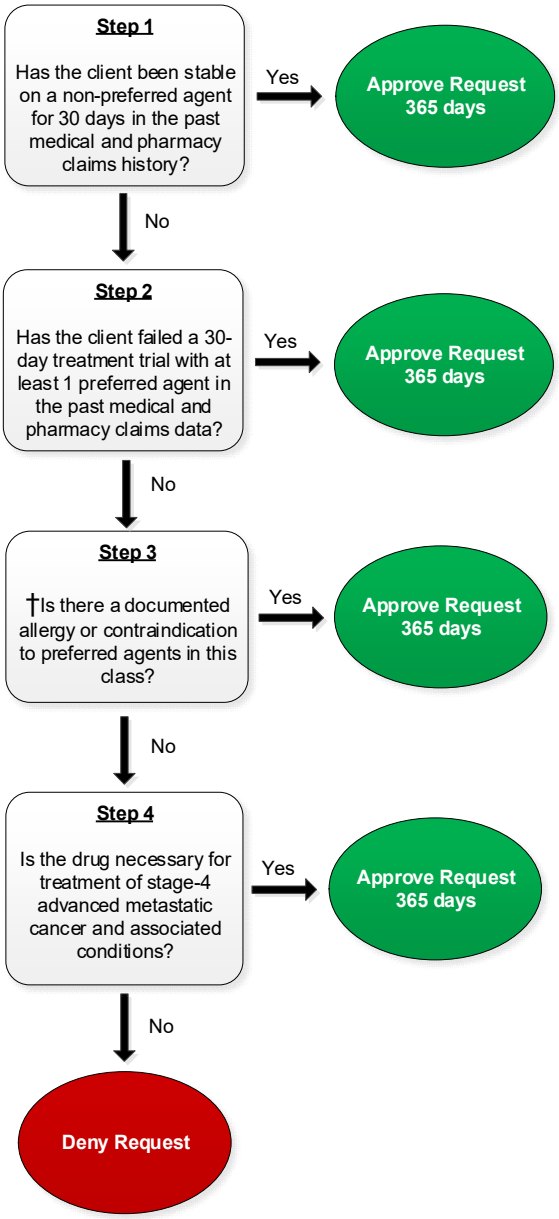
2. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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.

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 100MG TABLET
16384	BUPROPION HCL 75MG TABLET
16387	BUPROPION HCL SR 100MG TABLET
16386	BUPROPION HCL SR 150MG TABLET
27901	BUPROPION HCL SR 150MG TABLET
17573	BUPROPION HCL SR 200MG TABLET
20317	BUPROPION HCL XL 150MG TABLET
20318	BUPROPION HCL XL 300MG TABLET
33081	FORFIVO XL 450MG TABLET
12529	MIRTAZAPINE 15MG ODT
16732	MIRTAZAPINE 15MG TABLET
12531	MIRTAZAPINE 30MG ODT
16733	MIRTAZAPINE 30MG TABLET
13041	MIRTAZAPINE 45MG ODT
16734	MIRTAZAPINE 45MG TABLET
21817	MIRTAZAPINE 7.5MG TABLET
16417	PHENELZINE SULFATE 15MG TABLET
38222	PRISTIQ ER 25MG TABLET
99451	PRISTIQ ER 50MG TABLET
99452	PRISTIQ ER 100MG TABLET
16392	TRAZODONE HCL 100MG TABLET
16393	TRAZODONE HCL 150MG TABLET
16394	TRAZODONE HCL 300MG TABLET
16391	TRAZODONE HCL 50MG TABLET
16815	VENLAFAXINE HCL 100MG TABLET
16811	VENLAFAXINE HCL 25MG TABLET
16812	VENLAFAXINE HCL 37.5MG TABLET
16813	VENLAFAXINE HCL 50MG TABLET
16814	VENLAFAXINE HCL 75MG TABLET
16818	VENLAFAXINE HCL ER 150MG CAPSULE
16816	VENLAFAXINE HCL ER 37.5MG CAPSULE
16817	VENLAFAXINE HCL ER 75MG CAPSULE
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 1 non-preferred agent for 30-days in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

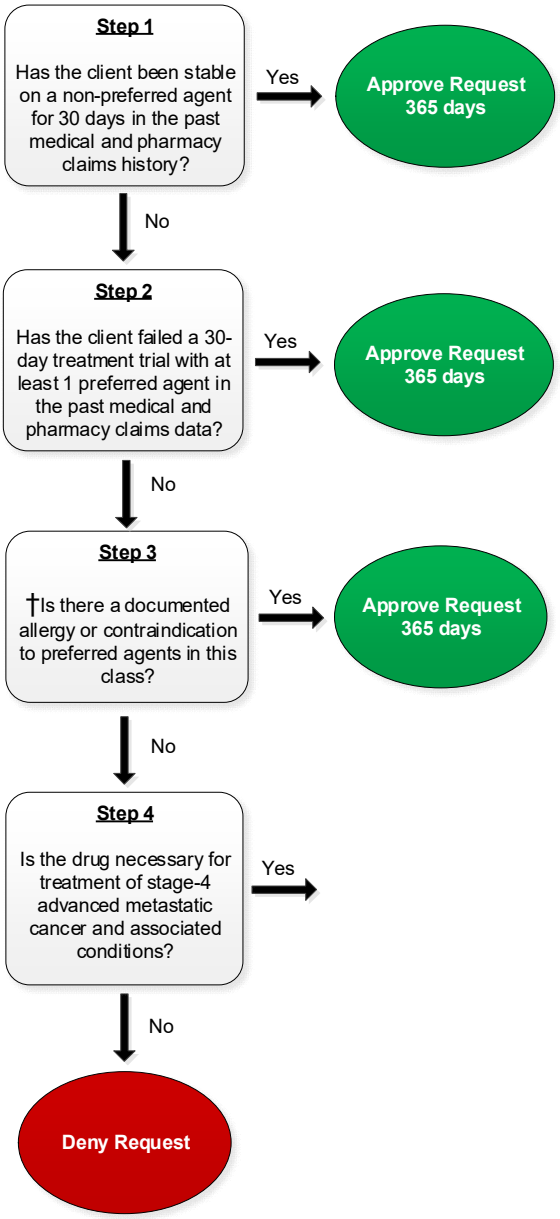
2. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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.

Antidepressants, SSRI
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, SSRI Alternate Therapies

Preferred SSRI Antidepressants

GCN	Drug Name
16345	CITALOPRAM HBR 10MG TABLET
16344	CITALOPRAM HBR 10MG/5ML SOLUTION
16342	CITALOPRAM HBR 20MG TABLET
16343	CITALOPRAM HBR 40MG TABLET
17851	ESCITALOPRAM 10MG TABLET
17987	ESCITALOPRAM 20MG TABLET
18975	ESCITALOPRAM 5MG TABLET
16353	FLUOXETINE HCL 10MG CAPSULE
16354	FLUOXETINE HCL 20MG CAPSULE
16357	FLUOXETINE HCL 20MG/5ML SOLUTION
16355	FLUOXETINE HCL 40MG CAPSULE
16349	FLUVOXAMINE MALEATE 100MG TABLET
16347	FLUVOXAMINE MALEATE 25MG TABLET
16348	FLUVOXAMINE MALEATE 50MG TABLET
16364	PAROXETINE HCL 10MG TABLET
16366	PAROXETINE HCL 20MG TABLET
16367	PAROXETINE HCL 30MG TABLET
16368	PAROXETINE HCL 40MG TABLET
16375	SERTRALINE HCL 100MG TABLET
16376	SERTRALINE HCL 20MG/ML ORAL CONCENTRATE
16373	SERTRALINE HCL 25MG TABLET
16374	SERTRALINE HCL 50MG 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 1 non-preferred agent for 30-days in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

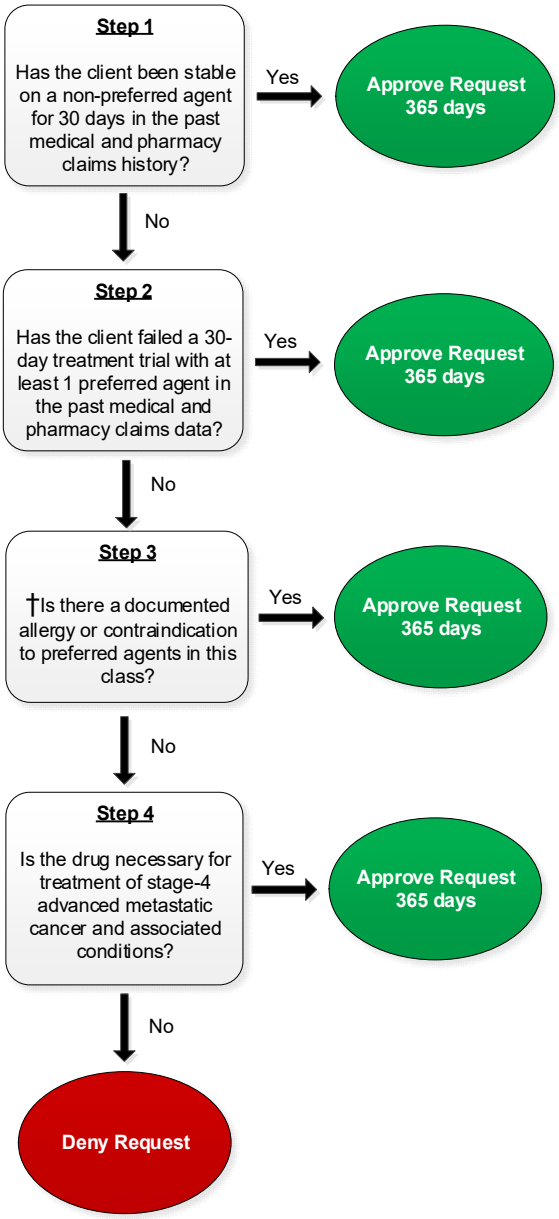
2. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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.

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

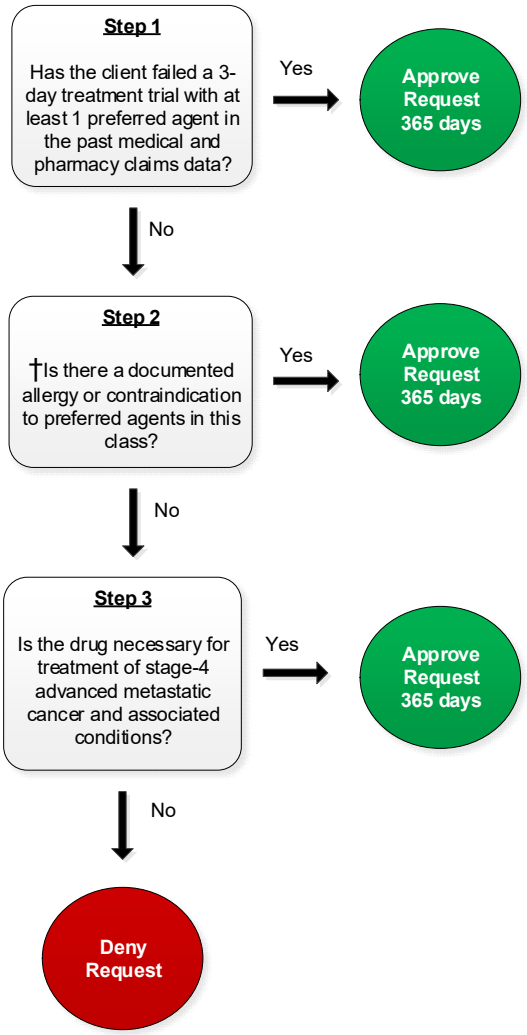
1. Has the client failed a 3-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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
73860	DICLEGIS DR 10-10 MG TABLE
73710	FORMULA EM SOLUTION
18301	MECLIZINE HCL 12.5MG TABLET
18302	MECLIZINE HCL 25MG TABLET
21020	METOCLOPRAMIDE 10MG TABLET
21021	METOCLOPRAMIDE 5MG TABLET
03610	METOCLOPRAMIDE 5MG/5ML SOLUTION
20040	ONDANSETRON 4MG/5ML SOLUTION
20041	ONDANSETRON HCL 4MG TABLET
20042	ONDANSETRON HCL 8MG TABLET
20045	ONDANSETRON ODT 4MG TABLET
20046	ONDANSETRON ODT 8MG TABLET
14771	PROCHLORPERAZINE 10MG TABLET
14773	PROCHLORPERAZINE 5MG TABLET
15042	PROMETHAZINE 12.5MG TABLET
15043	PROMETHAZINE 25MG TABLET
15044	PROMETHAZINE 50MG TABLET
15035	PROMETHAZINE HCL 6.25MG/5ML SYRUP
18160	TRANSDERM-SCOP 1 MG/3 DAY PTCH
18312	TRAVEL SICKNESS 25MG TAB CHEW
18231	TRAVEL SICKNESS 50MG TABLET

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

Antifungals, Oral

Antifungals, Oral
Prior Authorization Criteria

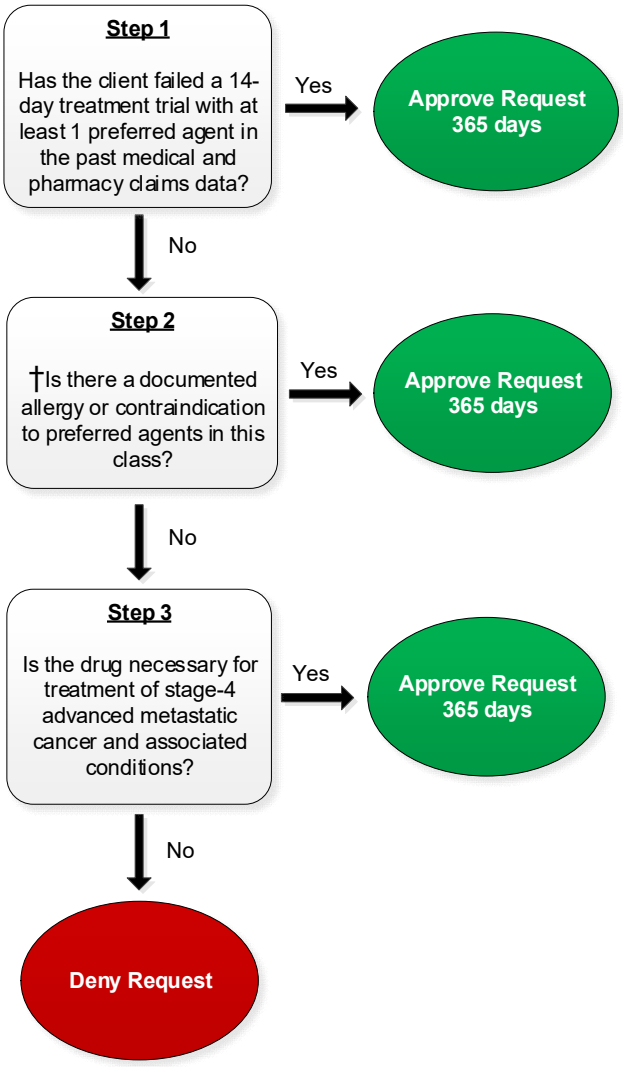
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

Preferred Oral Antifungals

GCN	Label Name
07590	CLOTRIMAZOLE 10MG TROCHE
42190	FLUCONAZOLE 100MG TABLET
60822	FLUCONAZOLE 10MG/ML SUSPENSION
42193	FLUCONAZOLE 150MG TABLET
42191	FLUCONAZOLE 200MG TABLET
60821	FLUCONAZOLE 40MG/ML SUSPENSION
42192	FLUCONAZOLE 50MG TABLET
42390	GRISEOFULVIN 125MG/5ML SUSPENSION
42590	KETOCONAZOLE 200MG TABLET
42440	NYSTATIN 100,000UNITS/ML SUSPENSION
42452	NYSTATIN 500,000 UNIT ORAL TAB
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

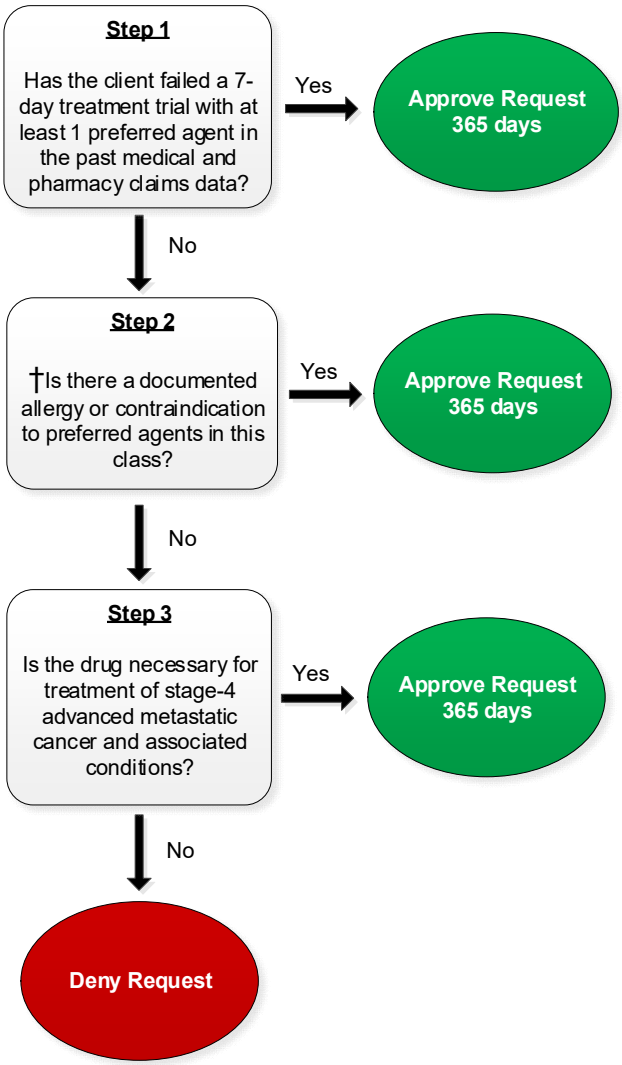
1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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
30310	ANTIFUNGAL 1% POWDER
30400	ANTIFUNGAL 2% TOPICAL CREAM
94677	CICLOPIROX 0.77% CREAM
30370	CLOTRIMAZOLE 1% CREAM
30380	CLOTRIMAZOLE 1% SOLUTION
06919	CLOTRIMAZOLE-BETAMETHASONE CREAM
31271	KETOCONAZOLE 2% SHAMPOO
30400	MICONAZOLE 2% TOPICAL CREAM
30160	NYAMYC 100,000UNITS/GM POWDER
30140	NYSTATIN 100,000UNIT/GM CREAM
30150	NYSTATIN 100,000UNIT/GM OINTMENT
30160	NYSTATIN 100,000UNIT/GM POWDER
30160	NYSTOP 100,000UNITS/GM POWDER
30300	QC TOLNAFTATE 1% CREAM
62498	TERBINAFINE 1% CREAM
30300	TOLNAFTATE 1% CREAM
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

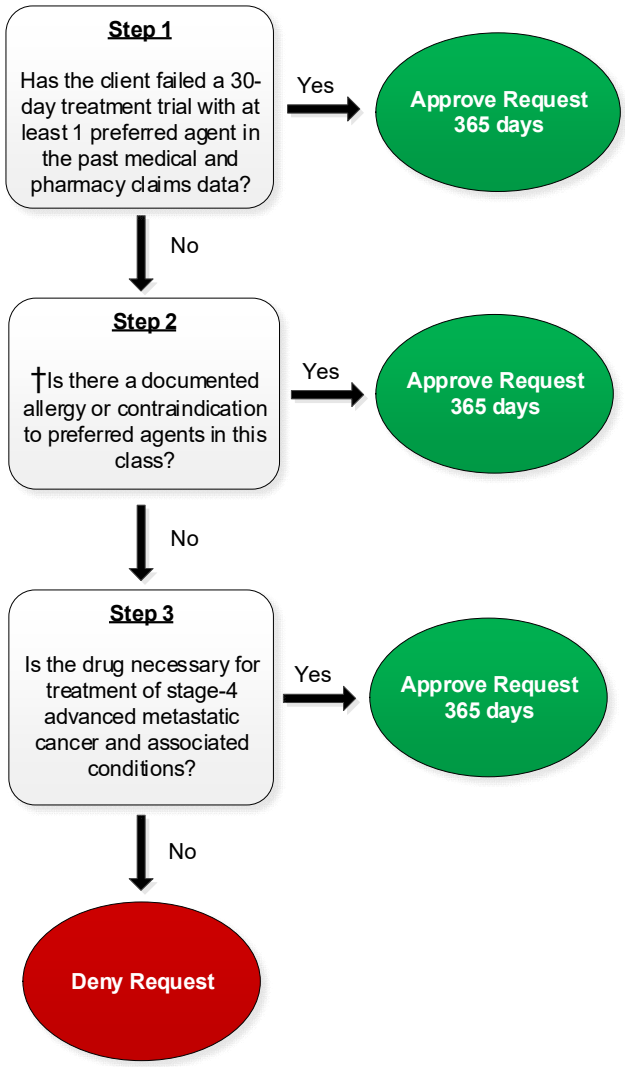
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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
46512	ALLER-CHLOR 4 MG TABLET
45971	ALLERGY 25 MG CAPSULE
46512	ALLERGY 4 MG TABLET
45971	ALLERGY RELIEF 25 MG SOFTGEL
46512	ALLERGY RELIEF 4 MG TABLET
45971	BANOPHEN 25 MG CAPSULE
45972	BANOPEHN 50 MG CAPSULE
14949	CARBINOXAMINE 4 MG/5 ML LIQUID
46170	CARBINOXAMINE MALEATE 4 MG TAB
48831	CHILD ALLERGY RLF 12.5 MG/5 ML
15803	CYPROHEPTADINE 2 MG/5 ML SYRUP
15811	CYPROHEPTADINE 4 MG TABLET
45971	DIPHENHIST 25 MG CAPSULE
48831	DIPHENYDRAMINE 12.5 MG/5 ML
45971	DIPHENHYDRAMINE 25 MG CAPSULE
45972	DIPHENHYDRAMINE 50 MG CAPSULE
42545	DIPHENHYDRAMINE 6.25 MG/ML DRP
36886	HISTEX 2.5 MG/5 ML SYRUP
36284	HISTEX PD 0.938 MG/ML DROPS
13932	HYDROXYZINE 10 MG/5 ML SOLN
13941	HYDROXYZINE HCL 10 MG TABLET
13951	HYDROXYZINE PAM 100 MG CAP
13943	HYDROXYZINE HCL 25 MG TABLET
13944	HYDROXYZINE HCL 50 MG TABLET
13952	HYDROXYZINE PAM 25 MG CAP
13953	HYDROXYZINE PAM 50 MG CAP
31501	PEDIACLEAR PD 0.625 MG/ML DROP
46798	PEDIACLEAR 8 12.5 MG/15 ML LIQ
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

GCN	Drug Name
36284	TRIPROLIDINE 0.938 MG/ML DROPS

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

Antihistamines, Minimally Sedating

Antihistamines, Minimally Sedating
Prior Authorization Criteria

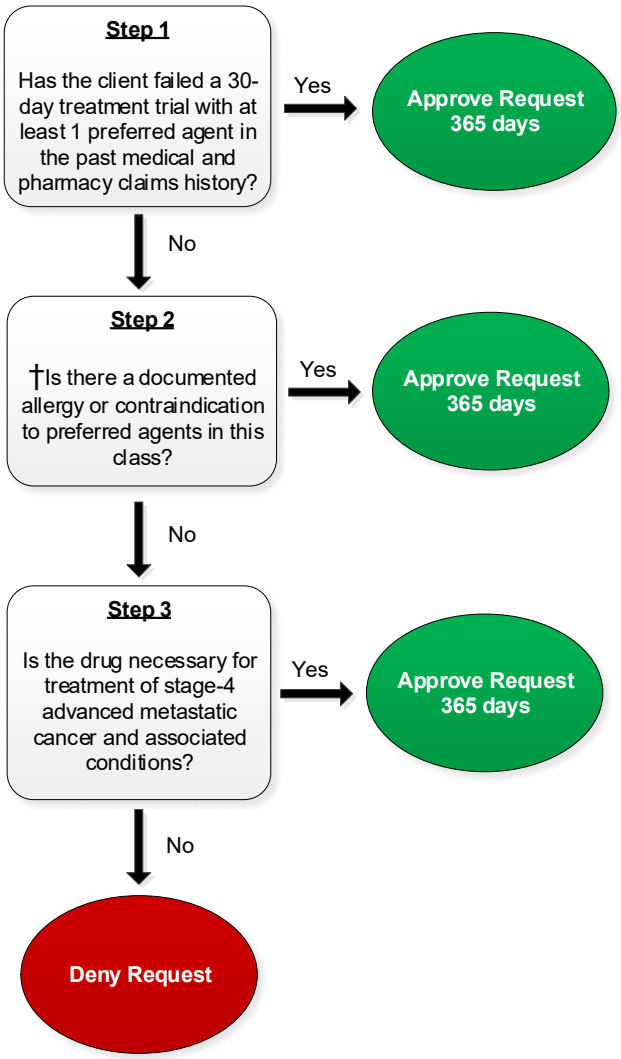
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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	ALL DAY ALLERGY 10MG TABLET
60563	ALLERGY (LORATADINE) 10 MG TABLET
60563	ALLERGY RELIEF 10 MG TABLET
60562	ALLERGY RELIEF 5 MG/5 ML SOLN
49291	CETIRIZINE HCL 10MG TABLET
49290	CETIRIZINE HCL 1MG/ML SYRUP
49292	CETIRIZINE HCL 5MG TABLET
49590	CHILD ALL DAY ALLERGY 1MG/ML
49590	CHILD CETIRIZINE HCL 1MG/ML
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

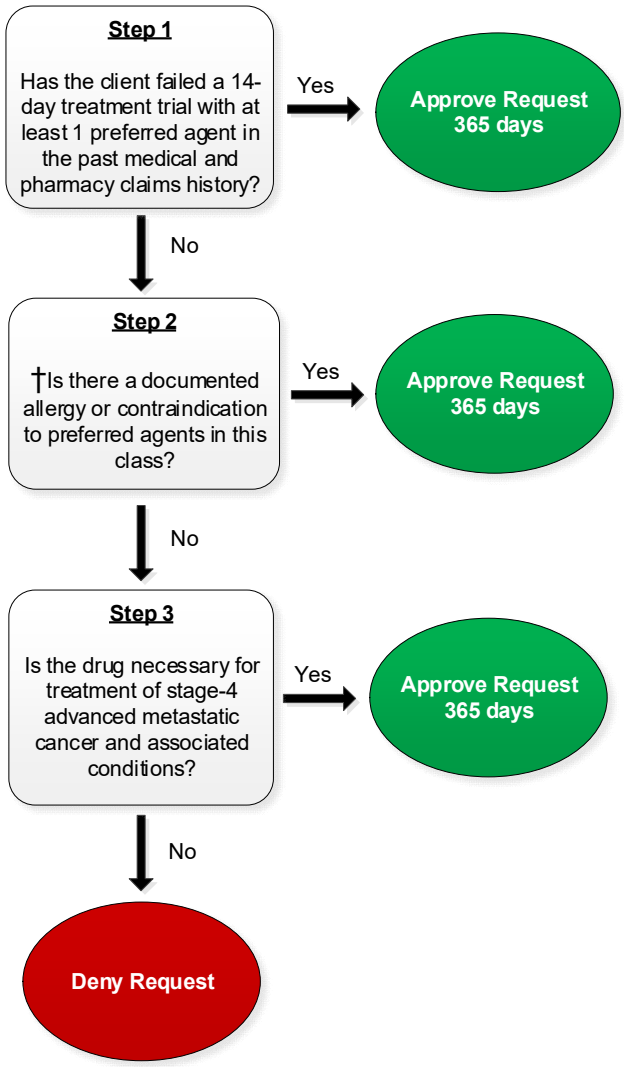
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

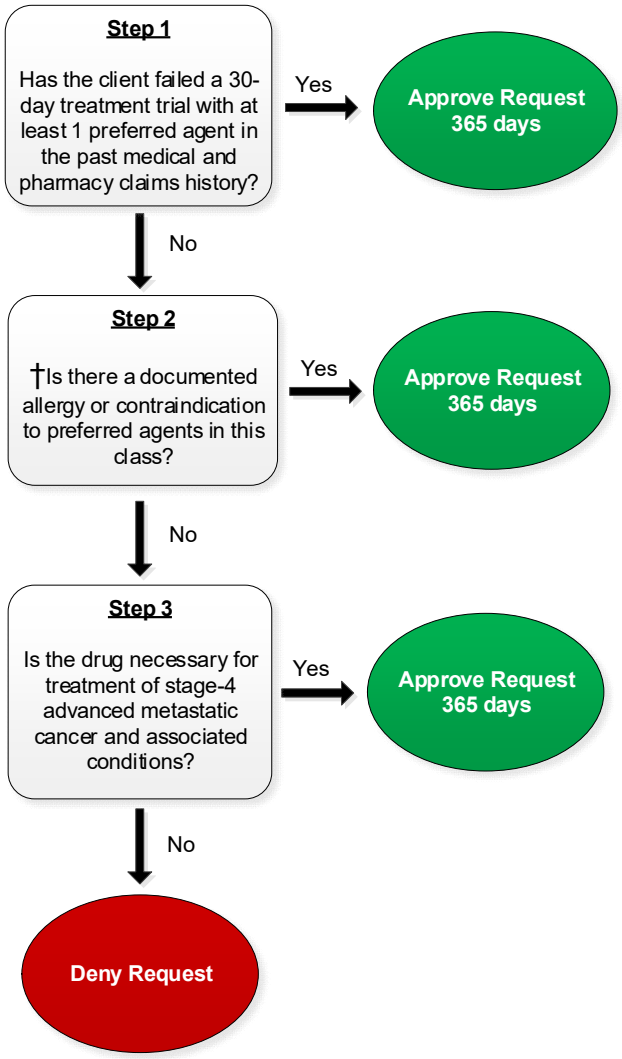
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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 100MG TABLET
07071	ALLOPURINOL 300MG TABLET
35674	COLCRYS 0.6MG TABLET
35072	PROBENECID 500MG 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

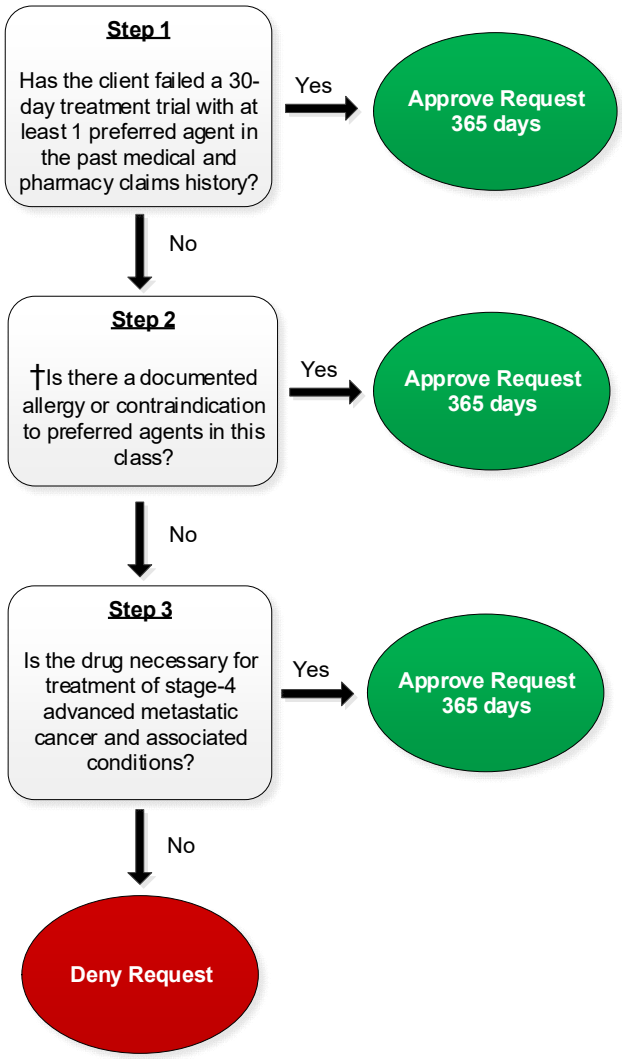
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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



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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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

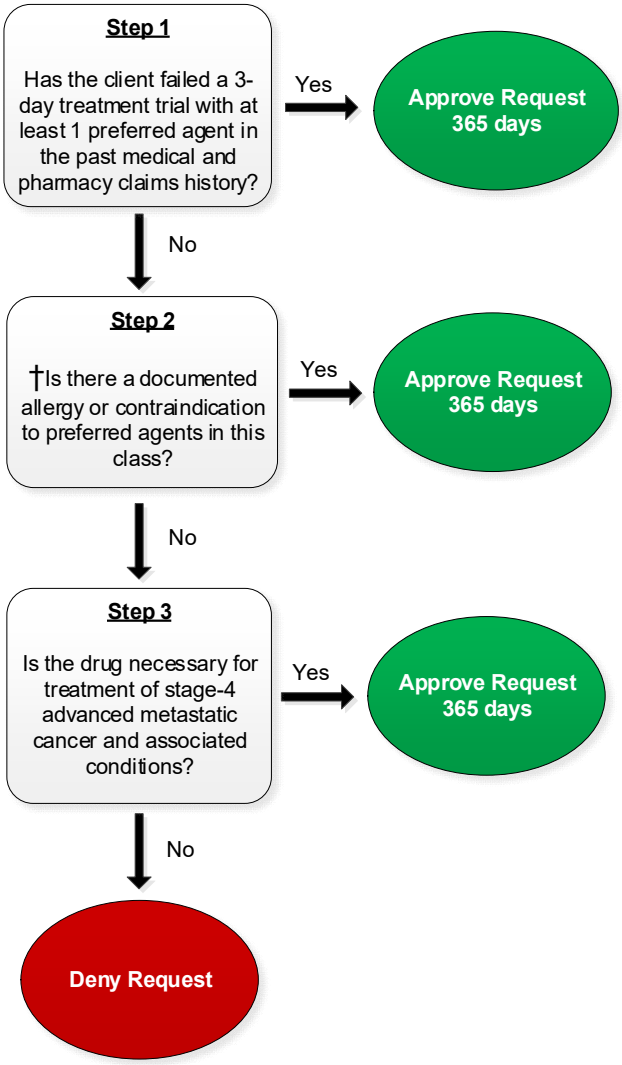
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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

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
05701	SUMATRIPTAN SUCC 100MG TABLET
05702	SUMATRIPTAN SUCC 25MG TABLET
05700	SUMATRIPTAN SUCC 50MG TABLET
24217	ZOMIG 2.5MG NASAL SPRAY
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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

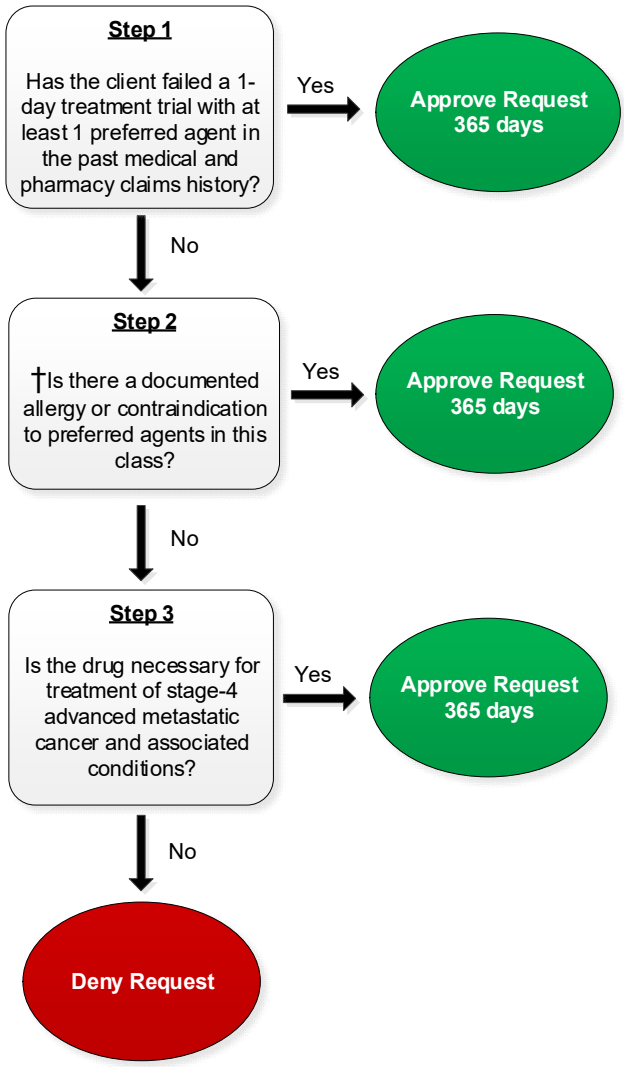
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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



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Antiparasitics, Topical

Alternate Therapies

Preferred Topical Antiparasitics

GCN	Drug Name
29436	NATROBA 0.9% TOPICAL SUSPENSION
44520	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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

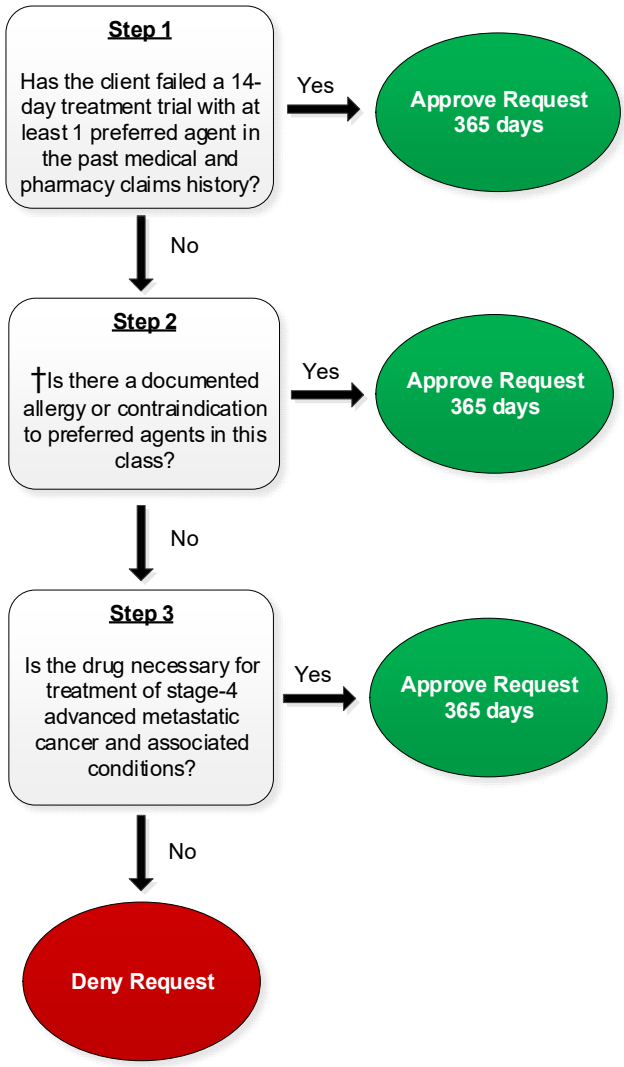
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 100MG CAPSULE
17521	AMANTADINE 100MG TABLET
17530	AMANTADINE 50MG/5ML SOLUTION
17620	BENZTROPINE MES 0.5MG TABLET
17621	BENZTROPINE MES 1MG TABLET
17622	BENZTROPINE MES 2MG TABLET
62740	CARBIDOPA/LEVODOPA 10-100MG TABLET
62741	CARBIDOPA/LEVODOPA 25-100MG TABLET
62742	CARBIDOPA/LEVODOPA 25-250MG TABLET
62591	CARBIDOPA/LEVODOPA ER 20-200MG TABLET
62592	CARBIDOPA/LEVODOPA ER 25-100MG TABLET
20146	CARBIDOPA-LEVODOPA-ENTA 100 MG
14474	CARBIDOPA-LEVODOPA-ENTA 125 MG
20145	CARBIDOPA-LEVODOPA-ENTA 150 MG
98948	CARBIDOPA-LEVODOPA-ENTA 200 MG
20150	CARBIDOPA-LEVODOPA-ENTA 50 MG
14473	CARBIDOPA-LEVODOPA-ENTA 75 MG
19873	PRAMIPEXOLE 0.125MG TABLET
19874	PRAMIPEXOLE 0.25MG TABLET
19875	PRAMIPEXOLE 0.5MG TABLET
98973	PRAMIPEXOLE 0.75MG TABLET
19872	PRAMIPEXOLE 1.5MG TABLET
19871	PRAMIPEXOLE 1MG TABLET
34100	ROPINIROLE HCL 0.25MG TABLET
34104	ROPINIROLE HCL 0.5MG TABLET
34101	ROPINIROLE HCL 1MG TABLET
34102	ROPINIROLE HCL 2MG TABLET
93048	ROPINIROLE HCL 3MG TABLET
93038	ROPINIROLE HCL 4MG TABLET
34103	ROPINIROLE HCL 5MG TABLET
17561	TRIHEXYPHENIDYL 2 MG TABLET

