# Medicaid Pharmacy Prior Authorization & Preferred Drug List

Individuals enrolled in either traditional Medicaid (fee-for-service) or Medicaid managed care adhere to the same formulary, and some drugs on the formulary may require prior authorization, either non-preferred, clinical, or both. Pharmacy prior authorization services needed by Medicaid managed care individuals are administered by that individual's managed care organization (MCO), while traditional Medicaid prior authorizations are administered by the Texas Prior Authorization Call Center.

### Formulary

The **Medicaid formulary** includes legend and over-the-counter drugs. In addition certain supplies and select vitamin and mineral products are also available as a pharmacy benefit.

Some drugs are subject to one or both types of prior authorization, clinical and non-preferred.

### Preferred Drug List

The **PDL** is arranged by PDL drug class, and contains a subset of many, but not all, drugs that are on the Medicaid formulary.

Most drugs are identified as preferred or non-preferred. Drugs listed on the PDL as preferred or not listed at all are available to individuals without prior authorization unless there is a clinical prior authorization associated with that drug.

### Clinical Prior Authorization

**Clinical prior authorizations** may apply to any individual drug or an entire drug class on the formulary, including some preferred and non-preferred drugs.

There are certain clinical PAs that all MCOs are required to perform. Usage of all other clinicial PAs will vary between MCOs at the descretion of each MCO.

### PDL Prior Authorization

Drugs identified as non-preferred on the PDL require a PDL prior authorization.

The PDL PA Criteria Guide explains the criteria used to evaluate the PDL PA requests.

## Obtaining PDL/Clinical Prior Authorization

As a prescribing provider you can help your Medicaid-eligible individuals receive medications quickly and conveniently with a few simple steps. Prescribing providers or their representatives should contact one of the following authorization authorities:

### Medicaid Managed Care

- Pharmacy prior authorization call centers vary by MCO. The **Prescriber Assistance Chart** identifies each MCO and its prior authorization and member call center phone numbers.

### Traditional Medicaid

- The **Texas PA Call Center** accepts PA requests by phone at 1-877-PA-TEXAS (1-877-728-3927) or online. Please note online submission is only available for PDL PA requests.
- Xenical and Enzyme Replacement Therapy products require prior authorization but are reviewed internally by HHSC staff.

## Obtaining PDL/Clinical Prior Authorization

1. Medicaid Managed Care
   - Prescriber Assistance Chart (TxVendorDrug.com/managed-care/downloads/prescriber-assistance-chart.pdf)
2. Traditional Medicaid
   - Texas Prior Authorization Call Center (TxVendorDrug.com/about/contact/prior-authorization-call-center.shtml)
   - Account Registration Instructions (https://paxpress.txpa.hidinc.com/Account_Reg_Instructions.pdf)
   - Provider Quick Reference (https://paxpress.txpa.hidinc.com/Provider_Quick_Ref_Guide.pdf)

## Finding Drugs on the Formulary

1. The Formulary Search identifies the list of covered Medicaid and CHIP drugs and whether a drug requires a PDL and/or a clinical prior authorization (TxVendorDrug.com/formulary/). CHIP drugs are not subject to PDL requirements.
2. Both the formulary and PDL are available for mobile devices through the free Epocrates drug information system (TxVendorDrug.com/formulary/epocrates.shtml).

## Preferred Drug List

1. The PDL is arranged by drug class, and contains a subset of many, but not all, drugs that are on the formulary (TxVendorDrug.com/formulary/preferred-drugs.shtml).
2. The Texas Medicaid Drug Utilization Review (DUR) Board makes recommendations for the preferred drug list four times a year. Close to 75 therapeutic classes are reviewed each year with approximately one-quarter of the classes reviewed at each session.
   a. Decisions made at the January and April board meetings are included on the July release of the PDL.
   b. Decisions made at the July and October board meetings are included on the January release of the PDL.
3. The PDL PA Criteria Guide explains the criteria used to evaluate PA requests (https://paxpress.txpa.hidinc.com/p_dl_crit_guide.pdf).

## Clinical Prior Authorization

1. All Texas Medicaid Drug Utilization Board-approved clinical prior authorizations are listed here: (TxVendorDrug.com/dur/clinical-edit-criteria.shtml).
2. The Clinical Prior Authorization Assistance Chart identifies which prior authorizations are utilized by each MCO and those used by traditional Medicaid (TxVendorDrug.com/pa/downloads/cpa-assistance-chart.pdf).

## Stay Informed with Updates from Texas Medicaid

- Texas Medicaid Email Notification Service: TxVendorDrug.com/news/email-notification.shtml

For questions or comments about the PDL please email vdp_formulary@hhsc.state.tx.us.

# HEALTH AND HUMAN SERVICES COMMISSION
# TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
## Effective January 26, 2017

| PREFERRED DRUG LIST PUBLICATION LOG | |
|---|---|
| The PDL is published biannually (January, July). Recent changes to the PDL status are highlighted: | |
| January 26, 2017: | Published |

| ACNE AGENTS, ORAL | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| AMNESTEEM (isotretinoin)<br>CLARAVIS (isotretinoin)<br>MYORISAN (isotretinoin)<br>ZENATANE (isotretinoin) | *ABSORICA (isotretinoin)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| ACNE AGENTS, TOPICAL | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Antibiotics** | | |
| clindamycin gel<br>clindamycin lotion<br>clindamycin medicated swab<br>clindamycin solution<br>erythromycin gel<br>erythromycin solution | *CLEOCIN-T (clindamycin)*<br>*clindamycin foam*<br>*erythromycin medicated swab* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Benzoyl Peroxide** | | |
| benzoyl peroxide cream<br>benzoyl peroxide gel (Rx)<br>benzoyl peroxide lotion<br>benzoyl peroxide wash | *benzoyl peroxide cleanser*<br>*benzoyl peroxide foam*<br>*benzoyl peroxide gel*<br>*benzoyl peroxide kit*<br>*benzoyl peroxide towelette* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ACNE AGENTS, TOPICAL | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Retinoids** | | |
| tretinoin (Avita, Retin-A) | *adapalene*<br>*ATRALIN (tretinoin)*<br>*AVITA (tretinoin)*<br>*DIFFERIN (adapalene)*<br>*FABIOR (tazarotene)*<br>*RETIN-A (tretinoin)*<br>*RETIN-A MICRO (tretinoin)*<br>*TAZORAC (tazarotene)*<br>*tretinoin gel (Atralin)*<br>*tretinoin microspheres* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Combination and Other Agents** | | |
| BENZACLIN (benzoyl peroxide/clindamycin) gel pump | *ACZONE (dapsone)*<br>*AZELEX (azelaic acid)*<br>*BENZACLIN GEL (benzoyl peroxide/clindamycin)*<br>*clindamycin/benzoyl peroxide*<br>*DUAC (benzoyl peroxide/clindamycin)*<br>*EPIDUO (benzoyl peroxide/adapalene)*<br>*EPIDUO FORTE (benzoyl peroxide/adapalene)*<br>*erythromycin/benzoyl peroxide*<br>*sulfacetamide*<br>*sulfacetamide sodium*<br>*sulfacetamide sodium/sulfur*<br>*sulfacetamide/sulfur*<br>*sulfacetamide/sulfur/urea*<br>*VELTIN (clindamycin/tretinoin)*<br>*ZIANA (clindamycin/tretinoin)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| ALZHEIMER'S AGENTS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Cholinesterase Inhibitors** | | |
| donepezil 5, 10 mg tablet<br>donepezil ODT<br>EXELON (rivastigmine) transdermal | *ARICEPT (donepezil)*<br>*donepezil 23 mg tablet*<br>*EXELON (rivastigmine) capsules*<br>*galantamine*<br>*galantamine ER*<br>*RAZADYNE ER (galantamine)*<br>*rivastigmine* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **NMDA Receptor Antagonist** | | |
| memantine tablets<br>NAMENDA (memantine) solution | *NAMENDA (memantine) tablets*<br>*NAMENDA XR (memantine)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Cholinesterase Inhibitor/NMDA Receptor Antagonist Combinations** | | |
| | *NAMZARIC (donepezil/memantine)* | |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANALGESICS, NARCOTIC – LONG ACTING | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| BUTRANS (buprenorphine)<br>EMBEDA (morphine/naloxone)*<br>fentanyl patch (12.5, 25, 50, 100 mcg)[PPG]*<br>HYSINGLA ER (hydrocodone) *<br>morphine ER[PPG] (generic MS Contin) *<br>tramadol ER (generic Ryzolt, Ultram ER) | *AVINZA (morphine) **<br>*BELBUCA (buprenorphine)*<br>*CONZIP (tramadol)*<br>*DURAGESIC (fentanyl) **<br>*EXALGO (hydromorphone) **<br>*fentanyl patch (37.5, 62.5, 87.5 mcg) **<br>*hydromorphone ER**<br>KADIAN (morphine) *<br>*morphine ER (generic Avinza, Kadian) ** | *MS CONTIN (morphine) **<br>*NUCYNTA ER (tapentadol) **<br>*OPANA ER (oxymorphone) **<br>*oxycodone ER **<br>*OXYCONTIN (oxycodone) **<br>*oxymorphone ER**<br>*tramadol ER (generic Conzip)*<br>*ULTRAM ER (tramadol)*<br>*XTAMPZA ER (oxycodone)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

## ANALGESICS, NARCOTIC – SHORT ACTING (NON-PARENTERAL)

| Preferred Agents | *Non-Preferred Agents* | PA Criteria |
|---|---|---|
| APAP/codeine[PPG]*<br>butalbital/APAP/caffeine/codeine*<br>codeine*<br>hydrocodone/APAP[PPG]*<br>hydrocodone/ibuprofen*<br>hydromorphone tablet[PPG]*<br>morphine tablets*<br>morphine solution*<br>oxycodone solution*<br>oxycodone tablet[PPG]*<br>oxycodone/APAP[PPG]*<br>tramadol<br>tramadol/APAP | *butalbital/ASA/caffeine/codeine**<br>*butorphanol**<br>*CAPITAL W/CODEINE (APAP/codeine)**<br>*carisoprodol/aspirin/codeine**<br>*dihydrocodeine/ASA/caffeine**<br>*DILAUDID (hydromorphone) **<br>*fentanyl buccal**<br>*FENTORA (fentanyl) **<br>*FIORICET W/CODEINE (butalbital/ APAP/caffeine/codeine) **<br>*FIORINAL W/CODEINE (butalbital/ASA/caffeine/codeine) **<br>*hydromorphone liquid**<br>*hydromorphone suppositories*<br>*IBUDONE (hydrocodone/ibuprofen) **<br>*levorphanol**<br>*LORTAB (hydrocodone/APAP) **<br>*meperidine**<br>*morphine concentrated solution**<br>*morphine suppositories **<br>*NORCO (hydrocodone/APAP)**<br>*NUCYNTA (tapentadol)**<br>*OPANA (oxymorphone)**<br>*oxycodone/ASA**<br>*oxycodone/ibuprofen**<br>*oxycodone capsule**<br>*oxycodone concentrated solution**<br>*oxymorphone**<br>*pentazocine/naloxone**<br>*PERCOCET (oxycodone/APAP)**<br>*REPREXAIN (hydrocodone/ibuprofen)**<br>*ROXICODONE (oxycodone)**<br>*TYLENOL-CODEINE (codeine/APAP)**<br>*ULTRACET (tramadol/APAP)*<br>*ULTRAM (tramadol)*<br>*XARTEMIS XR (oxycodone/APAP)**<br>*XODOL (hydrodone/APAP)** | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

## ANDROGENIC AGENTS, TOPICAL

| Preferred Agents | *Non-Preferred Agents* | PA Criteria |
|---|---|---|
| ANDROGEL (testosterone) | *ANDRODERM (testosterone)*<br>*AXIRON (testosterone)*<br>*FORTESTA (testosterone)*<br>*NATESTO (testosterone)*<br>*TESTIM (testosterone)*<br>*testosterone gel*<br>*VOGELXO (testosterone)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANGIOTENSIN MODULATORS | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| **Ace Inhibitors** | | | |
| benazepril<br>captopril<br>enalapril<br>lisinopril<br>ramipril | *ACCUPRIL (quinapril)*<br>*ALTACE (ramipril)*<br>*EPANED (enalapril)*<br>*fosinopril*<br>*LOTENSIN (benazepril)*<br>*MAVIK (trandolapril)*<br>*moexepril*<br>*perindopril*<br>*PRINIVIL (lisinopril)* | *quinapril*<br>*trandolapril*<br>*VASOTEC (enalapril)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ Epaned will be authorized for patients six years of age and under |
| **ACE Inhibitor/Diuretic Combinations** | | | |
| benazepril/HCTZ<br>captopril/HCTZ<br>enalapril/HCTZ<br>lisinopril/HCTZ | *ACCURETIC (quinapril/HCTZ)*<br>*fosinopril/HCTZ*<br>*moxepril/HCTZ*<br>*quinapril/HCTZ*<br>*ZESTORETIC (lisinopril/HCTZ)* | | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Angiotensin II Receptor Blockers (ARBs)** | | | |
| BENICAR (olmesartan)<br>DIOVAN (valsartan)<br>losartan | *ATACAND (candesartan)*<br>*AVAPRO (irbesartan)*<br>*candesartan*<br>*COZAAR (losartan)*<br>*EDARBI (azilsartan)*<br>*eprosartan* | *irbesartan*<br>*MICARDIS (telmisartan)*<br>*telmisartan*<br>*valsartan* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANGIOTENSIN MODULATORS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **ARB/Diuretic Combinations** | | |
| BENICAR-HCT (olmesartan/HCTZ)<br>losartan/HCTZ | *ATACAND-HCT (candesartan/HCTZ)*<br>*AVALIDE (irbesartan/HCTZ)*<br>*candesartan/HCTZ*<br>*DIOVAN-HCT (valsartan/HCTZ)*<br>*EDARBYCLOR (azilsartan/chlorthalidone)*<br>*HYZAAR (losartan/HCTZ)*<br>*irbesartan/HCTZ*<br>*MICARDIS-HCT (telmisartan/HCTZ)*<br>*telmisartan /HCTZ*<br>*valsartan/HCTZ* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Direct Renin Inhibitors** | | |
| | *TEKTURNA (aliskerin)** | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |
| **Direct Renin Inhibitor/Diuretic Combinations** | | |
| | *TEKTURNA HCT (aliskerin/HCTZ)** | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANGIOTENSIN MODULATORS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **ARB/Neprilysin Inhibitor Combinations** | | |
| ENTRESTO (valsartan/sacubitril) | | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| ANGIOTENSIN MODULATOR COMBINATIONS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| benazepril /amlodipine<br>EXFORGE (valsartan/amlodipine)<br>EXFORGE HCT (valsartan/amlodipine/HCTZ)<br>TARKA (trandolapril/verapamil) | *AZOR (olmesartan/amlodipine)*<br>*LOTREL (benazepril/amlodipine)*<br>*telmisartan/amlodipine*<br>*trandolapril/verapamil*<br>*TRIBENZOR (olmesartan/amlodipine/HCTZ)*<br>*TWYNSTA (telmisartan/amlodipine)*<br>*valsartan /amlodipine*<br>*valsartan/amlodipiine/HCTZ* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

