

Duplicate Therapy Clinical Edit Criteria



Drug/Drug Class:

Duplicate Therapy

Superior HealthPlan follows the guidance of the Texas Vendor Drug Program (VDP) for all clinical edit criteria. This clinical edit criteria applies to all Superior HealthPlan STAR, STAR Health, STAR Kids, STAR+PLUS and CHIP members. Superior has adjusted the duplicate therapy clinical criteria to ease the prior authorization process regarding this clinical edit.

Superior HealthPlan has adjusted the definition of duplicate therapy from greater than 35 days of overlapping therapy between different agents in the last 60 days to greater than or equal to 56 days of overlapping therapy between different agents in the last 90 days.

Additionally, certain drug classes and individual drugs were removed from the edit. Adjusted definition and removed drug classes/drugs are highlighted in yellow.

Drugs requiring prior authorization are listed by GPI level the clinical edit is programmed by instead of GPI listed in the VDP edit.

The original clinical edit can be referenced at <https://paxpress.txpa.hidinc.com/duptherapy.pdf>

Clinical Edit Information Included in this Document:

- **Prior authorization criteria logic:** a description of how the prior authorization request will be evaluated against the clinical criteria rules.
- **Logic diagram:** a visual depiction of the clinical edit criteria logic.
- **Supporting tables:** a collection of information associated with the steps within the criteria; provided when applicable
- **Clinical Edit References:** clinical edit references as provided by the Texas Vendor Drug Program.
- **Publication history:** to track when the eased criteria was put into production and any updates since this time.

Please note: All tables are provided by original Duplicate Therapy Texas Vendor Drug Program Edit.

Superior HealthPlan Clinical Criteria Logic – Duplicate Therapy

1. Does the client have greater than or equal to (\geq) 2 different drugs within theselected drug class? (Use the following table for reference.)

Yes (Deny)

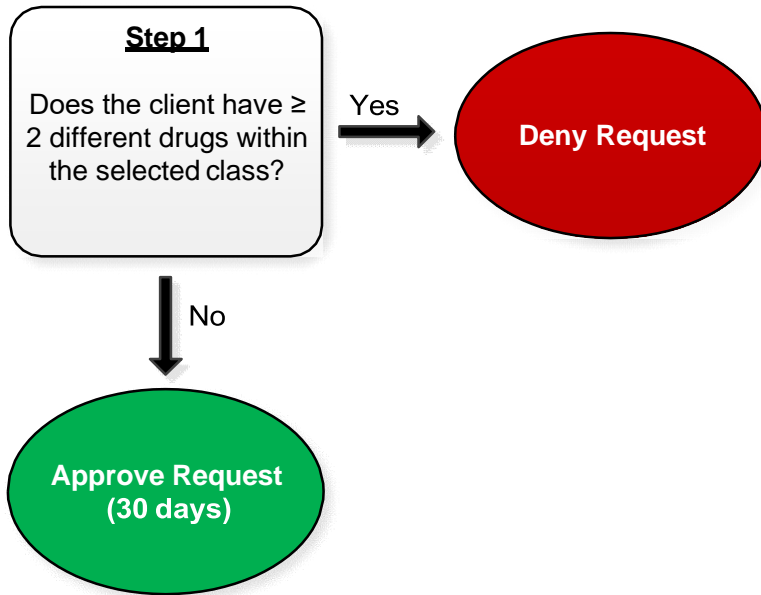
No (Approve – 30 days)

Note: Duplicate therapy is defined as greater than ($>$) 35 or equal to (\geq) 56 days of overlapping therapy between different agents in the last 60 90 days.

Drug Class	Drug Combinations		Number of Physicians
	Trigger Drug	Checks For	
Anticoagulants	Anticoagulant	<ul style="list-style-type: none"> Anticoagulant 	Not applicable (NA)
Antidiabetic Agents	Meglitinide	<ul style="list-style-type: none"> Meglitinide 	NA
Angiotensin Modulators	ARB	<ul style="list-style-type: none"> ARB 	NA
Antihistamines	Antihistamine	<ul style="list-style-type: none"> Antihistamine 	NA
Short-acting beta-2 agonists (SABA)	SABA	<ul style="list-style-type: none"> SABA 	NA
Long-acting beta-2 agonists (LABA)	LABA	<ul style="list-style-type: none"> LABA LABA/AM ICS/LABA ICS/LABA/AM 	NA
Inhaled corticosteroid/long-acting beta-2 agonist combination (ICS/LABA)	ICS/LABA	<ul style="list-style-type: none"> ICS/LABA ICS/LABA/AM ICS LABA LABA/AM 	NA
Inhaled corticosteroid/long-acting beta-2 agonist/antimuscarinic combination (ICS/LABA/AM)	ICS/LABA/AM	<ul style="list-style-type: none"> ICS/LABA ICS/LABA/AM ICS LABA LABA/AM 	NA
Inhaled corticosteroids (ICS)	ICS	<ul style="list-style-type: none"> ICS ICS/LABA ICS/LABA/AM 	NA
Long-acting beta-2 agonist/antimuscarinic combination (LABA/AM)	LABA/AM	<ul style="list-style-type: none"> ICS/LABA ICS/LABA/AM LABA LABA/AM 	NA
Diuretics	Thiazide Diuretic	<ul style="list-style-type: none"> Thiazide Diuretic 	NA

Drug Class	Drug Combinations		Number of Physicians
	Trigger Drug	Checks For	
Hormone Replacement Therapy (HRT)	HRT	• Raloxifene	NA
Selective Estrogen Receptor Modifiers	Raloxifene	• HRT	NA
NSAIDs	NSAIDs	<ul style="list-style-type: none"> • NSAIDs • COX-2 Inhibitors 	NA
COX-2 Inhibitor	COX-2 Inhibitor	<ul style="list-style-type: none"> • NSAIDs • COX-2 Inhibitors 	NA
Statins	Statins	• Statin Combes	NA
Statin Combes	Statin Combes	• Statins	NA