GCN	Drug Name
17550	TRIHEXYPHENIDYL 2MG/5ML ELX
17563	TRIHEXYPHENIDYL 5MG 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 prescribed and is taking a non-preferred agent before being discharged from an inpatient facility?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. Has the client been stable on a non-preferred agent for 30-days in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. 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 #4)

4. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #5)

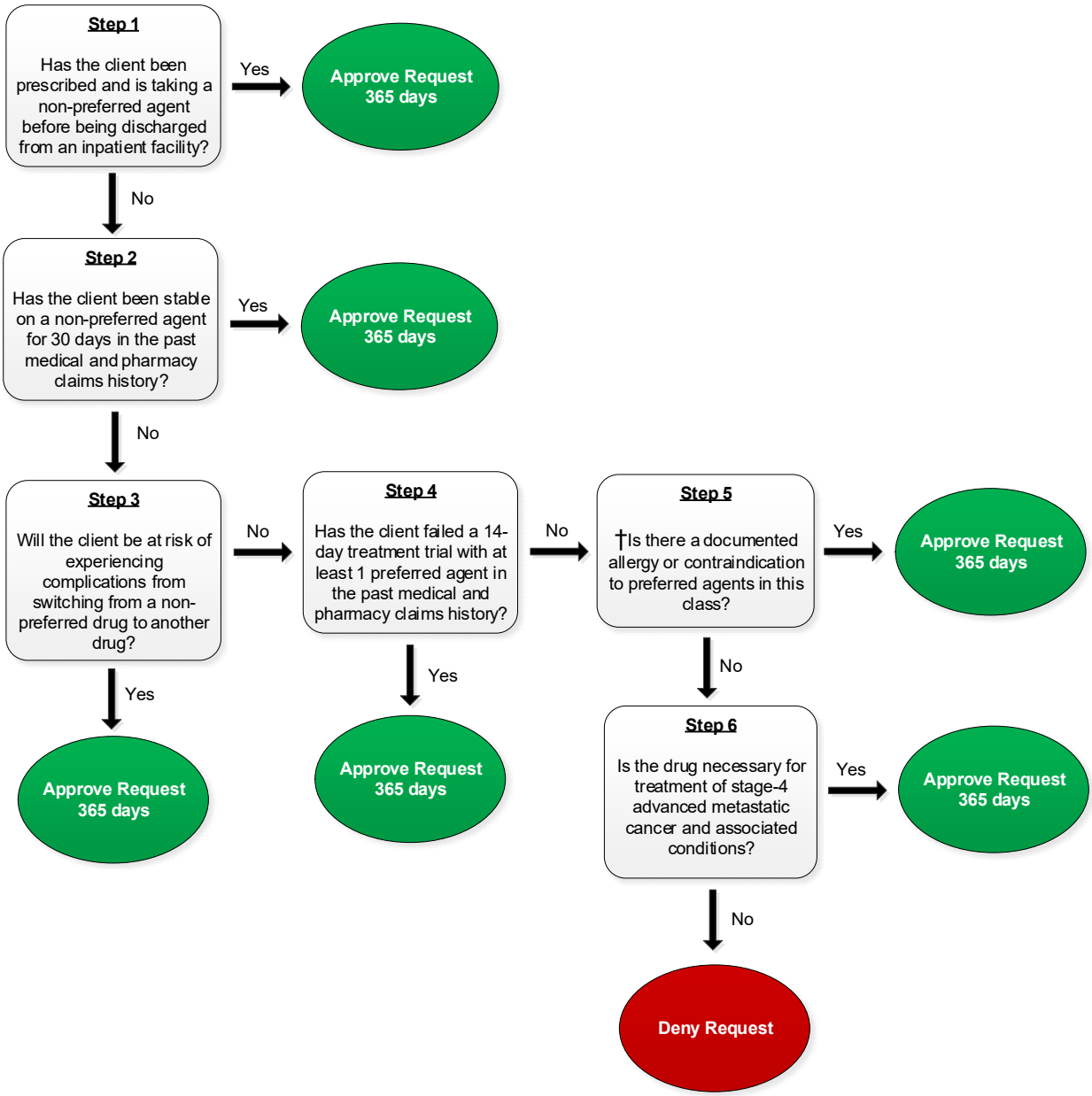
5. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #6)

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
31672	CLOZAPINE 200MG TABLET
18141	CLOZAPINE 25MG TABLET
18143	CLOZAPINE 50MG TABLET
18142	CLOZAPINE100MG TABLET
14603	FLUPHENAZINE 10MG TABLET
14602	FLUPHENAZINE 1MG TABLET

GCN	Drug Name
14604	FLUPHENAZINE 2.5MG TABLET
14580	FLUPHENAZINE 25MG/5ML ELIXIR
14605	FLUPHENAZINE 5MG TABLET
14590	FLUPHENAZINE 5MG/ML CONCENTRATE
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
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
44959	NUPLAZID 10MG 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

GCN	Drug Name
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
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

GCN	Drug Name
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 prescribed and is taking a non-preferred agent before being discharged from an inpatient facility?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

2. Has the client been stable on 1 non-preferred agent for 30-days in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. 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 #4)

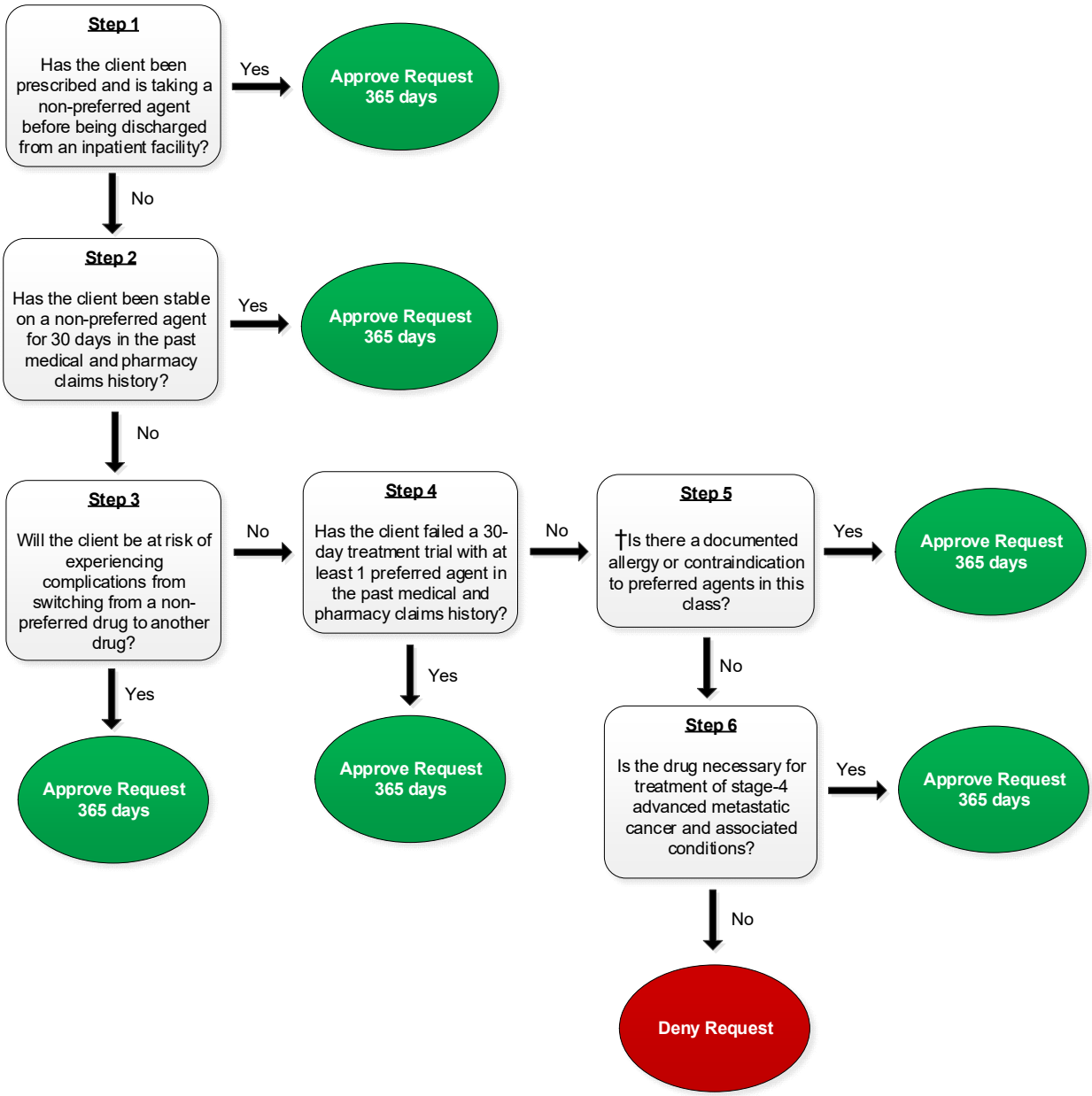
4. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #5)

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
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
14801	HALOPERIDOL DEC 100MG/ML AMP
14781	HALOPERIDOL DEC 100MG/ML VIAL
14800	HALOPERIDOL DEC 50MG/ML AMP
14780	HALOPERIDOL DEC 50MG/ML VIAL
50889	INVEGA HAFYERA 1,092MG/3.5ML
50891	INVEGA HAFYERA 1,560MG/5ML
27416	INVEGA SUSTENNA 117MG PREFILLED SYRINGE
27417	INVEGA SUSTENNA 156MG PREFILLED SYRINGE
27418	INVEGA SUSTENNA 234MG PREFILLED SYRINGE
27414	INVEGA SUSTENNA 39MG PREFILLED SYRINGE
27415	INVEGA SUSTENNA 78MG PREFILLED SYRINGE
38697	INVEGA TRINZA 273MG/0.875ML
38698	INVEGA TRINZA 410MG/1.315ML
38699	INVEGA TRINZA 546MG/1.75ML
38702	INVEGA TRINZA 819MG/2.625ML
98414	RISPERDAL CONSTA 12.5MG SYRINGE
20217	RISPERDAL CONSTA 25MG SYRINGE
20218	RISPERDAL CONSTA 37.5MG SYRINGE
20219	RISPERDAL CONSTA 50MG SYRINGE

**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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

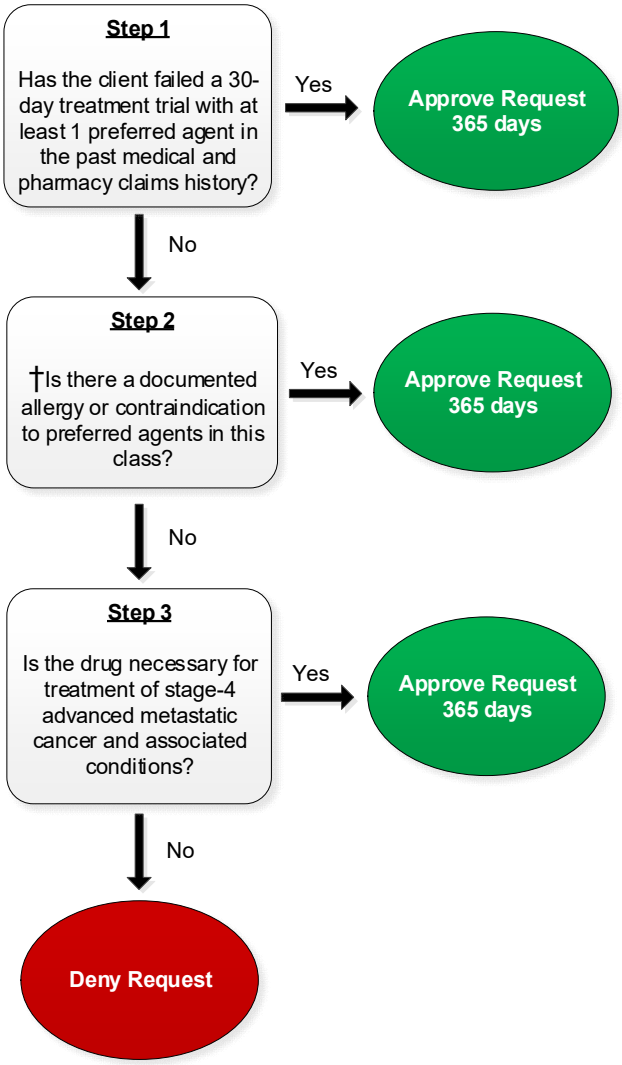
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 SUSPENSION
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
13088	VALCYTE 450MG TABLET
14453	VALCYTE 50MG/ML SOLUTION

**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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

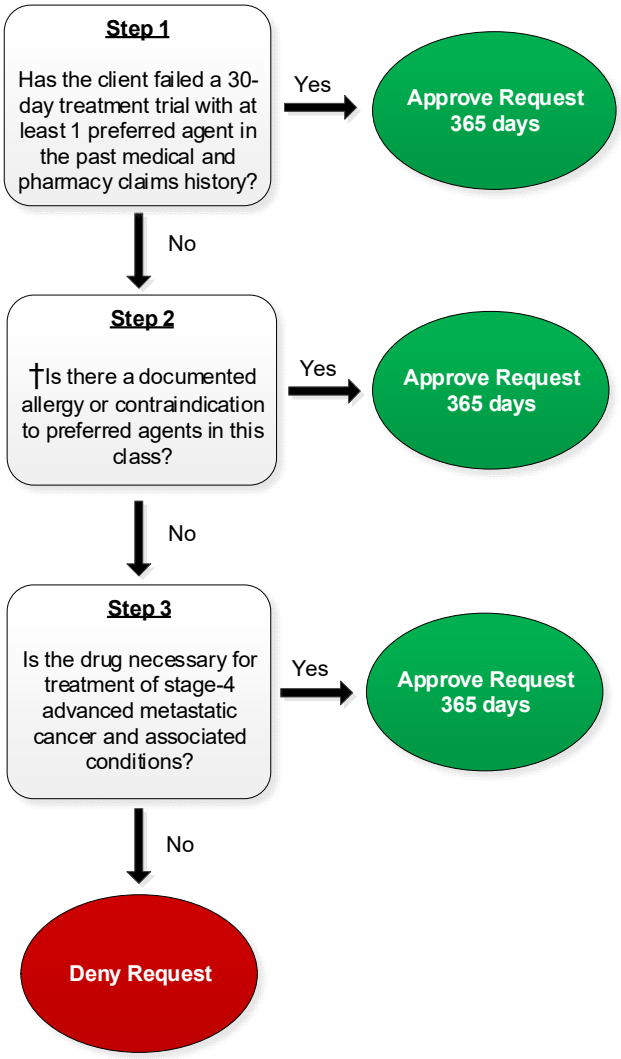
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

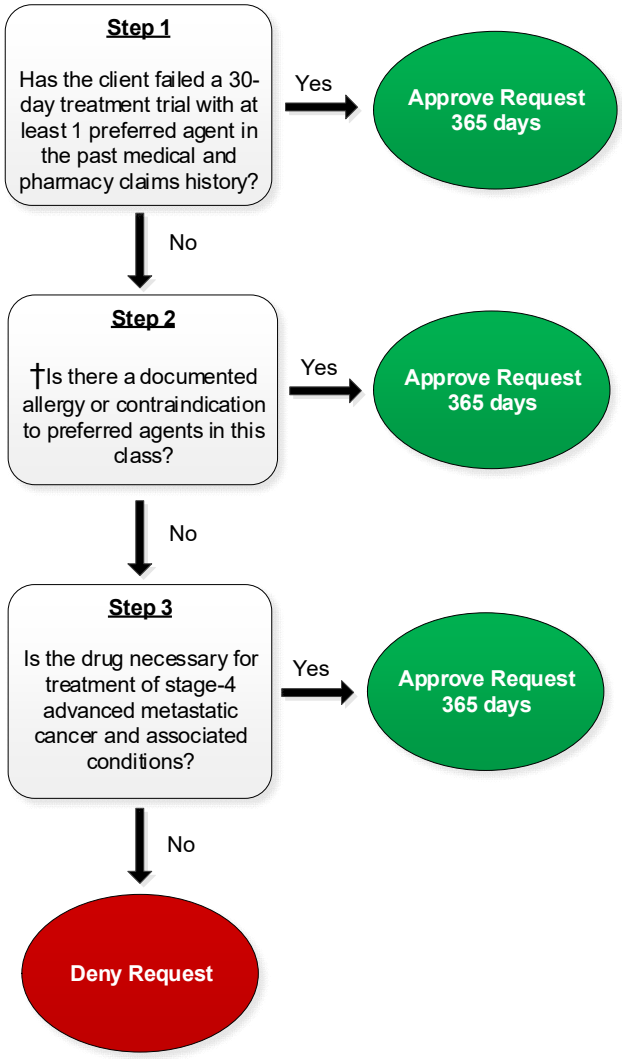
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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
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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

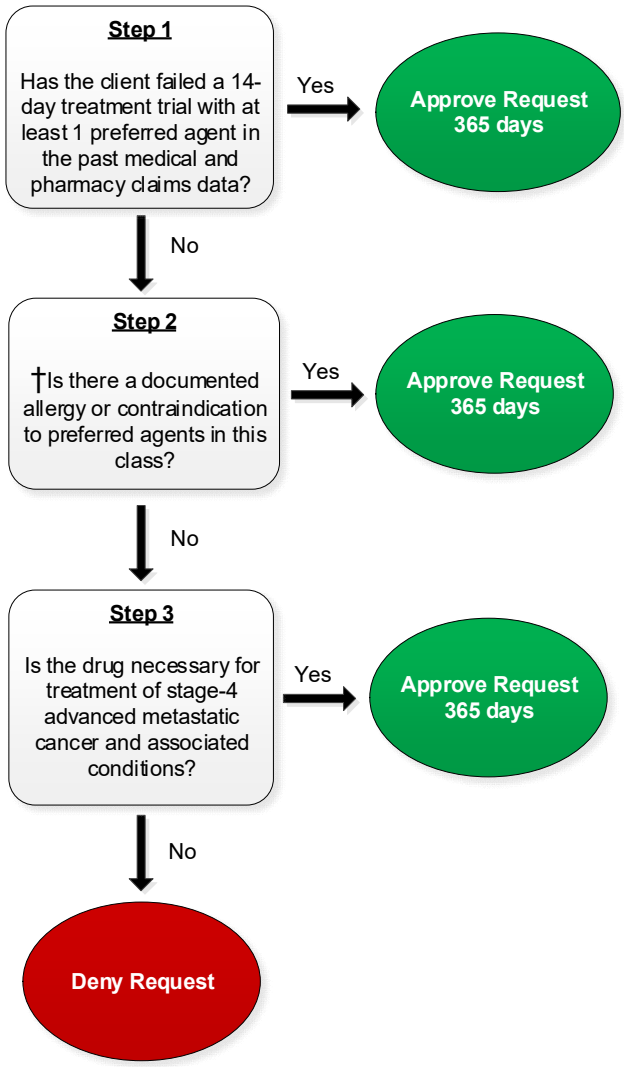
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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.

RxPERT®

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
20642	METOPROLOL TARTRATE 50MG TABLET

GCN	Drug Name
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	SOTALOL 120MG TABLET
39511	SOTALOL 160MG TABLET
39512	SOTALOL 80MG TABLET
39513	SOTALOL HCL 240MG 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

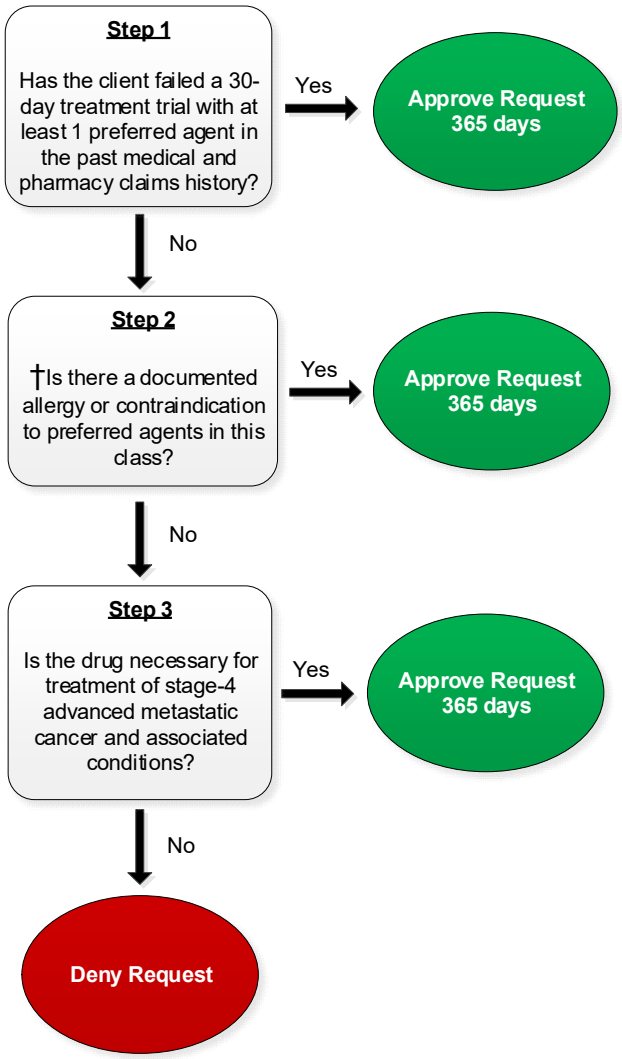
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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

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

Bladder Relaxant Preparations

Bladder Relaxant Preparations
Prior Authorization Criteria

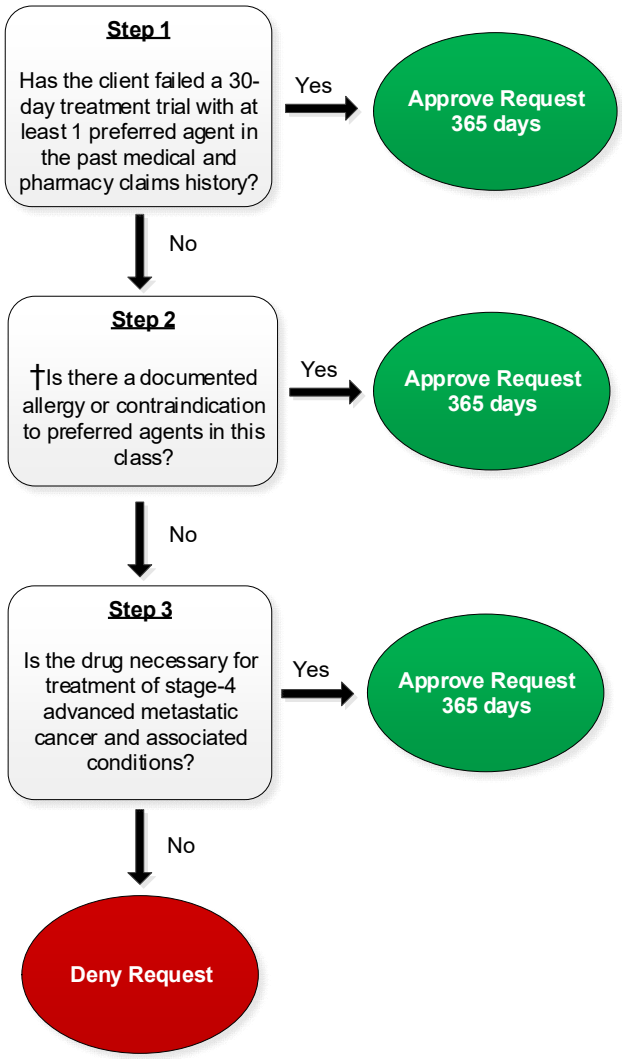
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

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 5MG TABLET
19370	OXYBUTYNIN CHLORIDE 5MG/5ML SYRUP
19389	OXYBUTYNIN CL ER 10MG TABLET
93557	OXYBUTYNIN CL ER 15MG TABLET
19388	OXYBUTYNIN CL ER 5MG TABLET
99711	TOVIAZ ER 4MG TABLET
99712	TOVIAZ ER 8MG TABLET
23277	VESICARE 10MG TABLET
23276	VESICARE 5MG 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

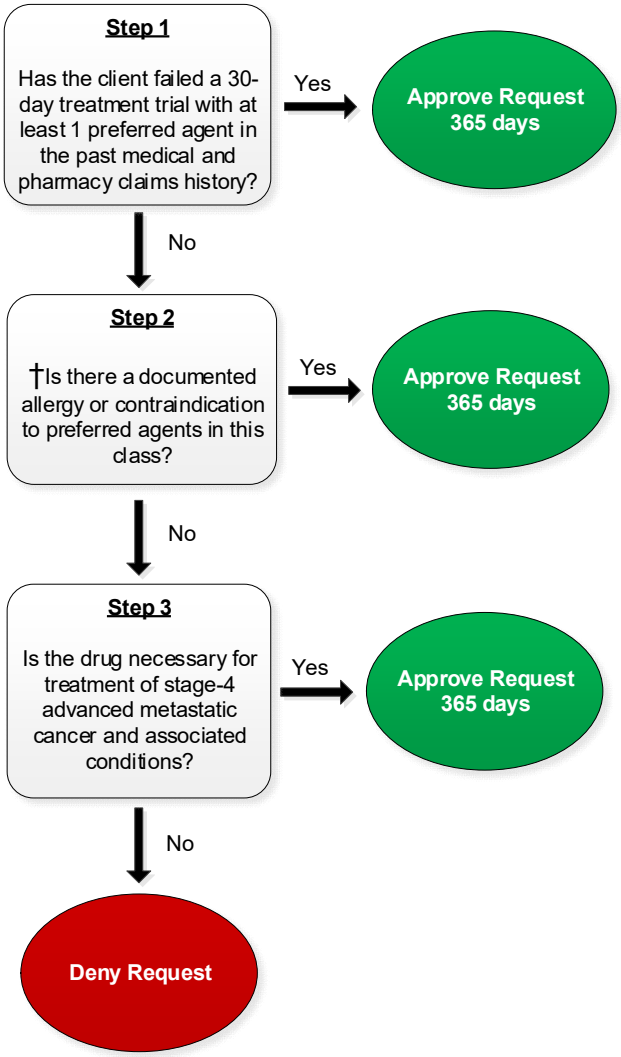
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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
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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

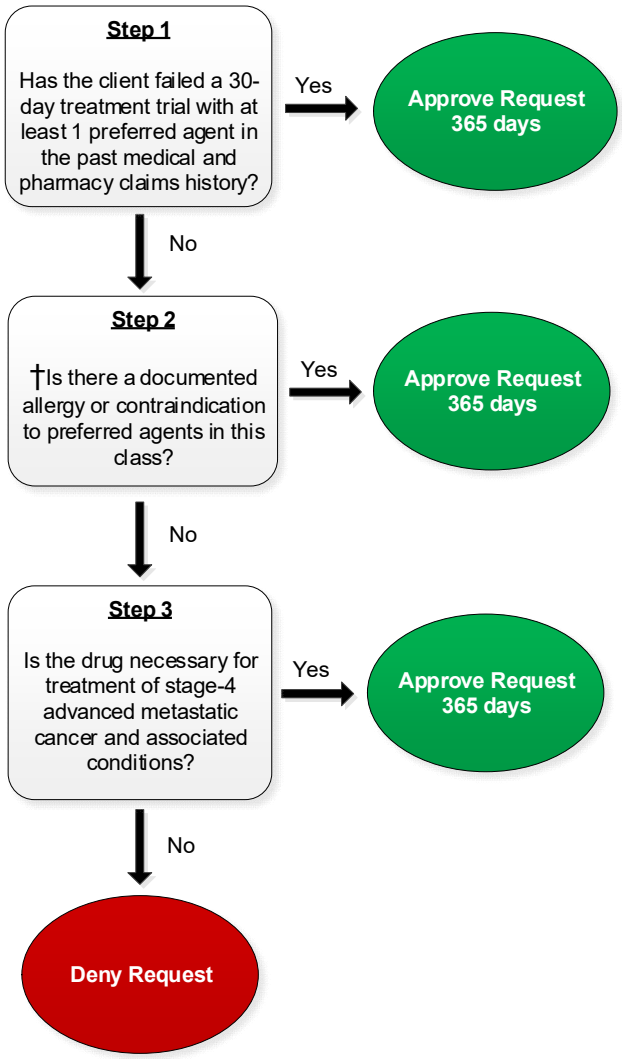
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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
29248	FINASTERIDE 1MG 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

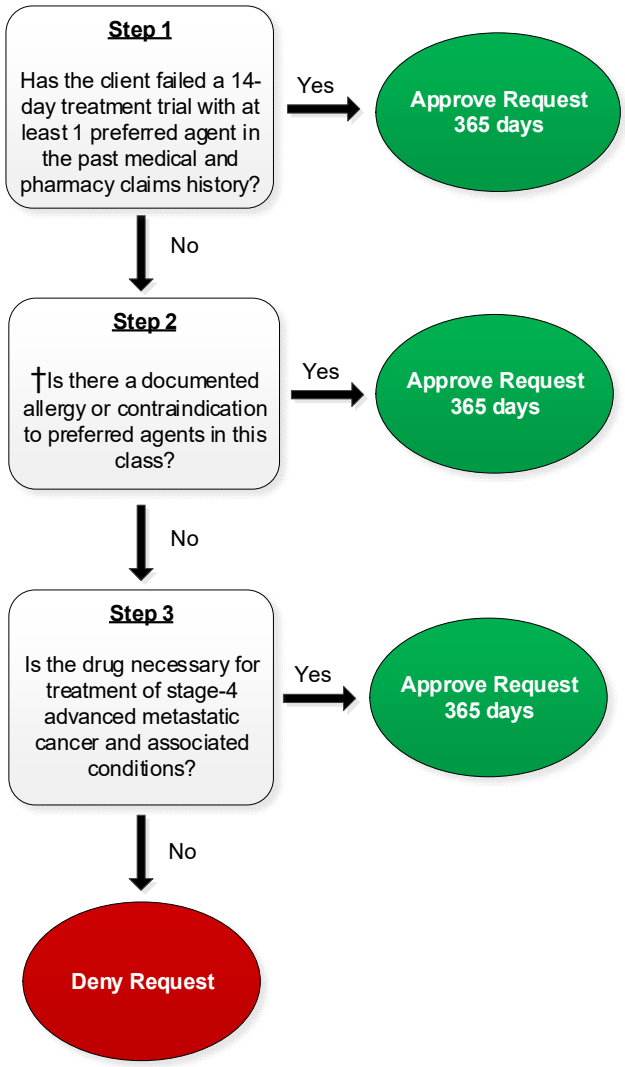
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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
22697	ALBUTEROL 2.5MG/0.5ML SOLUTION
14633	ALBUTEROL SULFATE 0.63MG/3ML SOLUTION
14634	ALBUTEROL SULFATE 1.25MG/3ML SOLUTION
41681	ALBUTEROL SULFATE 2.5MG/3ML SOLUTION
22780	ALBUTEROL SULFATE 2MG/5ML SYRUP
41680	ALBUTEROL SULFATE 5MG/ML SOLUTION
22913	PROAIR HFA 90MCG INHALER
22913	PROVENTIL HFA 90MCG INHALER
64012	SEREVENT DISKUS 50 MCG
15665	XOPENEX 0.31 MG/3 ML SOLUTION
24540	XOPENEX 0.63 MG/3 ML SOLUTION
24541	XOPENEX 1.25 MG/3 ML SOLUTION
24422	XOPENEX HFA 45 MCG INHALER
22913	VENTOLIN HFA 90 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

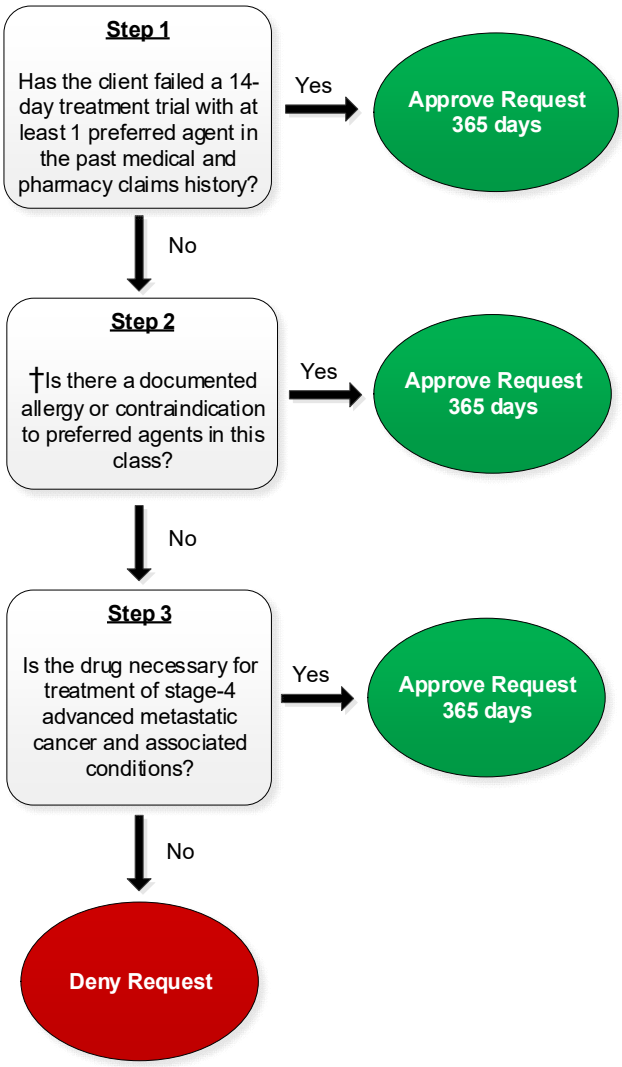
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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 10MG TABLET
02681	AMLODIPINE BESYLATE 2.5MG TABLET
02683	AMLODIPINE BESYLATE 5MG TABLET
02326	CARTIA XT 120MG CAPSULE
02323	CARTIA XT 180MG CAPSULE
02324	CARTIA XT 240MG CAPSULE
02325	CARTIA XT 300MG CAPSULE
07463	DILT XR 120MG CAPSULE
07461	DILT XR 180MG CAPSULE
07462	DILT XR 240MG CAPSULE
02325	DILTIAZEM 24HR ER 300MG CAPSULE
02363	DILTIAZEM 120MG TABLET
02321	DILTIAZEM 12HR ER 120MG CAPSULE
02322	DILTIAZEM 12HR ER 60MG CAPSULE
02320	DILTIAZEM 12HR ER 90MG CAPSULE
02324	DILTIAZEM 24 HR ER 240MG CAPSULE
02326	DILTIAZEM 24HR ER 120MG CAPSULE
02323	DILTIAZEM 24HR ER 180MG CAPSULE
07460	DILTIAZEM 24HR ER 360MG CAPSULE
02360	DILTIAZEM 30MG TABLET
02361	DILTIAZEM 60MG TABLET
02362	DILTIAZEM 90MG TABLET
02330	DILTIAZEM ER 120MG CAPSULE
02329	DILTIAZEM ER 180MG CAPSULE
02332	DILTIAZEM ER 240MG CAPSULE
02333	DILTIAZEM ER 300MG CAPSULE
02328	DILTIAZEM ER 360MG CAPSULE
94691	DILTIAZEM ER 420MG CAPSULE
02622	FELODIPINE ER 10MG TABLET
02620	FELODIPINE ER 2.5MG TABLET
02621	FELODIPINE ER 5MG TABLET
46652	KATERZIA 1MG/ML SUSPENSION
02226	NIFEDIPINE ER 30MG TABLET

GCN	Drug Name
02221	NIFEDIPINE ER 30MG TABLET
02227	NIFEDIPINE ER 60MG TABLET
02222	NIFEDIPINE ER 60MG TABLET
02228	NIFEDIPINE ER 90MG TABLET
02223	NIFEDIPINE ER 90MG TABLET
02330	TAZTIA XT 120MG CAPSULE
02329	TAZTIA XT 180MG CAPSULE
02332	TAZTIA XT 240MG CAPSULE
02333	TAZTIA XT 300MG CAPSULE
02328	TAZTIA XT 360MG CAPSULE
02341	VERAPAMIL 120MG TABLET
47110	VERAPAMIL 40MG TABLET
02342	VERAPAMIL 80MG TABLET
03003	VERAPAMIL ER 120MG CAPSULE
32472	VERAPAMIL ER 120MG TABLET
03001	VERAPAMIL ER 180MG CAPSULE
32471	VERAPAMIL ER 180MG TABLET
03002	VERAPAMIL ER 240MG CAPSULE
32470	VERAPAMIL ER 240MG TABLET

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

Cephalosporins and Related Antibiotics

Cephalosporins and Related Antibiotics (Oral) Prior Authorization Criteria

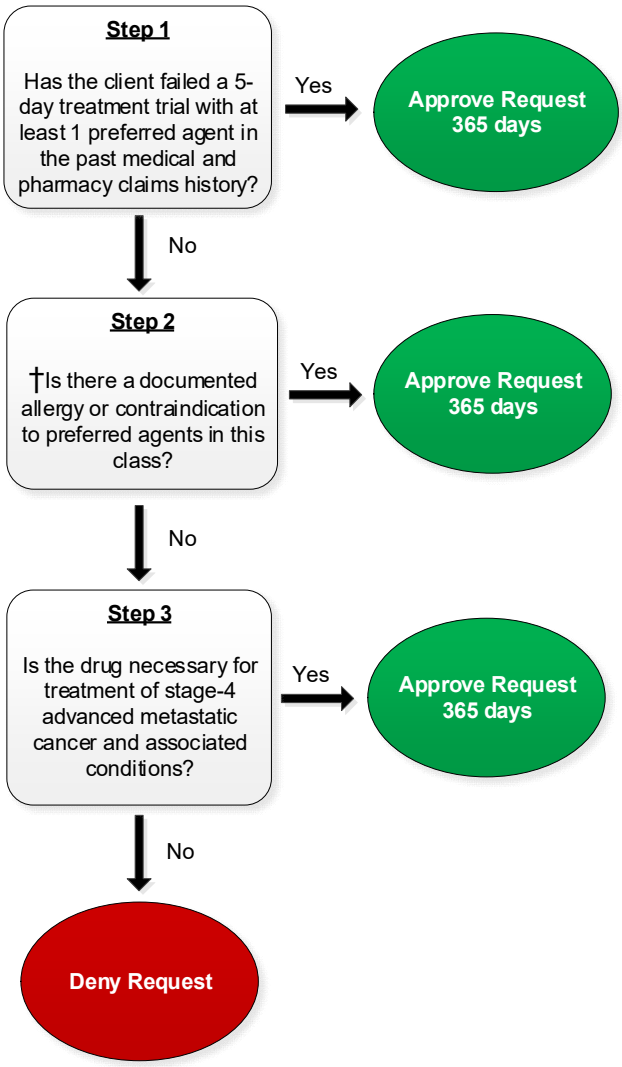
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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	AMOXICILLIN/POTASSIUM CLAV 200-28.5MG/5ML SUSPENSION
67070	AMOXICILLIN/POTASSIUM CLAV 250-125MG TABLET
67151	AMOXICILLIN/POTASSIUM CLAV 250-62.5MG/5ML SUSPENSION
67153	AMOXICILLIN/POTASSIUM CLAV 400-57MG/5ML SUSPENSION
67071	AMOXICILLIN/POTASSIUM CLAV 500-125MG TABLET
28020	AMOXICILLIN/POTASSIUM CLAV 600-42.9MG/5ML SUSPENSION
67076	AMOXICILLIN/POTASSIUM CLAV 875-125MG TABLET
45343	CEFADROXIL 250MG/5ML SUSPENSION
45341	CEFADROXIL 500MG CAPSULE
45344	CEFADROXIL 500MG/5ML SUSPENSION
32232	CEFDINIR 125MG/5ML SUSPENSION
23308	CEFDINIR 250MG/5ML SUSPENSION
32231	CEFDINIR 300MG CAPSULE
48821	CEFPODOXIME 100MG TABLET
49302	CEFPODOXIME 100MG/5ML SUSP
48822	CEFPODOXIME 200MG TABLET
49301	CEFPODOXIME 50MG/5ML SUSP
29291	CEFPROZIL 125MG/5ML SUSPENSION
29292	CEFPROZIL 250MG/5ML SUSPENSION
29271	CEFPROZIL 250MG TABLET
29272	CEFPROZIL 500MG TABLET
47281	CEFUROXIME AXETIL 250MG TABLET
47282	CEFUROXIME AXETIL 500MG TABLET
39811	CEPHALEXIN 125MG/5ML SUSPENSION
39801	CEPHALEXIN 250MG CAPSULE
39812	CEPHALEXIN 250MG/5ML SUSPENSION
39802	CEPHALEXIN 500MG CAPSULE
27016	CEPHALEXIN 750MG 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

