



230 N. Main St. Dayton, OH 45402 | 833-230-2005 | CareSourcePASSE.com

Re: Summary of Formulary/Prior Authorization Changes Effective JANUARY 1, 2024.

Your health care is our priority. That is why we are writing to tell you that on JANUARY 1, 2024, there will be changes made to Arkansas Medicaid’s Preferred Drug List (PDL) and CareSource PASSE’s management of products not on Arkansas Medicaid’s PDL. A PDL is a list of preferred drugs.

SUMMARY OF CHANGES TO THE ARKANSAS MEDICAID PDL EFFECTIVE JANUARY 1, 2024:

THE FOLLOWING MEDICATION(S) WILL BE PREFERRED ON THE PDL EFFECTIVE JANUARY 1, 2024.

Product Name	Dose(s)	Notes – If Applicable
Austedo® Austedo® XR tablet	All	Prior authorization criteria apply; New PDL class
Ezetimibe tablet (Generic for Zetia®)	10mg	
Fynetra® syringe	6mg/0.6mL	
Ingrezza® capsule	All	Preferred with prior authorization criteria; New PDL class
Niacin® ER tablet (Generic for Niaspan ER®)	All	
Praluent® pen	All	Manual review criteria apply
Repatha® syringe, autoinjector, pushtronex	All	Manual review criteria apply
Tetrabenazine tablet (Generic for Xenazine®)	All	Point of Sale criteria applies; New PDL class
Xtampza® ER capsule	All	Preferred with criteria

THE FOLLOWING MEDICATION(S) WILL BE NON-PREFERRED ON THE PDL EFFECTIVE JANUARY 1, 2024.

Product Name	Dose(s)	Notes – If Applicable
Juxtapid® capsule	All	
Lovaza® capsule	All	Generic Lovaza (omega-3 acid ethyl esters) is preferred
Nexletol® tablet	All	
Nexlizet® tablet	All	
Nyvepria® syringe	6mg/0.6mL	
Prevalite® powder	4gm	
Vascepa® capsule	All	Generic icosapent ethyl is also non-preferred
Xenazine® tablet	All	New PDL class

THE FOLLOWING MEDICATION(S) HAVE A CHANGE IN PRIOR AUTHORIZATION/CRITERIA ON THE PDL EFFECTIVE JANUARY 1, 2024.

Product Name	Dose(s)	Notes – If Applicable
Buprenorphine patch (Generic for Butrans®)	All	Criteria applies
Icosapent ethyl capsule (Generic for Vascepa®)	All	Manual review criteria apply
Leqvio® syringe	284mg/1.5mL	Prior authorization is required for medical benefit J1306
Lurasidone tablet (Generic for Latuda®)	All	Updated criteria
Omega-3 acid ethyl esters capsule (Generic for Lovaza®)	All	Point-of-sale criteria apply

SUMMARY OF CHANGES TO PRODUCTS NOT ON THE ARKANSAS MEDICAID PDL EFFECTIVE JANUARY 1, 2024

THE FOLLOWING MEDICATION(S) HAVE A CHANGE IN PRIOR AUTHORIZATION/CRITERIA EFFECTIVE JANUARY 1, 2024.

Product Name	Dose(s)	Notes – If Applicable
Akeega® tablet	50/500mg, 100/500mg	New prior authorization criteria; Quantity Limit: 62 tablets per 31 days
Beyfortus® vial	All	Medical benefit - No Prior authorization required
Dalvance® vial	500mg	Medical Benefit - No prior authorization required; Check for diagnosis
Elevidys® kit	All	Medical Benefit with Medical Necessity Review
Elfabrio® vial	20mg/10ml	Medical Benefit with Medical Necessity Review
Feraheme® vial	All	Prior authorization is required for medical benefit: Q0138 code
Ferrlecit® vial	All	Prior authorization is required for medical benefit: J2916 code
Glassia® vial	1gm/50mL	Now accepted on pharmacy and medical benefit; Prior authorization is required for medical benefit J0257
Infed® vial	All	Prior authorization is required for medical benefit: J1750 code
Injectafer® vial	All	Prior authorization is required for medical benefit: J1439 code
Mvasi® vial	All	Medical benefit - Preferred with Prior Authorization required
Rezzayo® vial	200mg	Medical Benefit with Medical Necessity Review
Roctavian® vial	All	Medical Benefit with Medical Necessity Review
Rystiggo® vial	280mg/2mL	Medical Benefit with Medical Necessity Review

Skyclarys® capsule	50mg	New prior authorization criteria; Quantity Limit: 90 capsules per 30 days
Triferic® ampule, powder packet	All	Prior authorization is required for medical benefit: J1443 code
Vanflyta® tablet	17.7mg, 26.5mg	New prior authorization criteria; Quantity Limit: 2 tablets per day
Venofer® vial	All	Prior authorization is required for medical benefit: J1756 code
Vyjuvek® gel	N/A	Medical Benefit with Medical Necessity Review
Vyvgart Hytrulo® vial	1,008mg/5.6mL	Medical Benefit with Medical Necessity Review
Ycanth® solution	0.7%	Now accepted on pharmacy and medical benefit; Medical Benefit with Medical Necessity Review; Pharmacy benefit - Non preferred; Quantity limit: 4 treatment courses (max of 12 weeks) per infection
Zirabev® vial	All	Medical benefit - Preferred with Prior Authorization required

What should you do?

First, talk to your prescriber. There are a few ways you and your prescriber can find medication information:

- You can look on our website at **CareSourcePASSE.com**. On the Members page, under **Tools & Resources** click on “**Find My Prescriptions**”.
- Or, call our Member Services Department at **1-833-230-2005 (TDD/TTY: 711)**.

We are here to help you. The CareSource PASSE Member Services Department is open Monday through Friday, 8 a.m. to 5 p.m. CST.

Sincerely,

CareSource PASSE

AR-PAS-M-1135300-V.10

DHS Approved: 2/23/2022