| ANTI-ALLERGENS, ORAL | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| None | *GRASTEK (Timothy grass pollen allergen extract)**<br>*ORALAIR (Sweet Vernal, Orchard, Perennial Rye, Timothy, & Kentucky Blue Grass mixed pollens allergen extract)**<br>*RAGWITEK (short ragweed pollen allergen extract)** | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANGIOTENSIN MODULATOR COMBINATIONS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |

| ANTIBIOTICS, GASTROINTESTINAL | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| metronidazole tablet<br>tinidazole<br>vancomycin | *ALINIA (nitazoxanide)**<br>*DIFICID (fidaxomicin)*<br>*FLAGYL (metronidazole)*<br>*FLAGYL ER (metronidazone)*<br>*metronidazole capsule*<br>*neomycin*<br>*paromomycin*<br>*TINDAMAX (tinidazole)*<br>*VANCOCIN (vancomycin)*<br>*XIFAXAN (rifaximin)** | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

| ANTIBIOTICS, INHALED | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| BETHKIS (tobramycin)<br>CAYSTON (aztreonam)<br>KITABIS PAK (tobramycin)<br>TOBI PODHALER (tobramycin) | *TOBI (tobramycin) solution*<br>*tobramycin solution* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANTIBIOTICS, INHALED | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |

| ANTIBIOTICS, TOPICAL | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| bacitracin ointment<br>BACTROBAN (mupirocin) cream<br>gentamicin<br>mupirocin ointment<br>triple antibiotic ointment | *ALTABAX (retapamulin)**<br>*bacitracin packet*<br>*bacitracin/polymyxin*<br>*BACTROBAN (mupirocin) ointment*<br>*CENTANY (mupirocin)*<br>*mupirocin cream*<br>*neomycin/polymyxin/pramoxine* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

| ANTIBIOTICS, VAGINAL | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| CLEOCIN (clindamycin) ovules<br>clindamycin<br>metronidazole | *CLEOCIN (clindamycin) cream*<br>*METROGEL-VAGINAL (metronidazole)*<br>*NUVESSA (metronidazole)*<br>*VANDAZOLE (metronidazole)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| ANTICOAGULANTS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| ELIQUIS (apixaban)<br>enoxaparin<br>FRAGMIN (dalteparin) syringe<br>PRADAXA (dabigatran)<br>warfarin<br>XARELTO (rivaroxaban) | *ARIXTRA (fondaparinux)*<br>*COUMADIN (warfarin)*<br>*fondaparinux*<br>*FRAGMIN (dalteparin) vial*<br>*LOVENOX (enoxaparin)*<br>*SAVAYSA (edoxaban)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANTIDEPRESSANTS, OTHER | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| bupropion<br>bupropion SR<br>bupropion XL<br>MARPLAN (isocarboxazid)<br>mirtazapine<br>phenelzine<br>trazodone<br>venlafaxine ER capsules | *APLENZIN (bupropion)*<br>*BRINTELLIX (vortioxetine)*<br>*desvenlafaxine ER*<br>*EFFEXOR XR (venlafaxine)*<br>*EMSAM (selegiline)*<br>*FETZIMA (levomilnacipran)*<br>*FORFIVO XL (bupropion)*<br>*KHEDEZLA (desvenlafaxine)*<br>*NARDIL (phenelzine)*<br>*nefazodone*<br>*OLEPTRO ER (trazodone)* | *PARNATE (tranylcypromine)*<br>*PRISTIQ (desvenlafaxine)*<br>*REMERON (mirtazapine)*<br>*tranylcypromine*<br>*venlafaxine IR*<br>*venlafaxine ER tablets*<br>*VIIBRYD (vilazodone)*<br>*WELLBUTRIN (bupropion)*<br>*WELLBUTRIN SR (bupropion)*<br>*WELLBUTRIN XL (bupropion)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| ANTIDEPRESSANTS, SSRIS | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| citalopram<br>escitalopram tablets<br>fluoxetine IR<br>fluvoxamine<br>paroxetine<br>sertraline | *BRISDELLE (paroxetine)*<br>*CELEXA (citalopram)*<br>*escitalopram solution*<br>*fluoxetine capsule DR*<br>*fluvoxamine ER*<br>*LEXAPRO (escitalopram)* | *paroxetine CR*<br>*PAXIL (paroxetine)*<br>*PAXIL CR (paroxetine)*<br>*PEXEVA (paroxetine)*<br>*PROZAC (fluoxetine)*<br>*ZOLOFT (sertraline)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANTIEMETIC-ANTIVERTIGO AGENTS (EXCLUDES INJECTABLES) | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Anticholinergics, Antihistamines, Dopamine Antagonists** | | |
| DICLEGIS (doxylamine/pyridoxine)<br>dimenhydrinate<br>meclizine<br>metoclopramide solution, tablets<br>phosphoric acid/dextrose/fructose<br>prochlorperazine (oral)<br>promethazine syrup, tablets* | *COMPRO (prochlorperazine)*<br>*metoclopramide ODT*<br>*METOZOLV ODT (metoclopramide)*<br>*prochlorperazine (rectal)*<br>*promethazine suppositories**<br>*REGLAN (metoclopramide)*<br>*TRANSDERM-SCOP (scopolamine)*<br>*trimethobenzamide* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |
| **Cannabinoids** | | |
| dronabinol | *MARINOL (dronabinol)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **5-HT3 Receptor Antagonists** | | |
| ondansetron | *ANZEMET (dolasetron)**<br>*granisetron*<br>*SANCUSO (granisetron)**<br>*ZOFRAN (ondansetron)** | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ Ondansetron solution will be authorized for patients six years of age and under<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANTIEMETIC-ANTIVERTIGO AGENTS (EXCLUDES INJECTABLES) | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Substance P Antagonists & Combinations** | | |
| | *AKYNZEO (netupitant/palonosetron)**<br>*EMEND (aprepitant)** | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

| ANTIFUNGALS, ORAL | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| clotrimazole<br>fluconazole<br>griseofulvin suspension<br>ketoconazole<br>nystatin<br>terbinafine | *CRESEMBA (isavuconazonium sulfate)*<br>*DIFLUCAN (fluconazole)*<br>*flucytosine*<br>*GRIS-PEG (griseofulvin)*<br>*griseofulvin tablets*<br>*itraconazole* | *LAMISIL (terbinafine)*<br>*NOXAFIL (posaconazole)*<br>*nystatin powder*<br>*ORAVIG (miconazole)*<br>*SPORANOX (itraconazole)*<br>*VFEND (voriconazole)*<br>*voriconazole* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANTIFUNGALS, TOPICAL | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| **Antifungals** | | | |
| clotrimazole<br>ketoconazole cream, shampoo<br>miconazole cream, powder<br>nystatin<br>terbinafine<br>tolnaftate cream, powder | *BENSAL HP (benzoic acid/salicylic acid)*<br>*ciclopirox*<br>*CNL 8 (ciclopirox)*<br>*econazole*<br>*EXTINA (ketoconazole)*<br>*FUNGOID (miconazole)*<br>*JUBLIA (efinaconazole)*<br>*KERYDIN (tavaborole)*<br>*ketoconazole foam*<br>*LAMISIL (terbinafine)* | *LOPROX (ciclopirox)*<br>*MENTAX (butenafine)*<br>*miconazole ointment, spray*<br>*naftifine*<br>*NAFTIN (naftifine)*<br>*oxiconazole*<br>*OXISTAT (oxiconazole)*<br>*tolnaftate aerosolized powder, solution, spray*<br>*VUSION (miconazole/ zinc/petrolatum)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Antifungal/Steroid Combinations** | | | |
| clotrimazole/betamethasone cream | *clotrimazole/betamethasone lotion*<br>*LOTRISONE (clotrimazole/betamethasone)*<br>*nystatin/triamcinolone* | | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANTIHISTAMINES, MINIMALLY SEDATING | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Antihistamines** | | |
| cetirizine solution, tablets<br>loratadine ODT, solution, tablets | *cetirizine capsule, chewable*<br>*CLARINEX (desloratadine)*<br>*desloratadine*<br>*fexofenadine*<br>*levocetirizine*<br>*XYZAL (levocetirizine)* | ▪ Treatment failure after no less than a 30-day trial of preferred drugs<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Antihistamine/Decongestant Combinations** | | |
| cetirizine/pseudoephedrine<br>loratadine/pseudoephedrine | *fexofenadine/pseudoephedrine*<br>*SEMPREX-D (acrivastine/pseudoephedrine)* | ▪ Treatment failure after no less than a 30-day trial of preferred drugs<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| ANTIHYPERTENSIVES, SYMPATHOLYTICS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| CATAPRES-TTS (clonidine)<br>clonidine IR tablets<br>guanfacine IR<br>methyldopa | *CATAPRES (clonidine)*<br>*clonidine transdermal*<br>*CLORPRES (clonidine / chlorthalidone)*<br>*methyldopa / HCTZ*<br>*methyldopate*<br>*reserpine* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANTIHYPERTENSIVES, SYMPATHOLYTICS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **ANTIHYPERURICEMICS** | | |
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| allopurinol<br>probenecid<br>probenecid/colchicine | *colchicine*<br>*COLCRYS (colchicine)*<br>*ULORIC (febuxostat)*<br>*ZYLOPRIM (allopurinol)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| ANTIMIGRAINE AGENTS | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| **Triptans** | | | |
| IMITREX (sumatriptan) injection kit<br>IMITREX (sumatriptan) nasal<br>RELPAX (eletriptan)<br>sumatriptan tablets | *almotriptan*<br>*AMERGE (naratriptan)*<br>*AXERT (almotriptan)*<br>*FROVA (frovatriptan)*<br>*IMITREX (sumatriptan) tablets*<br>*IMITREX (sumatriptan) vial*<br>*MAXALT (rizatriptan)*<br>*naratriptan*<br>*ONZETRA XSAIL (sumatriptan)* | *rizatriptan*<br>*sumatriptan injection*<br>*sumatriptan nasal*<br>*SUMAVEL DOSEPRO (sumatriptan)*<br>*TREXIMET (sumatriptan/naproxen)*<br>*ZECUITY (sumatriptan)*<br>*ZEMBRACE SYMTOUCH (sumatriptan)*<br>*zolmitriptan*<br>*ZOMIG (zolmitriptan)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Non-Triptans** | | | |
| | *CAMBIA (diclofenac)*<br>*D.H.E. 45 (dihydroergotamine)*<br>*dihydroergotamine mesylate*<br>*isometheptene/caffeine/APAP*<br>*isometheptene/dichloralphenazone/APAP*<br>*MIGRANAL (dihydroergotamine mesylate)* | | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANTIPARASITICS, TOPICAL | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| NATROBA (spinosad)<br>permethrin<br>SKLICE (ivermectin) | *EURAX (crotamiton)*<br>*lindane*<br>*malathion*<br>*OVIDE (malathion)*<br>*piperonyl butoxide/pyrethrins*<br>*spinosad* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| ANTIPARKINSON'S AGENTS (ORAL/TRANSDERMAL) | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Anticholinergics** | | |
| benztropine<br>trihexyphenidyl | | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **COMT Inhibitors** | | |
| | *COMTAN (entacapone)*<br>*entacapone*<br>*TASMAR (tolcapone)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANTIPARKINSON'S AGENTS (ORAL/TRANSDERMAL) | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Dopamine Agonists** | | |
| bromocriptine<br>pramipexole<br>ropinirole | *MIRAPEX (pramipexole)*<br>*MIRAPEX ER (pramipexole)*<br>*NEUPRO transdermal (rotigotine)*<br>*pramipexole ER*<br>*REQUIP (ropinirole)*<br>*REQUIP XL (ropinirole)*<br>*ropinirole ER* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **MAO-B Inhibitors** | | |
| | *AZILECT (rasagiline)*<br>*selegiline*<br>*ZELAPAR (selegiline)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Others** | | |
| amantadine<br>carbidopa/levodopa tablets<br>carbidopa/levodopa ER<br>carbidopa/levodopa/entacapone | *carbidopa*<br>*carbidopa/levodopa ODT*<br>*DUOPA (carbidopa/levodopa)*<br>*LODOSYN (carbidopa)*<br>*RYTARY (carbidopa/levodopa)*<br>*SINEMET (carbidopa/levodopa)*<br>*STALEVO (levodopa/carbidopa/entacapone)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANTIPSYCHOTICS | | | | |
|---|---|---|---|---|
| **Preferred Agents** | | ***Non-Preferred Agents*** | | **PA Criteria** |
| **Antipsychotics** | | | | |
| ABILIFY (aripiprazole) tablets<br>chlorpromazine<br>clozapine<br>FANAPT (iloperidone)<br>fluphenazine<br>haloperidol<br>LATUDA (lurasidone)<br>olanzapine<br>olanzapine ODT | perphenazine<br>quetiapine IR<br>risperidone tablets, solution<br>SAPHRIS (asenapine)<br>thioridazine<br>thiothixene<br>trifluoperazine<br>VERSACLOZ (clozapine)<br>ziprasidone | *aripiprazole*<br>*clozapine ODT*<br>*CLOZARIL (clozapine)*<br>*FAZACLO (clozapine)*<br>*GEODON (ziprasidone)*<br>*INVEGA (paliperidone)*<br>*loxapine*<br>*molindone*<br>*ORAP (pimozide)*<br>*paliperidone* | *pimozide*<br>*REXULTI (brexpiprazole)*<br>*RISPERDAL (risperidone)*<br>*risperidone ODT*<br>*SEROQUEL (quetiapine)*<br>*SEROQUEL XR (quetiapine)*<br>*VRAYLAR (cariprazine)*<br>*ZYPREXA (olanzapine)*<br>*ZYPREXA ZYDIS (olanzapine)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |
| **Antipsychotic/SSRI Combinations** | | | | |
| amitriptyline/perphenazine | | *olanzapine/fluoxetine**<br>*SYMBYAX (olanzapine/fluoxetine)** | | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |
| **Long-Acting Injectables** | | | | |
| ABILIFY MAINTENA (aripiprazole)*<br>ARISTADA (aripiprazole)*<br>INVEGA SUSTENNA (paliperidone)*<br>INVEGA TRINZA (paliperidone)*<br>RISPERDAL CONSTA (risperidone)* | | *ZYPREXA RELPREVV (olanzapine)** | | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANTIVIRALS (ORAL/NASAL) | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Antiherpetic** | | |
| acyclovir<br>famciclovir<br>valacyclovir | *FAMVIR (famciclovir)*<br>*VALTREX (valacyclovir)*<br>*ZOVIRAX (acyclovir)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Anti-influenza** | | |
| RELENZA (zanamivir)<br>rimantadine<br>TAMIFLU (oseltamivir) | | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Anti-CMV** | | |
| VALCYTE (valganciclovir) tablets | *VALCYTE (valganciclovir) solution*<br>*valganciclovir tablets* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ANTIVIRALS, TOPICAL | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| acyclovir ointment<br>DENAVIR (penciclovir) | *XERESE (acyclovir/hydrocortisone)*<br>*ZOVIRAX (acyclovir)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| BETA BLOCKERS (ORAL) | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| **Beta Blockers** | | | |
| acebutolol<br>atenolol<br>bisoprolol<br>metoprolol IR<br>metoprolol XL<br>propranolol IR<br>sotalol | *betaxolol*<br>*BYSTOLIC (nebivolol)*<br>*CORGARD (nadolol)*<br>*HEMANGEOL (propranolol)*<br>*INDERAL LA (propranolol)*<br>*INNOPRAN XL (propranolol)*<br>*nadolol*<br>*pindolol* | *propranolol ER*<br>*SECTRAL (acebutolol)*<br>*SOTYLIZE (sotalol)*<br>*TENORMIN (atenolol)*<br>*timolol*<br>*TOPROL XL (metoprolol succinate)*<br>*ZEBETA (bisoprolol)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Beta Blocker Combinations** | | | |
| atenolol/chlorthalidone<br>bisoprolol/HCTZ | *CORZIDE (nadolol/bendroflumethiazide)*<br>*DUTOPROL (metoprolol succinate ER/HCTZ)*<br>*metoprolol/HCTZ*<br>*nadolol/bendroflumethiazide*<br>*propranolol/HCTZ*<br>*TENORETIC (atenolol/HCTZ)*<br>*ZIAC (bisoprolol/HCTZ)* | | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