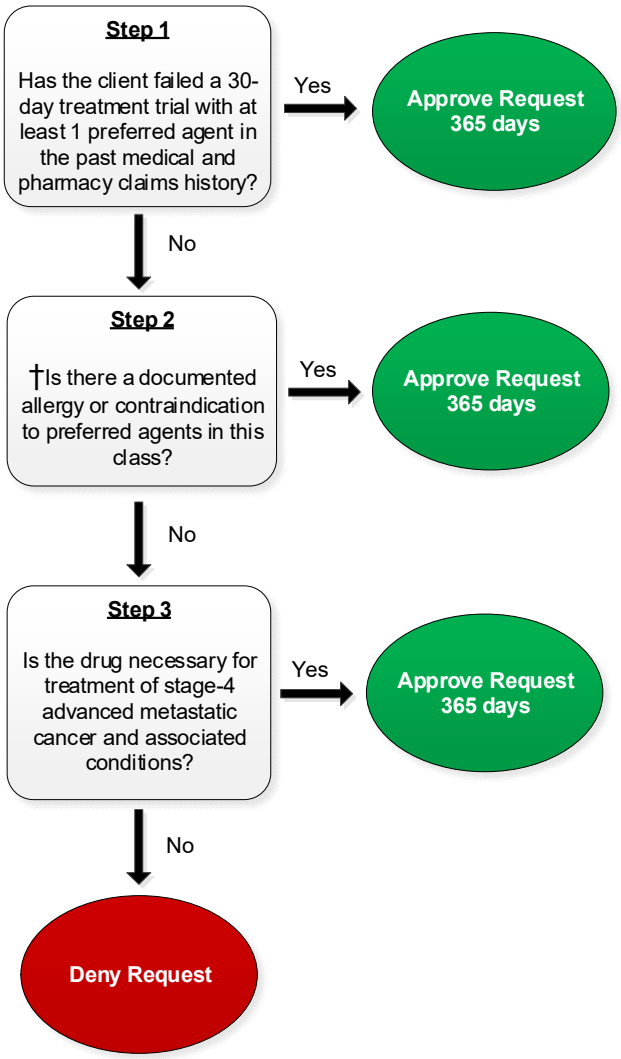
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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

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

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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

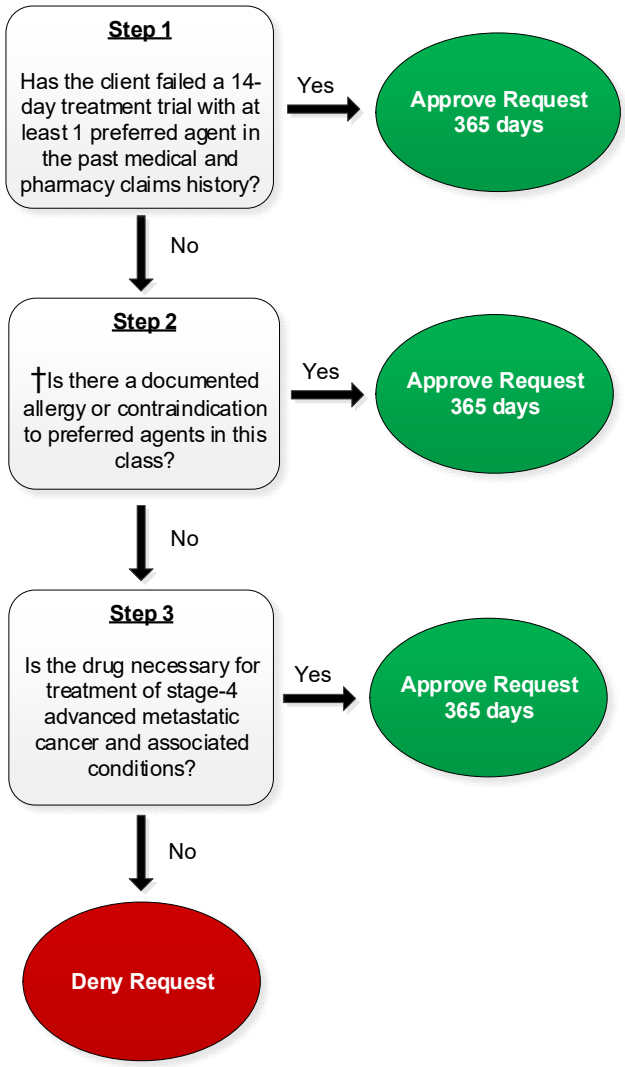
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 62.5-25MCG INH
24621	ATROVENT HFA INHALER
32395	COMBIVENT RESPIMAT INHALATION SPRAY
42235	IPRATROPIUM BR 0.02% SOLUTION
13456	IPRAT-ALBUT 0.5-3(2.5)MG/3ML
28934	ROFLUMILAST 500 MCG TABLET
17853	SPIRIVA 18MCG CAP-HANDIHALER
39587	SPIRIVA RESPIMAT 1.25 MCG INH
98921	SPIRIVA RESPIMAT 2.5 MCG INH
38687	STIOLTO RESPIMAT INHAL SPRAY

**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

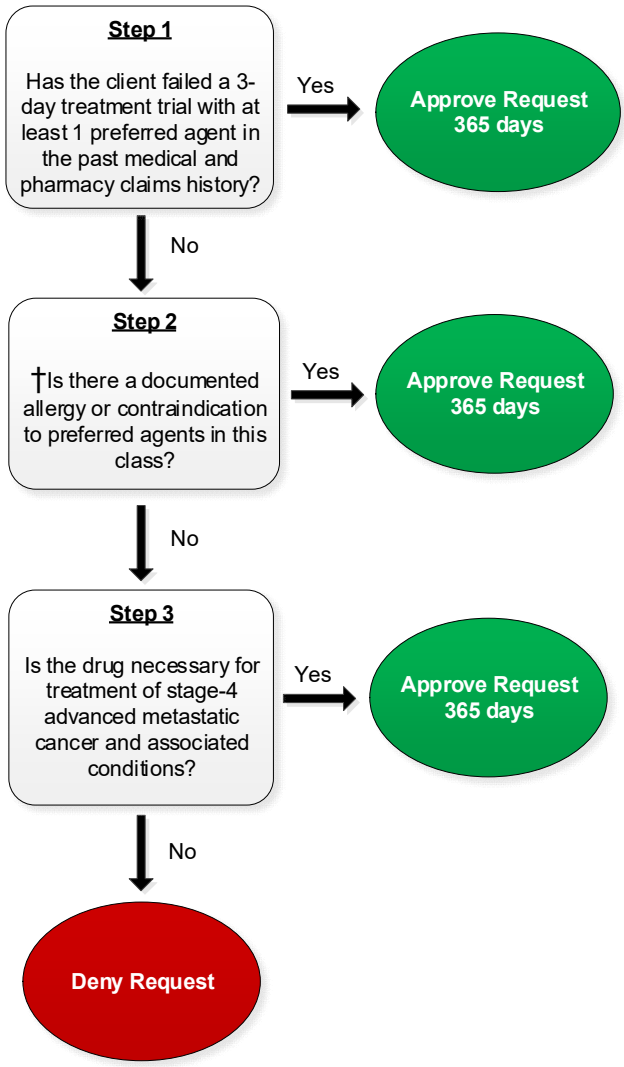
1. Has the client failed a 3-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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.

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Cough and Cold Non-Antitussive Alternate Therapies

Preferred Cough and Cold Non-Antitussives

GCN	Drug Name
46711	ALA-HIST IR 2MG TABLET
28379	ALA-HIST PE TABLET
96445	APRODINE TABLET
02512	CHILD MUCINEX CHEST CONGESTION
30579	CHILDS MUCINEX COLD-FEVER LIQ
37876	CHL MUCINEX M-S COLD DAY-NITE
02512	COUGH SYRUP 200MG/10ML
42022	DECONEX IR TABLET
27207	DIMAPHEN ELIXIR
25462	ED-A-HIST 4MG-10MG TABLET
54250	ED BRON GP LIQUID
02512	GUAIFENESIN 100MG/5ML SYRUP
54980	GUAIFENESIN-PSE ER 600-60MG TABLET
30577	MUCINEX COLD-FLU-SORE THROAT LIQ
89731	MUCINEX D ER 1200-120MG TABLET
54980	MUCINEX D ER 600-60MG TABLET
98863	MUCINEX ER 1,200MG TABLET
35905	MUCINEX ER 600MG TABLET
26743	MUCINEX FAST-MAX COLD-SINUS TAB
36524	MUCINEX FAST-MAX CONGEST-COUGH
30577	MUCINEX FAST-MAX SEV COLD LIQ
26743	MUCINEX SINUS-MAX PRESSURE-PAIN
02512	MUCUS-CHEST CONG 200MG/10ML
18906	MUCUS RELIEF 400 MG TABLET
35905	MUCUS RELIEF ER 600MG TABLET
34062	NASAL DECONGESTANT 0.05% SPRAY
32676	NASOPEN PE LIQUID
35587	POLY HIST FORTE TABLET
02512	ROBAFEN 100MG/5ML LIQUID
27207	RYNEX PE LIQUID
02512	SILTUSSIN SA 100MG/5ML SYR

GCN	Drug Name
34062	SM NASAL SPRAY 0.05%
44023	SUDOGEST SINUS & 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

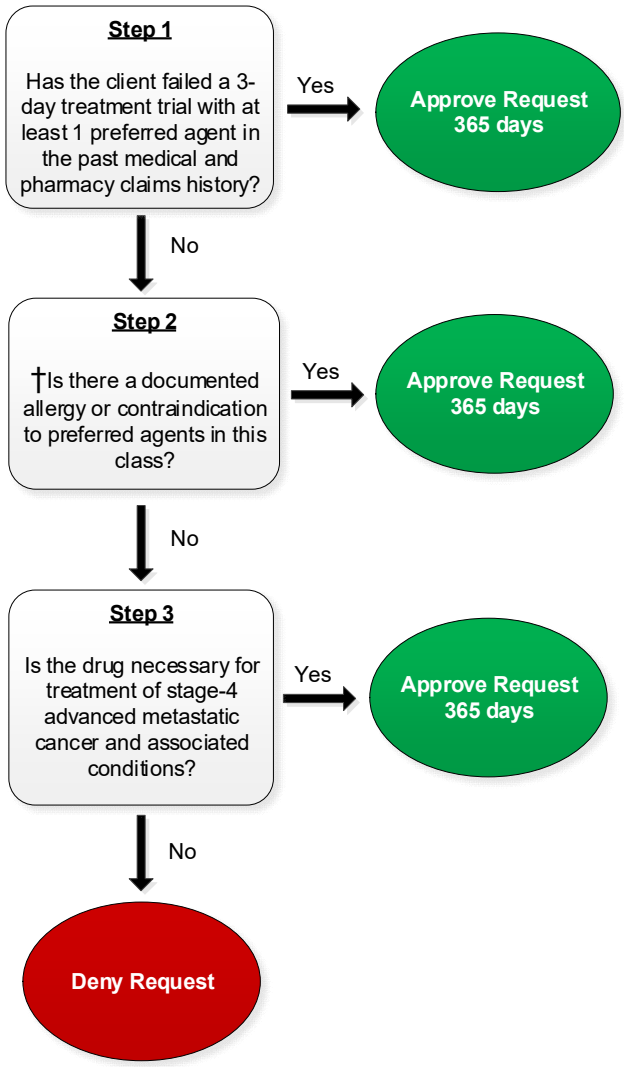
1. Has the client failed a 3-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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



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Cough and Cold Narcotic Antitussive Alternate Therapies

Preferred Cough and Cold, Narcotic Antitussives

GCN	Drug Name
91713	CHERATUSSIN AC SYRUP
91713	CODEINE-GUAIF 10-100MG/5ML
91713	GUAIFENESIN AC COUGH SYRUP
91713	GUAIFENESIN-CODEINE SYRUP
13971	PROMETHAZINE/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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

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

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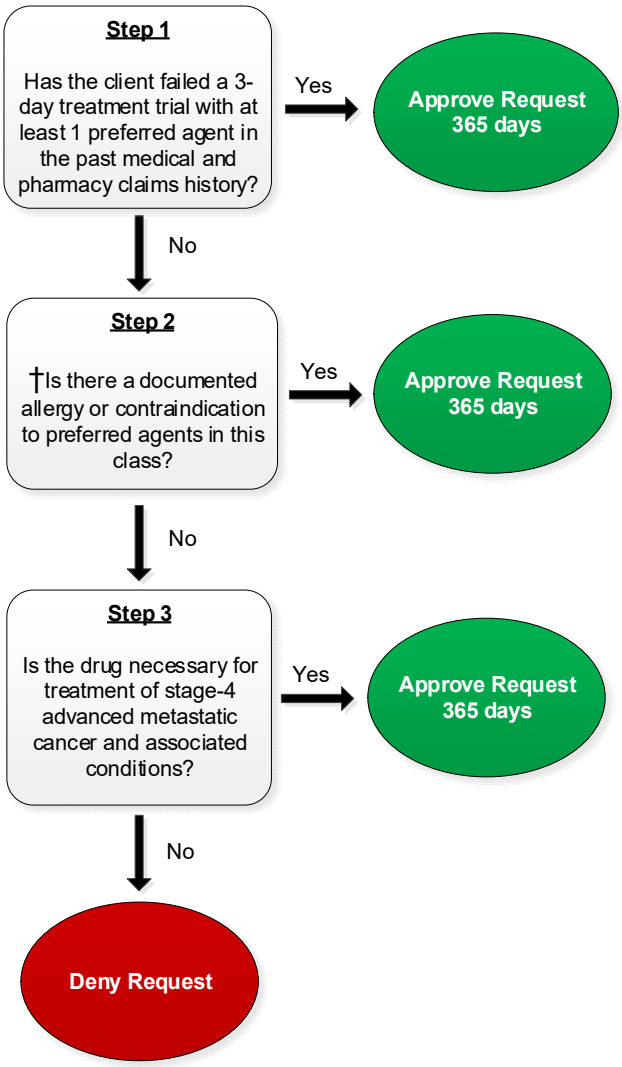
Cough and Cold Non-Narcotic Antitussive Prior Authorization Criteria



†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
43882	ALAHIST CF TABLET
42443	ALAHIST DM LIQUID
29840	BENZONATATE 100MG CAPSULE
93007	BENZONATATE 200MG CAPSULE
28229	BENZONATATE 150MG CAPSULE
96136	BROMPHENIR-PSEUDOEPHED-DM SYR
12934	BROTAPP DM LIQUID
17802	CHILD DELSYM COUGH 30MG/5ML
37876	CHILD MUCINEX M-S COLD DAY-NITE
53497	CHILDREN'S MUCINEX COUGH LIQ
17802	COUGH DM 30MG/5ML SUSP
42056	DECONEX DMX TABLET
17802	DELSYM 30MG/5ML SUSPENSION
53497	DELSYM COUGH+CHEST CNGST DM LQ
17802	DEXTROMETHORPHAN ER 30MG/5ML
17770	DEXTROMETHORPHAN 15MG LIQ GEL
26808	DIMAPHEN DM ELIXIR
42056	DM-GUAIF-PE 17.5-385-10MG TAB
34782	DM-GUAIF-PE 18-200-10MG/15ML
39986	DURAFLU 325-20-200-60 MG TAB
19347	ED-A-HIST DM LIQUID
26808	ENDACOF-DM LIQUID
36311	HISTEX-DM SYRUP
15847	LOHIST-DM SYRUP
30577	MUCINEX COLD-FLU & SORE THROAT LIQUID
99068	MUCINEX COUGH MINI-MELT PACK
93677	MUCINEX DM ER 1200-60MG TABLT
53550	MUCINEX DM ER 600-30MG TABLET
36524	MUCINEX FAST-MAX CONGESTION-COUGH
53497	MUCINEX FAST-MAX DM MAX LIQUID
19347	NO-HIST DM LIQUID
34835	POLY-HIST DM LIQUID

GCN	Drug Name
34799	POLY-VENT DM TABLET
42443	POLYTUSSIN DM 2-15-7.5 MG/5 ML
13975	PROMETHAZINE DM SYRUP
53491	ROBAFEN DM COUGH LIQUID
26808	RYNEX DM LIQUID
53491	SILTUSSIN DM LIQUID
53491	SM TUSSIN DM LIQUID
34782	VANACOF DM LIQUID
47463	VANCOF DMX 18-396-10 MG/15 ML
99788	VANACOF LIQUID
43602	VANATAB DM CAPLET

**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

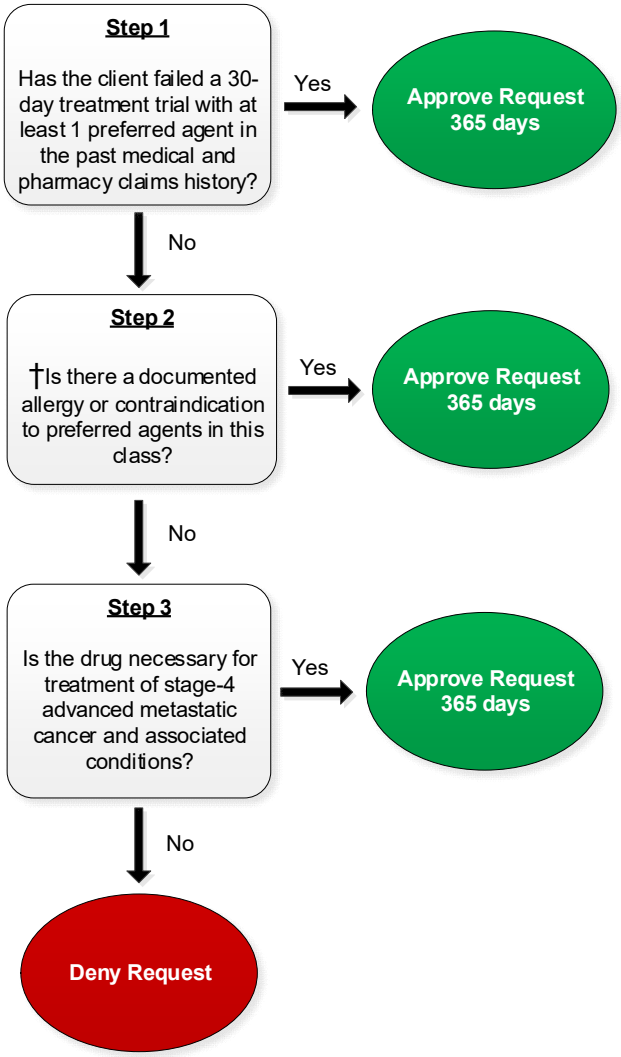
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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
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*

Cytokine and CAM Antagonists, Rinvoq

Cytokine and CAM Antagonists, Rinvoq

Prior Authorization Criteria

1. Does the client have a diagnosis of atopic dermatitis in the last 365 days?
   [ ] Yes (Go to #2)
   [ ] No (Go to #3)

2. 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Does the client have a diagnosis of ankylosing spondylitis (AS), Crohn's disease (CD), non-radiographic axial spondyloarthritis (nr-AxSpA), rheumatoid arthritis (RA), psoriatic arthritis (PsA) or ulcerative colitis (UC) in the last 365 days?
   [ ] Yes (Go to #4)
   [ ] No (Go to #5)

4. 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #5)

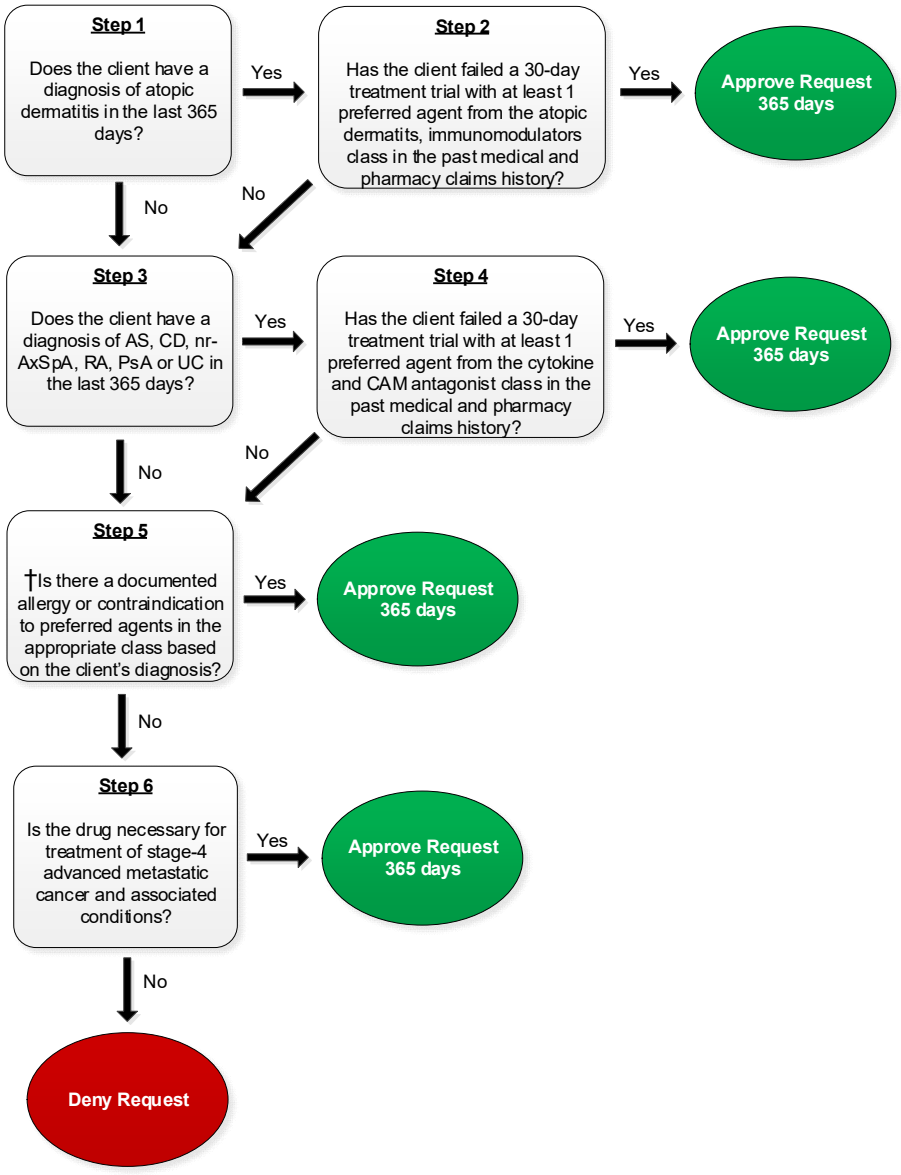
5. †Is there a documented allergy or contraindication to preferred agents in the appropriate class based on the client's diagnosis?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #6)

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.

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, Rinvoq

Alternate Therapies

Preferred Agents

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

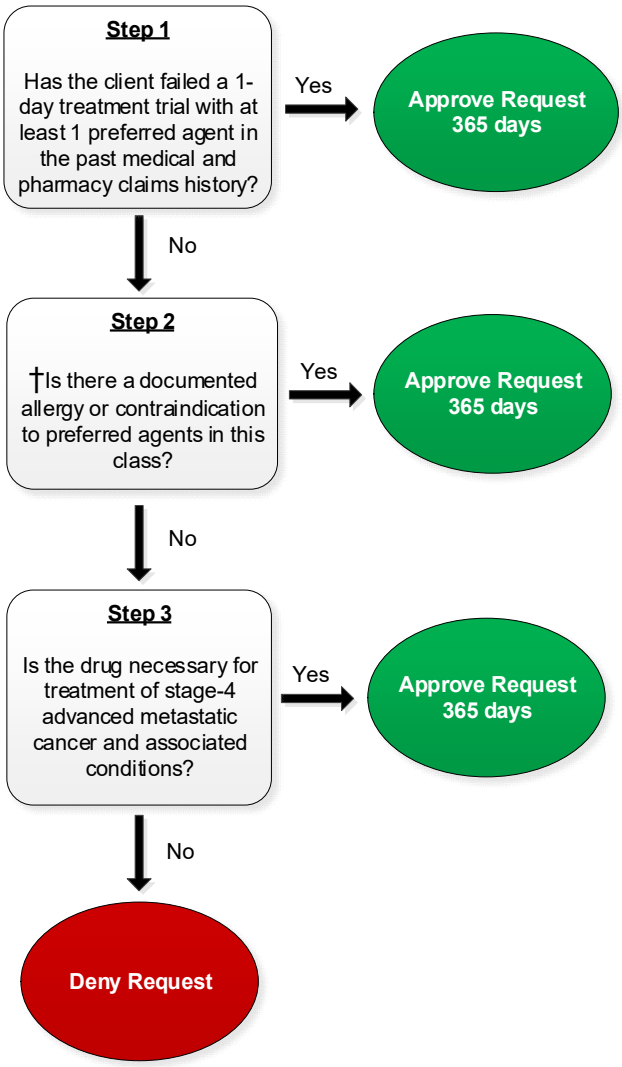
1. Has the client failed a 1-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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.

RxPERT®

Epinephrine, Self-Injected Alternate Therapies

Preferred Self-Injected Epinephrine Agents

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

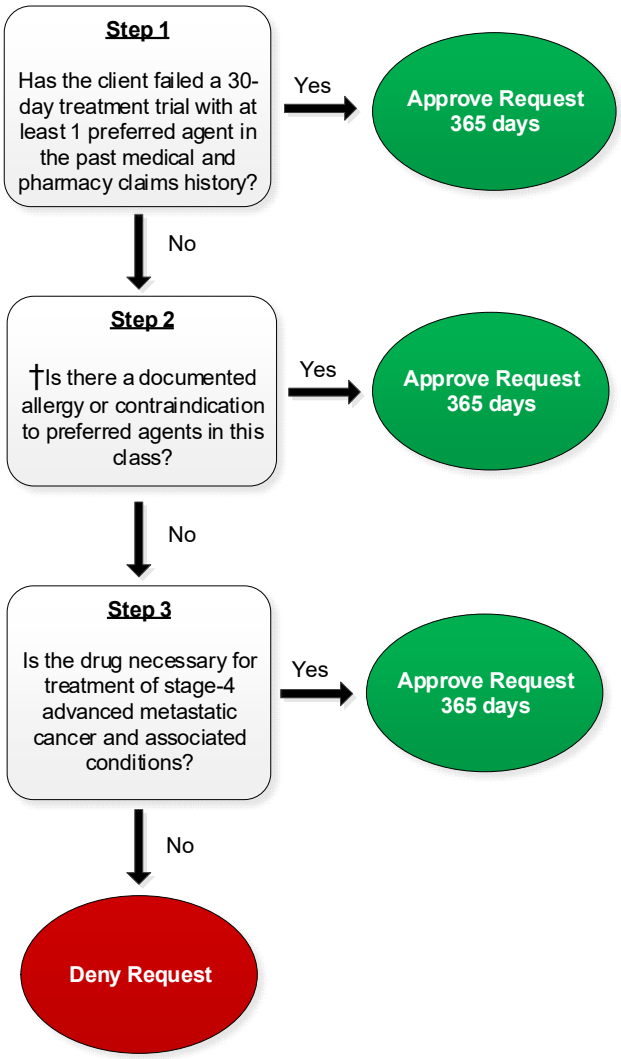
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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
14894	ARANESP 100 MCG/0.5ML SYRINGE
14055	ARANESP 100 MCG/ML VIAL
15202	ARANESP 150 MCG/0.3ML SYRINGE
97063	ARANESP 200 MCG/0.4ML SYRINGE
14056	ARANESP 200 MCG/ML VIAL
97064	ARANESP 25 MCG/0.42ML SYRINGE
14049	ARANESP 25 MCG/ML VIAL
97065	ARANESP 300 MCG/0.6ML SYRINGE
14891	ARANESP 40 MCG/0.4ML SYRINGE
14053	ARANESP 40 MCG/ML VIAL
27164	ARANESP 500 MCG/1ML SYRINGE
14893	ARANESP 60 MCG/0.3ML SYRINGE
14054	ARANESP 60 MCG/ML VIAL
24059	EPOGEN 20,000 UNITS/2ML VIAL
25110	EPOGEN 2,000 UNITS/ML VIAL
25111	EPOGEN 4,000 UNITS/ML VIAL
25112	EPOGEN 10,000 UNITS/ML VIAL
25113	EPOGEN 3,000 UNITS/ML VIAL
44767	RETACRIT 10,000 UNIT/ML VIAL
44764	RETACRIT 2000 UNIT/ML VIAL
44765	RETACRIT 3000 UNIT/ML VIAL
44768	RETACRIT 40,000 UNIT/ML VIAL
44766	RETACRIT 4000 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

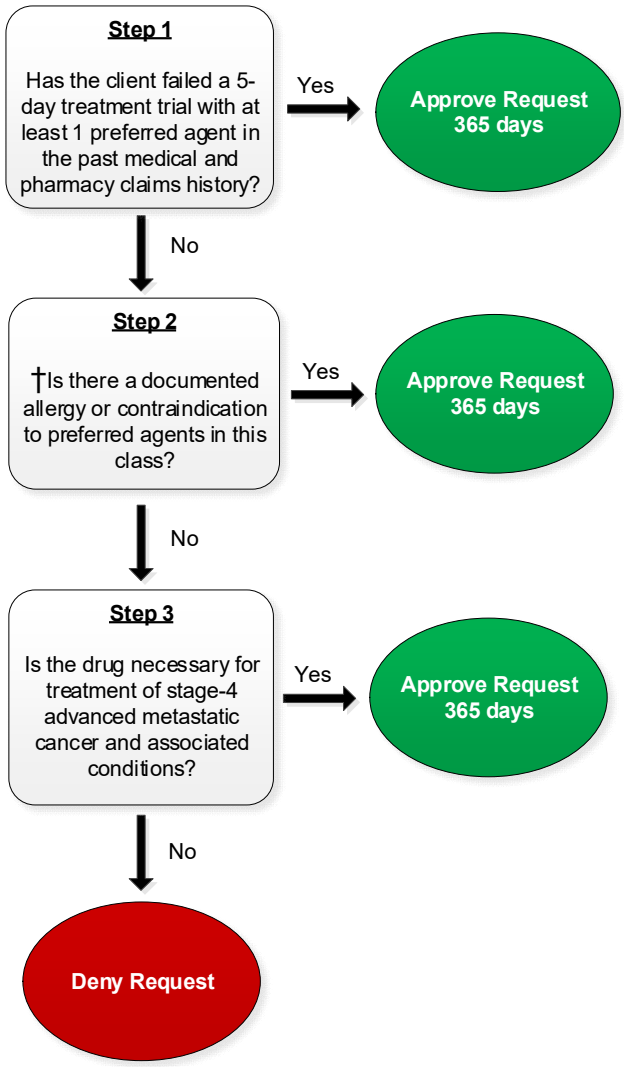
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 100MG TABLET
47050	CIPROFLOXACIN HCL 250MG TABLET
47051	CIPROFLOXACIN HCL 500MG TABLET
47052	CIPROFLOXACIN HCL 750MG TABLET
47073	LEVOFLOXACIN 250MG TABLET
47074	LEVOFLOXACIN 500MG TABLET
89597	LEVOFLOXACIN 750MG TABLET

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

GI Motility, Chronic

GI Motility, Chronic
Prior Authorization Criteria

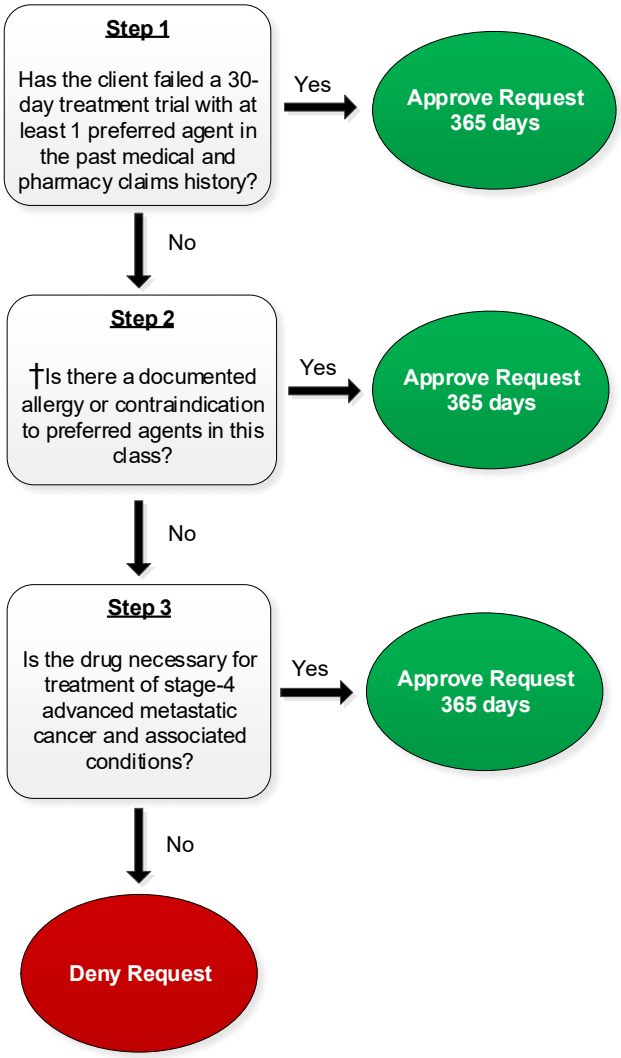
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent (including GI motility OTC products) in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

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

Glucagon Agents

Glucagon Agents
Prior Authorization Criteria

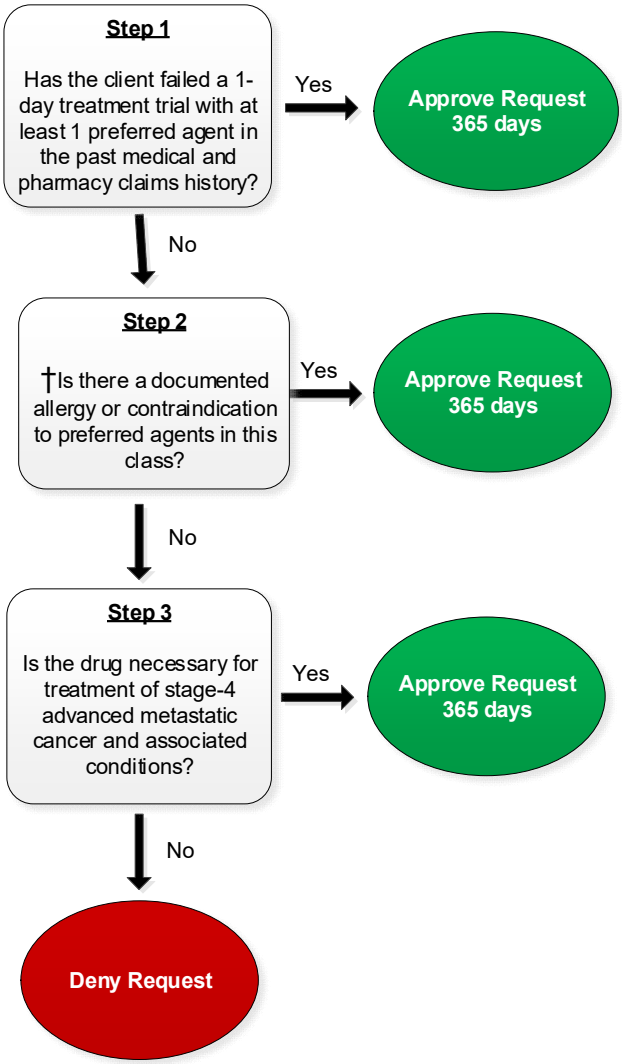
1. Has the client failed a 1-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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 3MG SPRAY
25473	GLUCAGON 1MG EMERGENCY KIT (LILLY)
25475	GLUCAGON 1MG EMERGENCY KIT (LILLY)
25470	GLUCAGON 1MG VIAL
46907	GVOKE HYPOPEN 1-PK 0.5 MG/0.1 ML
46907	GVOKE HYPOPEN 2-PK 0.5 MG/0.1 ML
46908	GVOKE HYPOPEN 1-PK 1 MG/0.2 ML
46908	GVOKE HYPOPEN 2-PK 1 MG/0.2 ML
01280	PROGLYCEM 50MG/ML ORAL SUSP

**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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

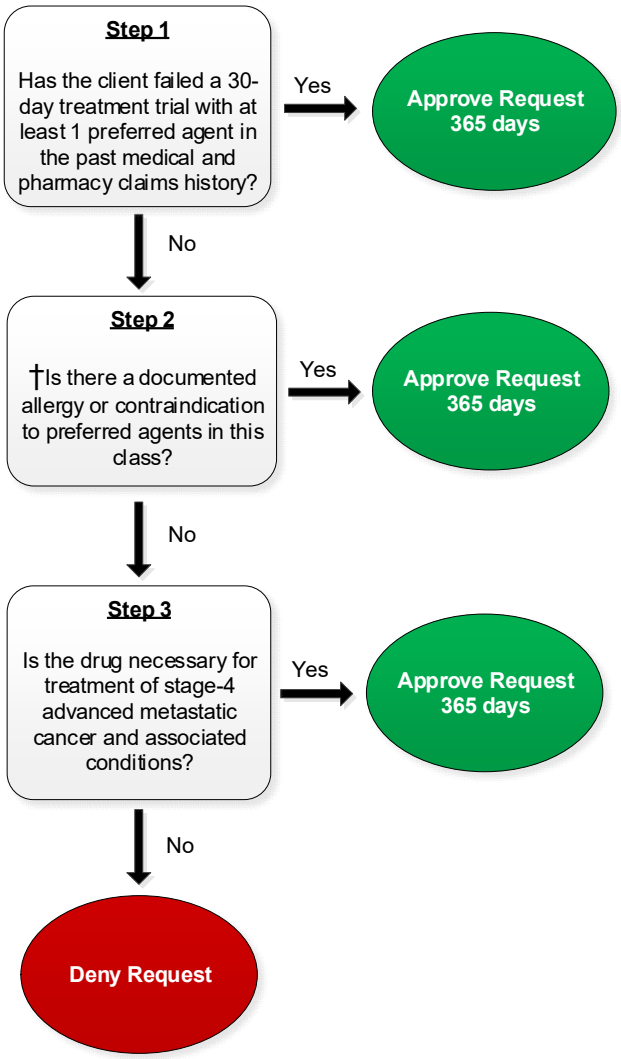
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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