Clinical Criteria Logic Diagram- Duplicate Therapy



Drugs Requiring Prior Authorization- Anticoagulants

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI-10
ARIXTRA 7.5MG/0.5ML SYRINGE	8310303010
BEVYXXA 40MG CAPSULE	8337001820
BEVYXXA 80MG CAPSULE	8337001820
COUMADIN 10MG TABLET	8320003020
COUMADIN 1MG TABLET	8320003020
COUMADIN 2.5MG TABLET	8320003020
COUMADIN 2MG TABLET	8320003020
COUMADIN 3MG TABLET	8320003020
COUMADIN 4MG TABLET	8320003020
COUMADIN 5MG TABLET	8320003020
COUMADIN 6MG TABLET	8320003020
COUMADIN 7.5MG TABLET	8320003020
ELIQUIS 2.5MG TABLET	8337001000
ELIQUIS 5MG STARTER PACK	8337001000
ELIQUIS 5MG TABLET	8337001000
ENOXAPARIN 100MG/ML SYRINGE	8310102010
ENOXAPARIN 120MG/0.8ML SYRINGE	8310102010
ENOXAPARIN 150MG/ML SYRINGE	8310102010
ENOXAPARIN 300MG/3ML VIAL	8310102010
ENOXAPARIN 30MG/0.3ML SYRINGE	8310102010
ENOXAPARIN 60MG/0.6ML SYRINGE	8310102010
ENOXAPARIN 80MG/0.8ML SYRINGE	8310102010
ENXAPARIN 40MG/0.4ML SYRINGE	8310102010
FONDAPARINUX 10MG/0.8ML SYRINGE	8310303010
FONDAPARINUX 2.5MG/0.5ML SYRINGE	8310303010
FONDAPARINUX 5MG/0.4ML SYRINGE	8310303010
FONDAPARINUX 7.5MG/0.5ML SYRINGE	8310303010
FRAGMIN 10,000 UNITS SYRINGE	8310101010
FRAGMIN 12,500 UNITS/0.5 ML	8310101010
FRAGMIN 15,000 UNITS/0.6 ML	8310101010
FRAGMIN 18,000 UNITS/0.72 ML	8310101010
FRAGMIN 2,500 UNITS/0.2ML SYRINGE	8310101010
FRAGMIN 25,000 UNITS/ML VIAL	8310101010
FRAGMIN 5,000 UNITS/0.2ML SYRINGE	8310101010
FRAGMIN 7,500 UNITS SYRINGE	8310101010
JANTOVEN 10MG TABLET	8320003020
JANTOVEN 1MG TABLET	8320003020
JANTOVEN 2.5MG TABLET	8320003020
JANTOVEN 2MG TABLET	8320003020
JANTOVEN 3MG TABLET	8320003020
JANTOVEN 4MG TABLET	8320003020
JANTOVEN 5MG TABLET	8320003020
JANTOVEN 6MG TABLET	8320003020
JANTOVEN 7.5MG TABLET	8320003020
LOVENOX 100MG/ML SYRINGE	8310102010

LOVENOX 120MG/0.8 ML SYRINGE	8310102010
LOVENOX 150MG/ML SYRINGE	8310102010
LOVENOX 300 MG/3 ML VIAL	8310102010
LOVENOX 30MG/0.3ML SYRINGE	8310102010
LOVENOX 40MG/0.4 ML SYRINGE	8310102010
LOVENOX 60MG/0.6 ML SYRINGE	8310102010
LOVENOX 80MG/0.8 ML SYRINGE	8310102010
PRADAXA 150MG CAPSULE	8333703020
PRADAXA 75MG CAPSULE	8333703020
SAVAYSA 15MG TABLET	8337003020
SAVAYSA 30MG TABLET	8337003020
SAVAYSA 60MG TABLET	8337003020
WARFARIN SODIUM 10MG TABLET	8320003020
WARFARIN SODIUM 1MG TABLET	8320003020
WARFARIN SODIUM 2.5MG TABLET	8320003020
WARFARIN SODIUM 2MG TABLET	8320003020
WARFARIN SODIUM 3MG TABLET	8320003020
WARFARIN SODIUM 4MG TABLET	8320003020
WARFARIN SODIUM 5MG TABLET	8320003020
WARFARIN SODIUM 6MG TABLET	8320003020
WARFARIN SODIUM 7.5MG TABLET	8320003020
XARELTO 10MG TABLET	8337006000
XARELTO 15MG TABLET	8337006000
XARELTO 2.5MG TABLET	8337006000
XARELTO 20MG TABLET	8337006000
XARELTO STARTER PACK	8337006000

Drugs Requiring Prior Authorization- Antidiabetics (Meglitidines)

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI-10
NATEGLINIDE 120MG TABLET	2728004000
NATEGLINIDE 60MG TABLET	2728004000
REPAGLINIDE 0.5MG TABLET	2728006000
REPAGLINIDE 1MG TABLET	2728006000
REPAGLINIDE 2MG TABLET	2728006000
REPAGLINIDE-METFORMIN 1-500MG	
REPAGLINIDE-METFORMIN 2-500MG	
STARLIX 120MG TABLET	2728004000
STARLIX 60MG TABLET	2728004000

Drugs Requiring Prior Authorization- Angiotensin Modulators (ARBs)

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI-10
AMLODIPINE-OLMESARTAN 10-20 MG	3699300205
AMLODIPINE-OLMESARTAN 10-40 MG	3699300205
AMLODIPINE-OLMESARTAN 5-20 MG	3699300205
AMLODIPINE-OLMESARTAN 5-40 MG	3699300205
AMLODIPINE-VALSARTAN 10-160MG TABLET	3699300210
AMLODIPINE-VALSARTAN 10-320MG TABLET	3699300210
AMLODIPINE-VALSARTAN 5-160MG TABLET	3699300210
AMLODIPINE-VALSARTAN 5-320MG TABLET	3699300210
AMLOD-VALSA-HCTZ 10-160-12.5MG TABLET	3699400270
AMLOD-VALSA-HCTZ 10-160-25MG TABLET	3699400270
AMLOD-VALSA-HCTZ 10-320-25MG TABLET	3699400270
AMLOD-VALSA-HCTZ 5-160-12.5MG TABLET	3699400270
AMLOD-VALSA-HCTZ 5-160-25MG TABLET	3699400270
ATACAND 16MG TABLET	3615002010
ATACAND 32MG TABLET	3615002010
ATACAND 4MG TABLET	3615002010
ATACAND 8MG TABLET	3615002010
ATACAND HCT 16-12.5MG TAB	3699400220
ATACAND HCT 32-12.5MG TAB	3699400220
AVALIDE 150-12.5MG TABLET	3699400230
AVALIDE 300-12.5MG TABLET	3699400230
AVAPRO 150MG TABLET	3615003000
AVAPRO 300MG TABLET	3615003000
AVAPRO 75MG TABLET	3615003000
AZOR 10-20MG TABLET	3699300205
AZOR 10-40MG TABLET	3699300205
AZOR 5-20MG TABLET	3699300205
AZOR 5-40MG TABLET	3699300205
BENICAR 20MG TABLET	3615005520
BENICAR 40MG TABLET	3615005520
BENICAR 5MG TABLET	3615005520
BENICAR HCT 20-12.5MG TABLET	3699400250
BENICAR HCT 40-12.5MG TABLET	3699400250
BENICAR HCT 40-25MG TABLET	3699400250
BYVALSON 5-80MG TABLET	
CANDESARTAN CILEXETIL 16MG TABLET	3615002010
CANDESARTAN CILEXETIL 32MG TABLET	3615002010
CANDESARTAN CILEXETIL 4MG TABLET	3615002010
CANDESARTAN CILEXETIL 8MG TABLET	3615002010
CANDESARTAN-HCTZ 16-12.5MG TABLET	3699400220
CANDESARTAN-HCTZ 32-12.5MG TABLET	3699400220
CANDESARTAN-HCTZ 32-25MG TABLET	3699400220