## BETA BLOCKERS (ORAL)

| Preferred Agents | *Non-Preferred Agents* | PA Criteria |
|---|---|---|
| **Beta- and Alpha-Blockers** | | |
| carvedilol<br>labetalol | *COREG (carvedilol)*<br>*COREG CR (carvedilol)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

## BILE SALTS

| Preferred Agents | *Non-Preferred Agents* | PA Criteria |
|---|---|---|
| ursodiol | *ACTIGALL (ursodiol)*<br>*CHENODAL (chenodiol)*<br>*CHOLBAM (cholic acid)*<br>*OCALIVA (obeticholic acid)*<br>*URSO (ursodiol)*<br>*URSO FORTE (urosodiol)* | ▪ Treatment failure with preferred drug<br>▪ Contraindication to preferred drug<br>▪ Allergic reaction to preferred drug |

## BLADDER RELAXANT PREPARATIONS

| Preferred Agents | *Non-Preferred Agents* | PA Criteria |
|---|---|---|
| oxybutynin IR<br>TOVIAZ (fesoterodine)<br>VESICARE (solifenacin) | *DETROL (tolterodine)*<br>*DETROL LA (tolterodine)*<br>*DITROPAN XL (oxybutynin)*<br>*ENABLEX (darifenacin)*<br>*flavoxate*<br>*GELNIQUE (oxybutynin)*<br>*MYRBETRIQ (mirabegron)*<br>*oxybutynin ER*<br>*OXYTROL (oxybutynin)*<br>*tolterodine*<br>*tolterodine ER*<br>*trospium*<br>*trospium ER* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| BONE RESORPTION SUPPRESSION AND RELATED AGENTS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Bisphosphonates** | | |
| alendronate tablets | *ACTONEL (risedronate)*<br>*alendronate solution*<br>*ATELVIA (risedronate)*<br>*BINOSTO (alendronate)*<br>*BONIVA (ibandronate)*<br>*etidronate*<br>*FOSAMAX (alendronate)*<br>*FOSAMAX PLUS D (alendronate/vitamin D)*<br>*ibandronate*<br>*risedronate* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Other Bone Resorption Suppression and Related Agents** | | |
| FORTICAL (calcitonin) | *calcitonin nasal*<br>*EVISTA (raloxifene)*<br>*FORTEO (teriparatide)*<br>*MIACALCIN (calcitonin)*<br>*raloxifene* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| BPH AGENTS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Alpha Blockers** | | |
| alfuzosin<br>doxazosin<br>tamsulosin<br>terazosin | *CARDURA (doxazosin)*<br>*FLOMAX (tamsulosin)*<br>*RAPAFLO (silodosin)*<br>*UROXATRAL (alfuzosin)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| BPH AGENTS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **5-Alpha-Reductase (5AR) Inhibitors** | | |
| finasteride | *AVODART (dutasteride)*<br>*PROSCAR (finasteride)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Alpha Blocker/5AR Inhibitor Combinations** | | |
| | *dutasteride/tamsulosin* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| BRONCHODILATORS, BETA AGONIST | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Inhalers, Short-Acting** | | |
| PROAIR HFA (albuterol)<br>PROVENTIL HFA (albuterol) | *PROAIR RESPICLICK (albuterol)*<br>*VENTOLIN HFA (albuterol)*<br>*XOPENEX HFA (levalbuterol)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ History of intolerable side effects to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| BRONCHODILATORS, BETA AGONIST | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Inhalers, Long-Acting** | | |
| | *ARCAPTA (indacaterol)*<br>*FORADIL (formoterol)*<br>*SEREVENT (salmeterol)*<br>*STRIVERDI RESPIMAT (olodaterol)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ History of intolerable side effects to preferred drugs |
| **Inhalation Solution** | | |
| albuterol | *BROVANA (arformoterol)*<br>*levalbuterol*<br>*PERFOROMIST (formoterol)*<br>*XOPENEX (levalbuterol)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ History of intolerable side effects to preferred drugs |
| **Oral** | | |
| albuterol syrup | *albuterol tablet*<br>*albuterol ER*<br>*metaproterenol*<br>*terbutaline* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ History of intolerable side effects to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| CALCIUM CHANNEL BLOCKERS (ORAL) | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Short-Acting** | | |
| diltiazem<br>verapamil | *isradipine*<br>*nicardipine*<br>*nifedipine*<br>*nimodipine*<br>*NYMALIZE (nimodipine)*<br>*PROCARDIA (nifedipine)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Long-Acting** | | |
| amlodipine<br>diltiazem ER<br>felodipine ER<br>nifedipine ER<br>verapamil ER capsules, tablets | *ADALAT CC (nifedipine)*<br>*CALAN SR (verapamil)*<br>*CARDIZEM CD (diltiazem)*<br>*CARDIZEM LA (diltiazem)*<br>*diltiazem LA*<br>*MATZIM LA (diltiazem)*<br>*nisoldipine*<br>*NORVASC (amlodipine)*<br>*PROCARDIA XL (nifedipine)*<br>*SULAR (nisoldipine)*<br>*verapamil 360 mg capsules*<br>*verapamil ER PM*<br>*VERELAN (verapamil)*<br>*VERELAN PM (verapamil)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL) | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Beta Lactam/Beta-Lactamase Inhibitor Combinations** | | |
| amoxicillin/clavulanate suspension, tablets | *amoxicillin/clavulanate XR*<br>*amoxicillin/clavulanate chewable IR tablets*<br>*AUGMENTIN suspension (amoxicillin/clavulanate)*<br>*AUGMENTIN tablets (amoxicillin/clavulanate)*<br>*AUGMENTIN XR (amoxicillin/clavulanate)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL) | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Cephalosporins – First Generation** | | |
| cefadroxil capsules, suspension<br>cephalexin capsules, suspension | *cefadroxil tablets*<br>*cephalexin tablets*<br>*KEFLEX (cephalexin)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Cephalosporins – Second Generation** | | |
| cefprozil suspension<br>cefuroxime tablets | *cefaclor ER*<br>*cefaclor IR capsules, suspension*<br>*cefprozil tablets*<br>*CEFTIN (cefuroxime)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Cephalosporins – Third Generation** | | |
| cefdinir<br>SUPRAX (cefixime) capsules, suspension | *CEDAX (ceftibuten)*<br>*cefixime*<br>*cefpodoxime*<br>*ceftibuten*<br>*SUPRAX (cefixime) chewable tablets, tablets* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| COLONY STIMULATING FACTORS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| GRANIX (tbo-filgrastim)<br>NEULASTA (pegfilgrastim)<br>NEUPOGEN (filgrastim) vial | *LEUKINE (sargramostim)*<br>*NEUPOGEN (filgrastim) syringe*<br>*ZARXIO (filgrastim-sndz)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| COPD AGENTS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Anticholinergics** | | |
| ATROVENT HFA (ipratropium)<br>ipratropium inhalation solution<br>SPIRIVA HANDIHALER (tiotropium) | *INCRUSE ELLIPTA (umeclidinium)*<br>*SEEBRI NEOHALER (glycopyrrolate)*<br>*SPIRIVA RESPIMAT (tiotropium)*<br>*TUDORZA (aclidinium)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Anticholinergic-Beta Agonist Combinations** | | |
| COMBIVENT RESPIMAT (albuterol/ipratropium)<br>STIOLTO RESPIMAT (tiotropium/olodaterol) | *albuterol/ipratropium*<br>*ANORO ELLIPITA (umeclidinium/vilanterol)*<br>*UTIBRON NEOHALER (glycopyrrolate/indacaterol)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

## COPD Agents

| Preferred Agents | *Non-Preferred Agents* | PA Criteria |
|---|---|---|
| **Phosphodiesterase Inhibitors** | | |
| | *DALIRESP (roflumilast)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

## Cough and Cold Agents

See Separate Preferred Cough and Cold Agent Listing.

## Cytokine and CAM Antagonists

| Preferred Agents | *Non-Preferred Agents* | PA Criteria |
|---|---|---|
| COSENTYX (secukinumab)<br>ENBREL (etanercept)<br>HUMIRA (adalimumab) | *ACTEMRA (tocilizumab)*<br>*CIMZIA (certolizumab)*<br>*ILARIS (canakinumab)*<br>*KINERET (anakinra)*<br>*ORENCIA (abatacept)*<br>*OTEZLA (apremilast)*<br>*SIMPONI (golimumab)*<br>*STELARA (ustekinumab)*<br>*XELJANZ (tofacitinib)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

## Epinephrine, Self-Injected

| Preferred Agents | *Non-Preferred Agents* | |
|---|---|---|
| epinephrine<br>EPIPEN<br>EPIPEN JR | | ▪ Treatment failure with preferred products<br>▪ Contraindication to preferred products<br>▪ Allergic reaction to preferred products |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ERYTHROPOIESIS STIMULATING PROTEINS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| EPOGEN (RhUEPO)<br>PROCRIT (RhUEPO) | *ARANESP (darbepoetin)** | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

| FLUOROQUINOLONES, ORAL | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| CIPRO (ciprofloxacin) suspension<br>ciprofloxacin IR<br>levofloxacin tablets | *AVELOX (moxifloxacin)*<br>*CIPRO (ciprofloxacin) tablets*<br>*ciprofloxacin ER*<br>*ciprofloxacin suspension*<br>*LEVAQUIN (levofloxacin)*<br>*levofloxacin solution*<br>*moxifloxacin*<br>*ofloxacin* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| GI MOTILITY, CHRONIC | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| None | *alosetron*<br>*AMITIZA (lubiprostone)**<br>*LINZESS (linaclotide)*<br>*LOTRONEX (alosetron)*<br>*MOVANTIK (naloxegol)*<br>*VIBERZI (eluxadoline)* | ▪ Treatment failure with preferred drugs within any subclass (including OTC products)<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| GLUCOCORTICOIDS, INHALED | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Glucocorticoids** | | |
| ASMANEX (mometasone)<br>FLOVENT (fluticasone)<br>QVAR (beclomethasone) | *AEROSPAN (flunisolide)*<br>*ALVESCO (ciclesonide)*<br>*ARNUITY ELLIPTA (fluticasone)*<br>*budesonide respules*<br>*PULMICORT 0.25, 0.5 MG RESPULES (budesonide) (See comment under PA criteria)*<br>*PULMICORT 1 MG RESPULES (budesonide)*<br>*PULMICORT FLEXHALER (budesonide)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ Pulmicort respules 0.25, 0.5 mg will be authorized for patients under four years of age |
| **Glucocorticoid/Bronchodilator Combinations** | | |
| ADVAIR (fluticasone/salmeterol)<br>DULERA (mometasone/formoterol)<br>SYMBICORT (budesonide/formoterol) | *BREO ELLIPTA (fluticasone/vilanterol)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| GLUCOCORTICOIDS, ORAL | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| budesonide EC<br>dexamethasone elixir, solution, tablets<br>hydrocortisone<br>methylprednisolone tablet dose pack<br>prednisolone sodium phosphate solution<br>prednisolone<br>prednisone solution, tablets | *CORTEF (hydrocortisone)*<br>*CORTISONE (hydrocortisone)*<br>*dexamethasone intensol*<br>*DEXPAK (dexamethasone)*<br>*ENTOCORT EC (budesonide)*<br>*MEDROL (methylprednisolone)*<br>*methylprednisolone tablets* | *MILLIPRED (prednisolone)*<br>*prednisolone sodium phosphate ODT*<br>*prednisone intensol*<br>*prednisone tablet dose pack*<br>*VERIPRED 20 (prednisolone)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| GROWTH HORMONE | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| GENOTROPIN *<br>NORDITROPIN * | *HUMATROPE **<br>*NUTROPIN AQ **<br>*OMNITROPE **<br>*SAIZEN **<br>*SEROSTIM **<br>*ZORBTIVE ** | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