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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 115-21MCG INHALER
97137	ADVAIR HFA 230-21MCG INHALER
97135	ADVAIR HFA 45-21MCG INHALER
99721	ASMANEX TWISTHALER 110MCG #30
18987	ASMANEX TWISTHALER 220MCG #120
24927	ASMANEX TWISTHALER 220MCG #14
24928	ASMANEX TWISTHALER 220MCG #30
24929	ASMANEX TWISTHALER 220MCG #60
62980	BUDESONIDE 1MG/2ML INH SUSP
17957	BUDESONIDE 0.25MG/2ML SUSP
17958	BUDESONIDE 0.5MG/2ML SUSP
28766	DULERA 100MCG/5MCG INHALER
28767	DULERA 200MCG/5MCG INHALER
30139	DULERA 50MCG/5MCG INHALER
53633	FLOVENT 100 MCG DISKUS
53634	FLOVENT 250 MCG DISKUS
53635	FLOVENT 50 MCG DISKUS
53636	FLOVENT HFA 110MCG INHALER
53639	FLOVENT HFA 220MCG INHALER
53638	FLOVENT HFA 44MCG INHALER
98025	PULMICORT 180MCG FLEXHALER
98024	PULMICORT 90MCG FLEXHALER
98500	SYMBICORT 160-4.5MCG INHALER NDC 00186-0370-20 only
98499	SYMBICORT 80-4.5MCG INHALER NDC 00186-0372-20 only

**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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

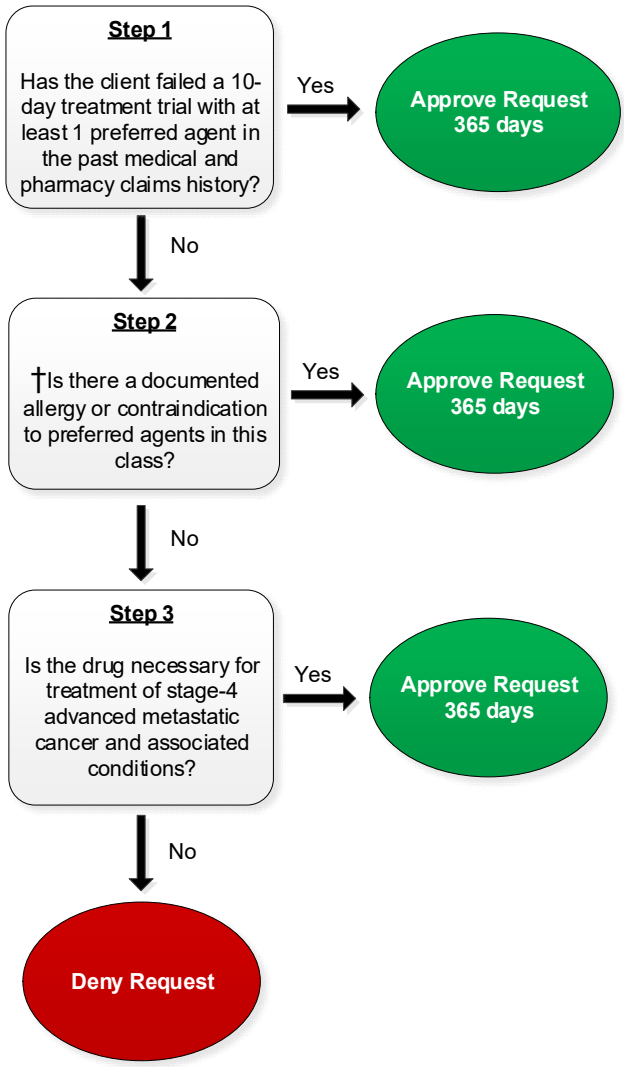
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 EC 3MG CAPSULE
27422	DEXAMETHASONE 0.5MG TABLET
27400	DEXAMETHASONE 0.5MG/5ML ELIXIR
27411	DEXAMETHASONE 0.5MG/5ML LIQUID
27425	DEXAMETHASONE 0.75MG TABLET
27427	DEXAMETHASONE 1.5MG TABLET
27424	DEXAMETHASONE 1MG TABLET
27426	DEXAMETHASONE 2MG TABLET
27428	DEXAMETHASONE 4MG TABLET
27429	DEXAMETHASONE 6MG TABLET
26781	HYDROCORTISONE 10MG TABLET
26782	HYDROCORTISONE 20MG TABLET
26783	HYDROCORTISONE 5MG TABLET
37499	METHYLPREDNISOLONE 4MG DOSEPACK
33806	PREDNISOLONE 15MG/5ML SOLUTION
26800	PREDNISOLONE 15MG/5ML SYRUP
09115	PREDNISOLONE 5MG/5ML SOLUTION
93945	PREDNISOLONE SOD PH 25MG/5ML
27172	PREDNISONE 10MG TABLET
27171	PREDNISONE 1MG TABLET
27173	PREDNISONE 2.5MG TABLET
27174	PREDNISONE 20MG TABLET
27177	PREDNISONE 50MG TABLET
27176	PREDNISONE 5MG TABLET
27160	PREDNISONE 5MG/5ML SOLUTION

**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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

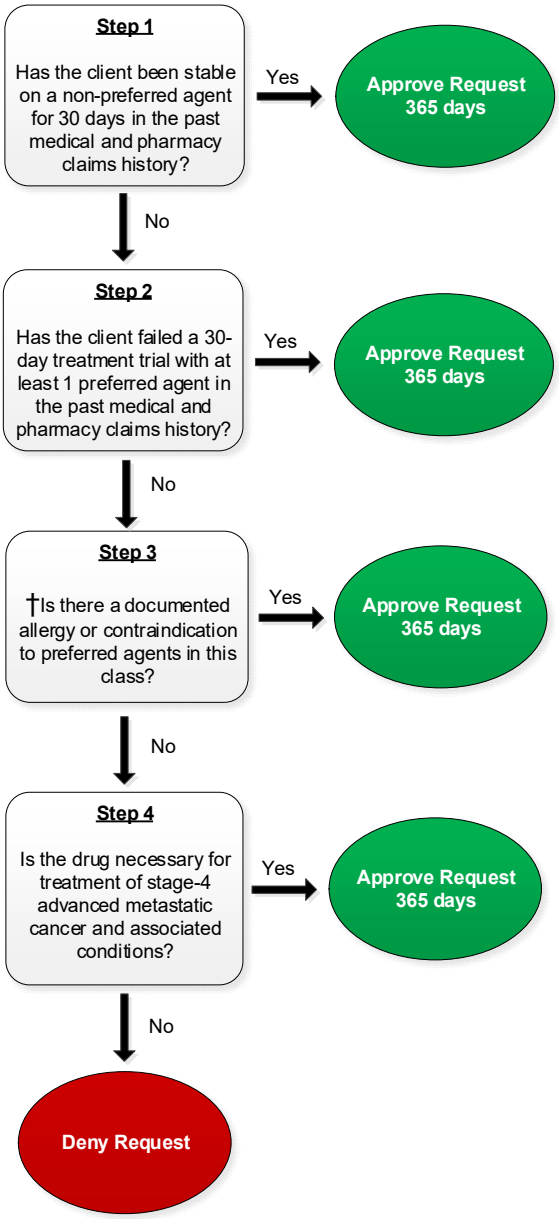
2. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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

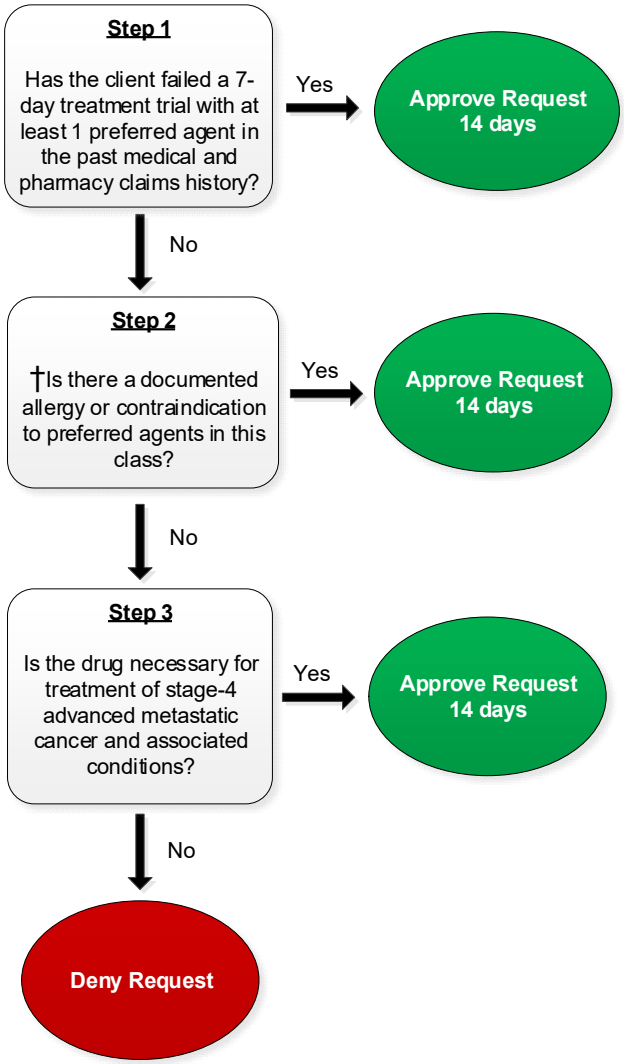
1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 14 days)
   [ ] No (Go to #2)

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 pharmacy claims history?
   [ ] Yes (Approve – 60 days)
   [ ] No (Go to #2)

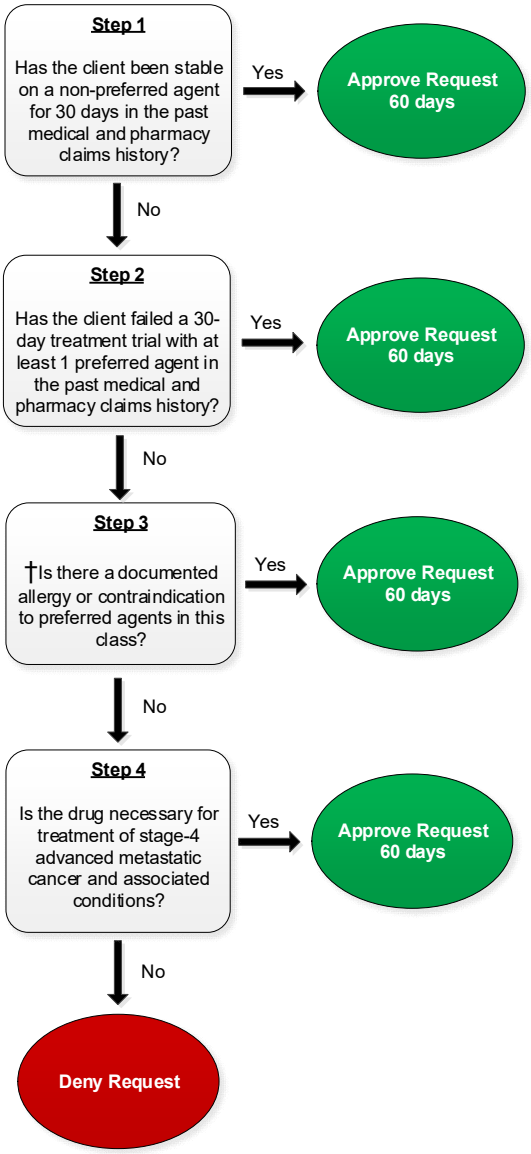
2. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 60 days)
   [ ] No (Go to #3)

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
18969	RIBAVIRIN 200 MG TABLET
14179	RIBAVIRIN 200 MG CAPSULE

**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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

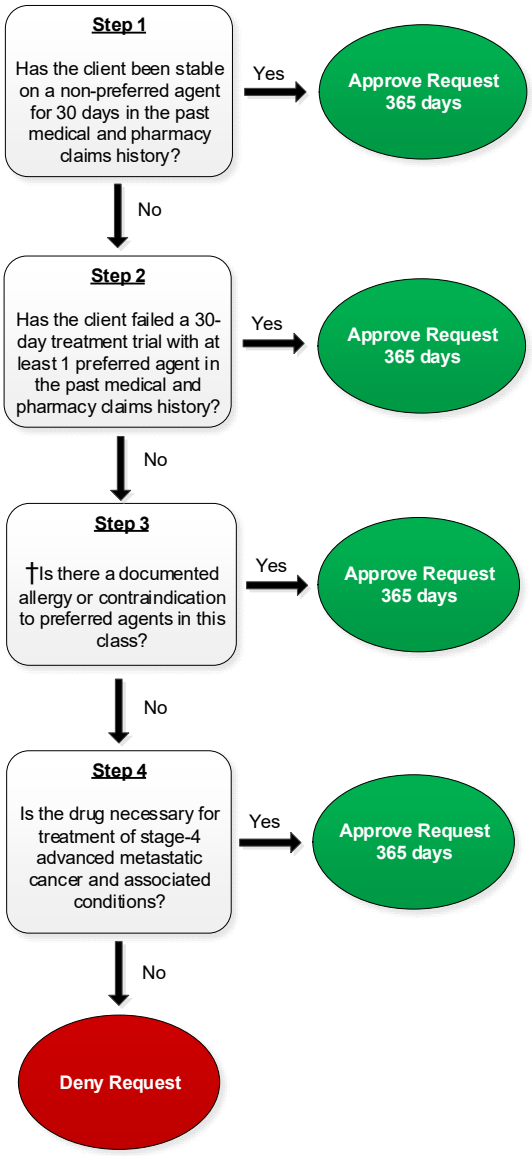
2. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 HAE Therapies

GCN	Drug Name
31159	BERINERT 500 UNIT KIT
10495	CINRYZE 500 UNIT VIAL
39478	HAEGARDA 2,000 UNIT VIAL
43356	HAEGARDA 3,000 UNIT VIAL
14778	ICATIBANT 30MG/3ML SYRINGE
28088	KALBITOR 10MG/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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

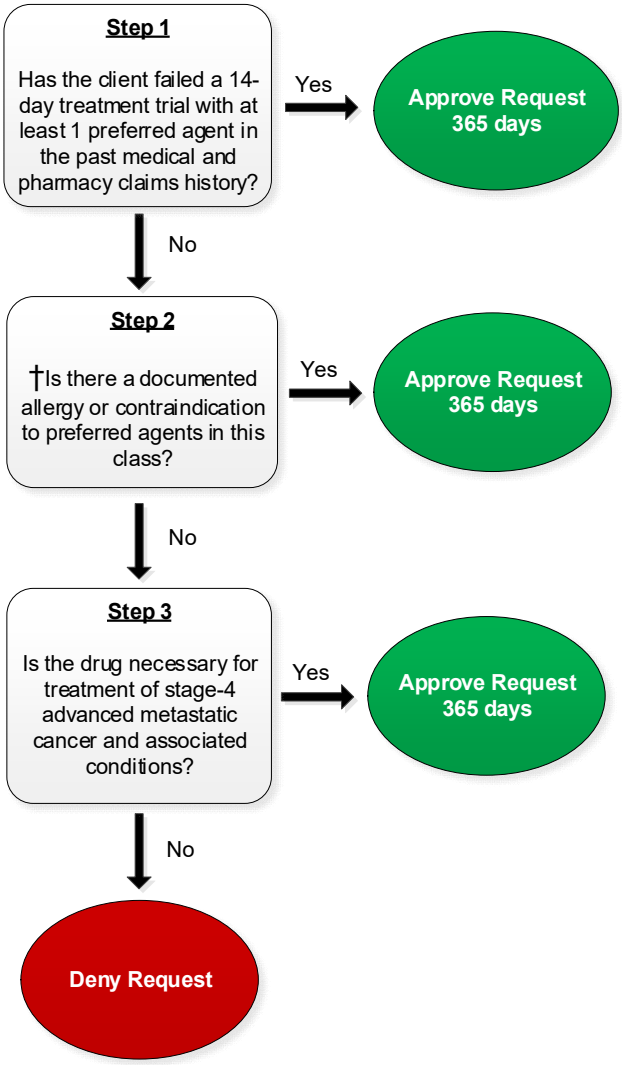
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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
24613	BYETTA 5MCG DOSE PEN INJECTION
24614	BYETTA 10MCG DOSE PEN INJECTION
37832	GLYXAMBI 10MG-5MG TABLET
37833	GLYXAMBI 25MG-5MG TABLET
98307	JANUMET 50-1,000MG TABLET
98306	JANUMET 50-500MG TABLET
31348	JANUMET XR 100-1,000MG TABLET
31340	JANUMET XR 50-1,000MG TABLET
31339	JANUMET XR 50-500MG TABLET
97400	JANUVIA 100MG TABLET
97398	JANUVIA 25MG TABLET
97399	JANUVIA 50MG TABLET
31315	JENTADUETO 2.5-500MG TABLET
31316	JENTADUETO 2.5-850MG TABLET
31317	JENTADUETO 2.5-1000MG TABLET
41637	JENTADUETO XR 2.5MG-1,000MG TABLET
41639	JENTADUETO XR 5MG-1,000MG TABLET
29225	KOMBIGLYZE XR 2.5-1000MG TABLET
29118	KOMBIGLYZE XR 5-500MG TABLET
29224	KOMBIGLYZE XR 5-1000MG TABLET
27393	ONGLYZA 2.5MG TABLET
27394	ONGLYZA 5MG TABLET
44163	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)
99514	SYMLINPEN 60 PEN INJECTOR
99450	SYMLINPEN 120 PEN INJECTOR
29890	TRADJENTA 5MG TABLET
47672	TRIJARDY XR 10-5-1,000 MG TAB
47671	TRIJARDY XR 12.5-2.5-1,000 MG
47673	TRIJARDY XR 25-5-1,000 MG TAB
47669	TRIJARDY XR 5-2.5-1,000 MG TAB

GCN	Drug Name
37171	TRULICITY 1.5MG/0.5ML PEN
48574	TRULICITY 3MG/0.5ML PEN
48573	TRULICITY 4.5MG/0.5ML PEN
37169	TRULICITY 0.75MG/0.5ML PEN
26189	VICTOZA 2-PAK 18MG/3ML 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

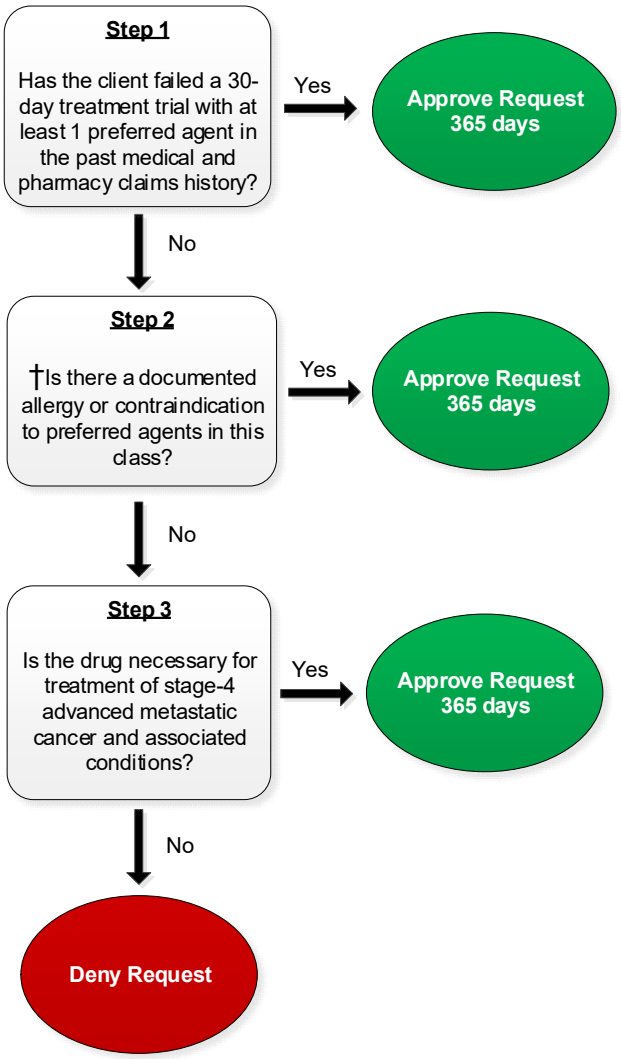
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 UNITS/ML CARTRIDGE
96719	HUMALOG 100UNITS/ML KWIKPEN
05679	HUMALOG 100UNITS/ML VIAL
43753	HUMALOG JR 100 UNIT/ML KWIKPEN
50461	HUMALOG MIX 50-50 KWIKPEN
97507	HUMALOG MIX 50-50 VIAL
93717	HUMALOG MIX 75-25 KWIKPEN
22681	HUMALOG MIX 75-25 VIAL
54975	HUMALOG TEMPO PEN 100 UNIT/ML
50001	HUMULIN 70-30 VIAL
11660	HUMULIN N 100UNITS/ML VIAL
11642	HUMULIN R 100UNITS/ML VIAL
09633	HUMULIN R 500UNITS/ML VIAL
92326	INSULIN ASPART 100UNITS/ML VL
92886	INSULIN ASPART 100UNITS/ML CRT
92336	INSULIN ASPART 100UNITS/ML PEN
19057	INSULIN ASPART PRO MIX 70-30 VL
17075	INSULIN ASPART PRO MIX 70-30 P
05679	INSULIN LISPRO 100UNITS/ML VL
43753	INSULIN LISPRO JR 100 UNITS/ML
96719	INSULIN LISPRO 100UNITS/ML PEN
13072	LANTUS 100UNITS/ML VIAL
98637	LANTUS SOLOSTAR 100UNITS/ML
25305	LEVEMIR 100 UNITS/ML VIAL
22836	LEVEMIR FLEXTOUCH 100UNITS/ML
11660	NOVOLIN N 100 UNIT/ML VIAL
11642	NOVOLIN R 100 UNIT/ML VIAL
92886	NOVOLOG 100UNITS/ML CARTRIDGE
92336	NOVOLOG 100UNITS/ML FLEXPEN
92326	NOVOLOG 100UNITS/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

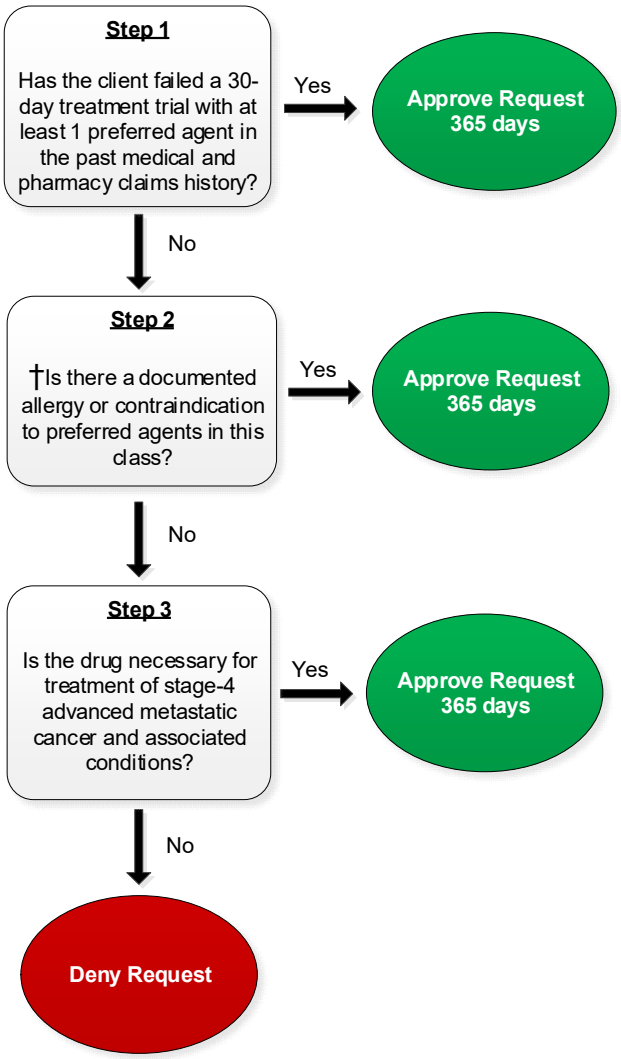
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

Preferred Meglitinides

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

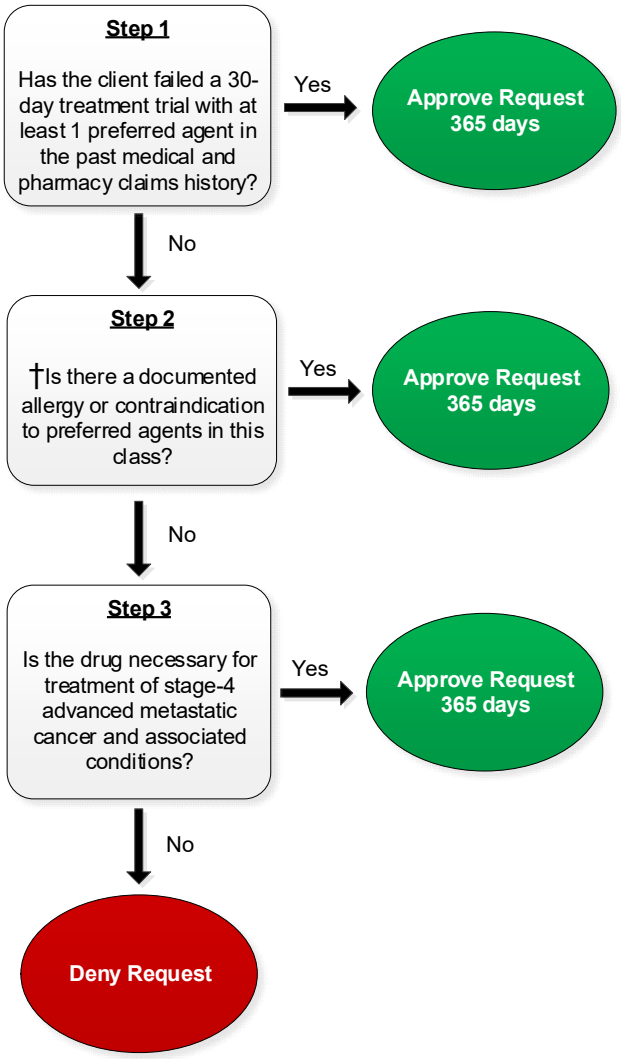
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

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

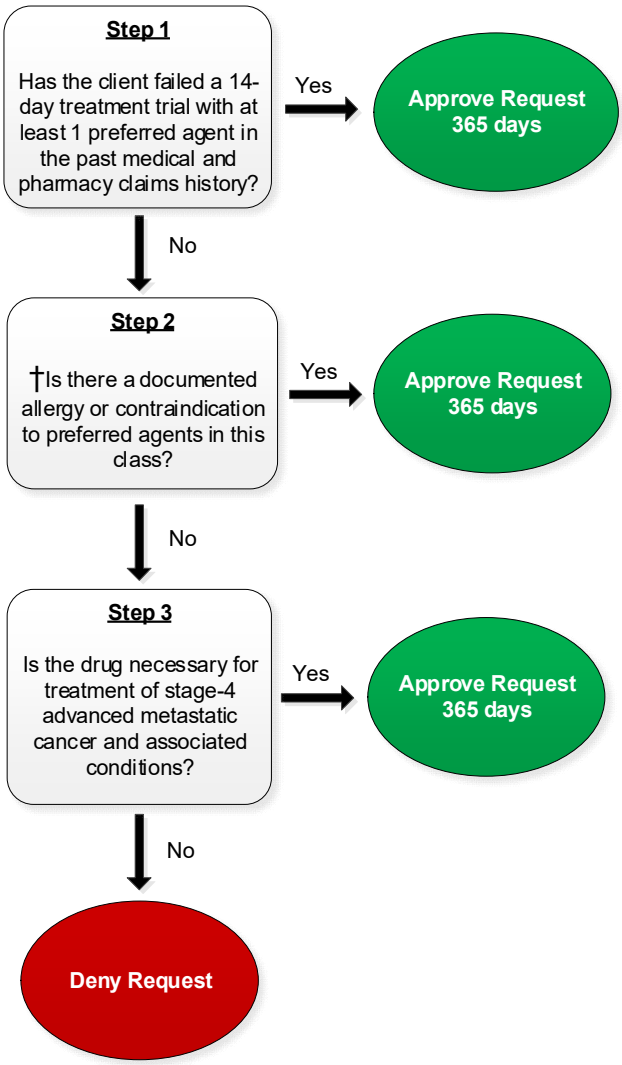
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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 10MG TABLET
35698	FARXIGA 5MG TABLET
36954	INVOKAMET 50-500 MG TABLET
36857	INVOKAMET 50-1,000 MG TABLET
36953	INVOKAMET 150-500 MG TABLET
36859	INVOKAMET 150-1,000 MG TABLET
42315	INVOKAMET XR 150-1,000 MG TABLET
42314	INVOKAMET XR 150-500 MG TABLET
42313	INVOKAMET XR 50-1,000 MG TABLET
42312	INVOKAMET XR 50-500 MG TABLET
34439	INVOKANA 100MG TABLET
34441	INVOKANA 300 MG TABLET
36716	JARDIANCE 10MG TABLET
36723	JARDIANCE 25MG TABLET
38932	SYNJARDY 12.5-1,000MG TABLET
39378	SYNJARDY 12.5-500MG TABLET
38929	SYNJARDY 5-1,000MG TABLET
37344	XIGDUO XR 10MG-1000MG TABLET
37342	XIGDUO XR 10MG-500MG TABLET
37343	XIGDUO XR 5MG-1000MG TABLET
37339	XIGDUO XR 5MG-500MG 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

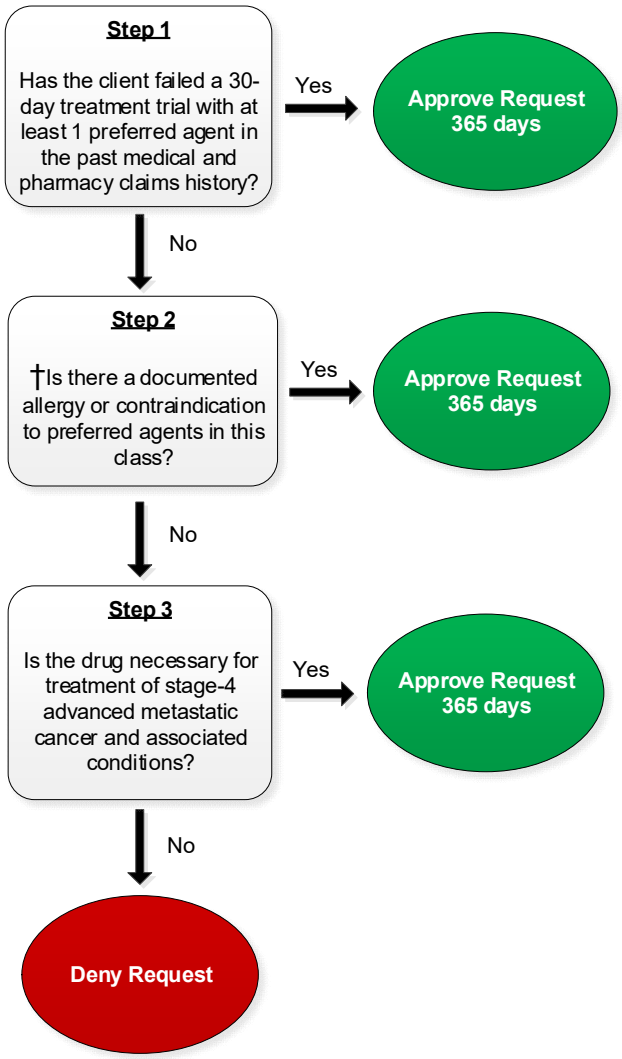
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 15MG TABLET
93001	PIOGLITAZONE HCL 30MG TABLET
93011	PIOGLITAZONE HCL 45MG 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

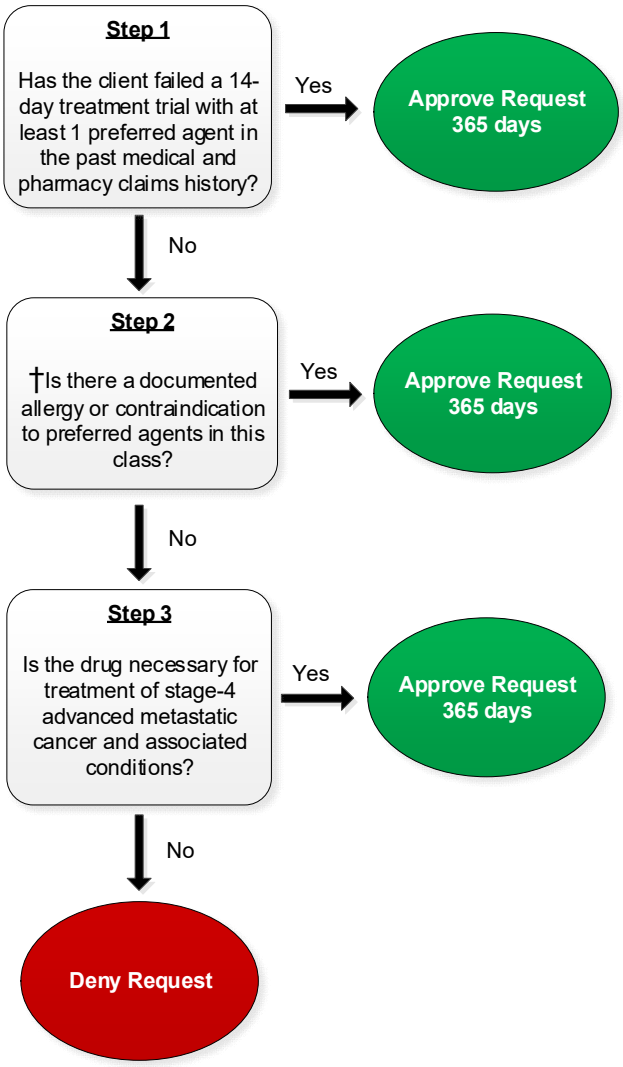
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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.