COZAAR 100MG TABLET	3615004020
COZAAR 25MG TABLET	3615004020
COZAAR 50MG TABLET	3615004020
DIOVAN 160MG TABLET	3615008000
DIOVAN 320MG TABLET	3615008000
DIOVAN 40MG TABLET	3615008000
DIOVAN 80MG TABLET	3615008000
DIOVAN HCT 160/12.5MG TABLET	3699400270
DIOVAN HCT 160/25MG TABLET	3699400270
DIOVAN HCT 320/12.5MG TABLET	3699400270
DIOVAN HCT 320/25MG TABLET	3699400270
DIOVAN HCT 80/12.5MG TABLET	3699400270
EDARBI 40MG TABLET	3615001020
EDARBI 80MG TABLET	3615001020
EDARBYCLOR 40-12.5MG TABLET	3699400210
ENTRESTO 24-26MG TABLET	4099200260
ENTRESTO 49-51MG TABLET	4099200260
ENTRESTO 97-103MG TABLET	4099200260
EPROSARTAN MESYLATE 600MG TABLET	3615002420
EXFORGE 10-160MG TABLET	3699300210
EXFORGE 10-320MG TABLET	3699300210
EXFORGE 5-160MG TABLET	3699300210
EXFORGE 5-320MG TABLET	3699300210
EXFORGE HCT 10-320-25MG TAB	3699450320
HYZAAR 100-12.5TABLET	3699400245
HYZAAR 100-25TABLET	3699400245
HYZAAR 50-12.5TABLET	3699400245
IRBESARTAN 150MG TABLET	3615003000
IRBESARTAN 300MG TABLET	3615003000
IRBESARTAN 75MG TABLET	3615003000
IRBESARTAN-HCTZ 150-12.5MG TABLET	3699400230
IRBESARTAN-HCTZ 300-12.5MG TABLET	3699400230
LOSARTAN POTASSIUM 100MG TABLET	3615004020
LOSARTAN POTASSIUM 25MG TABLET	3615004020
LOSARTAN POTASSIUM 50MG TABLET	3615004020
LOSARTAN-HCTZ 100-12.5MG TABLET	3699400245
LOSARTAN-HCTZ 100-25MG TABLET	3699400245
LOSARTAN-HCTZ 50-12.5MG TABLET	3699400245
MICARDIS 20MG TABLET	3615007000
MICARDIS 40MG TABLET	3615007000
MICARDIS 80MG TABLET	3615007000
MICARDIS HCT 40/12.5MG TABLET	3699400260
MICARDIS HCT 80/12.5MG TABLET	3699400260
MICARDIS HCT 80/25MG TABLET	3699400260
OLMESARTAN MEDOXOMIL 20 MG TAB	3615005520
OLMESARTAN MEDOXOMIL 40 MG TAB	3615005520
OLMESARTAN MEDOXOMIL 5 MG TAB	3615005520
OLMESARTAN-HCTZ 20-12.5 MG TAB	3699400250
OLMESARTAN-HCTZ 40-12.5 MG TAB	3699400250

OLMESARTAN-HCTZ 40-25 MG TAB	3699400250
OLMSRTN-AMLDPN-HCTZ 20-5-12.5	3699450345
OLMSRTN-AMLDPN-HCTZ 40-10-12.5	3699450345
OLMSRTN-AMLDPN-HCTZ 40-10-25MG	3699450345
OLMSRTN-AMLDPN-HCTZ 40-5-12.5	3699450345
OLMSRTN-AMLDPN-HCTZ 40-5-25 MG	3699450345
TELMISARTAN 20MG TABLET	3615007000
TELMISARTAN 40MG TABLET	3615007000
TELMISARTAN 80MG TABLET	3615007000
TELMISARTAN-AMLODIPINE 40-10MG TABLET	3699300270
TELMISARTAN-AMLODIPINE 40-5MG TABLET	3699300270
TELMISARTAN-AMLODIPINE 80-10MG TABLET	3699300270
TELMISARTAN-AMLODIPINE 80-5MG TABLET	3699300270
TELMISARTAN-HCTZ 40-12.5MG TABLET	3699400260
TELMISARTAN-HCTZ 80-12.5MG TABLET	3699400260
TELMISARTAN-HCTZ 80-25MG TABLET	3699400260
TRIBENZOR 20-5-12.5MG TABLET	3699450345
TRIBENZOR 40-10-12.5MG TABLET	3699450345
TRIBENZOR 40-10-25MG TABLET	3699450345
TRIBENZOR 40-5-12.5MG TABLET	3699450345
TRIBENZOR 40-5-25MG TABLET	3699450345
TWYNSTA 40-10MG TABLET	3699300270
TWYNSTA 40-5 MGTABLET	3699300270
TWYNSTA 80-10 MGTABLET	3699300270
TWYNSTA 80-5 MGTABLET	3699300270
VALSARTAN 160MG TABLET	3615008000
VALSARTAN 320MG TABLET	3615008000
VALSARTAN 40MG TABLET	3615008000
VALSARTAN 80MG TABLET	3615008000
VALSARTAN-HCTZ 160-12.5MG TABLET	3699400270
VALSARTAN-HCTZ 160-25MG TABLET	3699400270
VALSARTAN-HCTZ 320-12.5MG TABLET	3699400270
VALSARTAN-HCTZ 320-25MG TABLET	3699400270
VALSARTAN-HCTZ 80-12.5MG TABLET	3699400270

Drugs Requiring Prior Authorization- Antihistamines

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI
ACETAMINOPHEN-DIPHENHYD 500-25	
ALA-HIST IR 2MG TABLET	
ALA-HIST PE TABLET	
ALL DAY ALLERGY 10MG TABLET	
ALL DAY ALLERGY-D TABLET	
ALLER-CHLOR 4MG TABLET	
ALLERGY 10MG TABLET	
ALLERGY 4MG TABLET	
ALLERGY RELIEF 10MG TABLET	
ALLERGY RELIEF 5MG/5ML SOLUTION	
ALLERGY RELIEF D-24 TABLET	
APRODINE TABLET	
BANOPHEN 12.5MG/5ML LIQUID	
BANOPHEN 25MG CAPSULE	
BANOPHEN 50MG CAPSULE	
BROMFED DM COUGH SYRUP	
BROMPHEIR-PSEUDOEPHED-DM SYRUP	
BROTAPP DM LIQUID	
BROTAPP LIQUID	
CARBINOXAMINE 4MG/5ML LIQUID	
CARBINOXAMINE MALEATE 4 MG TAB	
CETIRIZINE HCL 10MG CHEWABLE TABLET	
CETIRIZINE HCL 10MG TABLET	
CETIRIZINE HCL 1MG/ML SOLUTION	
CETIRIZINE HCL 5MG CHEWABLE TABLET	
CETIRIZINE HCL 5MG TABLET	
CETIRIZINE HCL 10MG TABLET	
CETIRIZINE-PSE ER 5-120MG TABLET	
CHILD ALL DAY ALLERGY 1MG/ML SOLUTION	
CHILD CETIRIZINE 5MG CHEWABLE TABLET	
CHILD CETIRIZINE HCL 1MG/ML SOLUTION	
CHILD LORATADINE 5MG/5ML SYRUP	
CHILD MUCINEX M-S COLD DAY-NITE	
CHILD MUCINEX NIGHT TIME LIQUID	
CHILDRENS DAYCLEAR ALLERGY COUGH	