| H. PYLORI TREATMENT | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| PYLERA (bismuth subcitrate/metronidazole/tetracycline) | *lansoprazole/amoxicillin/clarithromycin*<br>*PREVPAC (lansoprazole/amoxicillin/clarithromycin)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| HEPATITIS C AGENTS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Pegylated Interferons** | | |
| PEG-INTRON (pegylated IFN alfa-2b) | *PEGASYS (pegylated IFN alfa-2a)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| HEPATITIS C AGENTS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Polymerase/Protease Inhibitors** | | |
| DAKLINZA (daclatasvir)*<br>EPCLUSA (sofosbuvir/velpatasvir)* – GENOTYPE 2 & 3 ONLY<br>TECHNIVIE (ombitasvir/paritaprevir/ritonavir)*<br>VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)*<br>VIEKIRA XR (dasabuvir/ombitasvir/paritaprevir/ritonavir)* | *HARVONI (sofosbuvir/ledipasvir)**<br>*OLYSIO (simeprevir)**<br>*SOVALDI (sofosbuvir)**<br>*ZEPATIER (elbasvir/grazoprevir)** | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |
| **Ribavirin** | | |
| ribavirin capsule<br>ribavirin tablet | *REBETOL solution*<br>*RIBASPHERE 400, 600 mg*<br>*ribavirin dose pack* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| HEREDITARY ANGIOEDEMA (HAE) TREATMENTS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| BERINERT (C1 esterase inhibitor)<br>CINRYZE (C1 esterase inhibitor)<br>FIRAZYR (icatibant)<br>KALBITOR (ecallantide) | *RUCONEST (C1 esterase inhibitor)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Amylin Analogs** | | |
| SYMLIN (pramlintide)* | | Patient must meet all of the following criteria:<br>▪ Diagnosis of diabetes mellitus<br>▪ Age >18 years<br>▪ HbA1C in past 6 months<br>▪ No history of gastroparesis, neurologic manifestations of diabetes or recent treatment of hypoglycemia<br>http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |
| **Incretin Enhancers** | | |
| JENTADUETO (linagliptin/metformin)<br>KOMBIGLYZE XR (saxagliptin/metformin)<br>ONGLYZA (saxagliptin)<br>TRADJENTA (linagliptin) | *alogliptin*<br>*alogilptin/metformin*<br>*alogliptin/pioglitazone*<br>*JANUMET (sitagliptin/metformin)**<br>*JANUMET XR (sitagliptin/metformin)**<br>*JANUVIA (sitagliptin)**<br>*JENTADUETO XR (linagliptin/metformin)*<br>*KAZANO (alogliptin /metformin )*<br>*NESINA (alogliptin)*<br>*OSENI (alogliptin / glimepiride)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Incretin Mimetics** | | |
| BYDUREON (exenatide ER) vials*<br>BYETTA (exenatide)*<br>VICTOZA (liraglutide)* | *BYDUREON (exenatide ER) pens*<br>*TANZEUM (albiglutide)*<br>*TRULICITY (dulaglutide)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |
| **Incretin Enhancers/SGLT2 Inhibitor Combinations** | | |
| | *GLYXAMBI (empagliflozin/linagliptin)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| HYPOGLYCEMICS, INSULIN | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| HUMALOG (insulin lispro) vials<br>HUMALOG MIX (insulin lispro/lispro protamine) vials<br>HUMULIN (insulin) vials<br>HUMULIN 500 UNITS/ML (insulin) vial<br>HUMULIN 70/30 (insulin) vials<br>LANTUS (insulin glargine)<br>LEVEMIR (insulin detemir)<br>NOVOLOG (insulin aspart)<br>NOVOLOG MIX (insulin aspart/aspart protamine) | *AFREZZA (insulin)*<br>*APIDRA (insulin glulisine)*<br>*HUMALOG (insulin lispro) pens*<br>*HUMALOG MIX (insulin lispro/lispro protamine) pens*<br>*HUMULIN (insulin) pens*<br>*HUMULIN 500 UNITS/ML (insulin) pen*<br>*HUMULIN 70/30 (insulin) pens* | *NOVOLIN (insulin)*<br>*NOVOLIN 70/30 (insulin)*<br>*TOUJEO (insulin glargine)*<br>*TRESIBA (insulin degludec)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| HYPOGLYCEMICS, MEGLITINIDES | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| nateglinide<br>repaglinide | *PRANDIMET (repaglinide/metformin)*<br>*PRANDIN (repaglinide)*<br>*repaglinide/metformin*<br>*STARLIX (nateglinide)* | ▪ Separate prescriptions for the individual components should be used instead of the combination drug. |

| HYPOGLYCEMICS, METFORMIN | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| glyburide/metformin<br>metformin<br>metformin ER (GLUCOPHAGE XR) | FORTAMET (metformin ER)<br>glipizide/metformin<br>GLUCOPHAGE (metformin)<br>GLUCOPHAGE XR (metformin ER)<br>GLUMETZA (metformin ER)<br>metformin ER (FORTAMET)<br>metformin ER (GLUMETZA)<br>RIOMET (metformin) | ▪ Separate prescriptions for the individual components should be used instead of the combination drug. |

| HYPOGLYCEMICS, SGLT2 | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| INVOKANA (canaglifozin) | *FARXIGA (dapagliflozin)*<br>*JARDIANCE (empagliflozin)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| HYPOGLYCEMICS, SGLT2 | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **SGLT2 Combinations** | | |
| *INVOKAMET (canagliflozin/metformin)* | *SYNJARDY (empagliflozin/metformin)*<br>*XIGDUO XR (dapagliflozin/metformin)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| HYPOGLYCEMICS, TZD | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Thiazolinediones** | | |
| Pioglitazone* | *ACTOS (pioglitazone)**<br>*AVANDIA (rosiglitazone)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |
| **TZD Combinations** | | |
| | *ACTOPLUS MET (pioglitazone/metformin)**<br>*ACTOPLUS MET XR (pioglitazone/metformin)**<br>*pioglitazone/metformin**<br>*pioglitazone/glimepiride** | ▪ Separate prescriptions for the individual components should be used instead of the combination drug. |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

## IMMUNE GLOBULINS

| Preferred Agents | *Non-Preferred Agents* | PA Criteria |
|---|---|---|
| CYTOGAM (CMV immune globulin)<br>GAMMAGARD (immune globulin)<br>GAMUNEX-C (immune globulin)<br>HIZENTRA (immune globulin) | *BIVIGAM (immune globulin)*<br>*CARIMUNE NF (immune globulin)*<br>*FLEBOGAMMA DIF (immune globulin)*<br>*GAMMAKED (immune globulin)*<br>*HYQVIA (immune globulin)*<br>*OCTAGAM (immune globulin)*<br>*PRIVIGEN (immune globulin)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

## IMMUNOMODULATORS, ATOPIC DERMATITIS

| Preferred Agents | *Non-Preferred Agents* | PA Criteria |
|---|---|---|
| None | *ELIDEL (pimecrolimus)**<br>*PROTOPIC (tacrolimus)**<br>*tacrolimus** | ▪ Prior authorization is required for all products in this class<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

## IMMUNOSUPPRESSIVES, ORAL

| Preferred Agents | *Non-Preferred Agents* | | PA Criteria |
|---|---|---|---|
| azathioprine<br>cyclosporine, modified<br>mycophenolate mofetil capsules, tablets<br>NEORAL (cyclosporine, modified) capsules<br>RAPAMUNE (sirolimus) solution<br>sirolimus tablets<br>tacrolimus | *ASTAGRAF XL (tacrolimus)*<br>*CELLCEPT (mycophenolate mofetil)*<br>*cyclosporine*<br>*ENVARSUS XR (tacrolimus)*<br>*IMURAN (azathioprine)*<br>*mycophenolate mofetil suspension*<br>*mycophenolic acid* | *MYFORTIC (mycophenolic acid)*<br>*NEORAL (cyclosporine, modified) solution*<br>*PROGRAF (tacrolimus)*<br>*RAPAMUNE (sirolimus) tablets*<br>*SANDIMMUNE (cyclosporine)*<br>*ZORTRESS (everolimus)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| INTRANASAL RHINITIS AGENTS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Glucocorticoids** | | |
| fluticasone<br>NASONEX (mometasone) | *BECONASE AQ (beclomethasone)*<br>*budesonide*<br>*flunisolide*<br>*OMNARIS (ciclesonide)*<br>*QNASL (beclomethasone dipropionate)*<br>*triamcinolone*<br>*VERAMYST (fluticasone furoate)*<br>*ZETONNA (ciclesonide)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Others** | | |
| PATANASE (olopatadine) | *ASTEPRO (azelastine)*<br>*ATROVENT (ipratropium) nasal spray*<br>*azelastine*<br>*ipratropium nasal spray*<br>*olopatadine* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Combinations** | | |
| | *DYMISTA (azelastine/fluticasone)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| IRON, ORAL |
|---|
| See Separate Listing Of Preferred Oral Iron Drugs. |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| LEUKOTRIENE MODIFIERS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| montelukast chewable tablets, tablets* | *ACCOLATE (zafirlukast)*<br>*montelukast granules**<br>*SINGULAIR (montelukast)**<br>*zafirlukast*<br>*ZYFLO (zileuton)*<br>*ZYFLO CR (zileuton)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

| LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| clindamycin capsules<br>clindamycin solution<br>linezolid tablets<br>ZYVOX (linezolid) suspension | *CLEOCIN (clindamycin)*<br>*clindamycin injection*<br>*LINCOCIN (lincomycin)*<br>*linezolid suspension*<br>*SIVEXTRO (tedizolid)*<br>*ZYVOX (linezolid) tablets* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| LIPOTROPICS, OTHER | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Bile Acid Sequestrants** | | |
| cholestyramine<br>colestipol tablets | *COLESTID (colestipol)*<br>*colestipol granules*<br>*QUESTRAN (cholestyramine)*<br>*QUESTRAN LIGHT (cholestyramine)*<br>*WELCHOL (colesevalam)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| LIPOTROPICS, OTHER | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Cholesterol Absorption Inhibitors** | | |
| ZETIA (ezetimibe) | | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Fibric Acid Derivatives** | | |
| fenofibrate (generic Lipofen, Lofibra, Tricor)<br>fenofibric acid (generic Trilipix)<br>gemfibrozil | *fenofibrate (generic Antara)*<br>*fenofibric acid (generic Fibricor)*<br>*FENOGLIDE (fenofibrate)*<br>*LIPOFEN (fenofibrate)*<br>*LOFIBRA (fenofibrate)*<br>*LOPID (gemfibrozil)*<br>*TRICOR (fenofibrate)*<br>*TRIGLIDE (fenofibrate)*<br>*TRILIPIX (fenofibric acid)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Homozygous Familial Hypercholesterolemia Treatments** | | |
| JUXTAPID (lomitapide)<br>KYNAMRO (mipomersen) | | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Niacin** | | |
| *niacin OTC*<br>NIACOR (niacin) | *niacin ER*<br>*NIASPAN (niacin)*<br>*SLO-NIACIN OTC (niacin)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| LIPOTROPICS, OTHER | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Omega-3 Fatty Acids** | | |
| | *LOVAZA (omega-3 fatty acids)**<br>*omega-3 fatty acids **<br>*VASCEPA (icosapent ethyl)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