RxPERT®

Immune Globulins Alternate Therapies

Preferred Immune Globulins

GCN	Drug Name
38016	GAMMAGARD LIQUID 10% VIAL
29308	GAMMAKED 10GRAM/100ML VIAL
29305	GAMMAKED 1GRAM/10ML VIAL
29309	GAMMAKED 20GRAM/200ML VIAL
29307	GAMMAKED 5GRAM/50ML VIAL
29308	GAMUNEX-C 10GRAM/100ML VIAL
29305	GAMUNEX-C 1GRAM/10ML VIAL
29306	GAMUNEX-C 2.5GRAM/25ML VIAL
29309	GAMUNEX-C 20GRAM/200ML VIAL
37322	GAMUNEX-C 40GRAM/400ML VIAL
29307	GAMUNEX-C 5GRAM/50ML VIAL
44679	HIZENTRA 1 GRAM/5 ML SYRINGE
28385	HIZENTRA 1 GRAM/5 ML VIAL
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*

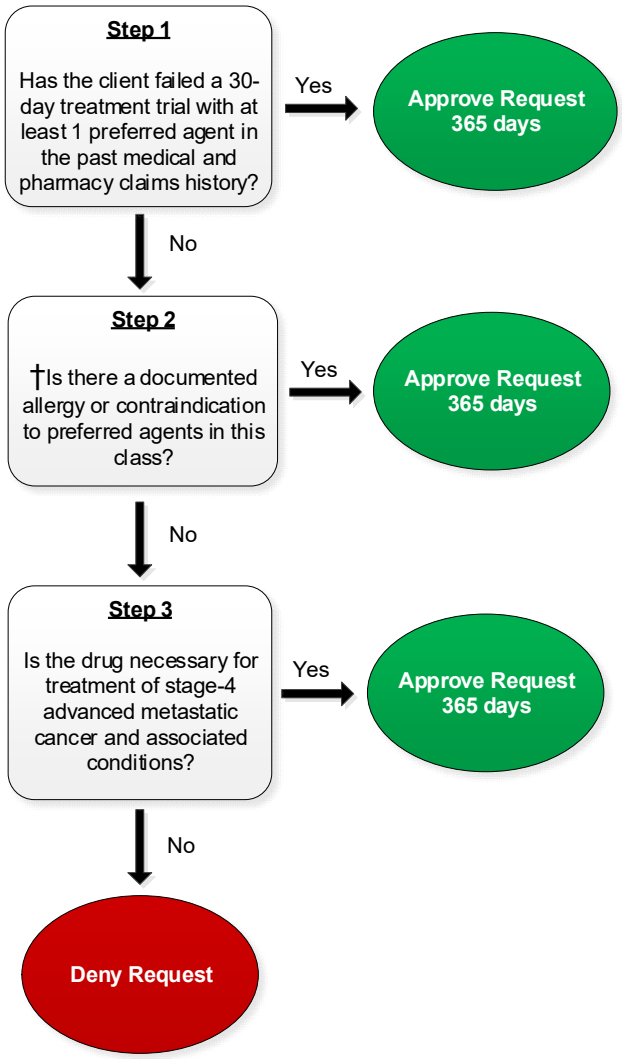
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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 150MG/ML SYRINGE
30555	XOLAIR 75MG/0.5ML 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.*

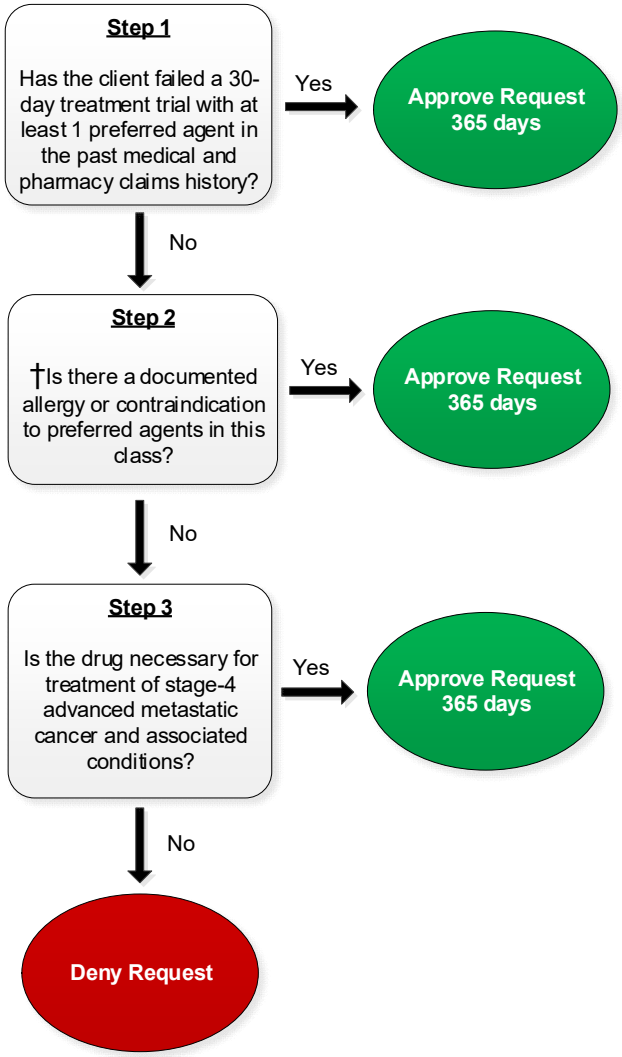
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

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*

Immunomodulators, Dupixent

Immunomodulators, Dupixent

Prior Authorization Criteria

1. Does the client have a diagnosis of atopic dermatitis in the last 365 days?
   [ ] Yes (Go to #2)
   [ ] No (Go to #3)

2. 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

3. Does the client have a diagnosis of asthma in the last 365 days?
   [ ] Yes (Go to #4)
   [ ] No (Go to #5)

4. 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #5)

5. Does the client have a diagnosis of rhinosinusitis with nasal polyposis in the last 365 days?
   [ ] Yes (Go to #6)
   [ ] No (Go to #7)

6. 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #7)

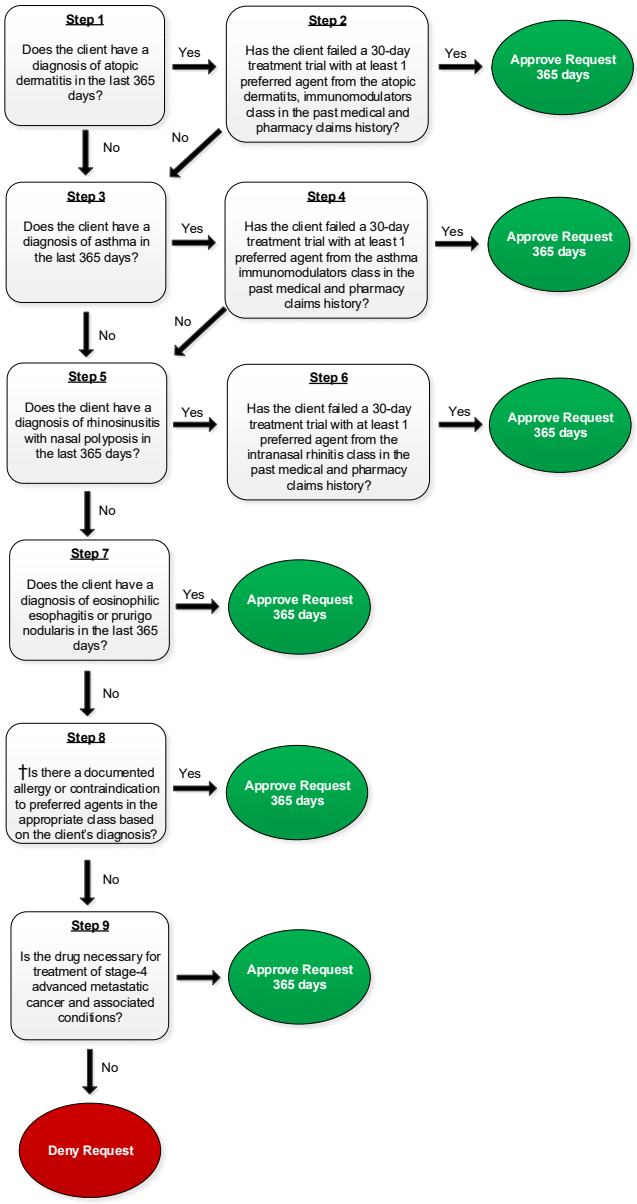
7. Does the client have a diagnosis of eosinophilic esophagitis or prurigo nodularis in the last 365 days?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #8)

8. †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 #9)

9. 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 Alternate Therapies

Preferred Immunomodulators

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

Immunosuppressives, Oral
Prior Authorization Criteria

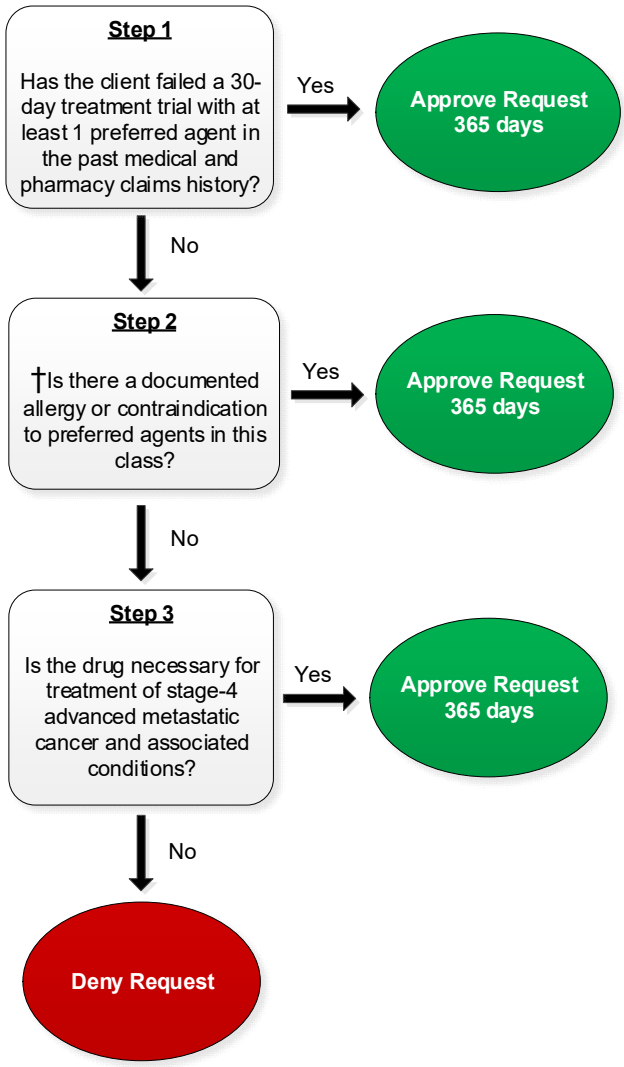
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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
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
Alternate Therapies

Preferred Oral Immunosuppressives

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

**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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

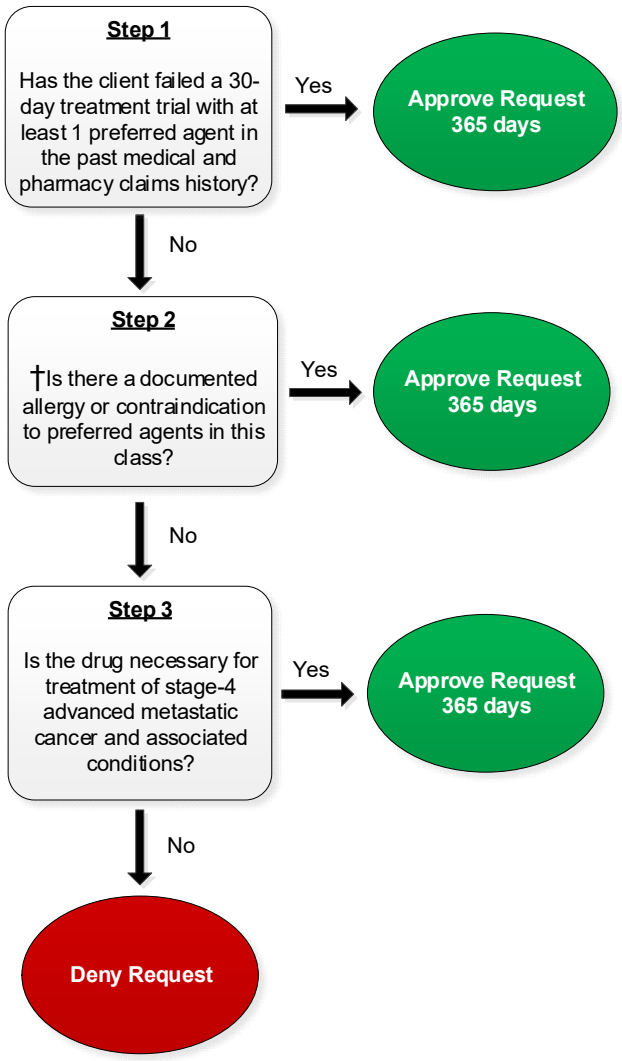
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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
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*

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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

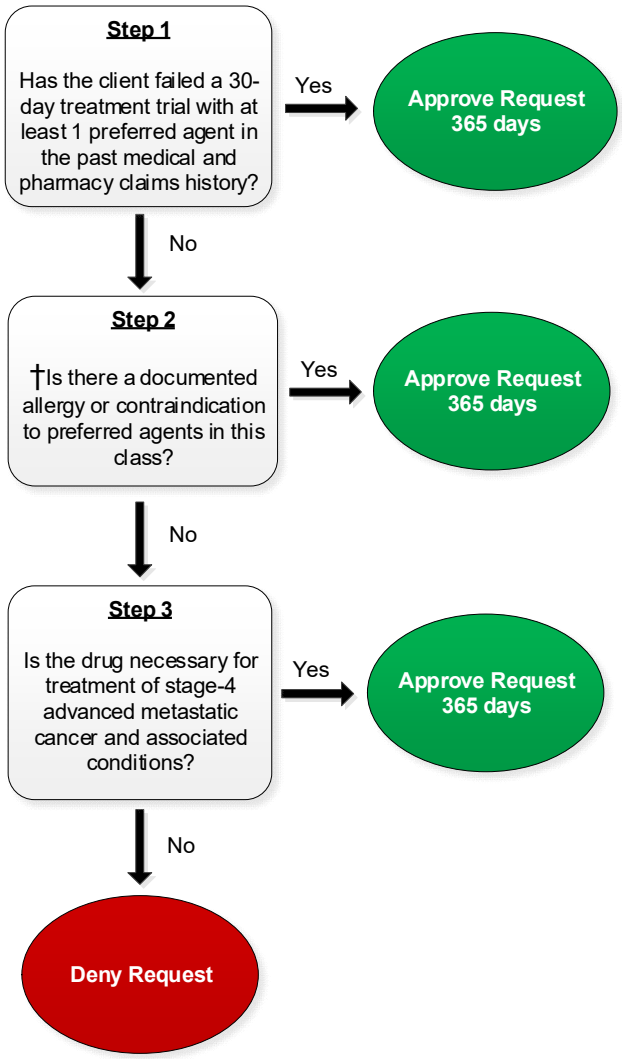
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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	FERROUS SULFATE 15MG/ML DROP
97721	CHILDRENS IRON 15MG/ML DROPS
97721	CHILD FERROUS SULFATE 15MG/ML
04695	FEOSOL 65MG TABLET
10510	FERATE 27MG TABLET
04515	FERROUS FUMARATE 324MG TABLET
97503	FERROUS GLUCONATE 324MG TABLET
04695	FEROSUL 325MG TABLET
04695	FERRO-TIME 325MG TABLET
99233	FERROUS SULF 220MG/5ML ELIX
04663	FERROUS SULF 300MG/5ML LIQAN
99233	FERROUS SULF 44MG IRON/5ML LQ
04701	FERROUS SULF EC 325MG TABLET
98527	FERROUS SULF EC 324MG TABLET
04695	FERROUS SULFATE 325MG TABLET
04695	FERROUSUL 325MG TABLET
13277	HEMOCYTE PLUS CAPSULE
60141	HEMOCYTE-F TABLET
29644	HM SLOW RELEASE IRON TABLET
10352	IFEREX 150 FORTE CAPSULE
04580	IFEREX 150 CAPSULE
22164	INTEGRA CAPSULE
22177	INTEGRA F CAPSULE
22148	INTEGRA PLUS CAPSULE
04695	IRON 65MG TABLET
95145	IRON 100-VITAMIN C TABLET
04580	POLYSACCHARIDE IRON 150MG CAP
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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

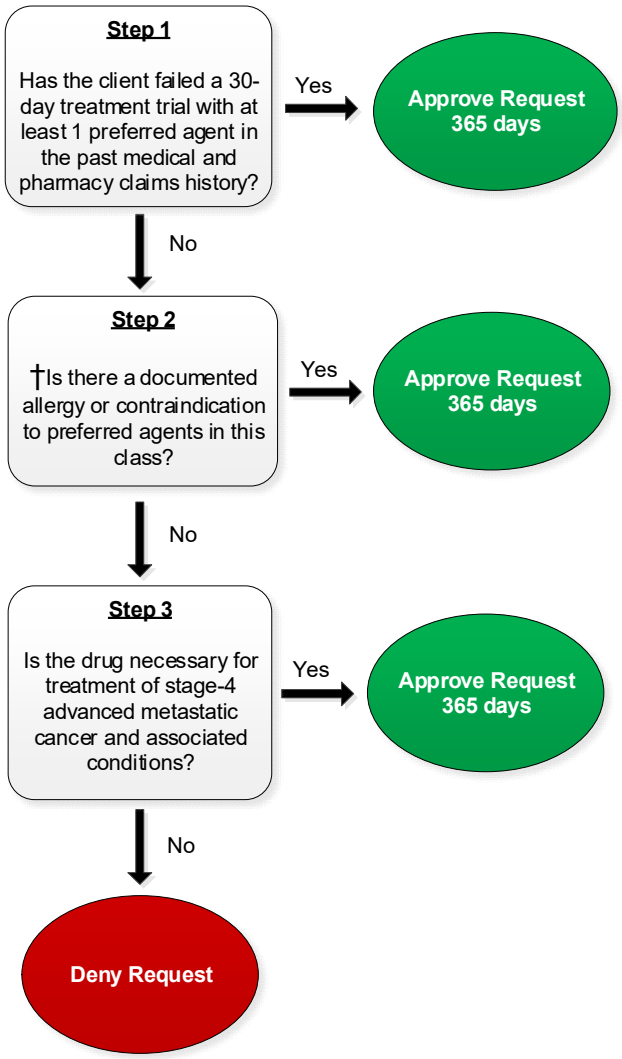
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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
94444	MONTELUKAST SODIUM 10MG TABLET
42373	MONTELUKAST SODIUM 4MG TABLET CHEW
94440	MONTELUKAST SODIUM 5MG TABLET CHEW

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

Lincosamides/Oxazolidinones/Streptogramins

Lincosamides/Oxazolidinones/ Streptogramins Prior Authorization Criteria

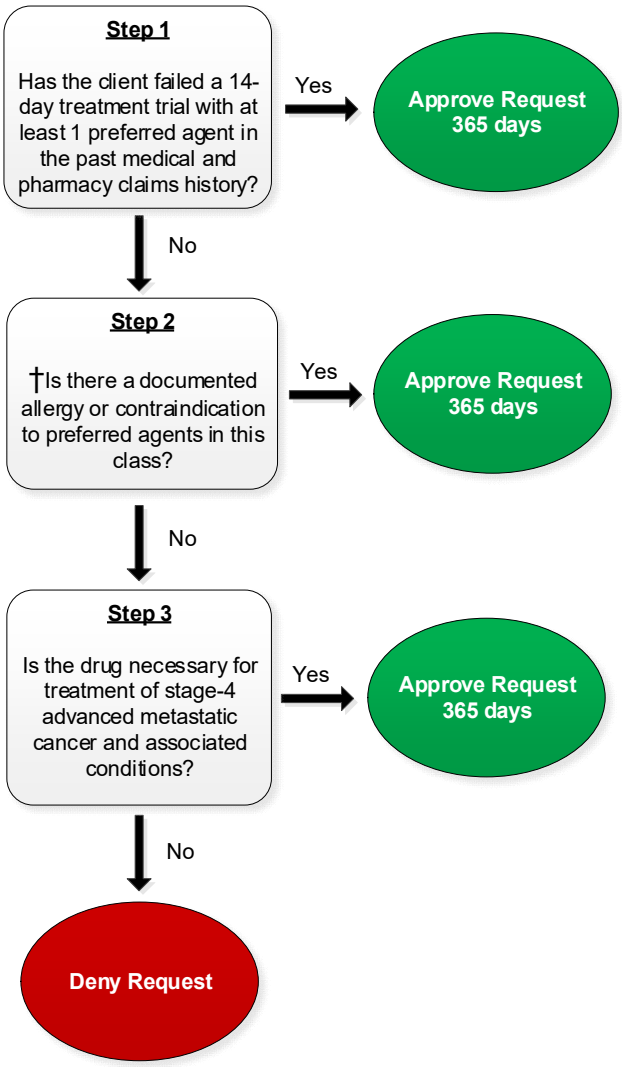
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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 75MG/5ML SOLUTION
40830	CLINDAMYCIN HCL 150MG CAPSULE
40832	CLINDAMYCIN HCL 300MG CAPSULE
26870	LINEZOLID 600MG TABLET
26873	LINEZOLID 600MG/300ML-D5W
26871	ZYVOX 100MG/5ML SUSPENSION

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

Lipotropics, Other

Lipotropics, Other (Except PCSK9 Inhibitors) Prior Authorization Criteria

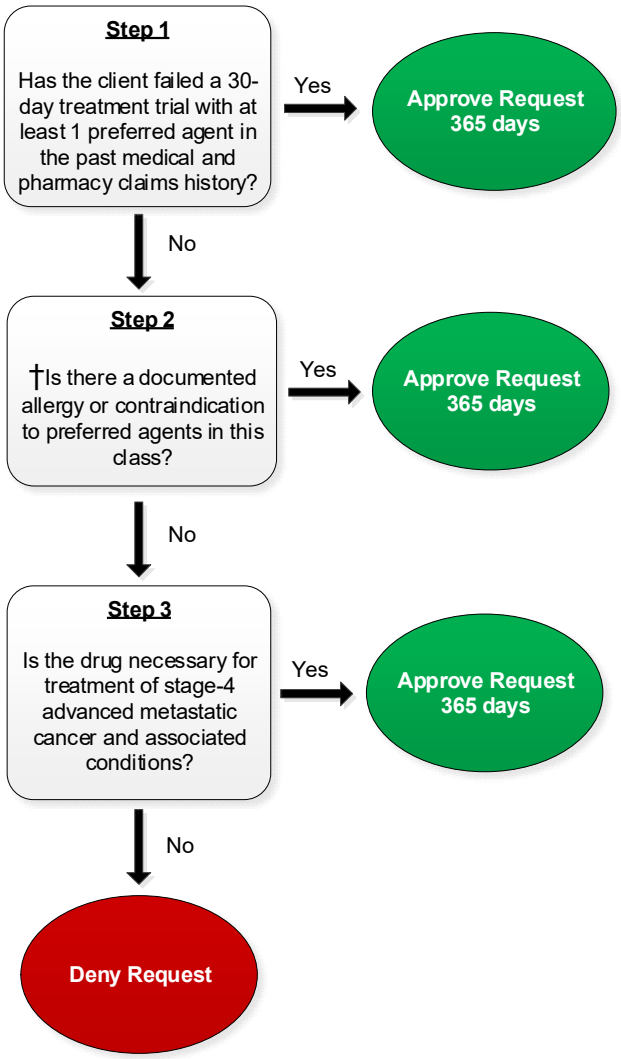
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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 (Except PCSK9 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.

Lipotropics, Other (PCSK9 Inhibitors) Prior Authorization Criteria

1. Has the client failed a 30-day treatment trial with atorvastatin, rosuvastatin and ezetimibe in the past medical and pharmacy claims history?
   [ ] Yes (Go to #2)
   [ ] No (Go to #3)

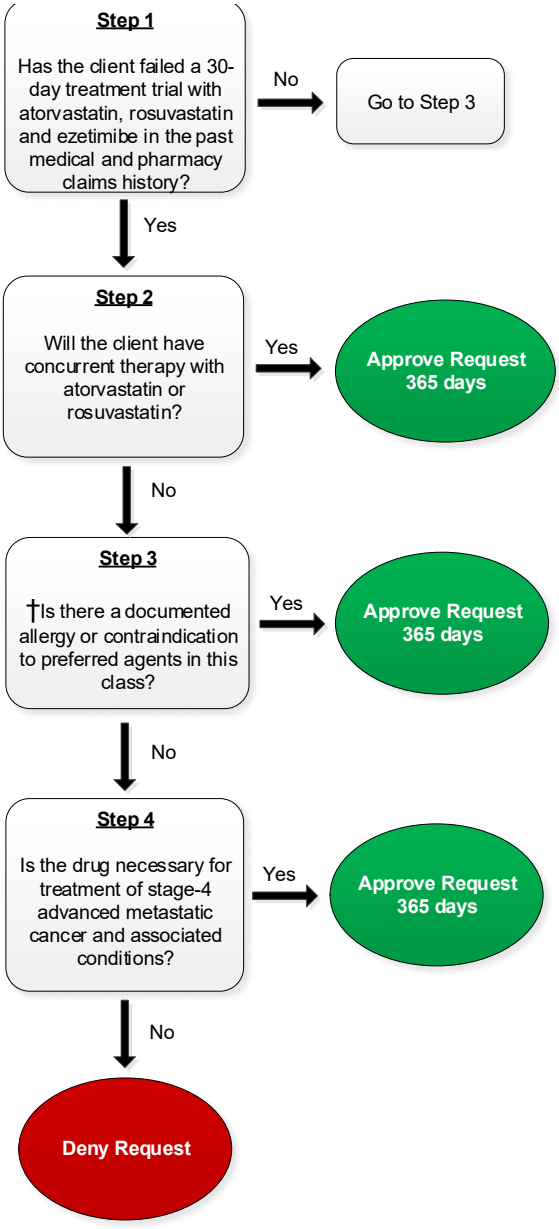
2. Will the client have concurrent therapy with atorvastatin or rosuvastatin?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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.

Lipotropics, Other (PCSK9 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.

RxPERT®

Lipotropics, Other

Alternate Therapies

Preferred Other Lipotropics

GCN	Drug Name
09850	CHOLESTYRAMINE LIGHT PACKET
98654	CHOLESTYRAMINE LIGHT POWDER
09920	CHOLESTYRAMINE PACKET
14295	CHOLESTYRAMINE POWDER
25442	COLESTID 1GM TABLET
92504	FENOFIBRATE 134MG CAPSULE
97003	FENOFIBRATE 145MG TABLET
12595	FENOFIBRATE 160MG TABLET
93437	FENOFIBRATE 200MG CAPSULE
97002	FENOFIBRATE 48MG TABLET
13266	FENOFIBRATE 54MG TABLET
93446	FENOFIBRATE 67MG CAPSULE
25540	GEMFIBROZIL 600MG TABLET
94890	HM NIACIN TR 250MG TABLET
94884	NIACIN 100MG TABLET
94881	NIACIN 500MG TABLET
94874	NIACIN SA 250MG CAPSULE
94891	NIACIN TR 500MG TABLET
23929	OMEGA-3 ETHYL ESTERS 1GM 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/3.5 ML PUSHTRONX
33238	VASCEPA 1 GM CAPSULE
28064	WELCHOL 3.75G PACKET
16300	WELCHOL 625MG TABLET
18387	ZETIA 10MG 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

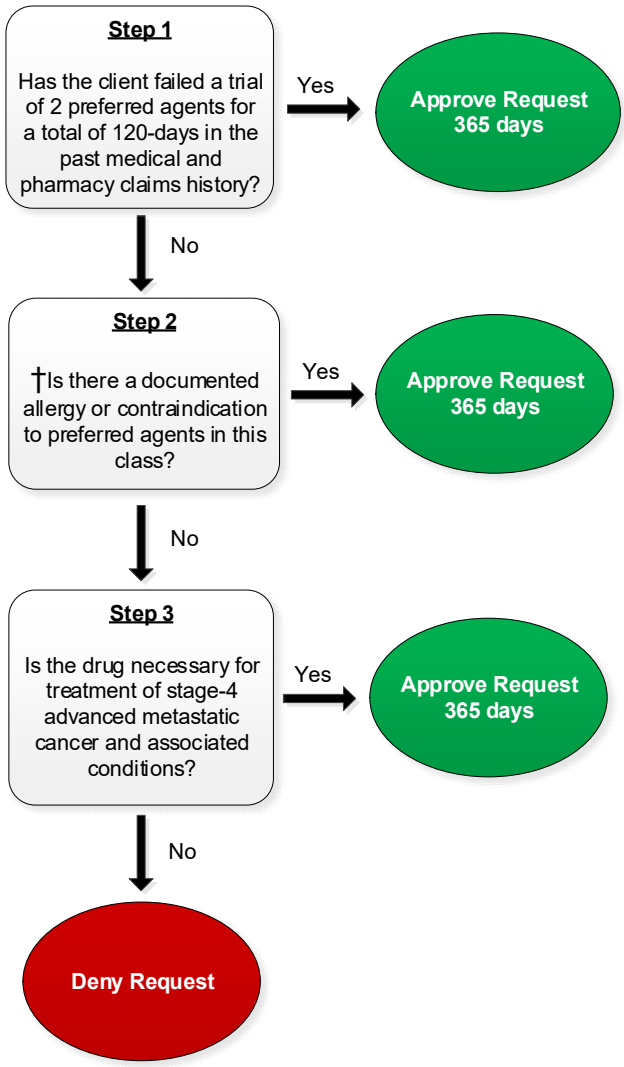
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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

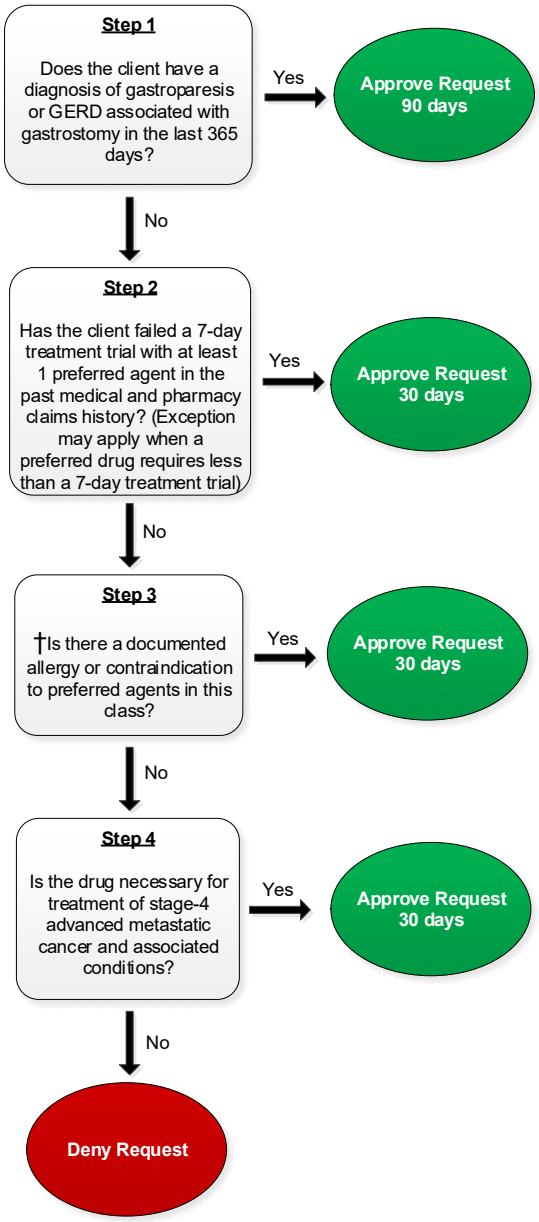
3. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 30 days)
   [ ] No (Go to #4)

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

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

Macrolides/Ketolides

Supporting Table

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

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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

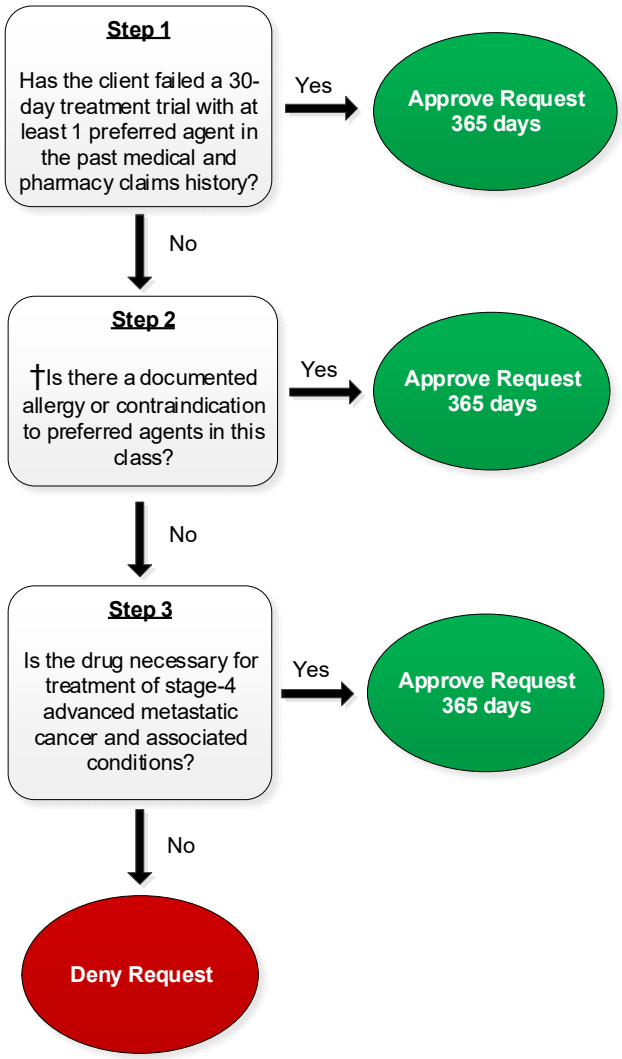
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 12MG TABLET
43228	AUSTEDO 6MG TABLET
43236	AUSTEDO 9MG TABLET
53737	AUSTEDO XR 12MG TABLET
53738	AUSTEDO XR 24 MG TABLET
53736	AUSTEDO XR 6MG TABLET
53741	AUSTEDO XR TITRATION KT (WK1-4)
43266	INGREZZA 40MG CAPSULE
49577	INGREZZA 60 MG CAPSULE
43934	INGREZZA 80MG CAPSULE
46216	INGREZZA INITIATION PACK
15508	XENAZINE 12.5 MG TABLET
49900	XENAZINE 25 MG TABLET

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

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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

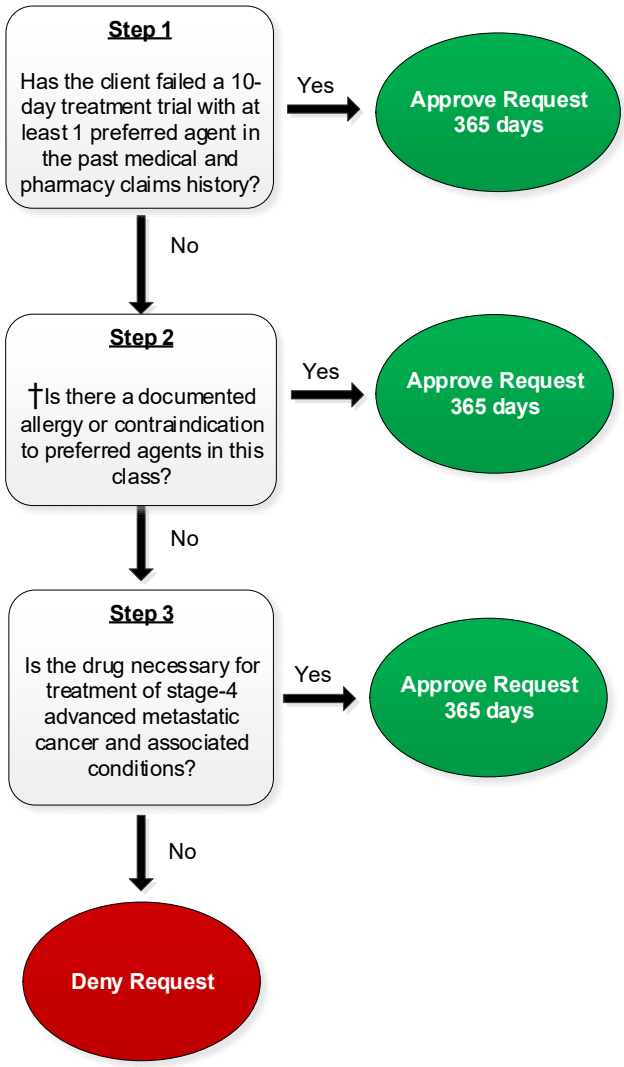
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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
33560	CAPSAICIN 0.025% CREAM
23161	DULOXETINE HCL DR 20MG CAPSULE
23162	DULOXETINE HCL DR 30MG CAPSULE
23164	DULOXETINE HCL DR 60MG CAPSULE
00780	GABAPENTIN 100MG CAPSULE
13235	GABAPENTIN 250MG/5ML SOLN
00781	GABAPENTIN 300MG CAPSULE
00782	GABAPENTIN 400MG CAPSULE
94624	GABAPENTIN 600MG TABLET
94447	GABAPENTIN 800MG TABLET
50272	LIDODERM 5% PATCH
23048	LYRICA 100MG CAPSULE
23049	LYRICA 150MG CAPSULE
23051	LYRICA 200MG CAPSULE
25019	LYRICA 225MG CAPSULE
23039	LYRICA 25MG CAPSULE
23052	LYRICA 300MG CAPSULE
23046	LYRICA 50MG CAPSULE
23047	LYRICA 75MG CAPSULE

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

NSAIDS

NSAIDS
Prior Authorization Criteria

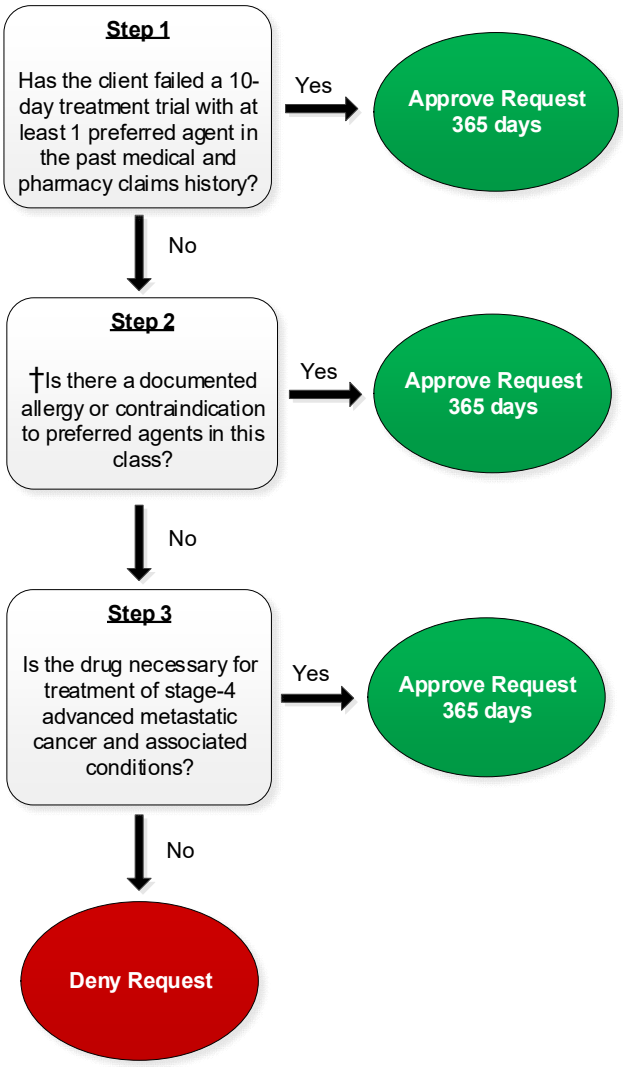
1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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
47132	ALL DAY RELIEF 220 MG CAPLET
42001	CELECOXIB 100 MG CAPSULE
42002	CELECOXIB 200 MG CAPSULE
18127	CELECOXIB 400 MG CAPSULE
97785	CELECOXIB 50 MG CAPSULE
35930	CHILDREN'S IBUPROFEN 100MG/5ML
13960	DICLOFENAC POT 50MG TABLET
45680	DICLOFENAC SODIUM 1% GEL
86831	DICLOFENAC SODIUM 3% GEL
35850	DICLOFENAC SOD EC 25 MG TAB
35851	DICLOFENAC SOD EC 50 MG TAB
35852	DICLOFENAC SOD EC 75 MG TAB
35743	GS IBUPROFEN 200MG TABLET
35743	IBU-200 200MG TABLET
35741	IBU 400MG TABLET
35742	IBU 600MG TABLET
35744	IBU 800MG TABLET
35930	IBUPROFEN 100MG/5ML SUSP
35431	IBUPROFEN 200MG SOFTGEL
35743	IBUPROFEN 200MG TABLET
35741	IBUPROFEN 400MG TABLET
35742	IBUPROFEN 600MG TABLET
35744	IBUPROFEN 800MG TABLET
35749	IBUPROFEN JR STR 100MG CHEW
35680	INDOMETHACIN 25MG CAPSULE
35681	INDOMETHACIN 50MG CAPSULE
35931	INFANT IBUPROFEN 50MG/1.25ML
32531	KETOROLAC 10 MG TABLET
13967	LOFENA 25 MG TABLET
31662	MELOXICAM 15MG TABLET
31661	MELOXICAM 7.5MG TABLET
35790	NAPROXEN 250MG TABLET

GCN	Drug Name
35792	NAPROXEN 375MG TABLET
35793	NAPROXEN 500MG 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

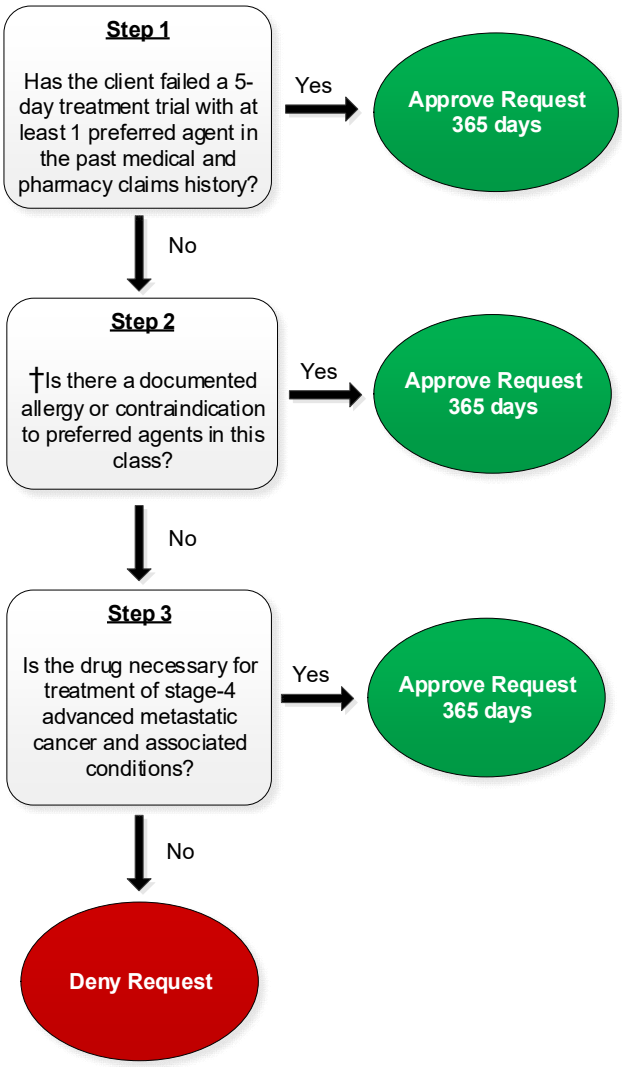
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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
14286	NEO/POLYMYX B SULF/DEXAMETH EYE DROPS
14285	NEO/POLYMYX B SULF/DEXAMETH EYE OINTMENT
86903	SULFACETAMIDE/PREDNISOLONE 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