CHLO TUSS LIQUID	
CHLORPHENIRAMINE ER 12MG TABLET	
CLARINEX 0.5 MG/ML SYRUP	
CLARINEX 5MG TABLET	
CLEMASTINE FUM 2.68MG TAB	
CYPROHEPTADINE 2MG/5ML SYRUP	
CYPROHEPTADINE 4MG TABLET	
DALLERGY 1-2.5MG/ML DROPS	
DAYHIST ALLERGY 1.34MG TABLET	
DESLORATADINE 2.5MG ODT	
DESLORATADINE 5MG ODT	
DESLORATADINE 5MG TABLET	
DIMAPHEN-DM ELIXIR	
DIMAPHEN ELIXIR	
DIPHENHIST 12.5MG/5ML SOLUTION	
DIPHENHIST 25MG CAPSULE	
DIPHENHYDRAMINE 25MG CAPSULE	
DIPHENHYDRAMINE 50MG CAPSULE	
DIPHENHYDRAMINE 50MG/ML VIAL	
DIPHENHYDRAMINE 6.25MG/ML DRP	
ED-A-HIST 4MG-10MG TABLET	
ED-A-HIST DM TABLET	
ED-A-HIST LIQUID	
ED-CHLORPED DROPS	
ED-CHLORPED JR SYRUP	
ED-CHLORPED D PEDIATRIC DROPS	
ED-A-HIST DM LIQUID	
ED-A-HIST PSE TABLET	
ENDACOF-DM LIQUID	
FEXOFENADINE HCL 180MG TABLET	
FEXOFENADINE HCL 30MG/5ML	
FEXOFENADINE HCL 60 MG TABLET	
GS ALLERGY RELIEF 10MG TABLET	
HISTEX 2.5MG/5ML SYRUP	
HISTEX PD 0.938MG/ML DROP	
HISTEX-DM SYRUP	
HISTEX-PE SYRUP	
HYDROCOD-CPM-PSEUDOEP 5-4-60/5	
HYDROCODONE-CHLORPHENIRAMINE ER SUSP	
HYDROXYZINE 10MG/5ML SOLUTION	
HYDROXYZINE 25MG/ML VIAL	
HYDROXYZINE HCL 10MG TABLET	
HYDROXYZINE HCL 25MG TABLET	
HYDROXYZINE HCL 50MG TABLET	
HYDROXYZINE PAM 100MG CAPSULE	
HYDROXYZINE PAM 25MG CAPSULE	
HYDROXYZINE PAM 50MG CAPSULE	

KARBINAL ER 4MG/5ML SUSP	
KIDKARE COUGH & COLD LIQUID	
LEVO CETIRIZINE 2.5MG/5ML SOL	
LEVO CETIRIZINE 5MG TABLET	
LODRANE D CAPSULE	
LOHIST-D LIQUID	
LOHIST-DM SYRUP	
LORATADINE 10MG TABLET	
LORATADINE 5MG/5ML SOLUTION	
LORATADINE-D 12 HOUR TABLET	
LORATADINE-D 24HR TABLET	
MAPAP PM CAPLET	
MECLIZINE 12.5MG TABLET	
MECLIZINE 25MG TABLET	
M-END DMX LIQUID	
M-HIST PD 0.625MG/ML DROPS	
MUCINEX FAST-MAX NITE COLD-FLU	
NASOPEN PE LIQUID	
NINJACOF LIQUID	
NINJACOF-A LIQUID	
NOHIST-DM LIQUID	
NOHIST-LQ LIQUID	
NON-DROWSY ALLERGY 10MG TABLET	
PEDIACLEAR ALLERGY 0.313MG/ML	
PEDIACLEAR PD 0.625 MG/ML DROP	
PEDIATRIC COUGH-COLD LIQUID	
PHENYLEPHRINE-PYRILAMINE 10-25	
POLY HIST FORTE 10.5-10MG TABLET	
POLY HIST FORTE 7.5-10MG TABLET	
POLY-HIST DM LIQUID	
POLYTUSSIN DM SYRUP	
PROMETHAZINE 6.25MG/5ML SOLN	
PROMETHAZINE VC SYRUP	
PROMETHAZINE VC-CODEINE SYRUP	
PROMETHAZINE-CODEINE SYRUP	
PROMETHAZINE-DM SOLUTION	
QC CHILD ALLERGY 12.5MG/5ML	
QC COMPLETE ALLERGY 25MG CAPSULE	
QC LORATADINE 10MG TABLET	
QC LORATADINE-D 24HR TABLET	
QC NIGHTTIME SLEEP 25MG TABLET	
QC NON-ASPIRIN PM CAPLET	
RESCON TABLET	
RESCON-DM LIQUID	
RU-HIST D 10-4MG TABLET	
RYMED TABLET	
RYCLORA 2MG/5ML SOLUTION	
RYNEX DM LIQUID	

RYNEX PE LIQUID	
RYNEX PSE LIQUID	
RYVENT 6MG TABLET	
SEMPREX-D 8-60MG CAPSULE	
SILADRYL 12.5MG/5ML LIQUID	
SM ALLERGY 4-HR 4MG TABLET	
SM ALLERGY RELIEF 1.34MG TABLET	
SM ALLERGY RELIEF 12.5MG/5ML	
SM LORATADINE 5MG/5ML SYRUP	
SM LORATADINE D 24HR TABLET	
STAHIST AD TABLET	
SUDOGEST SINUS & ALLERGY TABLET	
TRAVEL SICKNESS 25MG TAB CHEW	
TRIPROLIDINE 0.313MG/ML DROP	
TRIPROLIDINE 0.625MG/ML DROPS	
TUSSIONEX PENNKINETIC SUSP	
VANACOF LIQUID	
VANAHIST PD 0.625MG/ML DROPS	
VANAMINE PD 6.25MG/ML DROPS	
VANATAB AC CAPLET	
VISTARIL 25MG CAPSULE	
VISTARIL 50MG CAPSULE	
ZUTRIPRO SOLUTION	

Drugs Requiring Prior Authorization- Short-Acting Beta Agonists (SABA)

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI
ALBUTEROL 0.63MG/3ML SOLUTION	
ALBUTEROL 1.25 MG/3 ML INH SOLN	
ALBUTEROL 2.5MG/0.5ML SOLUTION	
ALBUTEROL 2.5MG/3ML SOLUTION	
ALBUTEROL 5 MG/ML SOLUTION	
LEVALBUTEROL 0.31MG/3ML SOLUTION	
LEVALBUTEROL 0.63MG/3ML SOLUTION	
LEVALBUTEROL 1.25MG/3ML SOLUTION	
LEVALBUTEROL CONC 1.25MG/0.5ML	
LEVALBUTEROL TAR HFA 45MCG INH	
PROAIR DIGIHALER 90MCG INHALER	
PROAIR HFA 90MCG INHALER	
PROAIR RESPICLICK INHALATION POWDER	
PROVENTIL HFA 90 MCG INHALER	
VENTOLIN HFA 90MCG INHALER	
XOPENEX 0.31 MG/3 ML SOLUTION	
XOPENEX 0.63 MG/3 ML SOLUTION	
XOPENEX 1.25 MG/3 ML SOLUTION	
XOPENEX HFA 45 MCG INHALER	