| LIPOTROPICS, STATINS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Statins** | | |
| atorvastatin<br>lovastatin<br>pravastatin<br>simvastatin | *ALTOPREV (lovastatin)*<br>*CRESTOR (rosuvastatin)*<br>*fluvastatin*<br>*fluvastatin ER*<br>*LESCOL (fluvastatin)*<br>*LESCOL XL (fluvastatin)*<br>*LIPITOR (atorvastatin)*<br>*LIVALO (pitavastatin)*<br>*PRAVACHOL (pravastatin)*<br>*ZOCOR (simvastatin)* | ▪ Treatment failure with at least two preferred drugs accounting for no less than 120 days of therapy combined<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| LIPOTROPICS, STATINS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Statin Combinations** | | |
| | *ADVICOR (lovastatin/niacin)*<br>*atorvastatin/amlodipine*<br>*CADUET (atorvastatin/amlodipine)*<br>*VYTORIN (simvastatin/ezetimibe)* | ▪ Treatment failure with at least two preferred drugs accounting for no less than 120 days of therapy combined<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| MACROLIDES/KETOLIDES (ORAL) | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Ketolides** | | |
| | *KETEK (telithromycin)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Macrolides** | | |
| azithromycin<br>clarithromycin suspension<br>ERY-TAB (erythromycin)<br>erythromycin base<br>PCE (erythromycin) | *BIAXIN (clarithromycin)*<br>*clarithromycin tablets*<br>*clarithromycin ER*<br>*E.E.S. (erythromycin)*<br>*ERYPED (erythromycin)*<br>*ERYTHROCIN (erythromycin)*<br>*KETEK (telithromycin)*<br>*Z-MAX (azithromycin)*<br>*ZITHROMAX (azithromycin)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| NEUROPATHIC PAIN | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Oral Agents** | | |
| duloxetine (Cymbalta)<br>gabapentin<br>LYRICA (pregabalin) | *CYMBALTA (duloxetine)*<br>*duloxetine (Irenka)*<br>*GRALISE (gabapentin)*<br>*HORIZANT (gabapentin enacarbil ER)*<br>*SAVELLA (milnacipran)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Topical Agents** | | |
| | *lidocaine patch*<br>*LIDODERM (lidocaine)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| NSAIDS | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| **Nonspecific** | | | |
| ibuprofen<br>INDOCIN (indomethacin) suspension<br>indomethacin capsules<br>ketorolac<br>naproxen tablets<br>naproxen sodium OTC | *ANAPROX (naproxen)*<br>*CHILDREN'S MOTRIN (ibuprofen)*<br>*DAYPRO (oxaprozin)*<br>*diclofenac*<br>*diclofenac SR*<br>*diflunisal*<br>*etodolac*<br>*etodolac SR*<br>*FELDENE (piroxicam)*<br>*fenoprofen*<br>*flurbiprofen*<br>*INDOCIN (indomethacin) capsules*<br>*indomethacin ER capsules*<br>*ketoprofen*<br>*ketoprofen ER*<br>*meclofenamate* | *mefenamic acid*<br>*nabumetone*<br>*NALFON (fenoprofen)*<br>*NAPROSYN (naproxen)*<br>*naproxen CR*<br>*naproxen EC*<br>*naproxen suspension*<br>*naproxen sodium (Rx)*<br>*oxaprozin*<br>*piroxicam*<br>*PONSTEL (meclofenamate)*<br>*SPRIX (ketorolac)*<br>*sulindac*<br>*tolmetin*<br>*VOLTAREN (diclofenac)*<br>*ZORVOLEX (diclofenac)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **NSAID/GI Protectant Combinations** | | | |
| | *ARTHROTEC (diclofenac/misoprostol)*<br>*diclofenac/misoprostol*<br>*DUEXIS (ibuprofen/famotidine)*<br>*VIMOVO (naproxen/ esomeprazole)* | | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| NSAIDS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **COX-II Selective** | | |
| meloxicam tablets | *CELEBREX (celecoxib)**<br>*celecoxib**<br>*meloxicam suspension*<br>*MOBIC (meloxicam)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |
| **Topical NSAIDs** | | |
| | *diclofenac*<br>*FLECTOR (diclofenac)*<br>*INDOCIN (indomethacin) suppositories*<br>*PENNSAID (diclofenac)*<br>*VOLTAREN (diclofenac)*<br>*XRYLIX KIT (diclofenac)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| OPHTHALMICS, ANTIBIOTIC – STEROID COMBINATIONS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| BLEPHAMIDE (sulfacetamide/prednisolone)<br>neomycin/polymyxin/dexamethasone<br>sulfacetamide/prednisolone<br>TOBRADEX (tobramycin/dexamethasone) ointment | *BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone)*<br>*MAXITROL (neomycin/polymyxin/ dexamethasone)*<br>*neomycin/bacitracin/polymyxin/hydrocortisone*<br>*neomycin/polymyxin/hydrocortisone*<br>*PRED-G (gentamicin/prednisolone)*<br>*TOBRADEX (tobramycin/dexamethasone) suspension*<br>*TOBRADEX ST (tobramycin/dexamethasone)*<br>*tobramycin/dexamethasone*<br>*ZYLET (tobramycin/loteprednol)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| OPHTHALMIC ANTIBIOTICS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Aminoglycosides** | | |
| gentamicin<br>tobramycin<br>TOBREX (tobramycin) ointment | *TOBREX (tobramycin) solution* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Quinolones** | | |
| ciprofloxacin<br>MOXEZA (moxifloxacin)<br>VIGAMOX (moxifloxacin) | *BESIVANCE (besifloxacin)*<br>*CILOXAN (ciprofloxacin)*<br>*gatifloxacin*<br>*levofloxacin*<br>*OCUFLOX (ofloxacin)*<br>*ofloxacin* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Macrolides** | | |
| erythromycin | *AZASITE (azithromycin)*<br>*ILOTYCIN (erythromycin)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Other** | | |
| bacitracin/polymyxin<br>polymyxin/trimethoprim | *bacitracin*<br>*BLEPH-10 (sulfacetamide)*<br>*NATACYN (natamycin)*<br>*neomycin/bacitracin/polymyxin*<br>*neomycin/polymyxin/gramicidin*<br>*POLYTRIM (polymyxin/trimethoprim)*<br>*sulfacetamide ointment, solution* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| cromolyn<br>PATADAY (olopatadine)<br>PAZEO (olopatadine) | *ALOCRIL (nedocromil)*<br>*ALOMIDE (lodoxamide)*<br>*ALREX (loteprednol)*<br>*azelastine*<br>*BEPREVE (bepotastine)*<br>*ELESTAT (epinastine)* | *EMADINE (emedastine)*<br>*epinastine*<br>*ketotifen*<br>*LASTACAFT (alcaftadine)*<br>*olopatadine*<br>*PATANOL (olopatadine)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| OPHTHALMICS, ANTI-INFLAMMATORIES | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| **NSAIDS** | | | |
| diclofenac<br>flurbiprofen<br>ILEVRO (nepafenac)<br>ketorolac<br>NEVANAC (nepafenac) | *ACULAR (ketorolac)*<br>*ACULAR LS (ketorolac)*<br>*ACUVAIL (ketorolac)*<br>*bromfenac*<br>*ketorolac LS* | | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Steroids** | | | |
| dexamethasone<br>DUREZOL (difluprednate)<br>LOTEMAX (loteprednol) suspension<br>prednisolone acetate | *FLAREX (fluorometholone)*<br>*fluoromethalone*<br>*FML (fluorometholone)*<br>*FML FORTE (fluorometholone)*<br>*FML S.O.P. (fluorometholone)*<br>*LOTEMAX (loteprednol) gel, ointment* | *MAXIDEX (dexamethasone)*<br>*OMNIPRED (prednisolone)*<br>*PRED FORTE (prednisolone)*<br>*PRED MILD (prednisolone)*<br>*prednisolone sodium phosphate*<br>*VEXOL (rimexolone)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| OPHTHALMICS, GLAUCOMA AGENTS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Sympathomimetics** | | |
| brimonidine<br>pilocarpine | *ALPHAGAN P (brimonidine)*<br>*apraclonidine*<br>*brimonidine P*<br>*IOPIDINE (apraclonidine)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Beta Blockers** | | |
| betaxolol<br>carteolol<br>levobunolol<br>timolol | *BETAGAN (levobunolol)*<br>*BETOPTIC S (betaxolol)*<br>*ISTALOL (timolol)*<br>*TIMOPTIC (timolol)*<br>*TIMOPTIC XE (timolol)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Carbonic Anhydrase Inhibitors** | | |
| AZOPT (brinzolamide)<br>dorzolamide | *TRUSOPT (dorzolamide)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Prostaglandin Analogs** | | |
| latanoprost<br>TRAVATAN-Z (travoprost) | *bimatoprost*<br>*LUMIGAN (bimatoprost)*<br>*travoprost*<br>*XALATAN (latanoprost)*<br>*ZIOPTAN (tafluprost)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| OPHTHALMICS, GLAUCOMA AGENTS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Combination Agents** | | |
| COMBIGAN (brimonidine/timolol)<br>dorzolamide/timolol<br>SIMBRINZA (brinzolamide/brimonidine) | *COSOPT (dorzolamide/timolol)*<br>*COSOPT PF (dorzolamide/timolol)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Miscellaneous** | | |
| | *phospholine iodide* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| OPIATE DEPENDENCE TREATMENTS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| BUNAVAIL (buprenorphine/naloxone)<br>buprenorpine<br>naloxone syringe<br>naloxone vial<br>naltrexone[PPG]<br>NARCAN (naloxone) nasal<br>SUBOXONE (buprenorphine/naloxone) film | *buprenorphine/naloxone*<br>*EVZIO (naloxone)*<br>*VIVITROL (naltrexone)*<br>*ZUBSOLV (buprenorphine/naloxone)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| OTIC ANTIBIOTICS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| CIPRODEX (ciprofloxacin/dexamethasone)<br>neomycin/polymyxin/hydrocortisone<br>ofloxacin | *CIPRO HC (ciprofloxacin/hydrocortisone)*<br>*ciprofloxacin*<br>*COLY-MYCIN S (colistin/neomycin/hydrocortisone)*<br>*CORTISPORIN-TC (colistin/neomycin/hydrocortisone)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| OTIC ANTI-INFECTIVES/ANESTHETICS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| acetic acid<br>antipyrine/benzocaine | *acetic acid/hydrocortisone*<br>*acetic acid/aluminum* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| PAH AGENTS (ORAL, INHALATION) | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| ADCIRCA (tadalafil)<br>LETAIRIS (ambrisentan)<br>sildenafil (generic Revatio)*<br>TRACLEER (bosentan) | *ADEMPAS (riociguat)*<br>*OPSUMIT (macitentan)*<br>*ORENITRAM ER (treprostinil)*<br>*REVATIO (sildenafil)**<br>*TYVASO Inhalation (treprostinil)*<br>*UPTRAVI (selexipag)*<br>*VENTAVIS Inhalation (iloprost)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| PANCREATIC ENZYMES | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| CREON (pancrelipase)<br>pancrelipase<br>ZENPEP (pancrelipase) | *PANCREAZE (pancrelipase)*<br>*PERTZYE (pancrelipase)*<br>*VIOKACE (pancrelipase)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| PENICILLINS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| amoxicillin<br>ampicillin<br>dicloxacillin<br>penicillin VK | *amoxicillin ER* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

## PHOSPHATE BINDERS

| Preferred Agents | *Non-Preferred Agents* | PA Criteria |
|---|---|---|
| calcium acetate<br>PHOSLYRA (calcium acetate)<br>RENAGEL (sevelamer HCl) | *AURYXIA (ferric citrate)*<br>*ELIPHOS (calcium acetate)*<br>*FOSRENOL (lanthanum)**<br>*RENVELA (sevelamer carbonate)*<br>*VELPHORO (sucroferric oxyhydroxide)* | Allergic reaction to preferred drug OR treatment failure with preferred drug; AND diagnosis of ESRD and hyperphosphatemia despite dietary phosphorous restrictions AND at least one of the following:<br>▪ hypercalcemia (corrected serum calcium >10.2 mg/dL)<br>▪ plasma PTH levels <150 pg/mL on two consecutive measurements<br>▪ dialysis patients with severe vascular and/or soft tissue calcifications<br>http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

## PLATELET AGGREGATION INHIBITORS

| Preferred Agents | *Non-Preferred Agents* | PA Criteria |
|---|---|---|
| AGGRENOX (dipyridamole/aspirin)<br>BRILINTA (ticagrelor)<br>clopidogrel<br>EFFIENT (prasugrel) | *dipyridamole*<br>*PERSANTINE (dipyridamole)*<br>*PLAVIX (clopidogrel)*<br>*ticlopidine*<br>*ZONTIVITY (vorapaxar)* | ▪ Treatment failure with preferred drug<br>▪ Contraindication to preferred drug<br>▪ Allergic reaction to preferred drug |

## PRENATAL VITAMINS

See Separate Preferred Prenatal Vitamin Listing.

**PA Criteria:**

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

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| PROGESTINS FOR CACHEXIA | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| megestrol | *MEGACE (megestrol)*<br>*MEGACE ES (megestrol)* | ▪ Treatment failure with preferred drug<br>▪ Contraindication to preferred drug<br>▪ Allergic reaction to preferred drug |

| PROTON PUMP INHIBITORS (ORAL) | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| NEXIUM (esomeprazole)<br>omeprazole Rx<br>pantoprazole<br>PROTONIX (pantoprazole) suspension | *ACIPHEX (rabeprazole)*<br>*DEXILANT (dexlansoprazole)*<br>*esomeprazole*<br>*lansoprazole*<br>*NEXIUM OTC (esomeprazole)*<br>*omeprazole OTC*<br>*omeprazole/sodium bicarbonate*<br>*PREVACID (lansoprazole)*<br>*PROTONIX tablets (pantoprazole)*<br>*rabeprazole*<br>*ZEGERID (omeprazole/sodium bicarbonate)* | ▪ Treatment failure after no less than a 30 day trial of each preferred drug<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ Prevacid Solutabs will be approved for children 10 years of age and under |

| SEDATIVE HYPNOTICS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Benzodiazepines** | | |
| flurazepam<br>temazepam 15, 30 mg<br>triazolam | *estazolam*<br>*RESTORIL (temazepam)*<br>*temazepam 7.5, 22.5 mg* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

## SEDATIVE HYPNOTICS

| Preferred Agents | *Non-Preferred Agents* | | PA Criteria |
|---|---|---|---|
| **Others** | | | |
| zolpidem* | *AMBIEN (zolpidem)**<br>*AMBIEN CR (zolpidem)**<br>*BELSOMRA (suvorexant)**<br>*EDLUAR (zolpidem)**<br>*eszopiclone**<br>*HETLIOZ (tasimelteon)*<br>*INTERMEZZO (zolpidem)** | *LUNESTA (eszopiclone)**<br>*ROZEREM (ramelteon)**<br>*SILENOR (doxepin)*<br>*SONATA (zaleplon)**<br>*zaleplon**<br>*zolpidem ER** | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

## SKELETAL MUSCLE RELAXANTS

| Preferred Agents | *Non-Preferred Agents* | | PA Criteria |
|---|---|---|---|
| baclofen<br>carisoprodol (except 250 mg)*<br>chlorzoxazone<br>cyclobenzaprine *<br>methocarbamol<br>tizanidine tablets | *AMRIX (cyclobenzaprine ER)**<br>*carisoprodol 250 mg**<br>*carisoprodol compound**<br>*DANTRIUM (dantrolene)*<br>*dantrolene*<br>*FEXMID (cyclobenzaprine)**<br>*LORZONE (chlorzoxazone)*<br>*metaxolone*<br>*orphenadrine* | *ROBAXIN (methocarbamol)*<br>*SKELAXIN (metaxolone)*<br>*SOMA (carisoprodol)**<br>*tizanidine capsules*<br>*ZANAFLEX (tizanidine)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