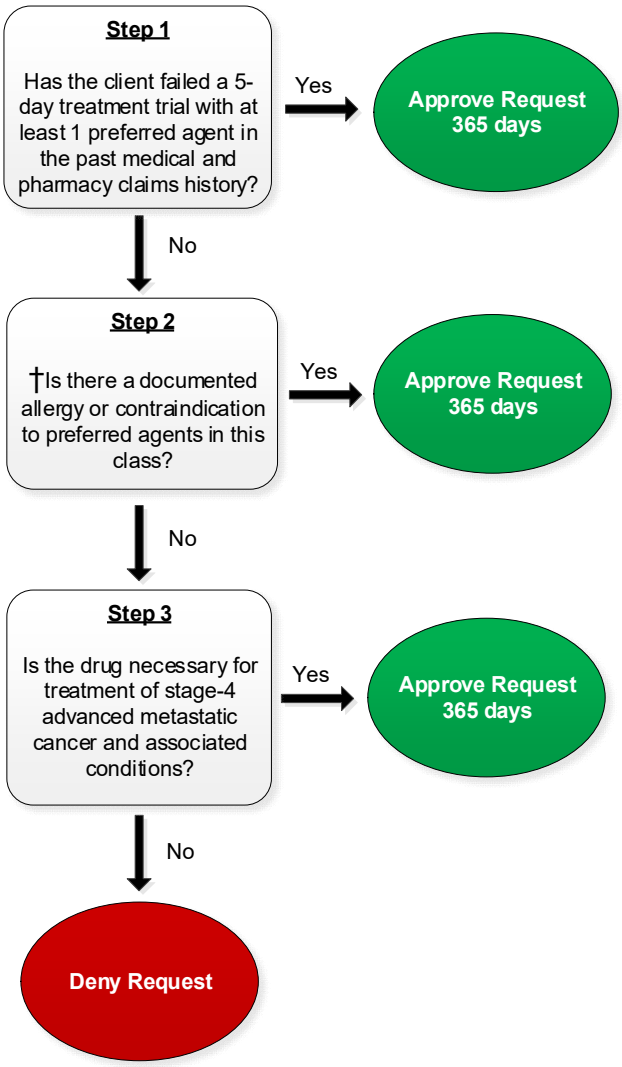
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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	BACITRACIN/POLYMYXIN EYE OINTMENT
33580	CIPROFLOXACIN 0.3% EYE DROPS
33540	ERYTHROMYCIN 0.5% EYE OINTMENT
33590	GENTAK 0.3% EYE OINTMENT
33600	GENTAMICIN 0.3% EYE DROPS
19542	MOXIFLOXACIN 0.5% EYE DROPS
36600	OFLOXACIN 0.3% EYE DROPS
25486	POLYCIN EYE OINTMENT
14294	POLYMYXIN B SULF/TRIMETHOPRIM EYE DROPS
09384	TOBRAMYCIN 0.3% EYE DROPS
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

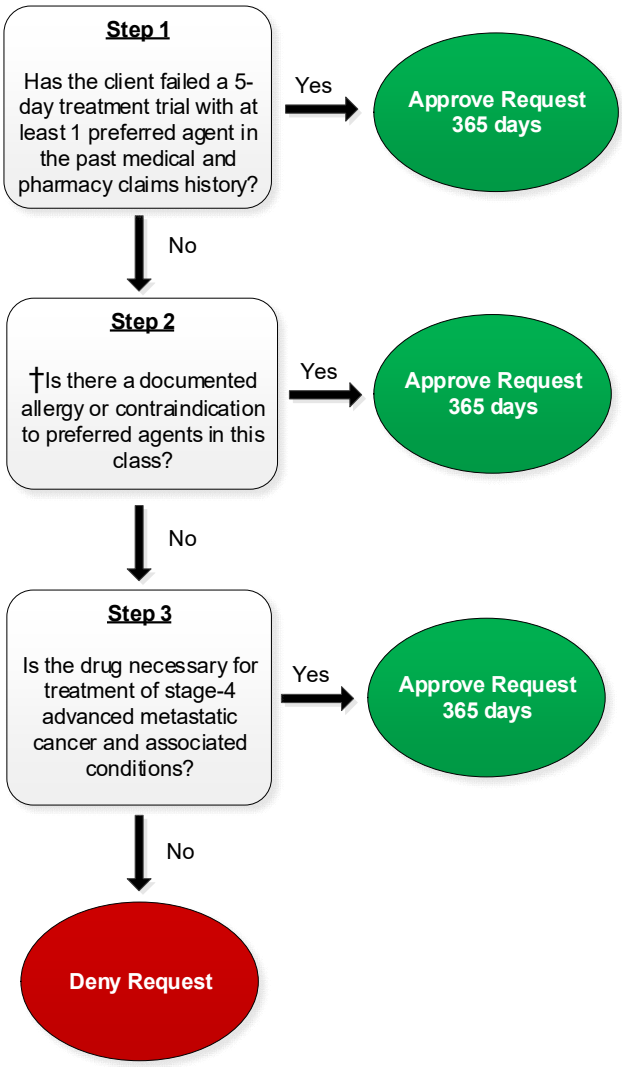
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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	OLOPATADINE OTC 0.1% EYE DROPS
97848	OLOPATADINE OTC 0.2% EYE DROPS
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

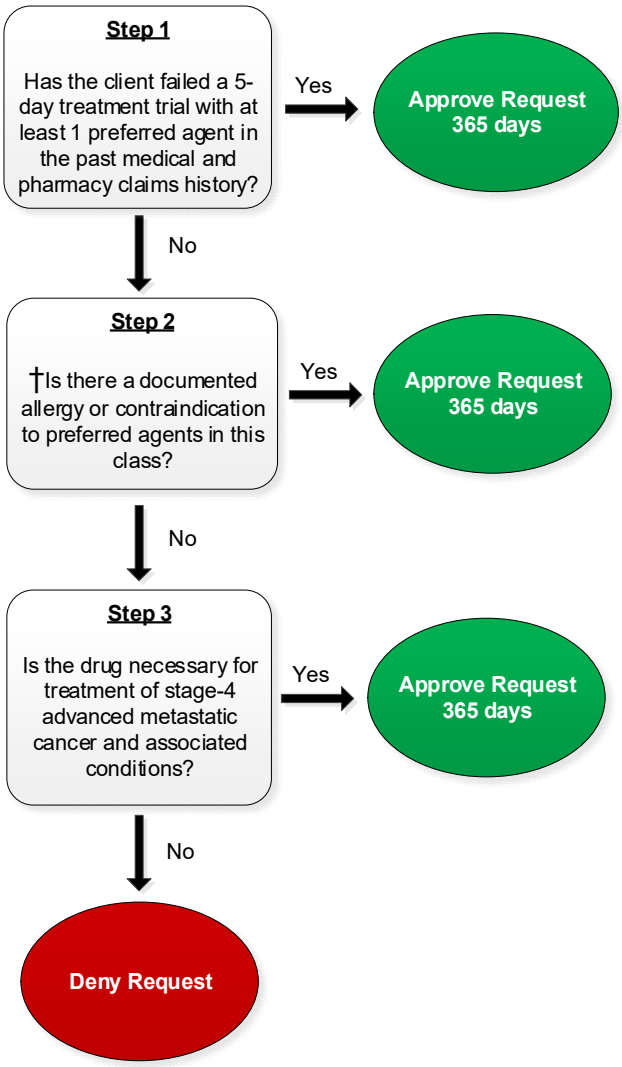
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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% OPHTH SOLUTION
95464	LOTEMAX 0.5% EYE DROPS 5 ML (NDC 24208029905 only)
95464	LOTEMAX 0.5% EYE DROPS 10 ML (NDC 24208029910 only)
95464	LOTEMAX 0.5% EYE DROPS 15 ML (NDC 24208029915 only)
30304	LOTEMAX 0.5% EYE OINTMENT
33153	PREDNISOLONE AC 1% EYE DROPS

**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

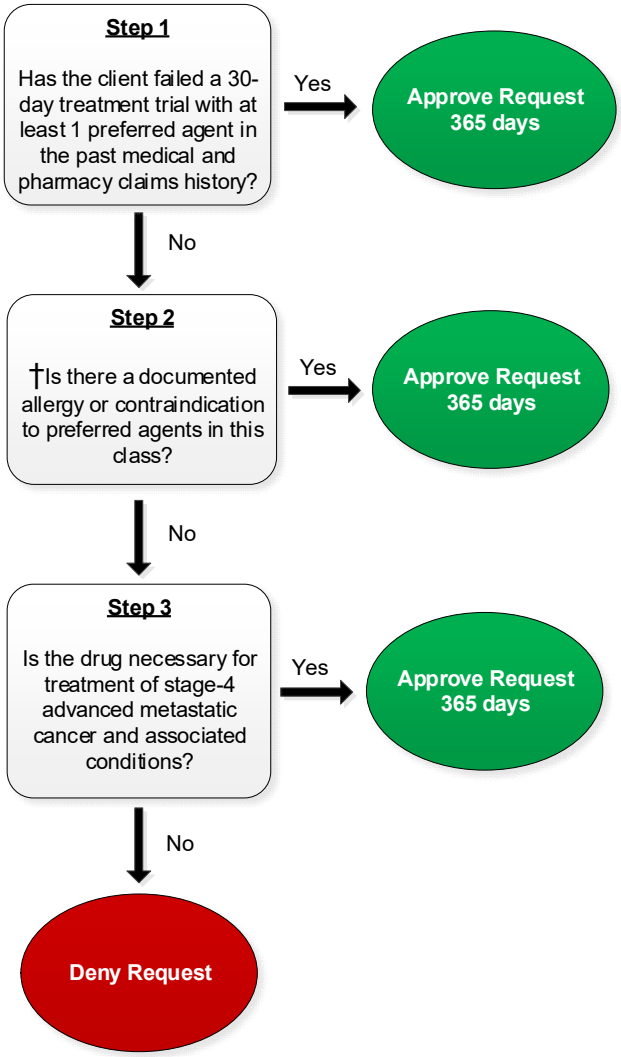
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

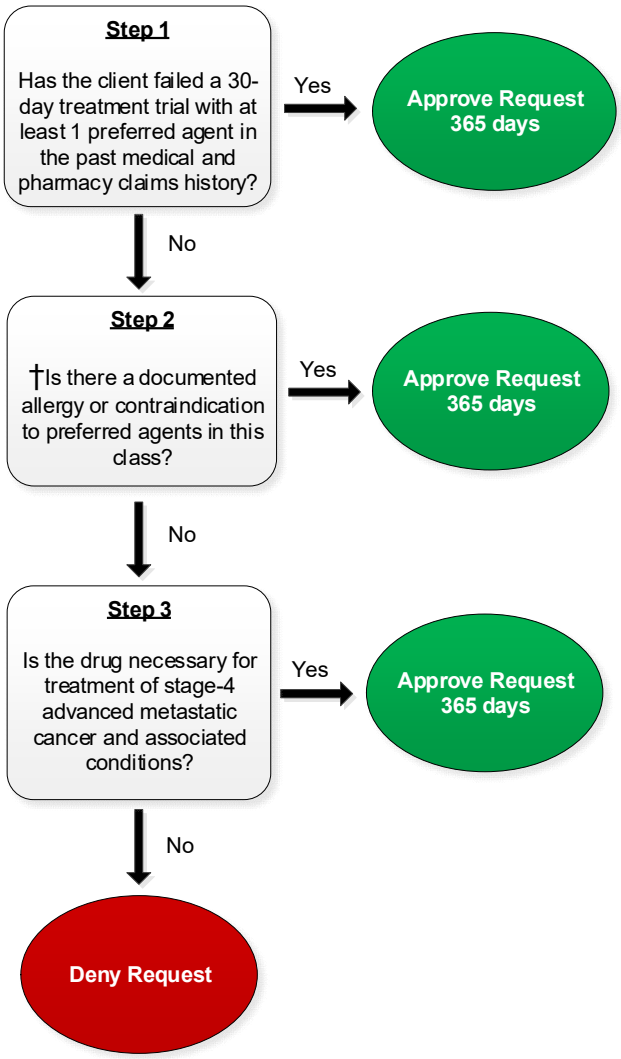
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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% DROPS
32261	CARTEOLOL HCL 1% EYE DROPS
20876	COMBIGAN 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% OPHTH SOLUTION
46097	ROCKLATAN 0.02%-0.005% EYE DRP
34579	SIMBRINZA 1-0.2% EYE DROPS
32820	TIMOLOL 0.25% EYE DROPS
32822	TIMOLOL 0.25% GEL SOLUTION
32821	TIMOLOL 0.5% EYE DROPS
32823	TIMOLOL 0.5% GEL SOLUTION
13002	TRAVATAN Z 0.004% EYE DROPS

**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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

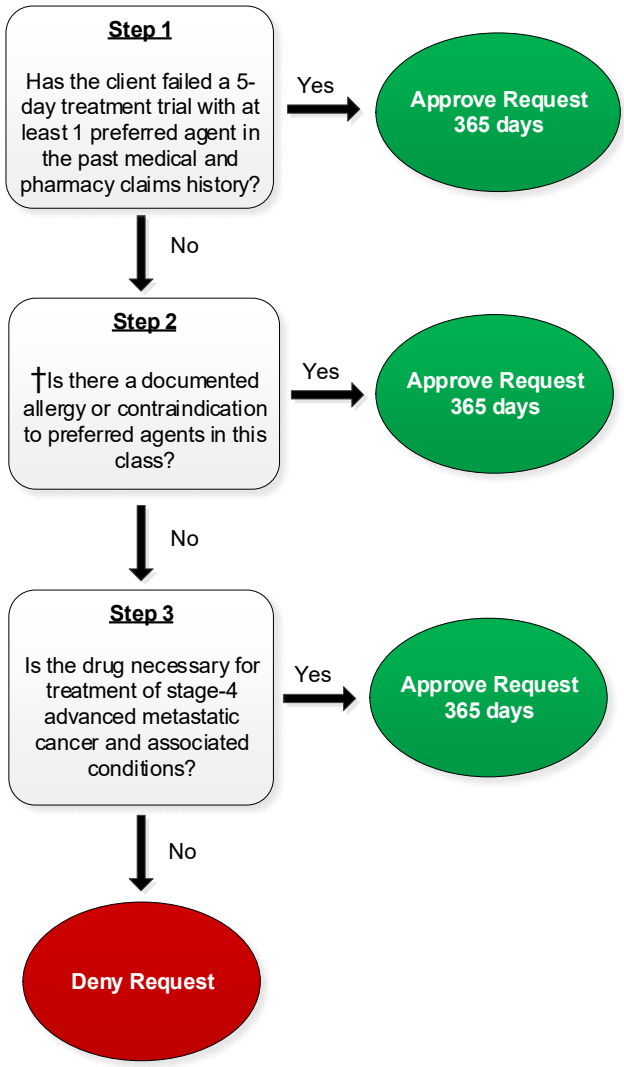
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 B SULF/HC EAR SOLUTION
14025	NEOMYCIN/POLYMYXIN B SULF/HC EAR SUSPENSION
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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

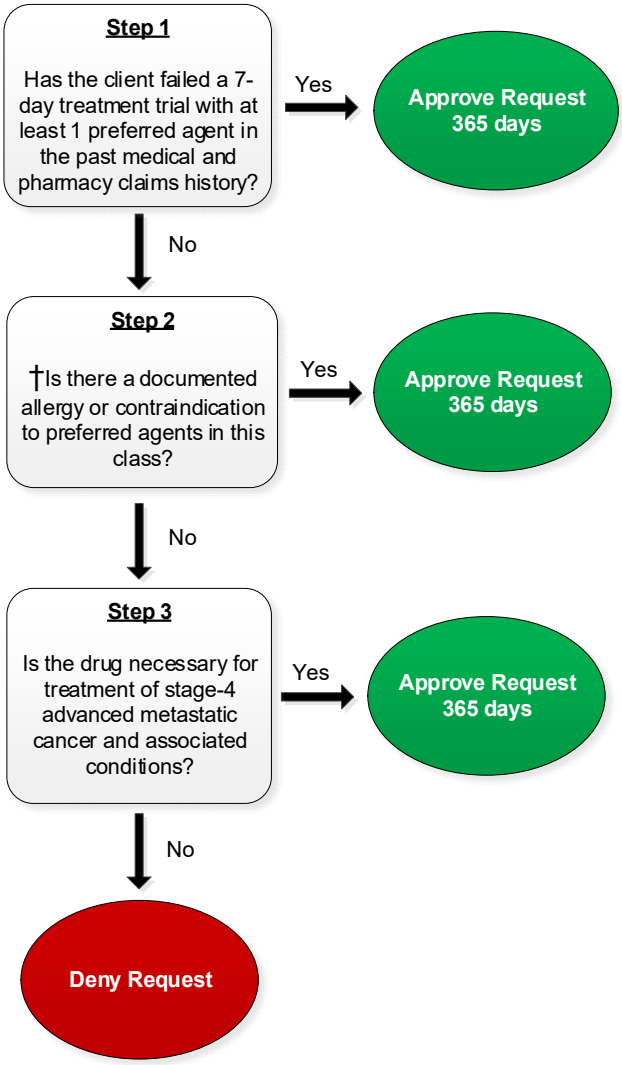
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

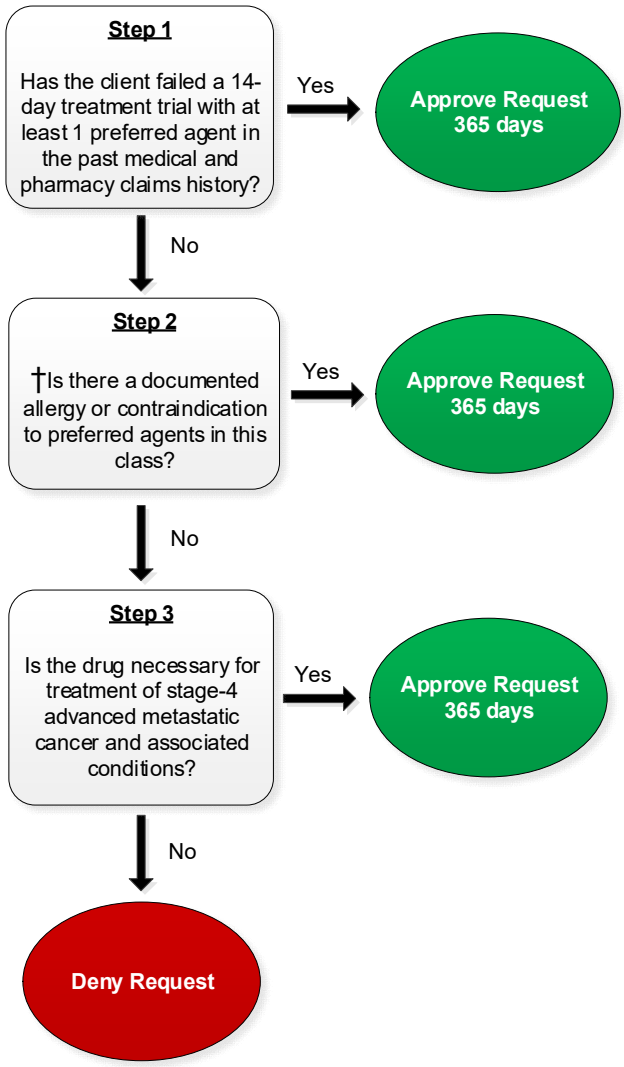
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 20MG TABLET
98567	LETAIRIS 10MG TABLET
98566	LETAIRIS 5MG TABLET
33186	REVATIO 10MG/ML ORAL SUSP
24758	REVATIO 20MG TABLET
14978	TRACLEER 125MG TABLET
14979	TRACLEER 62.5MG 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

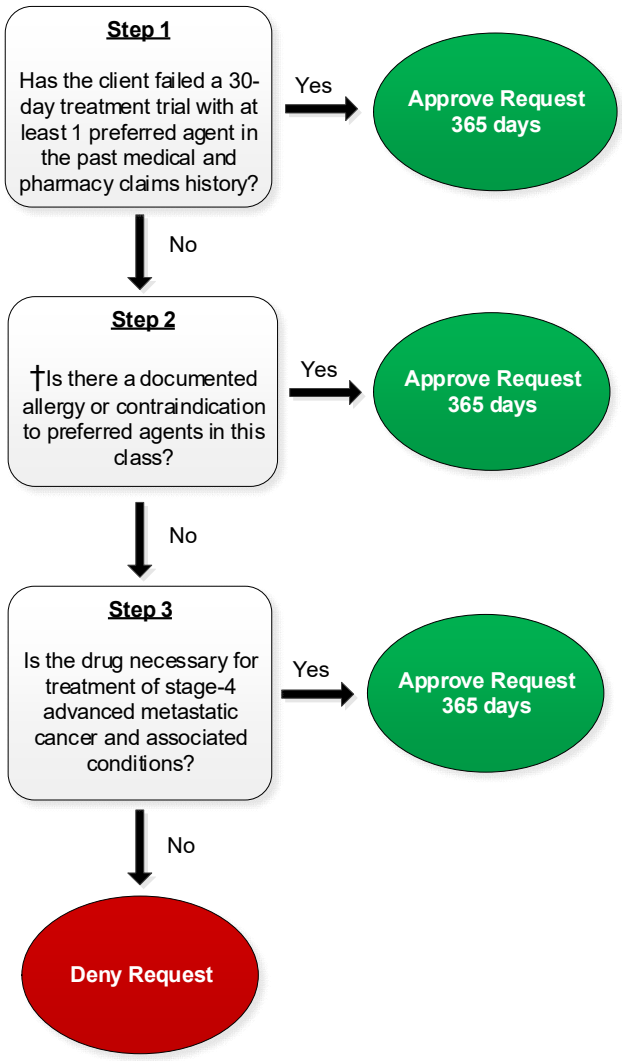
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 UNITS CAPSULE
26178	CREON DR 24,000 UNITS CAPSULE
30217	CREON DR 3,000 UNITS CAPSULE
34557	CREON DR 36,000 UNITS CAPSULE
26176	CREON DR 6,000 UNITS CAPSULE
42319	PANCREAZE DR 10,500 UNIT CAP
42317	PANCREAZE DR 16,800 UNIT CAP
49506	PANCREAZE DR 2,600 UNIT CAP
42318	PANCREAZE DR 21,000 UNIT CAP
42324	PANCREAZE DR 4,200 UNIT CAP
44601	ZENPEP DR 10,000 UNIT CAPSULE
44697	ZENPEP DR 15,000 UNITS CAPSULE
44131	ZENPEP DR 20,000 UNIT CAPSULE
44449	ZENPEP DR 25,000 UNIT CAPSULE
44742	ZENPEP DR 3,000 UNITS CAPSULE
44136	ZENPEP DR 40,000 UNIT CAPSULE
44448	ZENPEP DR 5,000 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

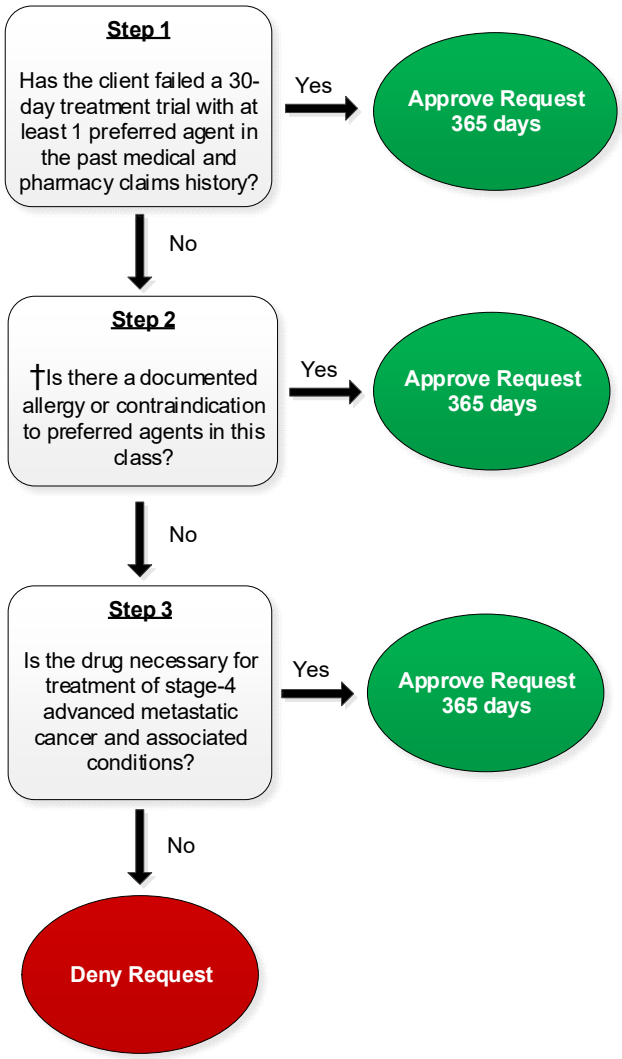
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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
97775	AQUADEKS PEDIATRIC LIQUID
27947	MULTIVIT-FLUORIDE 1 MG TAB CHW
48289	POLY-VI-SOL 250 MCG-50 MG/ML DRP
48106	POLY-VI-SOL WITH IRON DROPS
28188	MULTIVIT-FLUORIDE 1 MG TAB CHEW
36434	MULTIVIT-FLUOR 0.5 MG/ML DROP
27946	MULTIVIT-FLUOR 0.5 MG TAB CHEW
28187	MULTIVIT-FLUOR 0.5 MG TAB CHEW
36433	MULTIVIT-FLUOR 0.25 MG/ML DROP
36455	MULTIVIT-FLUOR-IRON 0.25 MG/ML
27945	MULTIVIT-FLUOR 0.25 MG TAB CHW
28186	MULTIVIT-FLUOR 0.25 MG TAB CHEW

**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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

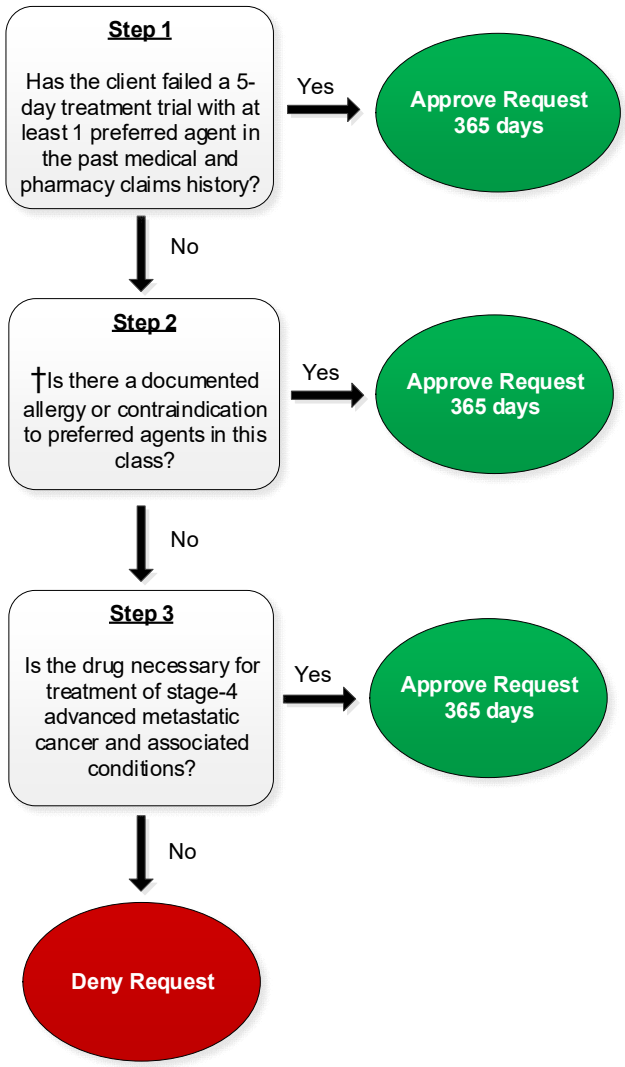
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 125MG TABLET CHEW
39681	AMOXICILLIN 125MG/5ML SUSPENSION
93385	AMOXICILLIN 200MG/5ML SUSPENSION
39660	AMOXICILLIN 250MG CAPSULE
39651	AMOXICILLIN 250MG TABLET CHEW
39683	AMOXICILLIN 250MG/5ML SUSPENSION
93375	AMOXICILLIN 400MG/5ML SUSPENSION
39661	AMOXICILLIN 500MG CAPSULE
61252	AMOXICILLIN 500MG TABLET
39632	AMOXICILLIN 875MG TABLET
39272	AMPICILLIN 500MG CAPSULE
39541	DICLOXACILLIN 250MG CAPSULE
39542	DICLOXACILLIN 500MG CAPSULE
39022	PENICILLIN VK 125MG/5ML SOLUTION
39053	PENICILLIN VK 250MG TABLET
39024	PENICILLIN VK 250MG/5ML SOLUTION
39055	PENICILLIN VK 500MG 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

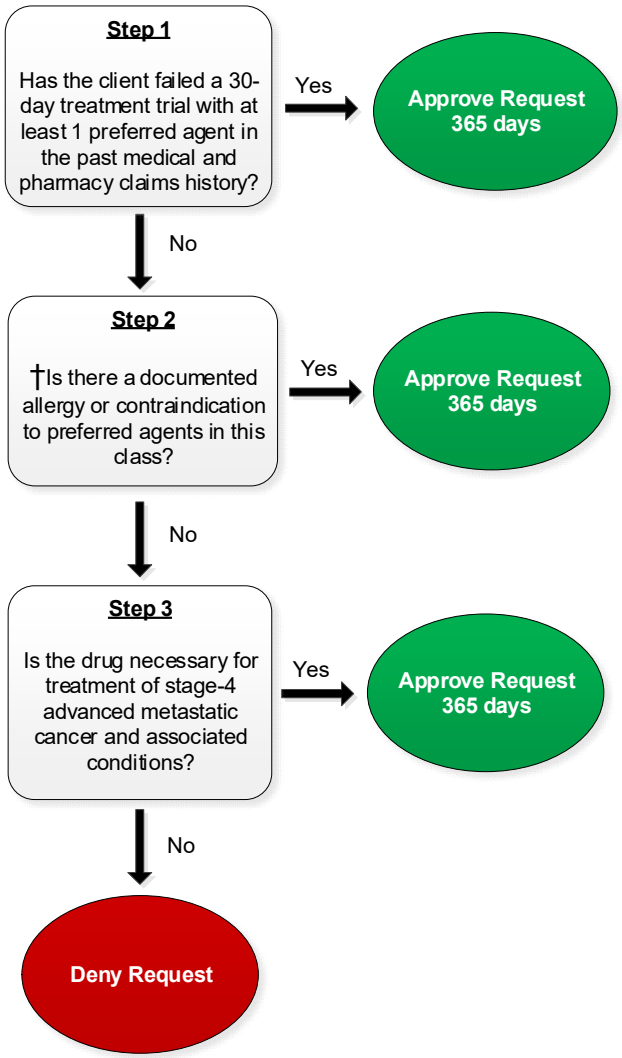
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 667MG CAPSULE
75051	CALCIUM ACETATE 667MG TABLET
03694	CALPHRON 667MG TABLET
96743	MAGNEBIND 200 TABLET
22954	MAGNEBIND 200 TABLET
96744	MAGNEBIND 300 TABLET
22955	MAGNEBIND 300 TABLET
49608	MAGNEBIND 400 TABLET
16853	RENAGEL 800MG TABLET
27484	RENVELA 2.4GM POWDER PACKET
99200	RENVELA 800MG 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

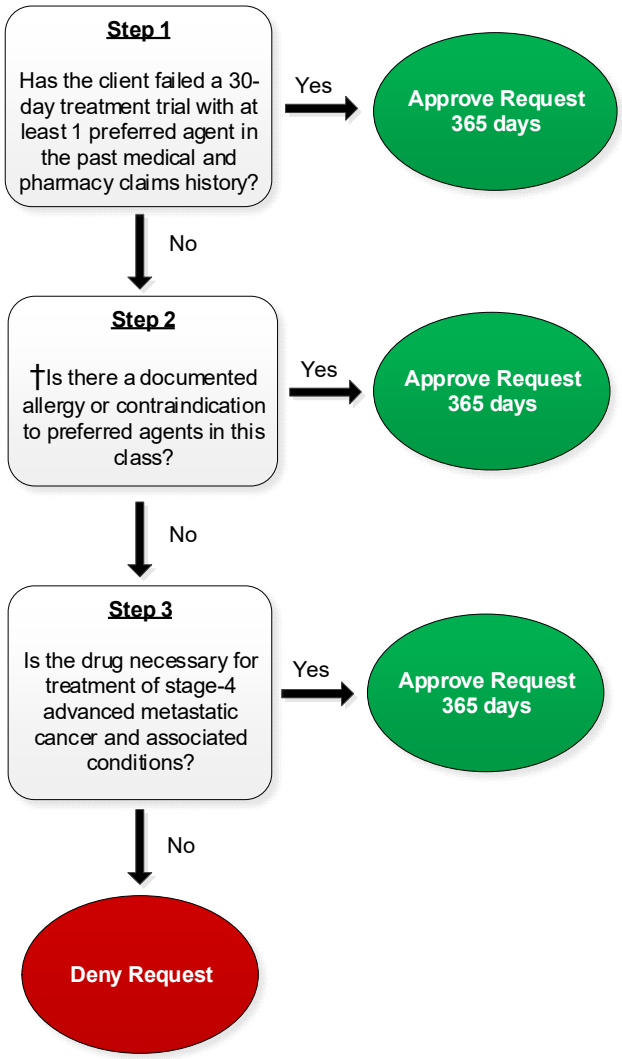
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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
39407	BRILINTA 60MG TABLET
29385	BRILINTA 90MG TABLET
99266	CLOPIDOGREL 300MG TABLET
96010	CLOPIDOGREL 75MG TABLET
17056	PRASUGREL 5MG TABLET
17157	PRASUGREL 10MG 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

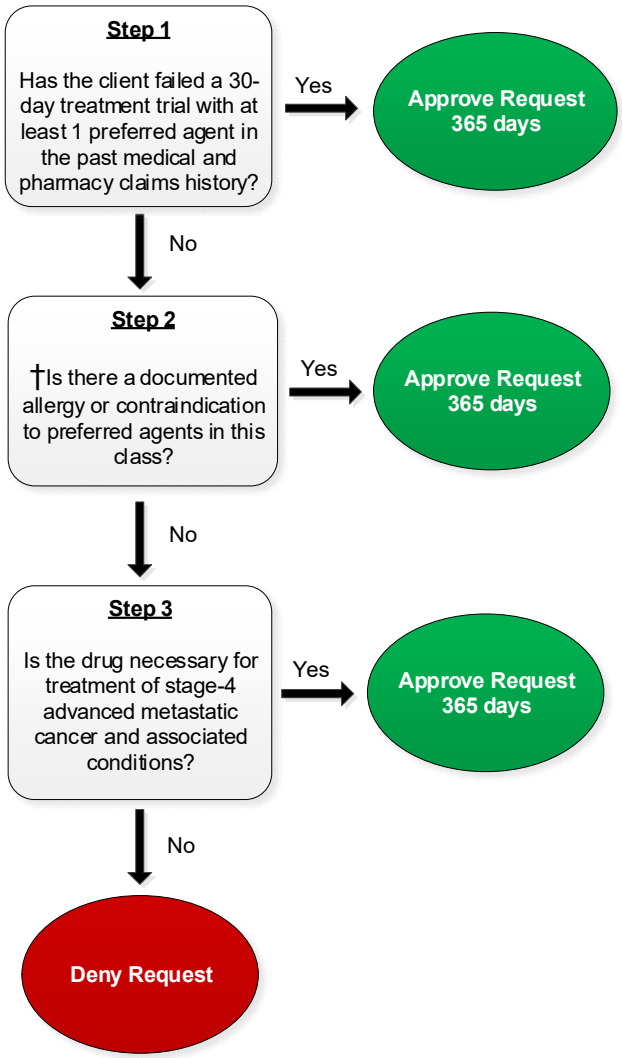
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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
44774	LOKELMA 5 GRAM POWDER PACKET
44775	LOKELMA 10 GRAM POWDER PACKET
02890	SODIUM POLYSTYRENE SULF POWDER

**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 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)

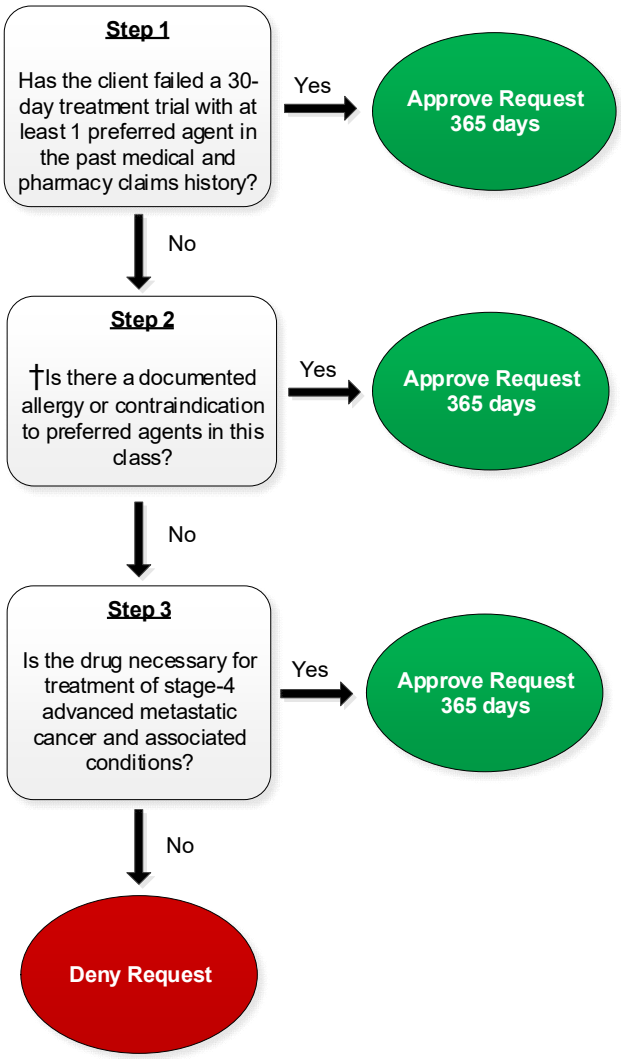
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

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
36358	CITRANATAL 90 DHA COMBO PACK
36296	CITRANATAL ASSURE COMBO PACK
36052	CITRANATAL HARMONY CAPSULE
21573	FOLIVANE-OB CAPSULE
28688	M-NATAL PLUS TABLET
28796	PNV 29-1 TABLET
28688	PRENATAL VITAMIN PLUS LOW IRON
35262	PRENATE ENHANCE SOFTGEL
28688	PREPLUS CA-FE 27 MG-FA 1 MG TAB
34796	PROVIDA OB CAPSULE
30684	SELECT-OB + DHA PACK
28796	THRIVITE RX TABLET
32229	TRICARE PRENATAL TABLET
99629	TRINATAL RX 1 TABLET
36546	VITAFOL NANO TABLET
35169	VITAFOL ULTRA SOFTGEL
98019	VITAFOL-OB + DHA COMBO PACK
97624	VITAFOL-OB CAPLET
30046	VITAFOL-ONE CAPSULE
44779	VOL-PLUS TABLET
28688	WESTAB PLUS TABLET

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

Progestational Agents

Progestational Agents
Prior Authorization Criteria

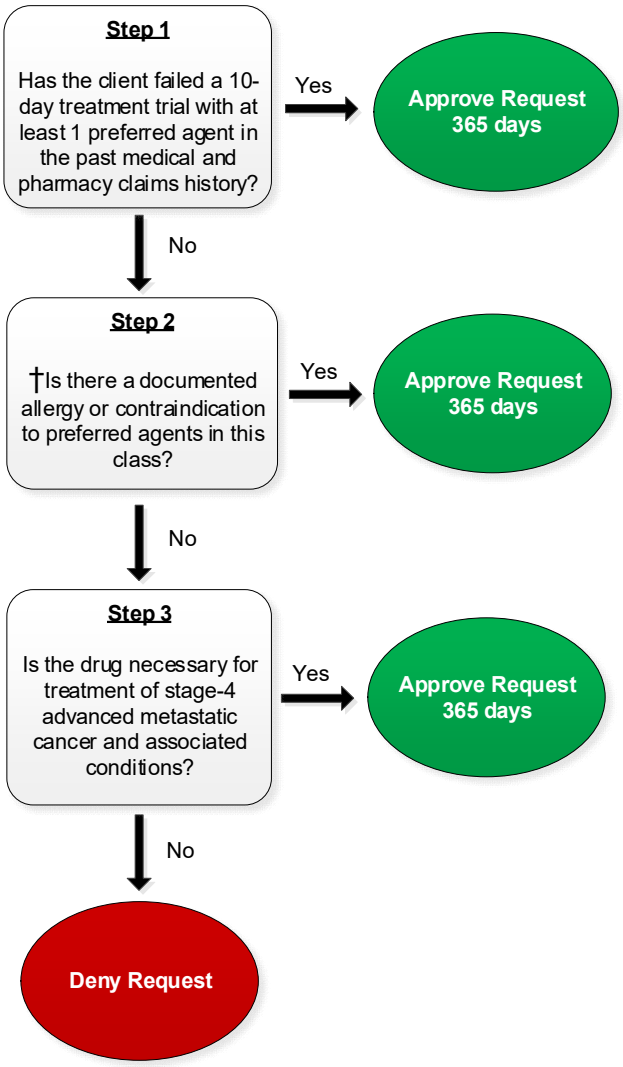
1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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.