Drugs Requiring Prior Authorization- Long-Acting Beta Agonists (LABA)

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI-10
ARCAPTA NEOHALER 75MCG CAPSULE	4420104220
BROVANA 15MCG/2ML SOLUTION	4420101210
PERFOROMIST 20MCG/2ML SOLUTION	4420102710
SEREVENT DISKUS 50MCG	4420105810
STRIVERDI RESPIMAT INHALATION SPRAY	4420105220

Drugs Requiring Prior Authorization- Inhaled Corticosteroid (ICS)/LABA

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI-10
ADVAIR 100-50 DISKUS	
ADVAIR 250-50 DISKUS	
ADVAIR 500-50 DISKUS	
ADVAIR HFA 115-21MCG INHALER	
ADVAIR HFA 230-21MCG INHALER	
ADVAIR HFA 45-21MCG INHALER	
AIRDUO DIGIHALER 113-14 MCG	
AIRDUO DIGIHALER 232-14 MCG	
AIRDUO DIGIHALER 55-14 MCG	
BREO ELLIPTA 100-25MCG INH	4420990275
BREO ELLIPTA 200-25MCG INHALER	4420990275
DULERA 100 MCG/5 MCG INHALER	
DULERA 200 MCG/5 MCG INHALER	
DULERA 50 MCG/5 MCG INHALER	
FLUTICASONE-SALMETEROL 55-14	
FLUTICASONE-SALMETEROL 113-14	
FLUTICASONE-SALMETEROL 232-14	
SYMBICORT 160-4.5 MCG INHALER	
SYMBICORT 80-4.5 MCG INHALER	
WIXELA 100-50 INHUB	
WIXELA 250-50 INHUB	
WIXELA 500-50	

Drugs Requiring Prior Authorization- Inhaled Corticosteroid (ICS)/LABA/Antimuscarinic (AM)

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI-10
BREZTRI AEROSPHERE INHALER	4420990330
TRELEGY ELLIPTA 100-62.5-25	4420990340
TRELEGY ELLIPTA 200-62.5-25	4420990340

Drugs Requiring Prior Authorization- Inhaled Corticosteroid (ICS)

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI-10
AEROSPAN 80MCG INHALER	
ALVESCO 160 MCG INHALER	
ALVESCO 80 MCG INHALER	
ARMONAIR DIGIHALER 113 MCG	
ARMONAIR DIGIHALER 232 MCG	
ARMONAIR DIGIHALER 55 MCG	
ARNUIITY ELLIPTA 100 MCG INH	
ARNUIITY ELLIPTA 200 MCG INH	
ARNUIITY ELLIPTA 50 MCG INH	
ASMANEX TWISTHALER 110 MCG #30	
ASMANEX TWISTHALER 220 MCG #30	
ASMANEX TWISTHALER 220 MCG #60	
ASMANEX TWISTHALR 220 MCG #120	
BUDESONIDE 0.25MG/2ML SUSPENSION	
BUDESONIDE 0.5MG/2ML SUSPENSION	
BUDESONIDE 1MG/2ML INHALATION SUSPENSION	
FLOVENT 100MCG DISKUS	
FLOVENT 250MCG DISKUS	
FLOVENT 50MCG DISKUS	
FLOVENT HFA 110 MCG INHALER	
FLOVENT HFA 220 MCG INHALER	
FLOVENT HFA 44 MCG INHALER	
PULMICORT 0.25 MG/2 ML RESPULE	
PULMICORT 0.5MG/2ML RESPULE	
PULMICORT 1 MG/2 ML RESPULE	
PULMICORT 180 MCG FLEXHALER	
PULMICORT 90 MCG FLEXHALER	
QVAR 40 MCG INHALER	
QVAR 80 MCG INHALER	
QVAR REDIHALER 40 MCG	
QVAR REDIHALER 80 MCG	

Drugs Requiring Prior Authorization- LABA/AM

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI-10
ANORO ELLIPTA 62.5-25MCG INHALER	4420990295
BEVESPI AEROSPHERE INHALER	4420990254
COMBIVENT RESPIMAT INHALATION SPRAY	
DUAKLIR PRESSAIR 400-12MCG INH	4420990226
IPRAT-ALBUT 0.5-3 (2.5)MG/3ML	
STIOLTO RESPIMAT INHALATION SPRAY	4420990292
UTIBRON NEOHALER	4420990260

Drugs Requiring Prior Authorization- Thiazide Diuretics

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI-10
ACCURETIC 10-12.5 MG TABLET	3699180265
ACCURETIC 20-12.5 MG TABLET	3699180265
ACCURETIC 20-25 MG TABLET	3699180265
ALDACTAZIDE 25-25 TABLET	
ALDACTAZIDE 50-50 TABLET	
AMILORIDE HCL-HCTZ 5-50 MG TAB	3799000210
AMLOD-VALSA-HCTZ 10-160-12.5MG	3699450320
AMLOD-VALSA-HCTZ 10-160-25MG	3699450320
AMLOD-VALSA-HCTZ 10-320-25MG	3699450320
AMLOD-VALSA-HCTZ 5-160-12.5MG	3699450320
AMLOD-VALSA-HCTZ 5-160-25MG	3699450320
AMTURNIDE 300-10-25MG TABLET	
AMTURNIDE 300-5-12.5MG TABLET	
AMTURNIDE 300-5-25MG TABLET	
ATACAND HCT 16-12.5MG TAB	3699400220
ATACAND HCT 32-12.5MG TAB	3699400220
AVALIDE 150-12.5MG TABLET	3699400230
AVALIDE 300-12.5MG TABLET	3699400230
BENAZEPRIL-HCTZ 10-12.5MG TAB	3699180215
BENAZEPRIL-HCTZ 20-12.5MG TAB	3699180215
BENAZEPRIL-HCTZ 20-25MG TAB	3699180215
BENAZEPRIL-HCTZ 5-6.25MG TAB	3699180215
BENICAR HCT 20-12.5MG TABLET	3699400250
BENICAR HCT 40-12.5MG TABLET	3699400250
BENICAR HCT 40-25MG TABLET	3699400250
BISOPROLOL HCTZ 10-6.25MG TAB	
BISOPROLOL HCTZ 2.5-6.25MG TB	
BISOPROLOL HCTZ 5-6.25MG TAB	
CANDESARTAN-HCTZ 16-12.5MG TB	3699400220
CANDESARTAN-HCTZ 32-12.5MG TB	3699400220
CANDESARTAN-HCTZ 32-25MG TAB	3699400220
CAPTOPRIL-HCTZ 25-15MG TABLET	3699180225
CAPTOPRIL-HCTZ 25-25MG TABLET	3699180225
CAPTOPRIL-HCTZ 50-15MG TABLET	3699180225
CAPTOPRIL-HCTZ 50-25MG TABLET	3699180225
CHLOROTHIAZIDE 250MG TABLET	
CHLOROTHIAZIDE 500 MG TABLET	
CORZIDE 40/5 TABLET	
CORZIDE 80/5 TABLET	
DIOVAN HCT 160/12.5MG TAB	3699400270
DIOVAN HCT 160/25MG TABLET	3699400270
DIOVAN HCT 320-12.5MG TABLET	3699400270