## SMOKING CESSATION

| Preferred Agents | *Non-Preferred Agents* | PA Criteria |
|---|---|---|
| bupropion SR<br>CHANTIX (varenicline)<br>NICODERM CQ (nicotine)<br>NICORETTE (nicotine) gum<br>nicotine gum<br>nicotine patch | *NICORETTE (nicotine) lozenge*<br>*nicotine lozenge* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| STEROIDS, TOPICAL | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| **Low Potency** | | | |
| fluocinolone oil<br>hydrocortisone cream, gel, lotion (OTC), ointment<br>hydrocortisone/aloe cream | *alclometasone*<br>*DERMA-SMOOTHE/FS (fluocinolone)*<br>*DESONATE (desonide)*<br>*desonide*<br>*hydrocortisone/mineral oil ointment*<br>*hydrocortisone lotion (Rx)* | *PEDIADERM HC (hydrocortisone)*<br>*PEDIADERM TA (triamcinolone)*<br>*TEXACORT (hydrocortisone) solution* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **Medium Potency** | | | |
| fluticasone propionate cream, ointment<br>mometasone cream, ointment, solution | *beclomethasone valerate foam*<br>*clocortolone cream*<br>*CLODERM (clocortolone)*<br>*CORDRAN (flurandrenolide)*<br>*CUTIVATE (fluticasone)*<br>*ELOCON (mometasone)*<br>*fluocinolone acetonide*<br>*flurandrenolide* | *fluticasone propionate lotion*<br>*hydrocortisone butyrate*<br>*hydrocortisone valerate*<br>*LUXIQ (betamethasone)*<br>*PANDEL (hydrocortisone probutate)*<br>*prednicarbate*<br>*SYNALAR (fluocinolone)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |
| **High Potency** | | | |
| betamethasone dipropionate lotion<br>betamethasone dipropionate/propylene glycol cream<br>betamethasone valerate cream<br>triamcinolone acetonide cream, ointment | *amcinonide*<br>*betamethasone dipropionate cream, gel, ointment*<br>*betamethasone dipropionate/ propylene glycol lotion, ointment*<br>*betamethasone valerate lotion, ointment*<br>*desoximetasone*<br>*diflorasone*<br>*DIPROLENE (betamethasone dipropionate)* | *fluocinonide*<br>*HALOG (halcinonide)*<br>*KENALOG aerosol (triamcinolone)*<br>*SERNIVO (betamethasone dipropionate)*<br>*TOPICORT (desoximetasone)*<br>*triamcinolone acetonide aerosol, lotion*<br>*triamcinolone/dimethicone*<br>*TRIANEX (triamcinolone)*<br>*VANOS (fluocinonide)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| STEROIDS, TOPICAL | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| **Very High Potency** | | | |
| clobetasol emollient<br>clobetasol propionate cream, gel, ointment, solution<br>halobetasol | *APEXICON E (diflorasone)*<br>*clobetasol lotion, shampoo*<br>*clobetasol propionate foam, spray*<br>*CLOBEX (clobetasol)*<br>*CLODAN (clobetasol)*<br>*OLUX, OLUX-E (clobetasol)* | *TEMOVATE (clobetasol)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

| STIMULANTS AND RELATED AGENTS | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| **Stimulants** | | | |
| ADDERALL XR (amphetamine salt combination)*<br>amphetamine salt combination IR*<br>DAYTRANA (methylphenidate)*<br>dexmethylphenidate IR *<br>dextroamphetamine IR*<br>DYANAVEL XR (amphetamine)<br>FOCALIN XR (dexmethylphenidate)*<br>methylphenidate IR[PPG*]<br>methylphenidate CD*<br>methylphenidate ER *<br>methylphenidate ER (authorized generic Concerta/Actavis) [PPG*]<br>QUILLICHEW ER (methylphenidate)*<br>QUILLIVANT XR (methylphenidate)*<br>VYVANSE (lisdexamfetamine)* | *ADZENYS XR ODT (amphetamine)**<br>*amphetamine salt combination ER**<br>*APTENSIO XR (methylphenidate)**<br>*CONCERTA (methylphenidate)**<br>*DESOXYN (methamphetamine)**<br>*DEXEDRINE (dextroamphetamine)**<br>*dexmethylphenidate IR (AG)**<br>*dexmethylphenidate ER**<br>*dextroamphetamine ER**<br>*dextroamphetamine solution**<br>*EVEKEO (amphetamine)**<br>*FOCALIN (dexmethylphenidate)**<br>*METADATE CD (methylphenidate)**<br>*methamphetamine** | *METHYLIN (methylphenidate) **<br>*methylphenidate chewable tablets**<br>*methylphenidate ER (generic Concerta)**<br>*methylphenidate CD **<br>*methylphenidate solution**<br>*modafanil**<br>*NUVIGIL (armodafinil)*<br>*PROCENTRA (dextroamphetamine)**<br>*PROVIGIL (modafinil)*<br>*RITALIN (methylphenidate) **<br>*RITALIN LA (methylphenidate ER) **<br>*ZENZEDI (dextroamphetamine)** | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ Methylin solution will not require previous use of a preferred drug for patients under six years of age<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| STIMULANTS AND RELATED AGENTS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Non-Stimulants** | | |
| guanfacine ER<br>STRATTERA (atomoxetine) | *clonidine ER*<br>*INTUNIV (guanfacine ER)* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs<br>▪ http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml |

| TETRACYCLINES | | | |
|---|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | | **PA Criteria** |
| doxycycline monohydrate 50, 100 mg capsules<br>minocycline capsules<br>VIBRAMYCIN (doxycycline) suspension | *demeclocycline*<br>*doxycycline hyclate IR*<br>*doxycycline hyclate DR*<br>*doxycycline monohydrate 40, 75, 150 mg capsules*<br>*doxycycline monohydrate suspension, tablets* | *minocycline tablets*<br>*minocycline ER*<br>*ORACEA (doxycycline)*<br>*SOLODYN (minocycline)*<br>*tetracycline*<br>*VIBRAMYCIN (doxycycline) capsule, syrup* | ▪ Treatment failure with preferred drugs within any subclass<br>▪ Contraindication to preferred drugs<br>▪ Allergic reaction to preferred drugs |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| ULCERATIVE COLITIS | | |
|---|---|---|
| **Preferred Agents** | ***Non-Preferred Agents*** | **PA Criteria** |
| **Oral** | | |
| DELZICOL (mesalamine)<br>LIALDA (mesalamine)<br>sulfasalazine<br>sulfasalazine DR | *APRISO (mesalamine)*<br>*ASACOL HD (mesalamine)*<br>*AZULFIDINE (sulfasalazine)*<br>*balsalazide*<br>*COLAZAL (balsalazide)*<br>*DIPENTUM (olsalazine)*<br>*GIAZO (balsalazide)*<br>*PENTASA (mesalamine)*<br>*UCERIS (budesonide)* | ▪ Treatment failure with preferred drugs within any subclass of same route<br>▪ Contraindication to preferred drugs of same route<br>▪ Allergic reaction to preferred drugs of same route |
| **Rectal** | | |
| CANASA (mesalamine) | *mesalamine*<br>*SFROWASA (mesalamine)*<br>*UCERIS (budesonide)* | ▪ Treatment failure with preferred drugs within any subclass of same route<br>▪ Contraindication to preferred drugs of same route<br>▪ Allergic reaction to preferred drugs of same route |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

PREMIUM PREFERRED GENERIC (PPG) MANUFACTURERS: These manufacturers have offered Supplemental Rebates to the state for their PDL drugs dispensed to Medicaid recipients. Pharmacists will receive an additional $0.50 dispensing fee when they dispense the PDL drugs of these manufacturers.

| Manufacturer | Labeler Code(s) |
|---|---|
| Mallinckrodt | 00406 |

**PDL Review and Implementation Schedule**

| 2017 Review | CLASS | Date of Most Recent PDL Change | Date of Next PDL Change (Tentative) | 2018 Review (Tentative) |
|---|---|---|---|---|
| JAN | ACNE AGENTS, ORAL | 7/1/2016 | 7/1/2017 | JAN |
| JAN | ACNE AGENTS, TOPICAL | 7/1/2016 | 7/1/2017 | JAN |
| JAN | ANALGESICS, NARCOTICS LONG | 7/1/2016 | 7/1/2017 | JAN |
| JAN | ANALGESICS, NARCOTICS SHORT | 7/1/2016 | 7/1/2017 | JAN |
| JAN | ANGIOTENSIN MODULATOR COMBINATIONS | 7/1/2016 | 7/1/2017 | JAN |
| JAN | ANGIOTENSIN MODULATORS | 7/1/2016 | 7/1/2017 | JAN |
| JAN | ANTIMIGRAINE AGENTS, OTHER | 7/1/2016 | 7/1/2017 | JAN |
| JAN | ANTIMIGRAINE AGENTS, TRIPTANS | 7/1/2016 | 7/1/2017 | JAN |
| JAN | BLADDER RELAXANT PREPARATIONS | 7/1/2016 | 7/1/2017 | JAN |
| JAN | H. PYLORI TREATMENT | 7/1/2016 | 7/1/2017 | JAN |
| JAN | IMMUNOMODULATORS, ATOPIC DERMATITIS | 7/1/2016 | 7/1/2017 | JAN |
| JAN | INTRANASAL RHINITIS AGENTS | 7/1/2016 | 7/1/2017 | JAN |
| JAN | NEUROPATHIC PAIN | 7/1/2016 | 7/1/2017 | JAN |
| JAN | OPHTHALMIC ANTI-INFLAMMATORY/IMMUNOMODULATORS | N/A | 7/1/2017 | JAN |
| JAN | PHOSPHATE BINDERS | 7/1/2016 | 7/1/2017 | JAN |
| JAN | PLATELET AGGREGATION INHIBITORS | 7/1/2016 | 7/1/2017 | JAN |
| JAN | PROGESTINS FOR CACHEXIA | 7/1/2016 | 7/1/2017 | JAN |
| JAN | PROTON PUMP INHIBITORS | 7/1/2016 | 7/1/2017 | JAN |
| JAN | SMOKING CESSATION | 7/1/2016 | 7/1/2017 | JAN |
| JAN | STIMULANTS AND RELATED AGENTS | 7/1/2016 | 7/1/2017 | JAN |
| APR | ANTI-ALLERGENS, ORAL | 7/1/2016 | 7/1/2017 | APR |
| APR | ANTIBIOTICS, INHALED | 7/1/2016 | 7/1/2017 | APR |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| 2017 Review | CLASS | Date of Most Recent PDL Change | Date of Next PDL Change (Tentative) | 2018 Review (Tentative) |
|---|---|---|---|---|
| APR | ANTICOAGULANTS | 7/1/2016 | 7/1/2017 | APR |
| APR | ANTIDEPRESSANTS, OTHER | 7/1/2016 | 7/1/2017 | APR |
| APR | ANTIDEPRESSANTS, SSRIs | 7/1/2016 | 7/1/2017 | APR |
| APR | ANTIHYPERURICEMICS | 7/1/2016 | 7/1/2017 | APR |
| APR | ANTIPARKINSONS AGENTS | 7/1/2016 | 7/1/2017 | APR |
| APR | BETA-BLOCKERS | 7/1/2016 | 7/1/2017 | APR |
| APR | BILE SALTS | 7/1/2016 | 7/1/2017 | APR |
| APR | BPH TREATMENTS | 7/1/2016 | 7/1/2017 | APR |
| APR | BRONCHODILATORS, BETA AGONIST | 7/1/2016 | 7/1/2017 | APR |
| APR | COPD AGENTS | 7/1/2016 | 7/1/2017 | APR |
| APR | COUGH AND COLD | 7/1/2016 | 7/1/2017 | APR |
| APR | ERYTHROPOIESIS STIMULATING PROTEINS | 7/1/2016 | 7/1/2017 | APR |
| APR | GLUCOCORTICOIDS, INHALED | 7/1/2016 | 7/1/2017 | APR |
| APR | HAE TREATMENTS | 7/1/2016 | 7/1/2017 | APR |
| APR | HEPATITIS C AGENTS | 4/1/2016 | 7/1/2017 | APR |
| APR | HYPOGLYCEMICS, SLGT2 | 7/1/2016 | 7/1/2017 | APR |
| APR | IMMUNE GLOBULINS, IV | 7/1/2016 | 7/1/2017 | APR |
| APR | LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS | 7/1/2016 | 7/1/2017 | APR |
| APR | LIPOTROPICS, OTHER | 7/1/2016 | 7/1/2017 | APR |
| APR | LIPOTROPICS, STATINS | 7/1/2016 | 7/1/2017 | APR |
| APR | PAH AGENTS, ORAL AND INHALED | 7/1/2016 | 7/1/2017 | APR |
| APR | PANCREATIC ENZYMES | 7/1/2016 | 7/1/2017 | APR |
| APR | SEDATIVE HYPNOTICS | 7/1/2016 | 7/1/2017 | APR |
| JUL | ALZHEIMERS AGENTS | 1/1/2017 | 1/1/2018 | JUL |
| JUL | ANTIHISTAMINES, MINIMALLY SEDATING | 1/1/2017 | 1/1/2018 | JUL |
| JUL | ANTIHYPERTENSIVES, SYMPATHOLYTIC | 1/1/2017 | 1/1/2018 | JUL |
| JUL | ANTIVIRALS, ORAL | 1/1/2017 | 1/1/2018 | JUL |
| JUL | CALCIUM CHANNEL BLOCKERS | 1/1/2017 | 1/1/2018 | JUL |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| 2017 Review | CLASS | Date of Most Recent PDL Change | Date of Next PDL Change (Tentative) | 2018 Review (Tentative) |
|---|---|---|---|---|
| JUL | CEPHALOSPORINS AND RELATED ANTIBIOTICS | 1/1/2017 | 1/1/2018 | JUL |
| JUL | FLUOROQUINOLONES, ORAL | 1/1/2017 | 1/1/2018 | JUL |
| JUL | GLUCOCORTICOIDS, ORAL | 1/1/2017 | 1/1/2018 | JUL |
| JUL | IMMUNOSUPPRESSIVES, ORAL | 1/1/2017 | 1/1/2018 | JUL |
| JUL | IRON, ORAL | 1/1/2017 | 1/1/2018 | JUL |
| JUL | LEUKOTRIENE MODIFIERS | 1/1/2017 | 1/1/2018 | JUL |
| JUL | NSAIDS | 1/1/2017 | 1/1/2018 | JUL |
| JUL | OPHTHALMIC ANTIBIOTICS | 1/1/2017 | 1/1/2018 | JUL |
| JUL | OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS | 1/1/2017 | 1/1/2018 | JUL |
| JUL | OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS | 1/1/2017 | 1/1/2018 | JUL |
| JUL | OPHTHALMICS, ANTI-INFLAMMATORY | 1/1/2017 | 1/1/2018 | JUL |
| JUL | OPHTHALMICS, GLAUCOMA AGENTS | 1/1/2017 | 1/1/2018 | JUL |
| JUL | OTIC ANTIBIOTICS | 1/1/2017 | 1/1/2018 | JUL |
| JUL | OTIC ANTI-INFECTIVES & ANESTHETICS | 1/1/2017 | 1/1/2018 | JUL |
| JUL | PRENATAL VITAMINS | 1/1/2017 | 1/1/2018 | JUL |
| JUL | SKELETAL MUSCLE RELAXANTS | 1/1/2017 | 1/1/2018 | JUL |
| JUL | STEROIDS, TOPICAL | 1/1/2017 | 1/1/2018 | JUL |
| JUL | ULCERATIVE COLITIS | 1/1/2017 | 1/1/2018 | JUL |
| OCT | ANDROGENIC AGENTS | 1/1/2017 | 1/1/2018 | OCT |
| OCT | ANTIBIOTICS, GI | 1/1/2017 | 1/1/2018 | OCT |
| OCT | ANTIBIOTICS, TOPICAL | 1/1/2017 | 1/1/2018 | OCT |
| OCT | ANTIBIOTICS, VAGINAL | 1/1/2017 | 1/1/2018 | OCT |
| OCT | ANTIEMETICS/ANTIVERTIGO AGENTS | 1/1/2017 | 1/1/2018 | OCT |
| OCT | ANTIFUNGALS, ORAL | 1/1/2017 | 1/1/2018 | OCT |
| OCT | ANTIFUNGALS, TOPICAL | 1/1/2017 | 1/1/2018 | OCT |
| OCT | ANTIPARASITICS, TOPICAL | 1/1/2017 | 1/1/2018 | OCT |
| OCT | ANTIPSYCHOTICS | 1/1/2017 | 1/1/2018 | OCT |
| OCT | ANTIVIRALS, TOPICAL | 1/1/2017 | 1/1/2018 | OCT |