Progestational 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.

Progestational Agents Alternate Therapies

Preferred Progestational Agents

GCN	Drug Name
39946	MAKENA 1,250 MG/5 ML VIAL
40784	MAKENA 250 MG/ML VIAL
44459	MAKENA 275MG/1.1ML AUTOINJCT

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

Progestins for Cachexia

Progestins for Cachexia Prior Authorization Criteria

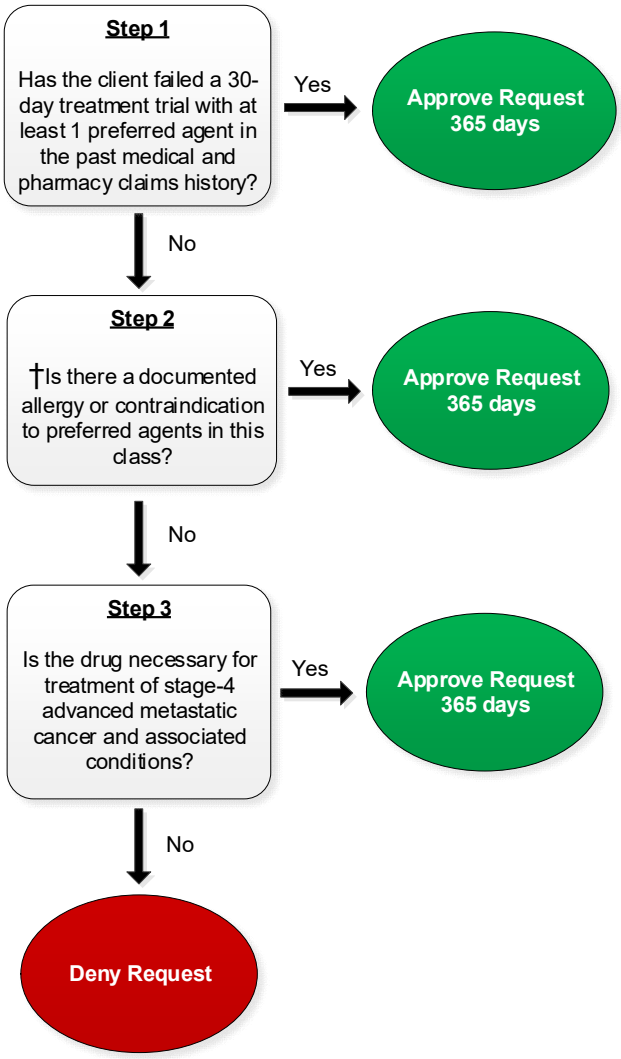
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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 20MG TABLET
38681	MEGESTROL 40MG TABLET
40381	MEGESTROL ACETATE 40MG/ML SUSPENSION

**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 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)

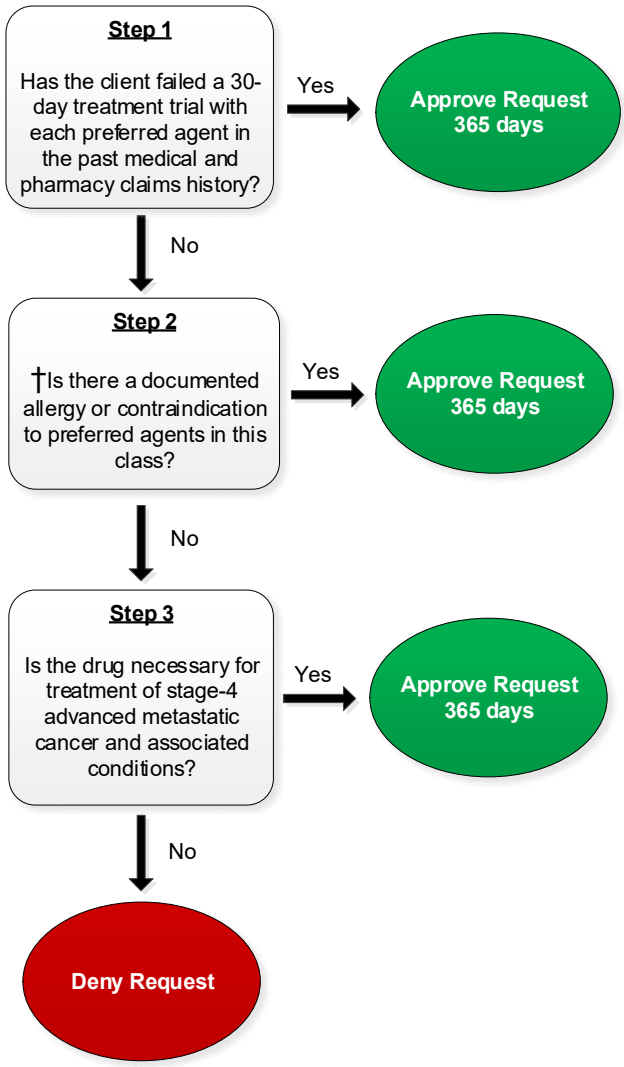
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

**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 10MG PACKET
98030	NEXIUM DR 20MG PACKET
33128	NEXIUM DR 2.5MG PACKET
98031	NEXIUM DR 40MG PACKET
33135	NEXIUM DR 5MG PACKET
92989	OMEPRAZOLE DR 10MG CAPSULE
04348	OMEPRAZOLE DR 20MG CAPSULE
92999	OMEPRAZOLE DR 40MG CAPSULE
95976	PANTOPRAZOLE SOD DR 20MG TABLET
40120	PANTOPRAZOLE SOD DR 40MG TABLET
99418	PROTONIX 40MG 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

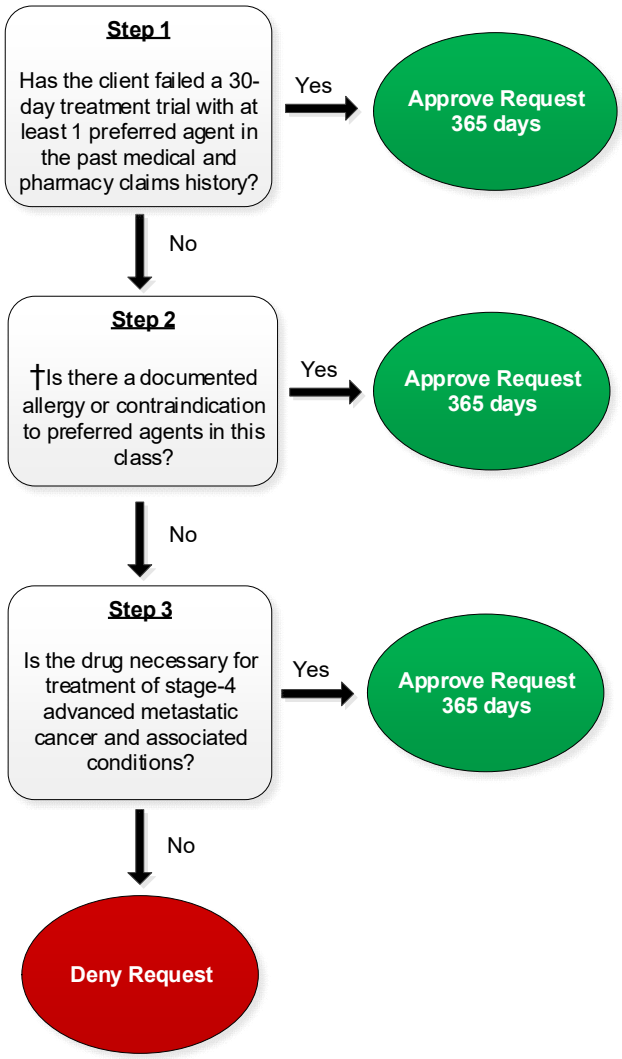
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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% GEL
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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

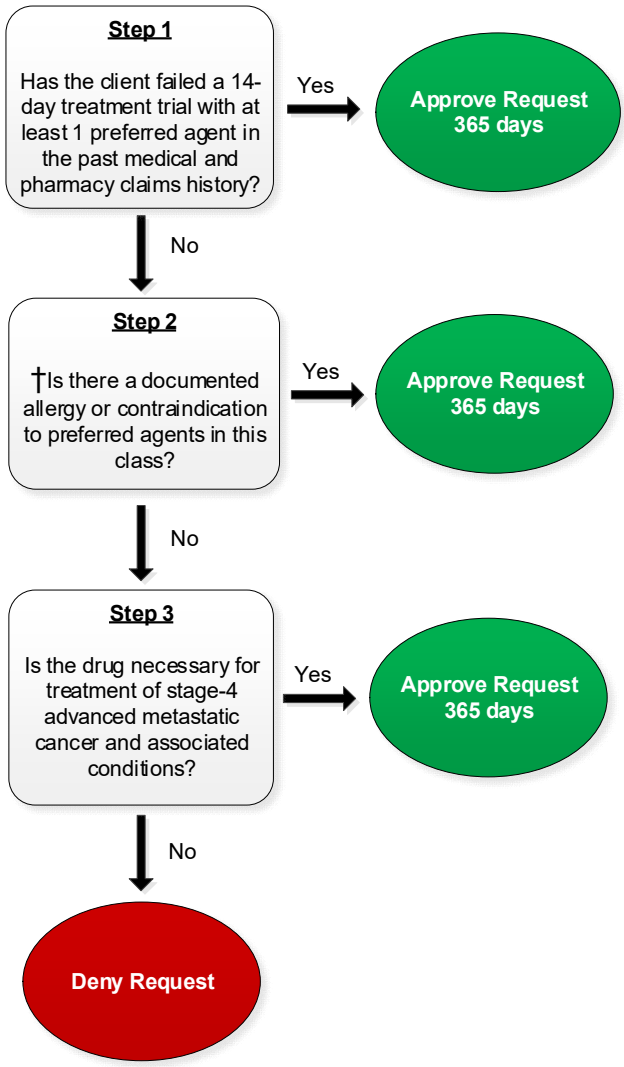
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 1MG TABLET
23926	ESZOPICLONE 2MG TABLET
23925	ESZOPICLONE 3MG TABLET
14250	FLURAZEPAM 15MG CAPSULE
14251	FLURAZEPAM 30MG CAPSULE
13840	TEMAZEPAM 15MG CAPSULE
13841	TEMAZEPAM 30MG CAPSULE
14282	TRIAZOLAM 0.125MG TABLET
14280	TRIAZOLAM 0.25MG TABLET
92723	ZALEPLON 10MG CAPSULE
92713	ZALEPLON 5MG CAPSULE
00871	ZOLPIDEM TARTRATE 10MG TABLET
00870	ZOLPIDEM TARTRATE 5MG 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

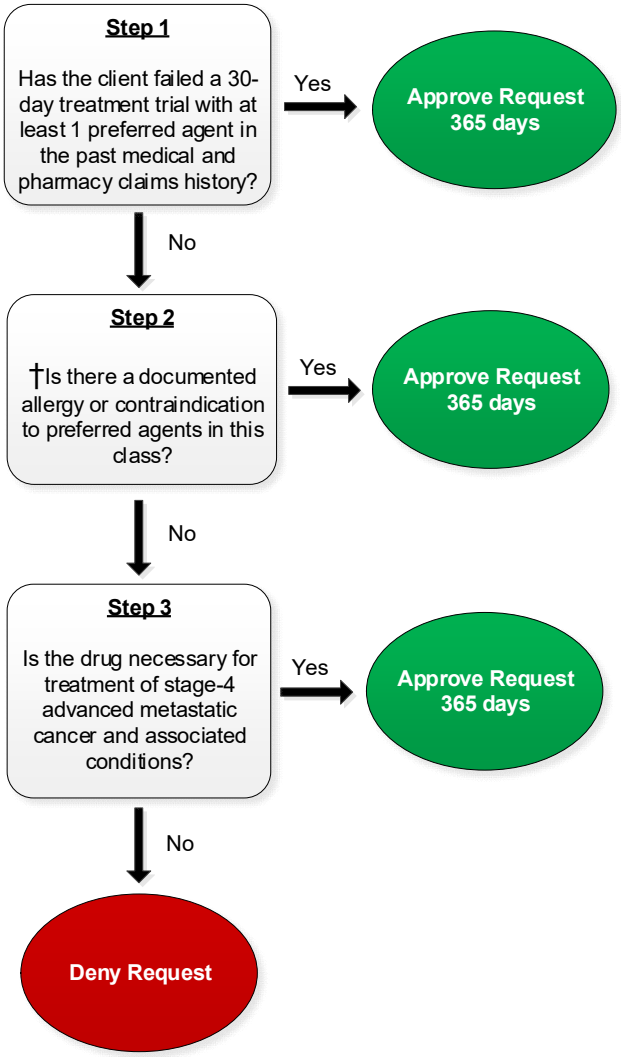
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 200MG CAPSULE
38403	DROXIA 300MG CAPSULE
38404	DROXIA 400MG CAPSULE
44283	ENDARI 5 GRAM POWDER PACKET
38400	HYDROXYUREA 500MG CAPSULE
47372	OXBRYTA 500MG TABLET
30164	SIKLOS 100MG TABLET
44626	SIKLOS 1,000MG 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

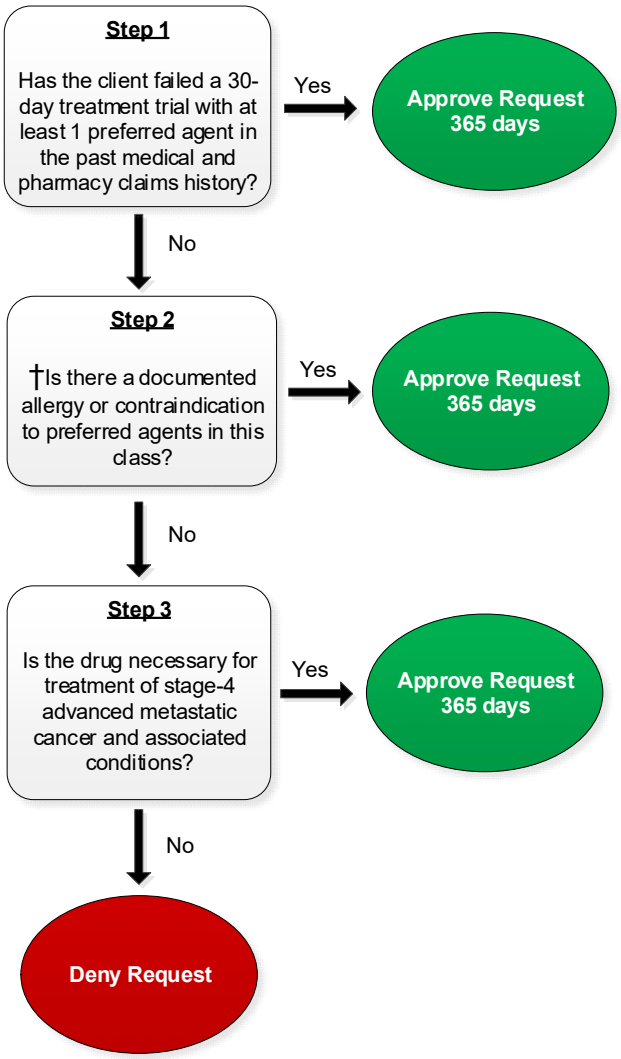
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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

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

Smoking Cessation

Smoking Cessation
Prior Authorization Criteria

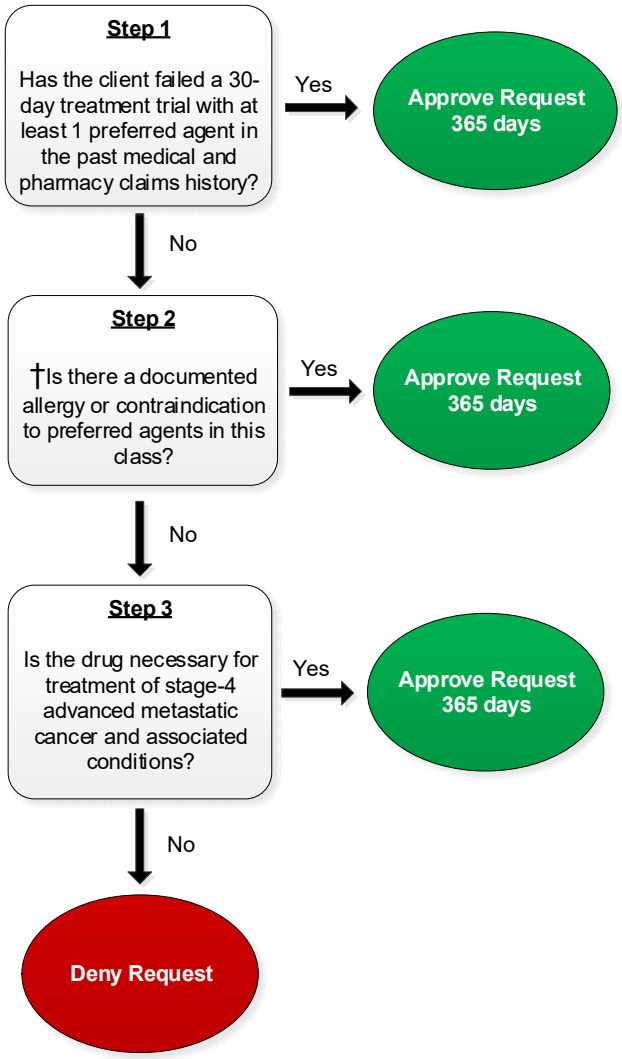
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 120 days)
   [ ] No (Go to #2)

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



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Smoking Cessation Alternate Therapies

Preferred Smoking Cessation Agents

GCN	Drug Name
16387	BUPROPION HCL SR 100MG TABLET
16386	BUPROPION HCL SR 150MG TABLET
17573	BUPROPION HCL SR 200MG TABLET
27046	CHANTIX 0.5MG TABLET
27047	CHANTIX 1MG TABLET
27048	CHANTIX STARTING MONTH BOX
43057	GS NICOTINE 2 MG MINI LOZENGE
03422	NICOTINE 14MG/24HR PATCH
03423	NICOTINE 21MG/24HR PATCH
03200	NICOTINE 2MG CHEWING GUM
43057	NICOTINE 2 MG MINI LOZENGE
14689	NICOTINE 2MG LOZENGE
03201	NICOTINE 4MG CHEWING GUM
43056	NICOTINE 4 MG MINI LOZENGE
14688	NICOTINE 4MG LOZENGE
03421	NICOTINE 7MG/24HR PATCH
18772	NICOTINE TRANSDERMAL PATCH
27047	VARENICLINE 1 MG TABLET
27046	VARENICLINE 0.5 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

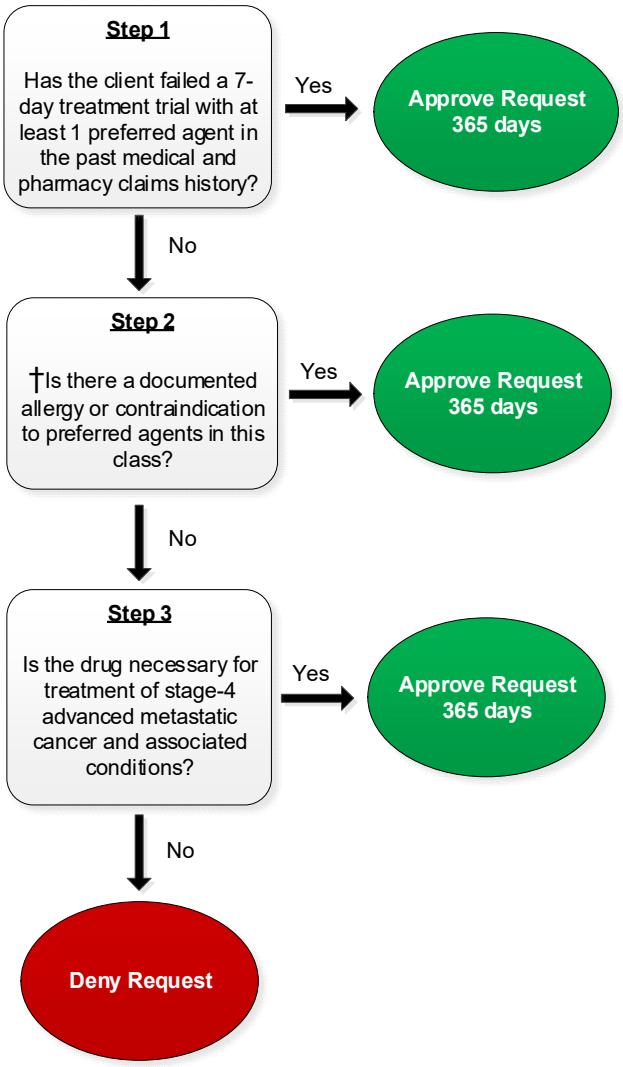
1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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.

RxPERT®

Steroids, Topical Alternate Therapies

Preferred Topical Steroids

GCN	Drug Name
28850	ANUSOL-HC 2.5% CREAM
31080	BETAMETHASONE DP 0.05% LOTION
31890	BETAMETHASONE DP AUG 0.05% CREAM
31101	BETAMETHASONE VALERATE 0.1% CREAM
31110	BETAMETHASONE VALERATE 0.1% OINTM
15892	CLOBETASOL 0.05% GEL
32130	CLOBETASOL 0.05% OINTMENT
15891	CLOBETASOL 0.05% SOLUTION
34141	CLOBETASOL EMOLLIENT 0.05% CREAM
32140	CLOBETASOL PROPIONATE 0.05% CREAM
85080	DERMA-SMOOTHE FS BODY OIL
24484	DERMA-SMOOTHE FS SCALP OIL
48641	FLUTICASONE PROP 0.005% OINTMENT
43951	FLUTICASONE PROP 0.05% CREAM
31251	HALOBETASOL PROP 0.05% CREAM
31211	HALOBETASOL PROP 0.05% OINTMENT
30950	HYDROCORTISONE 0.5% OINTMENT
92421	HYDROCORTISONE-ALOE 1% CREAM
30942	HYDROCORTISONE 1% CREAM
30951	HYDROCORTISONE 1% OINTMENT
30943	HYDROCORTISONE 2.5% CREAM
28850	HYDROCORTISONE 2.5% CREAM
30952	HYDROCORTISONE 2.5% OINTMENT
45850	MOMETASONE FUROATE 0.1% CREAM
45930	MOMETASONE FUROATE 0.1% OINTMENT
06034	MOMETASONE FUROATE 0.1% SOLN
28850	PROCTO-MED HC 2.5% CREAM
28850	PROCTOSOL-HC 2.5% CREAM
28850	PROCTOZONE-HC 2.5% CREAM
47387	SILA III 0.1% KIT
31231	TRIAMCINOLONE 0.025% CREAM
31260	TRIAMCINOLONE 0.025% LOTION

GCN	Drug Name
31241	TRIAMCINOLONE 0.025% 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*

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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

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

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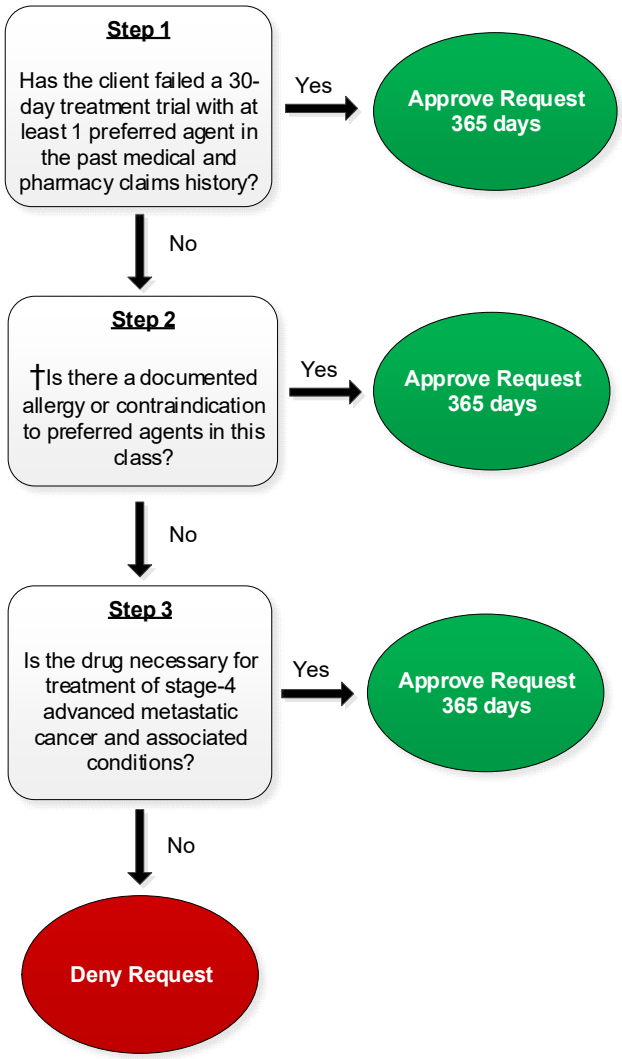
Stimulants and Related Agents
Prior Authorization Criteria



†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
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
56971	AMPHETAMINE SALTS 10MG TABLET
29008	AMPHETAMINE SALTS 12.5MG TABLET
29009	AMPHETAMINE SALTS 15MG TABLET
56973	AMPHETAMINE SALTS 20MG TABLET
56972	AMPHETAMINE SALTS 30MG TABLET
56970	AMPHETAMINE SALTS 5MG TABLET
29007	AMPHETAMINE SALTS 7.5MG TABLET
26539	ATOMOXETINE 100MG CAPSULE
18776	ATOMOXETINE 10MG CAPSULE
18777	ATOMOXETINE 18MG CAPSULE
18778	ATOMOXETINE 25MG CAPSULE
18779	ATOMOXETINE 40MG CAPSULE
18781	ATOMOXETINE 60MG CAPSULE
26538	ATOMOXETINE 80MG 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 10MG/9HR PATCH
26802	DAYTRANA 15MG/9HR PATCH
26803	DAYTRANA 20MG/9HR PATCH
26804	DAYTRANA 30MG/9HR PATCH
14975	DEXMETHYLPHENIDATE 10MG TABLET
14973	DEXMETHYLPHENIDATE 2.5MG TABLET
14974	DEXMETHYLPHENIDATE 5MG TABLET

GCN	Drug Name
19880	DEXTROAMPHETAMINE 10MG TABLET
19881	DEXTROAMPHETAMINE 5MG TABLET
39686	DYANAVEL XR 2.5MG/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 1MG TABLET
27578	GUANFACINE HCL ER 2MG TABLET
27579	GUANFACINE HCL ER 3MG TABLET
27582	GUANFACINE HCL ER 4MG 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 10MG/5ML SOLUTION
22685	METHYLIN 5MG/5ML SOLUTION
15911	METHYLPHENIDATE 10MG TABLET
15920	METHYLPHENIDATE 20MG TABLET
15913	METHYLPHENIDATE 5MG TABLET
33887	QUILLIVANT XR 25MG/5ML SUSPENSION
37674	VYVANSE 10MG CAPSULE
42969	VYVANSE 10MG CHEWABLE TABLET
98366	VYVANSE 20MG CAPSULE
43058	VYVANSE 20MG CHEWABLE TABLET
98071	VYVANSE 30MG CAPSULE
43059	VYVANSE 30MG CHEWABLE TABLET
99367	VYVANSE 40MG CAPSULE
43063	VYVANSE 40MG CHEWABLE TABLET
98072	VYVANSE 50MG CAPSULE
43064	VYVANSE 50MG CHEWABLE TABLET
99368	VYVANSE 60MG CAPSULE
43065	VYVANSE 60MG CHEWABLE TABLET
98073	VYVANSE 70MG CAPSULE

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

Tetracyclines

Tetracyclines
Prior Authorization Criteria

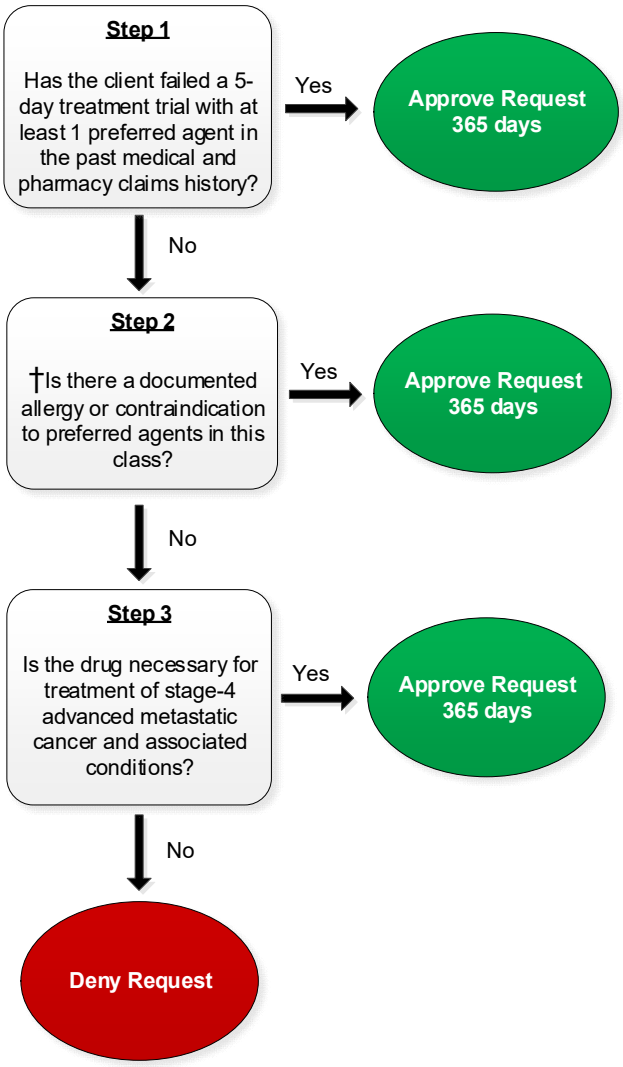
1. Has the client failed a 5-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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



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Tetracyclines Alternate Therapies

Preferred Tetracyclines

GCN	Drug Name
40331	DOXYCYCLINE HYCLATE 100 MG CAP
40333	DOXYCYCLINE HYCLATE 50 MG CAP
40651	DOXYCYCLINE MONOHYDRATE 100MG CAPSULE
40652	DOXYCYCLINE MONOHYDRATE 50MG CAPSULE
40410	MINOCYCLINE 100MG CAPSULE
40411	MINOCYCLINE 50MG CAPSULE
93387	MINOCYCLINE 75MG 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

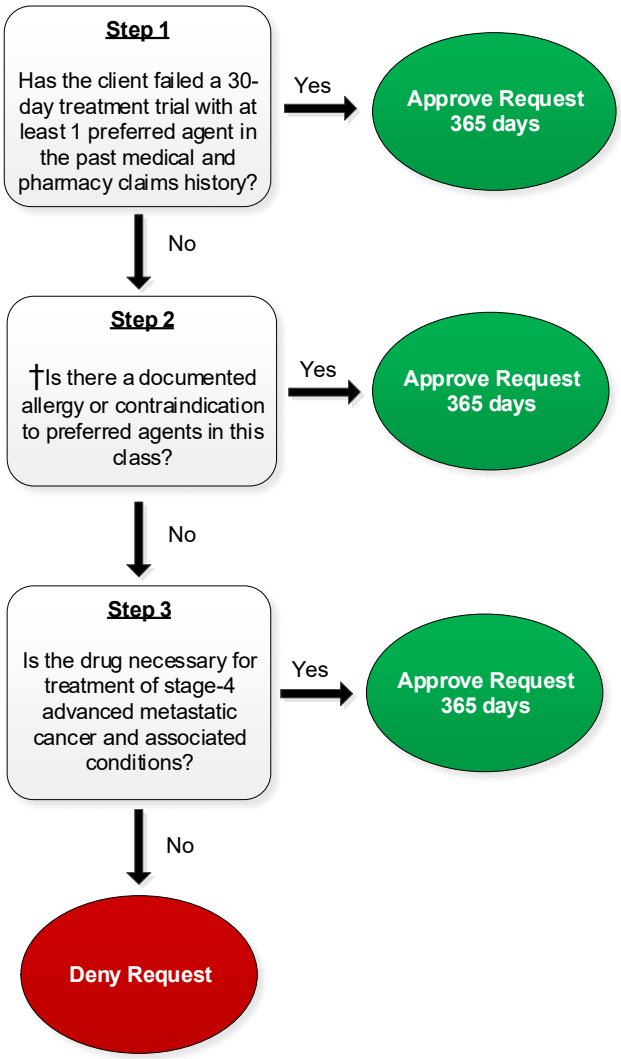
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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 12.5MG TABLET
15994	PROMACTA 25MG TABLET
15995	PROMACTA 50MG TABLET
28344	PROMACTA 75MG 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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

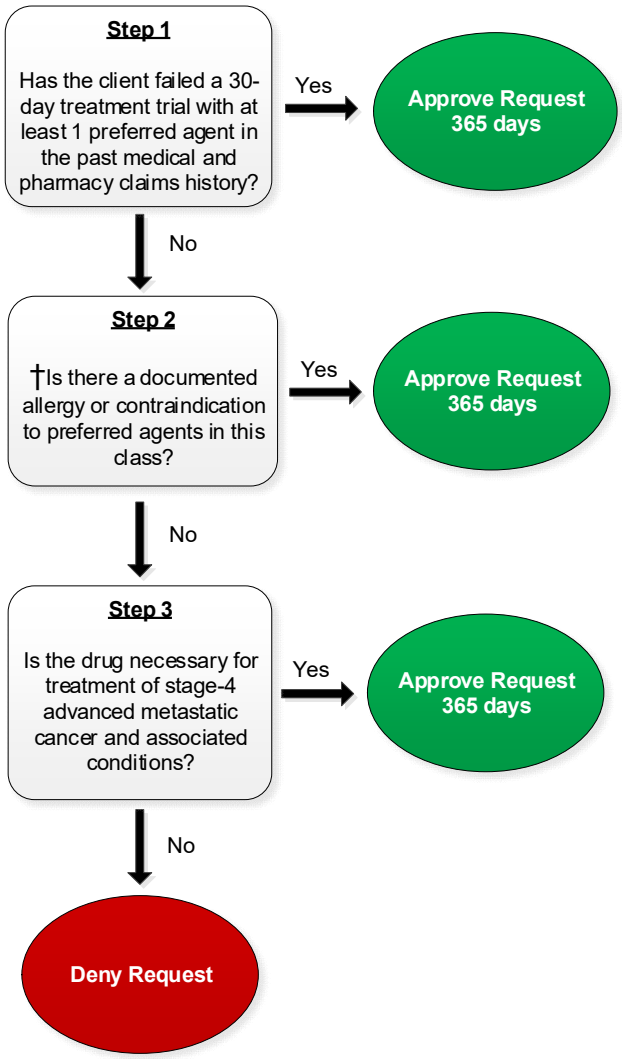
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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 400MG CAPSULE
30220	PENTASA 250 MG CAPSULE
23422	PENTASA 500 MG CAPSULE
41611	SULFASALAZINE 500MG TABLET
41620	SULFASALAZINE DR 500MG TABLET

**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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

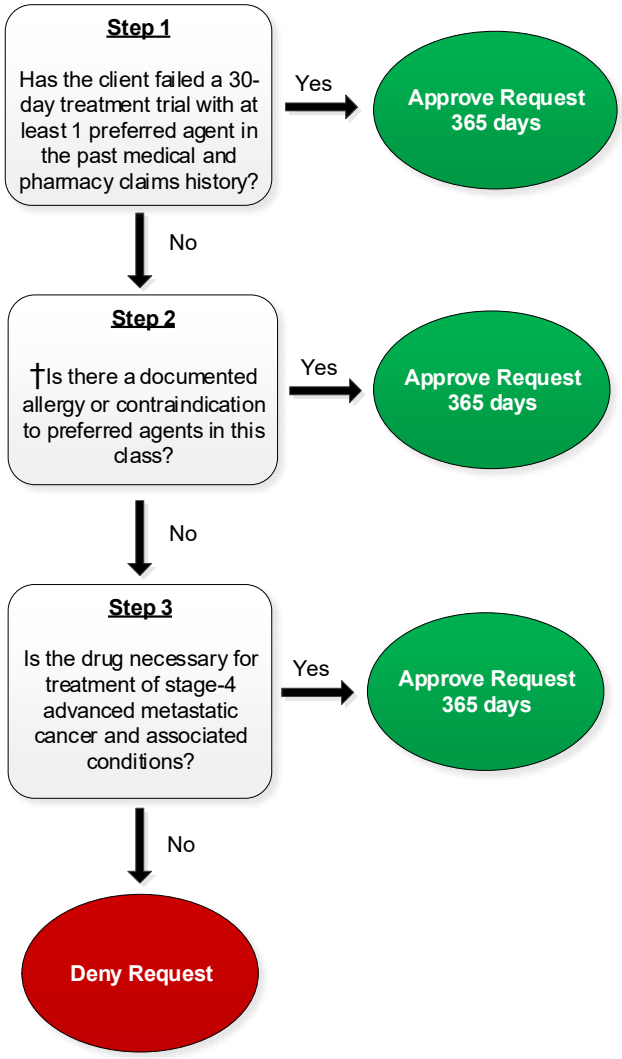
2. †Is there a documented allergy or contraindication to preferred agents in this class?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #3)

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



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Uterine Disorder Treatments

Alternate Therapies

All products in this class are preferred.
To verify formulary coverage for any drugs listed on PDL, search the Medicaid formulary.