DIOVAN HCT 320-25MG TABLET	3699400270
DIOVAN HCT 80/12.5MG TABLET	3699400270
DIURIL 250 MG/5 ML ORAL SUSP	
DUTOPROL 100-12.5MG TABLET	
DUTOPROL 25-12.5MG TABLET	
DUTOPROL 50-12.5MG TABLET	
DYAZIDE 37.5/25 CAPSULE	
EDARBYCLOR 40-12.5MG TABLET	
ENALAPRIL-HCTZ 10-25MG TABLET	3699180235
ENALAPRIL-HCTZ 5-12.5MG TAB	3699180235
EXFORGE HCT 10-160-12.5MG TAB	3699450320
EXFORGE HCT 10-160-25MG TAB	3699450320
EXFORGE HCT 10-320-25MG TAB	3699450320
EXFORGE HCT 5-160-12.5MG TAB	3699450320
EXFORGE HCT 5-160-25MG TAB	3699450320
FOSINOPRIL-HCTZ 10-12.5MG TAB	3699180240
FOSINOPRIL-HCTZ 20-12.5MG TAB	3699180240
HYDROCHLOROTHIAZIDE 12.5 MG CP	
HYDROCHLOROTHIAZIDE 12.5 MG TB	
HYDROCHLOROTHIAZIDE 25 MG TB	
HYDROCHLOROTHIAZIDE 50 MG TB	
HYZAAR 100-12.5 TABLET	3699400245
HYZAAR 100-25 TABLET	3699400245
HYZAAR 50-12.5 TABLET	3699400245
IRBESARTAN-HCTZ 150-12.5MG TB	3699400230
IRBESARTAN-HCTZ 300-12.5MG TB	3699400230
LISINOPRIL-HCTZ 10-12.5MG TAB	3699180255
LISINOPRIL-HCTZ 20-12.5MG TAB	3699180255
LISINOPRIL-HCTZ 20-25MG TAB	3699180255
LOSARTAN-HCTZ 100-12.5MG TAB	3699400245
LOSARTAN-HCTZ 100-25MG TAB	3699400245
LOSARTAN-HCTZ 50-12.5MG TAB	3699400245
MAXZIDE 50-75MG TABLET	
MAXZIDE-25MG TABLET	
METHYLDOPA/HCTZ 250-25 TAB	
METHYLDOPA-HCTZ 250-15 TAB	
METOPROLOL-HCTZ 100-25MG TABLET	
METOPROLOL-HCTZ 100-50MG TABLET	
METOPROLOL-HCTZ 50-25MG TABLET	
MICARDIS HCT 40/12.5MG TAB	3699400260
MICARDIS HCT 80/12.5MG TAB	3699400260
MICARDIS HCT 80/25MG TABLET	3699400260
MOEXIPRIL-HCTZ 15-12.5MG TABLET	
MOEXIPRIL-HCTZ 15-25MG TABLET	
MOEXIPRIL-HCTZ 7.5-12.5MG TABLET	
NADOLOL-BENDROFLU 40-5MG TABLET	
NADOLOL-BENDROFLU 80-5MG TABLET	
PROPRANOLOL-HCTZ 40-25MG TAB	
PROPRANOLOL-HCTZ 80-25MG TAB	

QUINAPRIL HCTZ 20-12.5MG TABLET	3699180265
QUINAPRIL HCTZ 20-25MG TABLET	3699180265
QUINAPRIL-HCTZ 10-12.5MG TABLET	3699180265
TEKTURNA HCT 150-12.5MG TAB	
TEKTURNA HCT 150-25MG TABLET	
TEKTURNA HCT 300-12.5MG TAB	
TEKTURNA HCT 300-25MG TABLET	
TELMISARTAN-HCTZ 40-12.5MG TB	3699400260
TELMISARTAN-HCTZ 80-12.5MG TB	3699400260
TELMISARTAN-HCTZ 80-25MG TAB	3699400260
TENORETIC 100 TABLET	
TENORETIC 50 TABLET	
TRIAMTERENE-HCTZ 37.5-25MG CAPSULE	
TRIAMTERENE-HCTZ 37.5-25MG TB	
TRIAMTERENE-HCTZ 50-25 MG CAP	
TRIAMTERENE-HCTZ 75-50MG TAB	
TRIBENZOR 20-5-12.5MG TABLET	3699450345
TRIBENZOR 40-10-12.5MG TABLET	3699450345
TRIBENZOR 40-10-25MG TABLET	3699450345
TRIBENZOR 40-5-12.5MG TABLET	3699450345
TRIBENZOR 40-5-25MG TABLET	3699450345
VALSARTAN-HCTZ 160-12.5MG TAB	3699400270
VALSARTAN-HCTZ 160-25MG TAB	3699400270
VALSARTAN-HCTZ 320-12.5MG TAB	3699400270
VALSARTAN-HCTZ 320-2 MG TAB	3699400270
VALSARTAN-HCTZ 80-12.5MG TAB	3699400270
VASERETIC 10-25 MG TABLET	3699180235
ZESTORETIC 20-12.5MG TABLET	3699180255
ZESTORETIC 20-25MG TABLET	3699180255
ZIAC 10-6.25MG TABLET	
ZIAC 2.5-6.25MG TABLET	
ZIAC 5-6.25MG TABLET	

Drugs Requiring Prior Authorization- Hormone Replacement Therapy

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI-10
ACTIVELLA 0.5-0.1MG TABLET	
ACTIVELLA 1-0.5MG TABLET	
ALORA 0.025MG PATCH	
ALORA 0.05MG PATCH	
ALORA 0.075MG PATCH	
ALORA 0.1MG PATCH	
AMABELZ 0.5-0.1MG TABLET	
AMABELZ 1-0.5MG TABLET	
ANGELIQ 0.5-1MG TABLET	
CLIMARA 0.025MG/DAY PATCH	
CLIMARA 0.0375 MG/DAY PATCH	
CLIMARA 0.05MG/DAY PATCH	
CLIMARA 0.06/MG DAY PATCH	
CLIMARA 0.075 MG/DAY PATCH	
CLIMARA 0.1MG/DAY PATCH	
CLIMARA PRO PATCH	
COMBIPATCH 0.05-0.14MG PATCH	
COMBIPATCH 0.05-0.25MG PATCH	
DELESTROGEN 10MG/ML VIAL	
DELESTROGEN 20MG/ML VIAL	
DELESTROGEN 40MG/ML VIAL	
DEPO-ESTRADIOL 5 MG/ML VIAL	
DIVIGEL 0.25 MG GEL PACKET	
DIVIGEL 0.5 MG GEL PACKET	
DIVIGEL 1 MG GEL PACKET	
DUAVEE 0.45-20MG TABLET	
ESTRACE 0.01% CREAM	
ESTRACE 0.5MG TABLET	
ESTRACE 1MG TABLET	
ESTRACE 2MG TABLET	
ESTRADIOL 0.025 MG PATCH	
ESTRADIOL 0.0375 MG PATCH	
ESTRADIOL 0.05 MG PATCH	
ESTRADIOL 0.075 MG PATCH	
ESTRADIOL 0.1 MG PATCH	
ESTRADIOL 0.5 MG TABLET	
ESTRADIOL 1 MG TABLET	
ESTRADIOL 2 MG TABLET	
ESTRADIOL TDS 0.025 MG/DAY	
ESTRADIOL TDS 0.0375 MG/DAY	
ESTRADIOL TDS 0.05 MG/DAY	
ESTRADIOL TDS 0.06 MG/DAY	