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* indicates that a product is subject to PA criteria.

| 2017 Review | CLASS | Date of Most Recent PDL Change | Date of Next PDL Change (Tentative) | 2018 Review (Tentative) |
|---|---|---|---|---|
| OCT | BONE RESORPTION SUPPRESSION AND RELATED | 1/1/2017 | 1/1/2018 | OCT |
| OCT | COLONY STIMULATING FACTORS | 1/1/2017 | 1/1/2018 | OCT |
| OCT | CYTOKINE AND CAM ANTAGONISTS | 1/1/2017 | 1/1/2018 | OCT |
| OCT | EPINEPHRINE, SELF-INJECTED | 1/1/2017 | 1/1/2018 | OCT |
| OCT | GI MOTILITY, CHRONIC | 1/1/2017 | 1/1/2018 | OCT |
| OCT | GROWTH HORMONE | 1/1/2017 | 1/1/2018 | OCT |
| OCT | HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS | 1/1/2017 | 1/1/2018 | OCT |
| OCT | HYPOGLYCEMICS, INSULIN AND RELATED | 1/1/2017 | 1/1/2018 | OCT |
| OCT | HYPOGLYCEMICS, MEGLITINIDES | 1/1/2017 | 1/1/2018 | OCT |
| OCT | HYPOGLYCEMICS, METFORMIN | 1/1/2017 | 1/1/2018 | OCT |
| OCT | HYPOGLYCEMICS, TZD | 1/1/2017 | 1/1/2018 | OCT |
| OCT | MACROLIDES-KETOLIDES | 1/1/2017 | 1/1/2018 | OCT |
| OCT | OPIATE DEPENDENCE TREATMENTS | 1/1/2017 | 1/1/2018 | OCT |
| OCT | PENICILLINS | 1/1/2017 | 1/1/2018 | OCT |
| OCT | TETRACYCLINES | 1/1/2017 | 1/1/2018 | OCT |

| Cough and Cold (Oral only) | | | | |
|---|---|---|---|---|
| Preferred Agents | | Non-Preferred Agents | | PA CRITERIA |
| Agent | Ingredients | Agent | Ingredients | |
| ALA-HIST IR | DEXBROMPHENIRAMINE MALEATE | BROTAPP | BROMPHENIRAMIN/PSEUDOEPHEDRINE | All products restricted to patients aged 2 years and above |
| ALA-HIST PE | DEXBROMPHENIRAMIN/PHENYLEPHRIN | CHEST CONGESTION RELIEF PE | GUAIFENESIN/PHENYLEPHRINE HCL | |
| APRODINE | TRIPROLIDINE/PSEUDOEPHEDRINE | GUAIFENESIN-PSEUDOEPHEDRINE ER | GUAIFENESIN/PSEUDOEPHEDRNE HCL | |
| CHEST CONGESTION RELIEF | GUAIFENESIN | LOHIST-D | CHLORPHENIRAMINE/PSEUDOEPHED | |
| CHILD DELSYM COUGH+COLD | DIPHENHYDRA/PHENYLEPH/ACETAMIN | LORTUSS LQ | DOXYLAMINE/PSEUDOEPHEDRINE HCL | |
| CHILD MUCINEX CHEST CONGESTION | GUAIFENESIN | MAPAP SINUS | PHENYLEPHRINE HCL/ACETAMINOPHN | |
| CHILDREN'S MUCINEX | DIPHENHYDRA/PHENYLEPH/ACETAMIN | MAXIPHEN | GUAIFENESIN/PHENYLEPHRINE HCL | |
| CHILDREN'S MUCINEX | GUAIFENESIN/PHENYLEPHRINE HCL | MUCUS RELIEF SINUS | GUAIFENESIN/PHENYLEPHRINE HCL | |
| COUGH SYRUP | GUAIFENESIN | PAIN RELIEF SINUS PE | PHENYLEPHRINE HCL/ACETAMINOPHN | |
| DALLERGY | CHLORPHENIRAMINE/PHENYLEPHRINE | PHENYLEPHRINE-PYRILAMINE | PHENYLEPHRINE/PYRILAMINE | |
| DALLERGY | DEXBROMPHENIRAMIN/PHENYLEPHRIN | PROMETHAZINE VC | PHENYLEPHRINE HCL/PROMETH HCL | |
| DECONEX IR | GUAIFENESIN/PHENYLEPHRINE HCL | RESCON | DEXCHLORPHENIRAMIN/PSEUDOEPHED | |
| DELSYM COUGH+COLD | DIPHENHYDRA/PHENYLEPH/ACETAMIN | RESCON-GG | GUAIFENESIN/PHENYLEPHRINE HCL | |
| DIMAPHEN | BROMPHENIRAMINE/PHENYLEPHRINE | RU-HIST D | BROMPHENIRAMINE/PHENYLEPHRINE | |
| ED A-HIST | CHLORPHENIRAMINE/PHENYLEPHRINE | STAHIST AD | CHLORCYCLIZINE/PSEUDOEPHEDRINE | |
| ED A-HIST PSE | TRIPROLIDINE/PSEUDOEPHEDRINE | | | |
| ED BRON GP | GUAIFENESIN/PHENYLEPHRINE HCL | | | |
| ED CHLORPED D | CHLORPHENIRAMINE/PHENYLEPHRINE | | | |
| GUAIFENESIN | GUAIFENESIN | | | |
| GUAIFENESIN ER | GUAIFENESIN | | | |
| HISTEX-PE | PHENYLEPHRINE/TRIPROLIDINE | | | |
| IOPHEN NR | GUAIFENESIN | | | |
| J-MAX | GUAIFENESIN/PHENYLEPHRINE HCL | | | |
| LODRANE D | BROMPHENIRAMIN/PSEUDOEPHEDRINE | | | |
| MUCAPHED | GUAIFENESIN/PHENYLEPHRINE HCL | | | |
| MUCINEX | GUAIFENESIN | | | |
| MUCINEX D | GUAIFENESIN/PSEUDOEPHEDRNE HCL | | | |
| MUCINEX FAST-MAX COLD-SINUS | GUAIFEN/PHENYLEPH/ACETAMINOPHN | | | |
| MUCINEX FAST-MAX NITE COLD-FLU | DIPHENHYDRA/PHENYLEPH/ACETAMIN | | | |
| MUCINEX SINUS-MAX | GUAIFEN/PHENYLEPH/ACETAMINOPHN | | | |
| MUCINEX SINUS-MAX DAY-NIGHT | DIPHENHYD/PE/ACETAMINOPHEN/GG | | | |
| MUCUS ER | GUAIFENESIN | | | |
| MUCUS RELIEF | GUAIFENESIN | | | |
| NASOPEN PE | THONZYLAMINE/PHENYLEPHRINE | | | |
| NOHIST-LQ | CHLORPHENIRAMINE/PHENYLEPHRINE | | | |
| ORGAN-I NR | GUAIFENESIN | | | |
| POLY-VENT IR | GUAIFENESIN/PSEUDOEPHEDRNE HCL | | | |
| Q-TUSSIN | GUAIFENESIN | | | |
| RESPAIRE-30 | GUAIFENESIN/PSEUDOEPHEDRNE HCL | | | |
| ROBAFEN | GUAIFENESIN | | | |
| RYMED | DEXCHLORPHENIRAM/PHENYLEPHRINE | | | |
| RYNEX PE | BROMPHENIRAMINE/PHENYLEPHRINE | | | |
| RYNEX PSE | BROMPHENIRAMIN/PSEUDOEPHEDRINE | | | |
| SILTUSSIN SA | GUAIFENESIN | | | |
| SUDOGEST SINUS & ALLERGY | CHLORPHENIRAMINE/PSEUDOEPHED | | | |
| TUSSIN | GUAIFENESIN | | | |

| Cough and Cold (Nasal) | | | |
|---|---|---|---|
| Preferred Agents | | Non-Preferred Agents | |
| Agent | Ingredients | Agent | Ingredients |
| NASAL DECONGESTANT | OXYMETAZOLINE HCL | NOSE DROPS | PHENYLEPHRINE HCL |
| NASAL SPRAY | OXYMETAZOLINE HCL | | |
| NRS-NASAL RELIEF | OXYMETAZOLINE HCL | | |

| Cough and Cold (Non-Narcotic) | | | | | |
|---|---|---|---|---|---|
| Preferred Agents | | Non-Preferred Agents | | PA CRITERIA |
| Agent | Ingredients | Agent | Ingredients | |
| ALA-HIST DM | BROMPHENIRAM/PHENYLEPHRINE/DM | ALL-NITE COLD-FLU RELIEF | DM/ACETAMINOPHEN/DOXYLAMINE | All products restricted to patients aged 2 years and above |
| AP-HIST DM | BROMPHENIRAM/PHENYLEPHRINE/DM | ALLFEN DM | GUAIFENESIN/DEXTROMETHORPHAN | |
| BENZONATATE | BENZONATATE | BROMPHENIRAMINE-PSEUDOEPHED-DM | BROMPHENIRAMINE/PSEUDOEPHED/DM | |
| BROMFED DM | BROMPHENIRAMINE/PSEUDOEPHED/DM | CHILDREN'S COLD & COUGH DM | BROMPHENIRAM/PHENYLEPHRINE/DM | |
| BROTAPP DM | BROMPHENIRAMINE/PSEUDOEPHED/DM | DAY TIME COLD-FLU RELIEF | D-METHORPHAN/PE/ACETAMINOPHEN | |
| CHILD DELSYM COUGH+CHEST DM | GUAIFENESIN/DEXTROMETHORPHAN | DIMAPHEN DM | BROMPHENIRAM/PHENYLEPHRINE/DM | |
| CHILD MUCINEX M-S COLD DAY-NTE | DIPHENHYDRAM/PE/DM/ACETAMIN/GG | DURAFLU | PSEUDOEPH/DM/GUAIFEN/ACETAMIN | |
| CHILDREN'S MUCINEX | GUAIFEN/DEXTROMETHORPHAN/PE | ENDACOF-DM | BROMPHENIRAM/PHENYLEPHRINE/DM | |
| CHILDREN'S MUCINEX | GUAIFENESIN/DEXTROMETHORPHAN | GUAIFENESIN-DM ER | GUAIFENESIN/DEXTROMETHORPHAN | |
| CHILDREN'S MUCINEX | PHENYLEPHRINE/DM/ACETAMINOP/GG | LORTUSS DM | DOXYLAMINE/PSEUDOEPHEDRINE/DM | |
| CHLO TUSS | DEXBROMPHEN/PSEUDOEPH/CHLOPHED | MAPAP COLD FORMULA | D-METHORPHAN/PE/ACETAMINOPHEN | |
| COUGH DM ER | DEXTROMETHORPHAN POLISTIREX | MAXIPHEN DM | GUAIFEN/DEXTROMETHORPHAN/PE | |
| DECONEX DMX | GUAIFEN/DEXTROMETHORPHAN/PE | MUCINEX FAST-MAX DAY-NITE COLD | DIPHENHYDRAM/PE/DM/ACETAMIN/GG | |
| DELSYM | DEXTROMETHORPHAN POLISTIREX | MUCINEX FAST-MAX SEVERE COLD | PHENYLEPHRINE/DM/ACETAMINOP/GG | |
| DELSYM COUGH-COLD | PHENYLEPHRINE/DM/ACETAMINOP/GG | NIGHT TIME COLD-FLU RELIEF | DM/ACETAMINOPHEN/DOXYLAMINE | |
| DELSYM COUGH+CHEST CONGEST DM | GUAIFENESIN/DEXTROMETHORPHAN | NIGHTTIME COUGH & SORE THROAT | DM/ACETAMINOPHEN/DOXYLAMINE | |
| DEXTROMETHORPHAN POLISTIREX | DEXTROMETHORPHAN POLISTIREX | NINJACOF | PYRILAMINE/CHLOPHEDIANOL | |
| ED A-HIST DM | CHLORPHENIRAMINE/PHENYLEPH/DM | NINJACOF-A | PYRILAM/CHLOPHED/ACETAMINOPHEN | |
| ED-A-HIST DM | CHLORPHENIRAMINE/PHENYLEPH/DM | ROBAFEN CF | GUAIFEN/DEXTROMETHORPHAN/PE | |
| EXTRA ACTION COUGH | GUAIFENESIN/DEXTROMETHORPHAN | ROBAFEN COUGH | DEXTROMETHORPHAN HBR | |
| HISTEX-DM | TRIPROLIDINE/PHENYLEPHRINE/DM | VANACOF-8 | PYRILAMINE/CHLOPHEDIANOL | |
| IOPHEN DM-NR | GUAIFENESIN/DEXTROMETHORPHAN | | | |
| KIDKARE | CHLORPHENIRAMIN/PSEUDOEPHED/DM | | | |
| LOHIST-DM | BROMPHENIRAM/PHENYLEPHRINE/DM | | | |
| M-END DMX | DEXBROMPHEN/PSEUDOEPHEDRINE/DM | | | |
| MUCINEX COLD-FLU-SORE THROAT | PHENYLEPHRINE/DM/ACETAMINOP/GG | | | |
| MUCINEX COUGH | GUAIFENESIN/DEXTROMETHORPHAN | | | |
| MUCINEX DM | GUAIFENESIN/DEXTROMETHORPHAN | | | |
| MUCINEX FAST-MAX COLD-FLU-THRT | PHENYLEPHRINE/DM/ACETAMINOP/GG | | | |
| MUCINEX FAST-MAX CONGEST-COUGH | GUAIFEN/DEXTROMETHORPHAN/PE | | | |
| MUCINEX FAST-MAX DAY-NITE CONG | DIPHENHYDRAM/PE/DM/ACETAMIN/GG | | | |
| MUCINEX FAST-MAX DM MAX | GUAIFENESIN/DEXTROMETHORPHAN | | | |
| MUCINEX FAST-MAX SEVERE COLD | PHENYLEPHRINE/DM/ACETAMINOP/GG | | | |
| NOHIST-DM | CHLORPHENIRAMINE/PHENYLEPH/DM | | | |
| PEDIATRIC COUGH-COLD | CHLORPHENIRAMIN/PSEUDOEPHED/DM | | | |
| POLY-HIST DM | THONZYLAMINE/PHENYLEPHRINE/DM | | | |
| POLY-HIST PD | THONZYLAMINE/CHLOPHEDIANOL | | | |
| POLY-VENT DM | GUAIFENESIN/DM/PSEUDOEPHEDRINE | | | |
| PROMETHAZINE-DM | PROMETHAZINE/DEXTROMETHORPHAN | | | |
| Q-TUSSIN DM | GUAIFENESIN/DEXTROMETHORPHAN | | | |
| RESCON-DM | CHLORPHENIRAMIN/PSEUDOEPHED/DM | | | |
| ROBAFEN DM COUGH | GUAIFENESIN/DEXTROMETHORPHAN | | | |
| ROBAFEN DM COUGH-CHEST CONGEST | GUAIFENESIN/DEXTROMETHORPHAN | | | |
| ROBAFEN-DM | GUAIFENESIN/DEXTROMETHORPHAN | | | |
| RYNEX DM | BROMPHENIRAM/PHENYLEPHRINE/DM | | | |
| SILTUSSIN DM | GUAIFENESIN/DEXTROMETHORPHAN | | | |
| SILTUSSIN DM DAS COUGH FORMULA | GUAIFENESIN/DEXTROMETHORPHAN | | | |
| TUSSIN DM | GUAIFENESIN/DEXTROMETHORPHAN | | | |
| VANACOF | DEXCHLORPHENIR/PSE/CHLOPHEDIAN | | | |
| VANACOF DM | GUAIFEN/DEXTROMETHORPHAN/PE | | | |