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 pharmacy claims history?
   [ ] Yes (Approve – 365 days)
   [ ] No (Go to #2)

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

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

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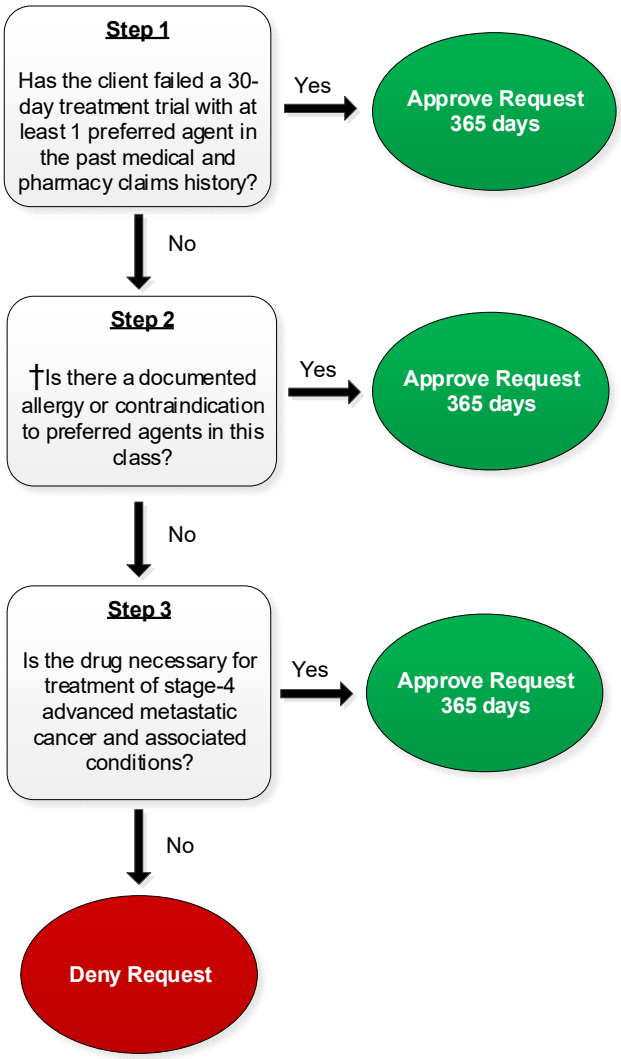
Urea Cycle Disorders, Oral

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

43371	BUPHENYL 500MG TABLET
43370	BUPHENYL POWDER
20522	CARBAGLU 200 MG TAB FOR SUSP
36733	PHEBURANE PELLET (ORAL)

**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
		Removed GCNs for clemastine fum 2.68mg, methylphenidate ER, metronidazole 0.75% vaginal gel and Granix Added the following statement to Hypoglycemics, TZD: Separate prescriptions for the individual components should be used instead of the combination drugs Added subsection for PCSK9 inhibitors under Lipotropics, Other 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 Added the following statement to Prenatal Vitamins: Prenatal vitamins are covered only for females less than 50 years of age. Removed diagnosis check of CVD and intolerable side effects for Inhaled Bronchodilators
04/13/2021	.29	For Macrolides criteria: revised prior therapy question to read: Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history? (Exception may apply when a preferred drug requires less than a 7-day treatment trial)
07/29/2021	.30	Updated PDL classes and GCNs Updated criteria for Phosphate Binders – removed checks for lab values and diagnosis
08/13/2021	.31	Revised lookback time frame for Ophthalmics, Anti-Inflammatory/Immunomodulators from 180 days therapy with a preferred agent in the last 200 days to 30 days therapy in the last 180 days
10/12/2021	.32	Added GCN for Lotemax 0.5% drops to preferred agents
12/20/2021	.33	Updated logic diagram for Topical antibiotics, question 1, to look for a 5-days supply of a preferred agent in the last 60 days
12/21/2021	.34	Updated PDL classes and GCNs
04/05/2022	.35	Updated Phosphate Binders criteria
06/22/2022	.36	Moved criteria for Rinvoq to Cytokine and CAM class section. Added diagnoses of ankylosing spondylitis and ulcerative colitis for Rinvoq – for clients with these diagnoses, preferred therapy is from the Cytokine and CAM class
07/28/2022	.37	Updated PDL classes and GCNs
08/10/2022	.38	Added diagnosis of eosinophilic esophagitis for Dupixent
09/16/2022	.39	Updated lookback for a preferred agent to 14 days supply in the last 180 days for Bronchodilators, Beta Agonists and 1 day supply in the last 180 days for Glucagon agents
01/01/2023	.40	Updated the preferred Hepatitis C Agents
01/26/2023	.41	Added criteria for Uterine Disorder Treatments Updated PDL classes and GCNs
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, 88th Legislature, Regular Session, 2023

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: • Alzheimer's Agents • Antidepressants, Other • Antidepressants, SSRI • Antipsychotics, Oral • Growth Hormones • Hepatitis C Agents	Added missing stable therapy step
	• Analgesics, Narcotic – Long Acting • Analgesics, Narcotic – Short Acting	Updated titles for checklist, flowchart and list to correspond with the section title
	• Analgesics, Narcotic – Long Acting • Analgesics, Narcotic – Short Acting	Updated the RxPert form code in title
	Anticoagulants, Injectable	Added allergy and contraindication step to checklist and flowchart
	Antidepressants	Divided section into Antidepressants, Other and Antidepressants, SSRI as shown in the PDL

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
	• Acne Agents, Topical • Analgesics, Narcotics Long • Analgesics, Narcotics Short • Angiotensin Modulators • Bladder Relaxant Preparations • Intranasal Rhinitis Agents • Neuropathic Pain • Platelet Aggregation Inhibitors • Proton Pump Inhibitors • Stimulants and Related Agents • Anticoagulants • Antidepressants, Other • Antiparkinson's Agents • Beta-Blockers • Bronchodilators, Beta Agonist • Glucocorticoids, Inhaled • Lipotropics, Other • Lipotropics, Statins	Updated list of preferred agents
.05	• All PDL Sections	Reviewed and updated all lists of preferred agents
.06	• Stimulants and Related Agents	Added criteria for Methylin solution

.07	• Alzheimer's Agents • Androgenic Agents • Antibiotics, GI • Antibiotics, Topical • Antibiotics, Vaginal • Antiemetic/Antivertigo Agents • Antifungals, Oral • Antifungals, Topical • Antihistamines, Minimally Sedating • Antihypertensives, Sympatholytics • Antiparasitics, Topical • Antipsychotics • Antivirals, Oral • Antivirals, Topical • Bone Resorption Suppression and Related Agents • Calcium Channel Blockers • Cephalosporins and Related Antibiotics • Colony Stimulating Factors • Cytokine and CAM Antagonists • Epinephrine, Self-Injected • Fluoroquinolones, Oral • GI Motility, Chronic • Glucocorticoids, Oral • Growth Hormone • Hypoglycemics, Incretin • Hypoglycemics, Insulin and Related Agents • Hypoglycemics, Meglitinides • Hypoglycemics, TZDs • Immunosuppressives, Oral • Iron, Oral • Leukotriene Modifiers • Macrolides/Ketolides • NSAIDs • Ophthalmic Antibiotics • Ophthalmic Antibiotic-Steroid • Ophthalmics for Allergic Conjunctivitis • Ophthalmics, Anti-Inflammatories	Updated list of preferred agents

Version Number	Chapter/Section	Change
	• Ophthalmics, Glaucoma Agents • Opiate Dependence Treatments • Otic Antibiotics • Otic Anti-Infectives & Anesthetics • Penicillins • Prenatal Vitamins • Skeletal Muscle Relaxants • Steroids, Topical • Tetracyclines • Ulcerative Colitis Agents	
	Antibiotics, Topical	Changed PDL Class Name from Agents for Impetigo to Topical Antibiotics

Version Number	Chapter/Section	Change
.08	• Acne Agents, Oral • Analgesics, Narcotic-Long Acting • Angiotensin Modulator Combinations • Antimigraine Agents • Antiparkinson's Agents, Oral/Transdermal • Antipsychotics • Antivirals, Oral/Nasal • Bile Salts • BPH Agents • COPD Agents • GI Motility, Chronic • Glucocorticoids, Inhaled • Hepatitis C Agents • Hypoglycemics, Insulin • Hypoglycemics, SGLT2 • Immune Globulins • Immunomodulators, Atopic Dermatitis • Immunosuppressives, Oral • Iron, Oral • Lincosamides/ Oxazolidinones/ Streptogramins • Lipotropics, Other • Lipotropics, Statins • Neuropathic Pain • Opiate Dependence Treatments • PAH Agents, Oral/Inhalation • Prenatal Vitamins • Steroids, Topical • Stimulants and Related Agents	Updated list of preferred agents and GCNs
.09	• Hypoglycemics, Metformin	New class: Added criteria logic, logic diagram and table of preferred agents

	• Alzheimer's Agents • Androgenic Agents • Antibiotics, GI • Antibiotics, Topical • Antibiotics, Vaginal • Antiemetic/Antivertigo Agents • Antifungals, Oral • Antifungals, Topical • Antihistamines, Minimally Sedating • Antihypertensives, Symmpatholytics • Antiparasitics, Topical • Antipsychotics • Antivirals, Oral • Antivirals, Topical • Bone Resorption Suppression and Related Agents • Calcium Channel Blockers • Cephalosporins and Related Antibiotics • Colony Stimulating Factors • Cytokine and CAM Antagonists • Epinephrine, Self-Injected • Fluoroquinolones, Oral • GI Motility, Chronic • Glucocorticoids, Oral • Growth Hormone • Hypoglycemics, Incretin Mimetics/Enhancers • Hypoglycemics, Insulin and Related Agents • Hypoglycemics, Meglitinides • Hypoglycemics, TZD • Immunosuppressives, Oral • Iron, Oral • Leukotriene Modifiers • Macrolides/Ketolides • NSAIDs • Ophthalmic Antibiotics • Ophthalmic Antibiotic-Steroid Combinations • Ophthalmics for Allergic Conjunctivitis	Updated list of preferred agents and GCNs

Version Number	Chapter/Section	Change
	• Ophthalmics, Anti-Inflammatories • Ophthalmics, Glaucoma Agents • Opiate Dependence Treatments • Otic Antibiotics • Otic Anti-Infectives & Anesthetics • Penicillins • Prenatal Vitamins • Skeletal Muscle Relaxants • Steroids, Topical • Tetracyclines • Ulcerative Colitis Agents	
.10	• Antidepressants, Tricyclic • Anxiolytics • Ophthalmics, Anti-Inflammatory/Immunomodulators • Urea Cycle Disorders	New classes: Added criteria logic, logic diagram and table of preferred agents

	• Acne Agents, Oral • Acne Agents, Topical • Analgesics, Narcotics Long • Analgesics, Narcotics Short • Angiotensin Modulators • Angiotensin Modulator Combinations • Anti-Allergens, Oral • Antibiotics, Inhaled • Anticoagulants • Antidepressants, Other • Antidepressants, SSRIs • Antihyperuricemics • Antimigraine Agents, Other • Antimigraine Agents, Triptans • Antiparkinson's Agents • Beta-Blockers • Bladder Relaxant Preparations • Bile Salts • BPH Treatments • Bronchodilators, Beta Agonist • COPD Agents • Cough and Cold, Cold • Cough and Cold, Narcotic • Cough and Cold, Non-Narcotic • Erythropoiesis Stimulating Proteins • Glucocorticoids, Inhaled • H. Pylori Treatment • HAE Treatments • Hepatitis C Agents • Hypoglycemics, SGLT2 • Immune Globulins • Immunomodulators, Atopic Dermatitis • Intranasal Rhinitis Agents • Lincosamides / Oxazolidinones / Streptogramins • Lipotropics, Other • Lipotropics, Statins • Neuropathic Pain • PAH, Oral and Inhaled • Pancreatic Enzymes	Updated list of preferred agents and GCNs

Version Number	Chapter/Section	Change
	• Phosphate Binders • Platelet Aggregation Inhibitors • Progestins for Cachexia • Proton Pump Inhibitors • Sedative Hypnotics • Smoking Cessation • Stimulants and Related Agents	
	• Angiotensin Modulators • Antiemetic and Antivertigo Agents	Updated criteria logic and logic diagram
.11	• Opthalmics, Anti-Inflammatory / Immunomodulators	Changed prior therapy requirements to 180 day trial of a preferred agent in the last 200 days
.12	• Progestational Agents	New classes: Added criteria logic, logic diagram and table of preferred agents

Version Number	Chapter/Section	Change
	• Alzheimer's Agents • Antihistamines, Minimally Sedating • Antihypertensives, Sympatholytics • Antivirals, Oral/Nasal • Calcium Channel Blockers • Cephalosporins and Related Antibiotics • Fluoroquinolones, Oral • Glucocorticoids, Oral • Hypoglycemics, SGLT2 • Immunosupressives, Oral • Iron, Oral • Leukotriene Modifiers • NSAIDs • Ophthalmic Antibiotics • Ophthalmic Antibiotic-Steroid Combinations • Ophthalmics for Allergic Conjunctivitis • Ophthalmics, Anti-Inflammatories • Ophthalmics, Glaucoma Agents • Otic Antibiotics • Otic Anti-Infectives and Anesthetics • Prenatal Vitamins • Skeletal Muscle Relaxants • Steroids, Topical • Ulcerative Colitis Agents	Updated list of preferred agents and GCNs
.13	• Antihistamines, First Generation • Pediatric Vitamin Preparations	New classes: Added criteria logic, logic diagram and table of preferred agents

Version Number	Chapter/Section	Change
	• Analgesics, Narcotic-Long Acting • Androgenic Agents • Antibiotics, GI • Antibiotics, Topical • Antibiotics, Vaginal • Antiemetic/Antivertigo Agents • Antifungals, Oral • Antifungals, Topical • Antihistamines, Minimally Sedating • Antiparasitics, Topical • Antiparkinson's Agents • Antipsychotics • Antivirals, Oral/Nasal • Antivirals, Topical • Bile Salts • Bone Resorption Suppression and Related Agents • Colony Stimulating Factors • Cytokine and CAM Antagonists • Epinephrine, Self-Injected • GI Motility, Chronic • Growth Hormone • Hepatitis C Agents • Hypoglycemics, Incretin Mimetics/Enhancers • Hypoglycemics, Insulin and Related Agents • Hypoglycemics, Meglitinides • Hypoglycemics, Metformins • Hypoglycemics, TZD • Macrolides/Ketolides • Opiate Dependence Treatments • Penicillins • Stimulants and Related Agents • Tetracyclines	Updated list of preferred agents and GCNs

.14	• Movement Disorders • Acne Agents, Oral • Acne Agents, Topical • Analgesics, Narcotics Long • Analgesics, Narcotics Short • Angiotensin Modulator Combinations • Angiotensin Modulators • Anti-Allergens, Oral • Antibiotics, GI • Antibiotics, Inhaled • Anticoagulants • Antidepressants, Other • Antidepressants, SSRIs • Antidepressants, Tricyclic • Antihyperuricemics • Antimigraine Agents, Other • Antimigraine Agentsm Triptans • Antiparkinson's Agents • Anxiolytics • Beta-Blockers • Bile Salts • Bladder Relaxant Preparations • BPH Treatments • Bronchodilators, Beta Agonist • COPD Agents • Cough and Cold Agents • Cytokine and CAM Antagonists • Erythropoiesis Stimulating Proteins • GI Motility, Chronic • Glucocorticoids, Inhaled • Glucocorticoids, Oral • HAE Treatments • H. Pylori Treatment • Hypoglycemics, Incretin Mimetics/Enhancers • Hypoglycemics, Insulin and Related • Hypoglycemics, SGLT2 • Immune Globulins • Immunomodulators, Atopic Dermatitis	New classes: Added criteria logic, logic diagram and table of preferred agents Updated list of preferred agents and GCNs

Version Number	Chapter/Section	Change
	• Intranasal Rhinitis Agents • Lincosamides/ Oxazolidinones/ Streptogramins • Lipotropics, Other • Lipotropics, Statins • Neuropathic Pain • Ophthalmics, Glaucoma Agents • Ophthalmics, Anti-Inflammatory/ Immunomodulator • PAH Agents, Oral and Inhaled • Pancreatic Enzymes • Phosphate Binders • Platelet Aggregation Inhibitors • Progestins for Cachexia • Proton Pump Inhibitors • Sedative Hypnotics • Smoking Cessation • Stimulants and Related Agents • Tetracyclines • Urea Cycle Disorders, Oral	

.15	• Alzheimer's Agents • Analgesics, Narcotics Short • Androgenic Agents • Antibiotics, GI • Antibiotics, Topical • Antibiotics, Vaginal • Anticoagulants • Antiemetic/Antivertigo Agents • Antifungals, Oral • Antifungals, Topical • Antihistamines, First Generation • Antihistamines, Minimally Sedating • Antihypertensives, Sympatholytics • Antimigraine Agents, Other • Antiparasitics, Topical • Antiparkinson's Agents • Antipsychotics • Antivirals, Oral • Antiviarals, Topical • Bone Resorption Suppression and Related Agents • Calcium Channel Blockers • Cephalosporins and Related Antibiotics • Colony Stimulating Factors • COPD Agents • Cytokine and CAM Antagonists • Epinephrine, Self-Injected • Erythropoiesis Stimulating Proteins • Fluoroquinolones, Oral • GI Motility, Chronic • Glucocorticoids, Oral • Growth Hormone • Hepatitis C Agents • Hypoglycemics, Incretin Mimetics/Enhancers • Hypoglycemics, Insulin and Related Agents • Hypoglycemics, Meglitinides	Updated list of preferred agents and GCNs

Version Number	Chapter/Section	Change
	• Hypoglycemics, Metformins • Hypoglycemics, SGLT2 • Hypoglycemics, TZD • Immunomodulators, Atopic Dermatitis • Immunosuppressives, Oral • Iron, Oral • Leukotriene Modifiers • Lipotropics, Statins • Macrolides/Ketolides • NSAIDs • Ophthalmic Antibiotics • Ophthalmic Antibiotic-Steroid Combinations • Ophthalmics for Allergic Conjunctivitis • Ophthalmics, Anti-Inflammatories • Ophthalmics, Glaucoma Agents • Opiate Dependence Treatments • Otic Antibiotics • Otic Anti-Infectives & Anesthetics • Pediatric Vitamin Preparations • Penicillins • Prenatal Vitamins • Progestational Agents • Skeletal Muscle Relaxants • Steroids, Topical • Tetracyclines • Ulcerative Colitis Agents	
.16	• All Classes	Reviewed and updated GCNs for all preferred agents

.17	• Thrombopoiesis Stimulating Proteins • Acne Agents, Oral • Acne Agents, Topical • Analgesics, Narcotics Long • Analgesics, Narcotics Short • Angiotensin Modulator Combinations • Angiotensin Modulators • Anti-Allergens, Oral • Antibiotics, Inhaled • Anticoagulants • Antidepressants, Other • Antidepressants, SSRIs • Antidepressants, Tricyclics • Antifungals, Oral • Antihistamines, First Generation • Antihyperuricemics • Antimigraine Agents, Other • Antimigraine Agents, Triptans • Antiparasitics, Topical • Antiparkinson's Agents • Antivirals, Oral • Anxiolytics • Beta-Blockers • Bile Salts • Bladder Relaxant Preparations • BPH Treatments • Bronchodilators, Beta Agonist • COPD Agents • Colony Stimulating Factors • Cough and Cold Agents • Cytokine and CAM Antagonists • Epinephrine, Self-Injected • Erythropoiesis Stimulating Proteins • Glucocorticoids, Inhaled • H. Pylori Treatment • HAE Treatments • Hypoglycemics, Insulin and Related Agents	New classes: Added criteria logic, logic diagram and table of preferred agents Updated list of preferred agents and GCNs

Version Number	Chapter/Section	Change
	• Hypoglycemics, SGLT2 • Immune Globulins • Immunomodulators, Atopic Dermatitis • Intranasal Rhinitis Agents • Lincosamides/ Oxazolidinones/ Streptogramins • Lipotropics, Other • Lipotropics, Statins • Movement Disorders • Neuropathic Pain • Ophthalmics, Anti-Inflammatories • Ophthalmics, Anti-Inflammatory/ Immunomodulator • Ophthalmics, Glaucoma Agents • PAH Agents, Oral and Inhaled • Pancreatic Enzymes • Pediatric Vitamin Preparations • Prenatal Vitamins • Phosphate Binders • Platelet Aggregation Inhibitors • Progestins for Cachexia • Proton Pump Inhibitors • Sedative-Hypnotics • Smoking Cessation • Steroids, Topical • Stimulants and Related Agents • Tetracyclines • Urea Cycle Disorders, Oral	
.18	• Proton Pump Inhibitors	Updated criteria to indicate that a minimum of 30-day trial of all preferred agents in the preceding 365 days is required before approval of a non-preferred agent.
.19	• Title Page • Document Overview	Removed references to Part I: PDL Criteria on title page and on purpose of document, page 1
.20	• Updated all criteria logic and logic diagrams	Added the following question to all criteria: Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

.20	• Alzheimer's Agents • Analgesics, Narcotic Short • Androgenic Agents • Antibiotics, GI • Antibiotics, Topical • Antibiotics, Vaginal • Antiemetic/Antivertigo Agents • Antifungals, Oral • Antifungals, Topical • Antihistamines, First Generation • Antihistamines, Minimally Sedating • Antihypertensives, Sympatholytics • Antimigraine Agents, Other • Antiparasitics, Topical • Antiparkinson's Agents • Antipsychotic Agents • Antivirals, Topical • Bone Resorption Suppression and Related Agents • BPH Agents • Calcium Channel Blockers • Cephalosporins and Related Antibiotics • Colony Stimulating Factors • Cytokine and CAM Antagonists • Epinephrine Self-Injected • Fluoroquinolones, Oral • GI Motility, Chronic • Glucocorticoids, Oral • Growth Hormone • Hepatitis C Agents • Hypoglycemics, Incretin Mimetics/Enhancers • Hypoglycemics, Insulin and Related Agents • Hypoglycemics, Meglitinides • Hypoglycemics, Metformins • Hypoglycemics, SGLT2 • Hypoglycemics, TZD • Immune Globulins	Updated preferred agents and GCNs

Version Number	Chapter/Section	Change
	• Immunosuppressives, Oral • Iron, Oral • Leukotriene Modifiers • Lipotropics, Statins • Macrolides and Ketolides • Movement Disorders • Neuropathic Pain • NSAIDs • Ophthalmic Antibiotics • Ophthalmic Antibiotic-Steroid Combinations • Ophthalmics for Allergic Conjunctivitis • Ophthalmics, Anti-inflammatories • Ophthalmics, Anti-inflammatory / Immunomodulator • Ophthalmics, Glaucoma Agents • Opiate Dependence Treatments • Otic Antibiotics • Otic Anti-infectives & Anesthetics • Penicillins • Progestational Agents • Skeletal Muscle Relaxants • Steroids, Topical • Stimulants and Related Agents • Tetracyclines • Ulcerative Colitis Agents	

.21	• Glucagon Agents • Immunomodulators, Asthma • Sickle Cell Anemia Treatment • Acne Agents, Oral • Acne Agents, Topical • Analgesics, Narcotics Long • Analgesics, Narcotics Short • Angiotensin Modulator Combinations • Angiotensin Modulators • Anti-Allergens, Oral • Anticoagulants • Antidepressants, Other • Antidepressants, SSRIs • Antidepressants, Tricyclics • Antihyperuricemics • Antimigraine Agents, Other • Antimigraine Agents, Triptans • Antiparkinson's Agents • Antipsychotics • Antivirals, Oral/Nasal • Anxiolytics • Beta-Blockers • Bile Salts • Bladder Relaxant Preparations • BPH Treatments • Bronchodilators, Beta Agonist • Colony Stimulating Factors • COPD Agents • Cough and Cold Agents • Erythropoiesis Stimulating Proteins • Glucocorticoids, Inhaled • HAE Treatments • H. Pylori Treatment • Hypoglycemics, Incretin Mimetics/Enhancers • Hypoglycemics, Insulin and Related Agents • Immune Globulins • Intranasal Rhinitis Agents	Added new classes and updated preferred drug lists and GCNs

Version Number	Chapter/Section	Change
	• Linconsamides/Oxazolidinones/Streptogramins • Lipotropics, Other • Lipotropics, Statins • Movement Disorders • Neuropathic Pain • PAH Agents, Oral and Inhaled • Pancreatic Enzymes • Pediatric Vitamin Preparations • Phosphate Binders • Platelet Aggregation Inhibitors • Prenatal Vitamins • Progestins for Cachexia • Proton Pump Inhibitors • Sedative Hypnotics • Smoking Cessation • Stimulants and Related Agents • Thrombopoiesis Stimulating Proteins • Urea Cycle Disorders, Oral	
.22	• Macrolides	Updated criteria and approval duration Updated diagnosis lookback timeframe for Immunomodulators, Dupixent
.23	• Immunomodulators, Atopic Dermatitis • Immunomodulators, Dupixent (atopic dermatitis step)	Updated lookback timeframe for preferred agents
.24	• Stimulants and Related Agents	Removed Methylin criteria logic and logic diagram – medication is currently preferred
.25	• Macrolides	Rearranged criteria logic and logic diagram for Macrolides
.26	• Neuropathic Pain	Removed duloxetine 40mg from the preferred agents table

.27	• Acne Agents Topical • Alzheimer's Agents • Androgenic Agents • Antiallergens, Oral • Antibiotics, GI • Antibiotics, Topical • Antibiotics, Vaginal • Anticonvulsants • Antiemetic/Antivertigo Agents • Antifungals, Oral • Antifungals, Topical • Antihistamines, First Generation • Antihistamines, Minimally Sedating • Antihypertensives, Sympatholytics • Antimigraine Agents, Other • Antiparasitics, Topical • Antipsychotics • Antipsychotics, Long-Acting Injectables • Antivirals, Topical • Bone Resorption Suppression and Related Agents • Calcium Channel Blockers • Cephalosporins and Related Antibiotics • Colony Stimulating Factors • Cytokine and CAM Antagonists • Epinephrine Self-Injected • Fluoroquinolones, Oral • GI Motility, Chronic • Glucocorticoids, Oral • Growth Hormone • Hemophilia Treatment • Hepatitis C Agents • HIV/AIDS • Hypoglycemics, Incretin Mimetics/Enhancers • Hypoglycemics, Insulin and Related Agents • Hypoglycemics, Meglitinides • Hypoglycemics, Metformin	Added new classes and updated preferred drug lists and GCNs

Version Number	Chapter/Section	Change
	• Hypoglycemics, SGLT2 • Hypoglycemics, TZD • Immune Globulins • Immunomodulators, Atopic Dermatitis • Immunosuppressives, Oral • Iron, Oral • Leukotriene Modifiers • Lipotropics, Other • Macrolides/Ketolides • Multiple Sclerosis Agents • NSAIDs • Oncology, Oral – Breast • Oncology, Oral – Hematologic • Oncology, Oral – Lung • Oncology, Oral – Other • Oncology, Oral – Prostate • Oncology, Oral – Renal Cell • Oncology, Oral - Skin • Ophthalmic Antibiotics • Ophthalmic Antibiotic-Steroid Combinations • Ophthalmics for Allergic Conjunctivitis • Ophthalmics, Anti-Inflammatories • Ophthalmics, Anti-Inflammatory/Immunomodulator • Ophthalmics, Glaucoma Agents • Opiate Dependence Treatments • Otic Antibiotics • Otic Anti-Infectives and Anesthetics • Penicillins • Progestational Agents • Rosacea Agents, Topical • Sedative/Hypnotics • Skeletal Muscle Relaxants • Steroids, Topical • Tetracyclines • Ulcerative Colitis Agents	

Version Number	Chapter/Section	Change
.28	• Anti-Allergen Agents • Antibiotics, Vaginal • Antiemetic-Antivertigo Agents • Bronchodilators, Inhaled • Colony Stimulating Factors • First Generation Antihistamines • Hypoglycemics, TZDs • Lipotropics, Other • Prenatal Vitamins • Stimulants and Related Agents	Removed exemption criteria for ondansetron solution because it is currently a preferred agent Removed GCNs for clemastine fum 2.68mg, methylphenidate ER, metronidazole 0.75% vaginal gel and Granix Added the following statement to Hypoglycemics, TZD: Separate prescriptions for the individual components should be used instead of the combination drugs Added subsection for PCSK9 inhibitors under Lipotropics, Other 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 Added the following statement to Prenatal Vitamins: Prenatal vitamins are covered only for females less than 50 years of age. Removed diagnosis check of CVD and intolerable side effects for Inhaled Bronchodilators
.29	• Macrolides	Revised prior therapy question to read: Has the client failed a 7-day treatment trial with at least 1 preferred agent in the past medical and pharmacy claims history? (Exception may apply when a preferred drug requires less than a 7-day treatment trial)

.30	• Acne Agents, Oral • Acne Agents, Topical • Analgesics, Narcotics Long • Analgesics, Narcotics Short • Angiotensin Modulator Combinations • Angiotensin Modulators • Anti-allergens, Oral • Antibiotics, GI • Antibiotics, Inhaled • Anticoagulants • Antidepressants, Other • Antidepressants, SSRI • Antidepressants, Tricyclic • Antihyperuricemics • Antimigraine Agents, Other • Antimigraine Agents, Triptans • Antiparkinson's Agents • Antivirals, Oral • Anxiolytics • Beta-Blockers • Bile Salts • Bladder Relaxant Preparations • BPH Treatments • Bronchodilators, Beta Agonist • Colony Stimulating Factors • COPD Agents • Cough and Cold • Cytokine and CAM Antagonists • Erythropoiesis Stimulating Proteins • Glucagon Agents • Glucocorticoids, Inhaled • Glucocorticoids, Oral • HAE Treatments • Hemophilia Treatment • H.Pylori Treatment • Hypoglycemics, Incretin Mimetics/Enhancers • Hypoglycemics, Insulin and Related Agents • Immune Globulins • Immunomodulators, Asthma	Updated preferred drug lists and GCNs

Version Number	Chapter/Section	Change
	• Immunomodulators, Atopic Dermatitis • Intranasal Rhinitis Agents • Lincosamides/ Oxazolidinones/ Streptogramins • Lipotropics, Other • Lipotropics, Statins • Movement Disorders • Multiple Sclerosis • Neuropathic Pain • NSAIDs • Oncology, Oral-Breast • Oncology, Oral-Hematologic • Oncology, Oral-Lung • Oncology, Oral-Other • Oncology, Oral-Prostate • Oncology, Oral-Renal Cell • Oncology, Oral-Skin • Ophthalmics for Allergic Conjunctivitis • Ophthalmics, Anti-Inflammatory/ Immunomodulators • PAH Agents, Oral and Inhaled • Pancreatic Enzymes • Pediatric Vitamin Preparations • Phosphate Binder • Platelet Aggregation Inhibitors • Prenatal Vitamins • Progestins for Cachexia • Proton Pump Inhibitors • Sedative Hypnotics • Sickle Cell Anemia Treatments • Smoking Cessation • Steroids, Topical • Stimulants and Related Agents • Thrombopoiesis Stimulating Proteins • Urea Cycle Disorders, Oral	

Version Number	Chapter/Section	Change
.31	• Ophthalmics, Anti-Inflammatory / Immunomodulators	Revised lookback timeframe from 180 days therapy with a preferred agent in the last 200 days to 30 days therapy in the last 180 days
.32	• Ophthalmics, Anti-Inflammatory Agents	Added GCN for Lotemax 0.5% drops to preferred agents
.33	• Antibiotics, Topical	Updated logic diagram, question 1, to look for a 5-days supply of a preferred agent in the last 60 days
.34	• Immunomodulators, Rinvoq	Added criteria for atopic dermatitis and check for prior therapy with preferred atopic dermatitis agents
	• Macrolides	Updated heading to Macrolides/Ketolides

	• Alzheimer's Agents • Androgenic Agents • Antibiotics, GI • Antibiotics, Topical • Antibiotics, Vaginal • Anticonvulsants • Antiemetic/Antivertigo Agents • Antifungals, Oral • Antifungals, Topical • Antihistamines, First Generation • Antihistamines, Minimally Sedating • Antihypertensives Sympatholytics • Antiparasitics, Topical • Antipsychotics • Antivirals, Topical • Bladder Relaxant Preparations • Bone Resorption Suppression and Related Agents • Calcium Channel Blockers • Cephalosporins and Related Antibiotics • Colony Stimulating Factors • Cytokine and CAM Antagonists • Epinephrine, Self-Injected • Fluoroquinolones, Oral • GI Motility, Chronic • Glucagon Agents • Glucocorticoids, Oral • Growth Hormone • Hepatitis C Agents • HIV/AIDS • Hypoglycemics, Insulin and Related Agents • Hypoglycemics, Meglitinides • Hypoglycemics, Metformins • Hypoglycemics, SGLT2 • Hypoglycemics, TZD • Immunosuppressives, Oral • Iron, Oral • Leukotriene Modifiers	Updated preferred drug lists and GCNs

Version Number	Chapter/Section	Change
	• Macrolides/Ketolides • Multiple Sclerosis Agents • NSAIDs • Oncology, Oral - Hematologic • Oncology, Oral – Lung • Oncology, Oral - Other • Ophthalmic Antibiotics • Ophthalmic Antibiotics-Steroid Combinations • Ophthalmics for Allergic Conjunctivitis • Opththalmics, Anti-Inflammatories • Ophthalmics, Anti-Inflammatory/Immunomodulator • Ophthalmics, Glaucoma Agents • Opiate Dependence Treatments • Otic Antibiotics • Otic Anti-Infectives & Anesthetics • Penicillins • Platelet Aggregation Inhibitors • Progestational Agents • Rosacea Agents, Topical • Sedative Hypnotics • Skeletal Muscle Relaxants • Steroids, Topical • Stimulants and Related Agents • Tetracyclines • Ulcerative Colitis Agents	
.35	• Phosphate Binders	Updated criteria
.36	• Rinvoq	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	• Potassium Binders	Added criteria for the new class, Potassium Binders

	• Acne Agents, Oral • Acne Agents, Topical • Analgesics, Narcotic Long • Analgesics, Narcotic Short • Angiotensin Modulator Combinations • Angiotensin Modulators • Anti-Allergens, Oral • Anticoagulants • Antidepressants, Other • Antidepressants, SSRIs • Antidepressants, TCAs • Antihyperuricemics • Antimigraine Agents, Other • Antimigraine Agents, Triptans • Antiparkinson's Agents • Antipsychotic Agents • Antivirals, Oral • Anxiolytics • Beta Blockers • Bile Salts • Bladder Relaxant Preparations • BPH Treatments • Bronchodilators, Beta Agonist • COPD Agents • Cough and Cold Agents • Erythropoiesis Stimulating Proteins • Glucagon Agents • Glucocorticoids, Inhaled • HAE Treatments • Hemophilia Treatments • H. Pylori Treatment • Immune Globulins • Immunomodulators, Asthma • Immunomodulators, Atopic Dermatitis • Intranasal Rhinitis Agents • Lincosamides/ Oxazolidinones/ Streptogramins • Lipotropics, Other • Lipotropics, Statins • Movement Disorders	Updated classes and GCNs

Version Number	Chapter/Section	Change
	• Multiple Sclerosis Agents • Neuropathic Pain • Oncology, Oral-Breast • Oncology, Oral-Hematologic • Oncology, Oral-Lung • Oncology, Oral-Other • Oncology, Oral – Prostate • Oncology, Oral-Renal Cell • Oncology, Oral-Skin • PAH Agents, Oral and Inhaled • Pancreatic Enzymes • Pediatric Vitamin Preparations • Phosphate Binders • Platelet Aggregation Inhibitors • Prenatal Vitamins • Progestins for Cachexia • PPIs • Sedative Hypnotics • Sickle Cell Anemia Treatments • Smoking Cessation • Stimulants and Related Agents • Thrombopoiesis Stimulating Proteins • Urea Cycle Disorders, Oral	
.38	• Immunomodulators, Dupixent	Added diagnosis of eosinophilic esophagitis for Dupixent
.39	• Bronchodilators, Beta Agonists • Glucagon Agents	Updated lookback for a preferred agent to 14 days supply in the last 180 days for Bronchodilators, Beta Agonists and 1 day supply in the last 180 days for Glucagon agents
.40	• Hepatitis C Agents	Updated preferred agents
.41	• Uterine Disorder Treatments	Added criteria for Uterine Disorder Treatments

	• Acne Agents, Topical • Alzheimer's Agents • Analgesics, Narcotic – Short • Androgenic Agents • Antibiotics, Vaginal • Antiemetic/Antivertigo Agents • Antifungals, Oral • Antifungals, Topical • Antihistamines, First Generation • Antipsychotic Agents • Antiviral Agents • Calcium Channel Blockers • Colony Stimulating Factors • Cytokine and CAM Antagonists • Epinephrine, Self-injected • Fluroquinolones, Oral • Glucocorticoids, Oral • GI Motility Agents • HAE Agents • HIV/AIDs • Hypoglycemics, Incretin Mimetics/Enhancers • Hypoglycemics, Insulin and Related Agents • Hypoglycemics, Metformin • Hypoglycemics, SGLT2 • Immunosuppressives, Oral • Macrolides/Ketolides • NSAIDs • Ophthalmic Antibiotics • Ophthalmic Antibiotic-Steroid Combinations • Ophthalmics for Allergic Conjunctivitis • Opiate Dependence Treatments • PAH Agents, Oral and Inhaled • Rosacea Agents, Topical • Sedative/Hypnotics • Skeletal Muscle Relaxants • Tetracyclines	Updated GCNs for preferred and nonpreferred agents

Version Number	Chapter/Section	Change
	• Ulcerative Colitis Agents	

.42	• Acne Agents, Oral • Acne Agents, Topical • Analgesics, Narcotic (Long) • Analgesics, Narcotic (Short) • Anti-allergens, Oral • Antibiotics, Inhaled • Anticoagulants • Antidepressants, Other • Antidepressants, SSRIs • Antidepressants, Tricyclic • Antifungals, Oral • Angiotensin Modulator Combinations • Angiotensin Modulators • Antihypertensives, Sympatholytics • Antihyperuricemics • Antimigraine Agents, Other • Antimigraine Agents, Triptans • Antiparkinson's Agents • Antivirals, Oral • Anxiolytics • Beta-Blockers • Bile Salts • Bladder Relaxant Preparations • BPH Treatments • Bronchodilators, Beta Agonist • Colony Stimulating Factors • COPD Agents • Cough and Cold, Cold • Cough and Cold, Narcotic • Cought and Cold, Non-Narcotic • Cytokine and CAM Antagonists • Erythropoiesis Stimulating Proteins • Glucagon Agents • Glucocorticoids, Inhaled • HAE Treatments • Hemophilia Treatments • HIV/AIDS • H. Pylori Treatment	Updated GCNs for preferred and nonpreferred agents

Version Number	Chapter/Section	Change
	• Hypoglycemics, Insulin and Related Agents • Immune Globulins • Immunomodulators, Asthma • Immunomodulators, Atopic Dermatitis • Intranasal Rhinitis Agents • Lincosamides/Oxazolidinones/Streptogramins • Lipotropics, Other • Lipotropics, Statins • Movement Disorders • MS Agents • Neuropathic Pain • Oncology, Oral-Breast • Oncology, Oral-Hematologic • Oncology, Oral-Lung • Oncology, Oral-Other • Oncology, Oral-Prostate • Oncology, Oral-Renal Cell • Oncology, Oral-Skin • PAH Agents, Oral and Inhaled • Pancreatic Enzymes • Pediatric Vitamin Preparations • Phosphate Binders • Platelet Aggregation Inhibitors • Potassium Binders • Prenatal Vitamins • Progesterones for Cachexia • Proton Pump Inhibitors • Sedative Hypnotics • Sickle Cell Treatments • Smoking Cessation • Stimulants and Related Agents • Thrombopoiesis Stimulating Proteins • Urea Cycle Disorders, Oral	

Version Number	Chapter/Section	Change
.43	• Rinvoq • Dupixent • Hepatitis C Agents	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	• Alzheimer's Agents • Androgenic Agents • Antibiotics, GI • Antibiotics, Topical • Antibiotics, Vaginal • Anticonvulsants • Antiemetic/Antivertigo Agents • Antifungals, Oral • Antifungals, Topical • Antihistamines, First Generation • Antihistamines, Minimally Sedating • Antimigraine Agents, Other • Antiparasitics, Topical • Antipsychotics • Antivirals, Topical • Bone Resorption Suppression and Related Agents • Calcium Channel Blockers • Cephalosporins and Related Antibiotics • Colony Stimulating Factors • Cytokine and CAM Antagonists • Epinephrine, Self-injected • Fluoroquinolones, Oral • GI Motility, Chronic • Glucocorticoids, Oral • Growth Hormone • Hemophilia Treatment • HIV/AIDS • Hypoglycemics, Incretin Mimetics/Enhancers • Insulin and Related Agents • Meglitinides • Metformins • SGLT2 • TZD • Immunomodulators, Lupus • Immunosuppressives, Oral • Iron, Oral • Leukotriene Modifiers • Macrolides/Ketolides	Updated GCNs for preferred and nonpreferred agents Added information from HB 3286, Section 2, 88th Legislature, Regular Session, 2023, including PDL criteria exceptions and additional criteria for the Antipsychotic PDL class

Version Number	Chapter/Section	Change
	• Movement Disorders • NSAIDs • Oncology, Oral • Ophthalmic Antibiotics • Ophthalmic Antibiotic-Steroid Combinations • Ophthalmics for Allergic Conjunctivitis • Ophthalmics, Anti-Inflammatories • Ophthalmics, Anti-Inflammatories/Immuno modulator • Ophthalmics, Glaucoma Agents • Opiate Dependence Treatments • Otic Antibiotics • Otic Anti-Infectives & Anesthetics • PAH Agents, Oral and Inhaled • Penicillins • Proton Pum Inhibitors • Rosacea Agents, Topical • Sedative Hypnotics • Skeletal Muscle Relaxants • Steroids, Topical • Tetracyclines • Ulcerative Colitis Agents • Uterine Disorder Treatments	