ESTRADIOL TDS 0.075 MG/DAY	
ESTRADIOL TDS 0.1 MG/DAY	
ESTRING 2 MG VAGINAL RING	
ESTROPIPATE 0.625 (0.75MG) TABLET	
ESTROPIPATE 1.25 (1.5MG) TABLET	
ESTROPIPATE 2.5 (3MG) TABLET	
EVAMIST 1.53MG/SPRAY	
FYAVOLV 0.5MG-2.5MCG TABLET	
FYAVOLV 1MG-5MCG TABLET	
JINTELI 1MG-5MCG TABLET	
LOPREEZA 0.5-0.1MG TABLET	
LOPREEZA 1-0.5MG TABLET	
MENEST 0.3MG TABLET	
MENEST 0.625MG TABLET	
MENEST 1.25MG TABLET	
MENEST 2.5MG TABLET	
MENOSTAR 14 MCG/DAY PATCH	
MIMVEY 1-0.5MG TABLET	
MIMVEY LO 0.5-0.1MG TABLET	
PREFEST TABLET	
PREMARIN 0.3MG TABLET	
PREMARIN 0.45MG TABLET	
PREMARIN 0.625MG TABLET	
PREMARIN 0.9MG TABLET	
PREMARIN 1.25MG TABLET	
PREMARIN 25MG VIAL	
PREMARIN VAGINAL CREAM-APPL	
PREMPRO 0.3-1.5MG TABLET	
PREMPRO 0.45-1.5MG TABLET	
PREMPRO 0.625-2.5MG TABLET	
PREMPRO 0.625-5MG TABLET	
VAGIFEM 10 MCG VAGINAL TAB	
VIVELLE-DOT 0.025MG PATCH	
VIVELLE-DOT 0.0375MG PATCH	
VIVELLE-DOT 0.05MG PATCH	
VIVELLE-DOT 0.075MG PATCH	
VIVELLE-DOT 0.1MG PATCH	
YUVAFEM 10MCG VAGINAL INSERT	

Drugs Requiring Prior Authorization- Selective Estrogen-Receptor Modifiers

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI-10
EVISTA 60MG TABLET	
RALOXIFENE HCL 60MG TABLET	

Drugs Requiring Prior Authorization- Non-Steroidal Anti-Inflammatory Agents (NSAIDs)

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI-10
ALL DAY PAIN RLF 220 MG CAPLET	6610006000
ALL DAY RELIEF 220 MG TABLET	6610006000
ARTHROTEC 50 MG-200 MCG TAB	6610990220
ARTHROTEC 75 MG-200 MCG TAB	6610990220
CHILDREN IBUPROFEN 100 MG/5 ML	6610002000
DAYPRO 600MG CAPLET	6610006500
DICLOFENAC 1.5% TOPICAL SOLN	
DICLOFENAC POT 50 MG TABLET	6610000710
DICLOFENAC SOD EC 25 MG TAB	6610000720
DICLOFENAC SOD EC 50 MG TAB	6610000720
DICLOFENAC SOD EC 75 MG TAB	6610000720
DICLOFENAC SOD ER 100 MG TAB	6610000720
DICLOFENAC SODIUM 1% GEL	
DICLOFENAC SODIUM 3% GEL	
DICLOFENAC-MISOPROST 50-200 TB	6610990220
DICLOFENAC-MISOPROST 75-0.2 TB	6610990220
DICLOTREX 1.5%-4%-10% KIT	
DIFLUNISAL 500MG TABLET	6410005000
DUEXIS 800-26.6MG TABLET	6610990232
ETODOLAC 200 MG CAPSULE	6610000800
ETODOLAC 300 MG CAPSULE	6610000800
ETODOLAC 400 MG TABLET	6610000800
ETODOLAC 500 MG TABLET	6610000800
ETODOLAC ER 400 MG TABLET	6610000800
ETODOLAC ER 500 MG TABLET	6610000800
ETODOLAC ER 600 MG TABLET	6610000800
FELDENE 10MG CAPSULE	6610007000
FELDENE 20MG CAPSULE	6610007000
FENOPROFEN 600MG TABLET	6610001010
FENOPROFEN CALCIUM 400 MG CAP	6610001010
FLECTOR 1.3% PATCH	
FLURBIPROFEN 100MG TABLET	6610001200
FLURBIPROFEN 50MG TABLET	6610001200
HYDROCODONE-IBUPROFEN 10-200MG TABLET	6599170250
HYDROCODONE-IBUPROFEN 5-200MG TABLET	6599170250
HYDROCODONE-IBUPROFEN 7.5-200MG TABLET	6599170250
IBUDONE 10-200 MG TABLET	6599170250
IBUDONE 5-200MG TABLET	6599170250
IBU-200 MG TABLET	6610002000
IBU 400 MG TABLET	6610002000
IBU 600 MG TABLET	6610002000

IBU 800 MG TABLET	6610002000
IBUPAK KIT	6610002000
IBUPROFEN 100 MG/5 ML SUSP	6610002000
IBUPROFEN 200 MG CAPLET	6610002000
IBUPROFEN 200 MG SOFTGEL	6610002000
IBUPROFEN 200 MG TABLET	6610002000
IBUPROFEN 400 MG TABLET	6610002000
IBUPROFEN 600 MG TABLET	6610002000
IBUPROFEN 800 MG TABLET	6610002000
IBUPROFEN JR STR 100 MG CHEW	6610002000
INDOCIN 25MG/5 ML SUSPENSION	6610003000
INDOCIN 50 MG SUPPOSITORY	6610003000
INDOMETHACIN 25MG CAPSULE	6610003000
INDOMETHACIN 50MG CAPSULE	6610003000
INDOMETHACIN ER 75MG CAPSULE	6610003000
KETOPROFEN 50MG CAPSULE	6610003500
KETOPROFEN 75MG CAPSULE	6610003500
KETOPROFEN ER 200MG CAPSULE	6610003500
KETOROLAC 10MG TABLET	6610003710
KETOROLAC 60MG/2ML VIAL	6610003710
MECLOFENAMATE 100 MG CAPSULE	6610004010
MECLOFENAMATE 50 MG CAPSULE	6610004010
MEFENAMIC ACID 250MG CAPSULE	6610005000
NABUMETONE 500MG TABLET	6610005500
NABUMETONE 750MG TABLET	6610005500
NALFON 400MG CAPSULE	6610001010
NAPROXEN 125 MG/5 ML SUSPEN	6610006000
NAPROXEN 250 MG TABLET	6610006000
NAPROXEN 375 MG TABLET	6610006000
NAPROXEN 500 MG TABLET	6610006000
NAPROXEN DR 375 MG TABLET	6610006000
NAPROXEN DR 500 MG TABLET	6610006000
NAPROXEN SOD 220 MG TABLET	6610006000
NAPROXEN SOD ER 375 MG TABLET	6610006000
NAPROXEN SOD ER 500 MG TABLET	6610006000
NAPROXEN SODIUM 275 MG TAB	6610006000
NAPROXEN SODIUM 550 MG TAB	6610006000
OXAPROZIN 600MG TABLET	6610006500
OXYCODONE-IBUPROFEN 5-400MG TABLET	6599000226
PENNSAID 2%-PUMP	
PIROXICAM 10MG CAPSULE	6610007000
PIROXICAM 20MG CAPSULE	6610007000
PONSTEL 250MG KAPSEALS	6610005000
QC IBUPROFEN 200 MG SOFTGEL	6610002000
QC NAPROXEN SOD 220 MG TABLET	6610006000
SM IBUPROFEN 200 MG TABLET	6610002000
SPRIX 15.75MG NASAL SPRAY	6610003710
SULINDAC 150MG TABLET	6610008000
SULINDAC 200MG TABLET	6610008000