| Cough and Cold (Narcotic) | | | | |
|---|---|---|---|---|
| Preferred Agents | | Non-Preferred Agents | | PA CRITERIA |
| Agent | Ingredients | Agent | Ingredients | |
| CHERATUSSIN AC | CODEINE PHOSPHATE/GUAIFENESIN | CHERATUSSIN DAC | PSEUDOEPHED/CODEINE/GUAIFEN | All products restricted to patients aged 2 years and above |
| CODEINE-GUAIFENESIN | CODEINE PHOSPHATE/GUAIFENESIN | FLOWTUSS | GUAIFENESIN/HYDROCODONE | |
| GUAIATUSSIN AC | CODEINE PHOSPHATE/GUAIFENESIN | HYCOFENIX | HYDROCODONE/PSEUDOEPHED/GUAIF | |
| GUAIFENESIN AC | CODEINE PHOSPHATE/GUAIFENESIN | HYDROCOD-CPM-PSEUDOEPHEDRINE | HYDROCODONE/CPM/PSEUDOEPHED | |
| GUAIFENESIN-CODEINE | CODEINE PHOSPHATE/GUAIFENESIN | HYDROCODONE BT-HOMATROPINE MBR | HYDROCODONE BIT/HOMATROP ME-BR | |
| IOPHEN-C NR | CODEINE PHOSPHATE/GUAIFENESIN | HYDROCODONE-CHLORPHENIRAMNE ER | HYDROCODONE/CHLORPHEN P-STIREX | |
| PROMETHAZINE-CODEINE | PROMETHAZINE HCL/CODEINE | HYDROCODONE-HOMATROPINE MBR | HYDROCODONE BIT/HOMATROP ME-BR | |
| VIRTUSSIN AC | CODEINE PHOSPHATE/GUAIFENESIN | HYDROMET | HYDROCODONE BIT/HOMATROP ME-BR | |
| | | LORTUSS EX | PSEUDOEPHED/CODEINE/GUAIFEN | |
| | | M-END MAX D | DEXBROMPHENIRAMINE/PSE/CODEINE | |
| | | NINJACOF-XG | CODEINE PHOSPHATE/GUAIFENESIN | |
| | | PHENYLHISTINE DH | PSEUDOEPHED/COD/CHLORPHENIR | |
| | | PROMETHAZINE VC-CODEINE | PROMETHAZINE/PHENYLEPH/CODEINE | |
| | | PROMETHAZINE-PHENYLEPH-CODEINE | PROMETHAZINE/PHENYLEPH/CODEINE | |
| | | REZIRA | PSEUDOEPHED/HYDROCODONE | |
| | | TUSSIONEX | HYDROCODONE/CHLORPHEN P-STIREX | |
| | | ZUTRIPRO | HYDROCODONE/CPM/PSEUDOEPHED | |

## Prenatal Vitamins

| Preferred Agents | |
|---|---|
| Agent | Ingredients |
| CITRANATAL 90 DHA | PNV72/IRON,GLUC/FOLIC/DSS/DHA |
| CITRANATAL ASSURE | PNV73/IRON,GLUC/FOLIC/DSS/DHA |
| CITRANATAL B-CALM | PRENATAL #48/IRON CB,GLU/FA/B6 |
| CITRANATAL HARMONY | PNV59/IRON,CARB,FUM/FA/DSS/DHA |
| NESTABS | PRENATAL VIT#86/IRON BISGLY/FA |
| NESTABS ABC | PNV #86/IRON POLY/FA/DHA/EPA |
| NESTABS DHA | PNV #87/IRON BISGLY/FA/DHA |
| SELECT-OB | PV W-O CAL/IRON PS CPLX/FOLIC |
| SELECT-OB + DHA | PRENATAL VITS #33/IRON/FA/DHA |
| TRICARE | PRENATAL #103/IRON FUMARATE/FA |
| TRINATAL RX 1 | PRENATAL VIT27,CALCIUM/IRON/FA |
| VITAFOL ULTRA | PNV#67/IRON PS/FA CMB#1/DHA |
| VITAFOL-OB+DHA | PRENAT VIT COMB.10/IRON/FA/DHA |
| VITAFOL-ONE | PNV#26/IRON POLY/FA/DHA |
| VOL-PLUS | PNV WITH CA#74/IRON/FOLIC ACID |

| Non-Preferred Agents | |
|---|---|
| Agent | Ingredients |
| ACTIVE OB | PNV NO.66/IRON,CARB/FOLIC/DHA |
| COMPLETE NATAL DHA | PNV2/IRON BG SUC-PR/FOLIC/OM-3 |
| COMPLETENATE | PNV #14/FERROUS FUM/FOLIC ACID |
| CONCEPT DHA | PNV 16/IRON FUM,PS/FOLIC/OM-3 |
| CONCEPT OB | PNV #15/IRON FUM,PS/FOLIC ACID |
| DOTHELLE DHA | PNV 16/IRON FUM,PS/FOLIC/OM-3 |
| ELITE-OB | IRON,CARBONYL/FOLIC ACID/MV-MN |
| EXTRA-VIRT PLUS DHA | PRENATAL #57/IRON/FA/DSS/DHA |
| FOCALGIN 90 DHA | PNV72/IRON,GLUC/FOLIC/DSS/DHA |
| FOCALGIN CA | PNV73/IRON,GLUC/FOLIC/DSS/DHA |
| FOLIVANE-OB | PNV #15/IRON FUM,PS/FOLIC ACID |
| NEXA PLUS | PNV53/IRON FUM/FA/DOCUSATE/DHA |
| OB COMPLETE | IRON,CARBONYL/FOLIC ACID/MV-MN |
| OB COMPLETE GOLD | PNV NO.106/IRON/FOLATE #6/DHA |
| OB COMPLETE ONE | PNV 85/IRON/FOLIC/DHA/FISH OIL |
| OB COMPLETE PETITE | PRENATAL56/IRON/FOLIC ACID/DHA |
| OB COMPLETE PREMIER | PNV83/IRON,CARB/IRON ASP GL/FA |
| PAIRE OB PLUS DHA | PNV #8/IRON PS CMP,ASPG/FA/DHA |
| PNV-SELECT | PNV W-CA #40/IRON FUM/FA CMB#1 |
| PR NATAL 400 | PNV53/IRON B-G HCL-P/FA/OMEGA3 |
| PR NATAL 400 EC | PNV19/IRON BD HC,S-P/FOLIC/OM3 |
| PR NATAL 430 EC | PNV55/IRON BG HC,SUCC-P/FA/OM3 |
| PREFERA-OB ONE | PNV 19/IRON PS,HEME/FOLIC/DHA |
| PRENATE AM | PRENATAL VIT NO.114/FA/GINGER |
| PRENATE CHEWABLE | PRENATAL VIT NO.112/FOLIC ACID |
| PRENATE DHA | PNV #78/IRON ASP GLY/FA#1/DHA |
| PRENATE ELITE | PRENATAL 114/IRON ASP GLY/FA 1 |
| PRENATE ENHANCE | PRENATAL VIT #68/IRON/FA#6/DHA |
| PRENATE ESSENTIAL | PRENATAL VIT#84/IRON/FA#1/DHA |
| PRENATE MINI | PRENATAL VIT NO.44/IRON/FA/DHA |
| PRENATE MINI | PRENATAL VIT NO.87/IRON/FA/DHA |
| PRENATE PIXIE | PRENATAL VIT#85/IRON/FA#1/DHA |
| PRENATE RESTORE | PRENATAL VIT #69/IRON/FA#6/DHA |
| PRENATE STAR | PRENATAL NO.77/IRON ASP GLY/FA |
| PROVIDA DHA | PRENATAL#90/IRON FUM,PS/FA/DHA |
| PROVIDA OB | PRENATAL VIT#65/IRON FUM,PS/FA |
| RELNATE DHA | PNV 11-IRON FUM-FOLIC ACID-OM3 |
| RULAVITE DHA | PNV COMBO#47/IRON/FA #1/DHA |
| SE-NATAL 19 | PNV NO.118/IRON FUMARATE/FA |
| SE-NATAL 19 | PNV119/IRON FUMARATE/FA/DSS |
| TARON-C DHA | PNV 16/IRON FUM,PS/FOLIC/OM-3 |
| THRIVITE 19 | PNV119/IRON FUMARATE/FA/DSS |
| TRICARE PRENATAL DHA ONE | PNV#20/IRON/FA/DS/FISH/DHA/EPA |
| TRINATAL GT | PRENATAL VIT 16/IRON CB/FA/DSS |
| TRIVEEN-DUO DHA | PNV53/IRON B-G HCL-P/FA/OMEGA3 |
| ULTIMATECARE ONE | PNV,CALCIUM37/IRON/FOLIC/OMEG3 |
| VIRT-SELECT | PNV80/IRON FUMARATE/FA/DSS/DHA |
| VITAFOL NANO | PRENATAL NO.75/IRON/FOLATE #1 |
| VITAFOL-OB | PRENATAL VIT COMB.10/IRON/FA |
| VOL-NATE | PRENATAL VIT NO.73/IRON/FA |
| VOL-TAB RX | PRENATAL VIT #76/IRON,CARB/FA |
| VP-CH-PNV | PNV34/IRON,CARBONYL/FA/DSS/DHA |
| VP-GGR-B6 | PNV/FOLIC AC/B6/CALCIUM/GINGER |
| VP-HEME OB | PNV 21/IRON PS,HEME PPEP/FOLIC |
| VP-HEME ONE | PNV 19/IRON PS,HEME/FOLIC/DHA |
| VP-PNV-DHA | PRENATAL NO.52/IRON/FA/DHA |
| ZATEAN-CH | PNV69/IRON,CARBONYL/FA/DSS/DHA |
| ZATEAN-PN DHA | PNV COMBO#47/IRON/FA #1/DHA |
| ZATEAN-PN PLUS | PNV WITH CA #68/IRON/FA#1/DHA |

## Iron Oral Agents

| Preferred Agents | |
|---|---|
| Agent | Ingredients |
| CENTRATEX | IRON FUM/FOLIC ACID/MV,MIN 15 |
| FERATE | FERROUS GLUCONATE |
| FERGON | FERROUS GLUCONATE |
| FERRALET 90 | IRON CARB,GL/FA/B12/C/DOCUSATE |
| FERRAPLUS 90 | IRON/FA/B12/C/DOCUSATE SODIUM |
| FUSION PLUS | IRON,FM,PS/FOLIC/B,C18/L.CASEI |
| HEMOCYTE PLUS | IRON FUM/FOLIC ACID/MV,MIN 15 |
| HEMOCYTE-F | FERROUS FUMARATE/FOLIC ACID |
| INTEGRA | IRON FUM,PS CMP/VIT C/NIACIN |
| INTEGRA F | IRON FUM,PS/FOLIC ACID/VITC/B3 |
| INTEGRA PLUS | IRON FUM,PS/FA/VIT B WITH C #9 |
| IROSPAN | IRON BG,PS/FOLIC/B,C NO.12/SUC |
| NEPHRON FA | IRON FUM/DOCUSAT/FOLIC/BCOMP,C |
| NOVAFERRUM | IRON POLYSACCHARIDE COMPLEX |
| NOVAFERRUM 125 | IRON POLYSACCHARIDE COMPLEX/D3 |
| NOVAFERRUM 50 | IRON POLYSACCHARIDE COMPLEX |
| SE-TAN PLUS | IRON FM,PS NO.1/FOLIC/MV NO.18 |
| TANDEM DUAL ACTION | FERROUS FUMARATE/IRON PS CPLX |
| TANDEM PLUS | IRON FM,PS NO.1/FOLIC/MV NO.18 |
| TARON FORTE | IRON BG,PS/VITC/B12/FA/CALCIUM |

| Non-Preferred Agents | |
|---|---|
| Agent | Ingredients |
| ACTIVE FE | IRON,CARBONYL/FOLIC ACID/MV-MN |
| FERIVA FA | IRON/FA#1/C/B12/BIOT/COPPR/DSS |
| FERIVA FA | IRON/FA#6/C/B12/BIOT/COP/DOCUS |
| FOCALGIN DSS | IRON CARB,GL/FA/B12/C/DOCUSATE |