SUMATRIPTAN-NAPROXEN 85-500 MG	
TOLMETIN SODIUM 200MG TABLET	6610009010
TOLMETIN SODIUM 400MG CAPSULE	6610009010
TOLMETIN SODIUM 600MG TABLET	6610009010
TREXIMET 85-500 MG TABLET	
VENNGEL ONE 1% KIT	
VIMOVO DR 375-20 MG TABLET	6610990244
VIMOVO DR 500-20 MG TABLET	6610990244
VOLTAREN 1% GEL	
ZORVOLEX 18MG CAPSULE	6610000700
ZORVOLEX 35MG CAPSULE	6610000700

Drugs Requiring Prior Authorization- COX-2 Inhibitors

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI-10
CELEBREX 100MG CAPSULE	6610052500
CELEBREX 200MG CAPSULE	6610052500
CELEBREX 400MG CAPSULE	6610052500
CELEBREX 50MG CAPSULE	6610052500
CELECOXIB 100MG CAPSULE	6610052500
CELECOXIB 200MG CAPSULE	6610052500
CELECOXIB 400MG CAPSULE	6610052500
CELECOXIB 50MG CAPSULE	6610052500
MELOXICAM 15MG TABLET	6610005200
MELOXICAM 7.5 MG/5ML SUSP	
MELOXICAM 7.5MG TABLET	6610005200
MOBIC 15MG TABLET	6610005200
MOBIC 7.5MG TABLET	6610005200
MOBIC 7.5MG/5ML SUSPENSION	
QMIIZ ODT 15MG TABLET	6610005200
QMIIZ ODT 7.5MG TABLET	6610005200

Drugs Requiring Prior Authorization- Statins

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI-10
ALTOPREV 20MG TABLET	
ALTOPREV 40MG TABLET	
ALTOPREV 60MG TABLET	
ATORVASTATIN 10 MG TABLET	
ATORVASTATIN 20 MG TABLET	
ATORVASTATIN 40 MG TABLET	
ATORVASTATIN 80 MG TABLET	
CRESTOR 10MG TABLET	
CRESTOR 20MG TABLET	
CRESTOR 40MG TABLET	
CRESTOR 5MG TABLET	
EZALLOR SPRINKLE 5MG CAPSULE	
EZALLOR SPRINKLE 10MG CAPSULE	
EZALLOR SPRINKLE 20MG CAPSULE	
EZALLOR SPRINKLE 40MG CAPSULE	
FLUVASTATIN ER 80MG TABLET	
FLUVASTATIN SODIUM 20MG CAPSULE	
FLUVASTATIN SODIUM 40MG CAPSULE	
LESCOL XL 80 MG TABLET	
LIPITOR 10MG TABLET	
LIPITOR 20MG TABLET	
LIPITOR 40MG TABLET	
LIPITOR 80MG TABLET	
LIVALO 1MG TABLET	
LIVALO 2MG TABLET	
LIVALO 4MG TABLET	
LOVASTATIN 10 MG TABLET	
LOVASTATIN 20 MG TABLET	
LOVASTATIN 40 MG TABLET	
PRAVACHOL 20MG TABLET	
PRAVACHOL 40MG TABLET	
PRAVACHOL 80MG TABLET	
PRAVASTATIN SODIUM 10 MG TAB	
PRAVASTATIN SODIUM 20 MG TAB	
PRAVASTATIN SODIUM 40 MG TAB	
PRAVASTATIN SODIUM 80 MG TAB	
ROSUVASTATIN 10MG TABLET	
ROSUVASTATIN 20MG TABLET	
ROSUVASTATIN 40MG TABLET	
ROSUVASTATIN 5MG TABLET	
SIMVASTATIN 10 MG TABLET	
SIMVASTATIN 20 MG TABLET	

SIMVASTATIN 40 MG TABLET	
SIMVASTATIN 5 MG TABLET	
SIMVASTATIN 80 MG TABLET	
ZOCOR 10MG TABLET	
ZOCOR 20MG TABLET	
ZOCOR 40MG TABLET	
ZOCOR 5MG TABLET	
ZOCOR 80MG TABLET	
ZYPITAMAG 1MG TABLET	
ZYPITAMAG 2MG TABLET	
ZYPITAMAG 4MG TABLET	

Drugs Requiring Prior Authorization- Statin Combos

The listed GPIs may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GPI-10
AMLODIPINE-ATORVAST 10-10 MG	
AMLODIPINE-ATORVAST 10-20 MG	
AMLODIPINE-ATORVAST 10-40 MG	
AMLODIPINE-ATORVAST 10-80 MG	
AMLODIPINE-ATORVAST 2.5-10 MG	
AMLODIPINE-ATORVAST 2.5-20 MG	
AMLODIPINE-ATORVAST 2.5-40 MG	
AMLODIPINE-ATORVAST 5-10 MG	
AMLODIPINE-ATORVAST 5-20 MG	
AMLODIPINE-ATORVAST 5-40 MG	
AMLODIPINE-ATORVAST 5-80 MG	
CADUET 10 MG-10 MG TABLET	
CADUET 10 MG-20 MG TABLET	
CADUET 10 MG-40 MG TABLET	
CADUET 10 MG-80 MG TABLET	
CADUET 5 MG-10 MG TABLET	
CADUET 5 MG-20 MG TABLET	
CADUET 5 MG-40 MG TABLET	
CADUET 5 MG-80 MG TABLET	
EZETIMIBE-SIMVASTATIN 10-10MG	
EZETIMIBE-SIMVASTATIN 10-10MG	
EZETIMIBE-SIMVASTATIN 10-20MG	
EZETIMIBE-SIMVASTATIN 10-40MG	
SIMCOR 1,000-20MG TABLET	
SIMCOR 1,000-40MG TABLET	
SIMCOR 500-20MG TABLET	
SIMCOR 500-40 MG TABLET	
SIMCOR 750-20MG TABLET	
VYTORIN 10-10 MG TABLET	
VYTORIN 10-20 MG TABLET	
VYTORIN 10-40 MG TABLET	
VYTORIN 10-80 MG TABLET	

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