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

Re: Summary of Formulary/Prior Authorization Changes Effective July 1, 2023.

Your health care is our priority. That is why we are writing to tell you that on July 1, 2023, 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 JULY 1, 2023:

THE FOLLOWING MEDICATION(S) WILL BE PREFERRED ON THE PDL EFFECTIVE JULY 1, 2023.

Product Name	Dose(s)	Notes
Baqsimi® nasal spray	3mg	Preferred without prior authorization
Clonidine extended release tablet (Generic for Kapvay®)	0.1mg	Preferred with prior authorization • Took effect 3/24/2023
EpiPen® auto-injector	0.3mg/0.3mL	Preferred without prior authorization
EpiPen Jr® auto-injector	0.15mg/0.3mL	Preferred without prior authorization
Fensolvi® syringe kit	45mg	Preferred with prior authorization
Finasteride tablet (Generic for Proscar®)	5mg	Preferred with prior authorization
Gvoke® syringe, auto-injector	All	Preferred without prior authorization
Insulin Aspart mix pen, vial (Generic for Novolog® Mix)	All	Preferred rapid/intermediate acting combination insulin alongside Novolog® Mix • Took effect 5/15/2023
Insulin Aspart cartridge, vial, FlexPen (Generic for Novolog®)	All	Preferred rapid acting insulin alongside Novolog® • Took effect 5/15/2023
Ketorolac vial	All	Preferred with criteria • Took effect 4/11/2023
Lamotrigine tablet (Generic for Lamictal®)	25mg, 100mg, 150mg, 200mg	Extended release or ODT preparations are not preferred • Took effect 5/15/2023
Lupaneta® kit	3.75-5mg	Preferred with criteria
Lupron® Depot kit	3.75 mg, 7.5mg, 11.25, mg-3month	Preferred with criteria
Lupron® Depot-Ped kit	7.5mg, 11.25, mg, 15mg, 11.25-3 month kit, 30mg-3 month kit, 45mg-6month kit	Preferred with prior authorization

Proglycem® oral suspension	5mg/mL	Preferred without prior authorization
Riluzole tablet (Generic for Rilutek®)	50mg	Prior authorization is not required • Quantity limit of 62 tablets per 31 days
Synarel® spray	2mg/mL	Preferred with prior authorization

THE FOLLOWING MEDICATION(S) WILL BE NON-PREFERRED ON THE PDL EFFECTIVE JULY 1, 2023.

Product Name	Dose	Notes
Chlordiazepoxide-Clidinium capsule (Generic for Librax®)	5mg-2.5mg	Not paid for by the Arkansas PASSE Medicaid program
Covaryx® Half Strength tablet	0.625mg-1.25mg	Not paid for by the Arkansas PASSE Medicaid program
Covaryx® tablet	1.25-2.5mg	Not paid for by the Arkansas PASSE Medicaid program
Diazoxide suspension (generic for Proglycem®)	5mg/mL	Prior authorization is required • Brand name Proglycem® is preferred without prior authorization
ED-Spaz® oral disintegrating tablet	0.125mg	Not paid for by the Arkansas PASSE Medicaid program
EEMT Double Strength tablet	1.25mg-2.5mg	Not paid for by the Arkansas PASSE Medicaid program
EEMT Half Strength tablet	0.625mg-1.25mg	Not paid for by the Arkansas PASSE Medicaid program
Epinephrine auto-injector (Generic for EpiPen® and EpiPen Jr®)	All	Prior authorization is required • Brand name EpiPen®/ EpiPen Jr® are preferred without prior authorization
Estrogen-Methyltestosterone Full Strength tablet	1.25mg-2.5mg	Not paid for by the Arkansas PASSE Medicaid program
Estrogen-Methyltestosterone Half Strength tablet	0.625mg-1.25mg	Not paid for by the Arkansas PASSE Medicaid program
Glucagon Emergency Kit	1mg	Prior authorization is required
Lamictal® tablet	25mg, 100mg, 150mg, 200mg	Generic lamotrigine tablet is preferred • Took effect 5/15/2023
Latuda® tablet	All	Generic lurasidone remains preferred with criteria • Took effect 5/19/2023
Nitro-Time® extended release capsule	2.5mg, 6.5mg	Not paid for by the Arkansas PASSE Medicaid program
Triptodur® vial	22.5mg-6month	Prior authorization is required

THE FOLLOWING MEDICATION(S) HAVE A CHANGE IN PRIOR AUTHORIZATION/CRITERIA ON THE PDL EFFECTIVE JULY 1, 2023.

Product Name	Strength(s)	Notes
Amitiza® capsule	All	Prior authorization is required if under 18 years of age
Camcevi® syringe	42mg	Medical benefit review to determine if treatment is essential for prostate cancer diagnosis
Eligard® syringe kit	7.5 mg, 22.5 mg-3 month, 30 mg-4 month, and 45 mg-6 month	Medical benefit review to determine if treatment is essential for prostate cancer diagnosis
Gabapentin solution (Generic for Neurontin®)	All	Prior authorization is not required if under 7 years of age or if you have had a medical condition called NPO (nothing by mouth) and it was billed as a diagnosis within the past year • Took effect 4/17/2023
Lupron® Depot syringe kit	22.5 mg-3 month, 30 mg-4 month, 45mg-6 month	Medical benefit review to determine if treatment is essential for prostate cancer diagnosis
Lupron 2 week kit	1mg/0.2mL	Medical benefit review to determine if treatment is essential for prostate cancer diagnosis
Sublocade® syringe	All	Now accepted on the pharmacy benefit in addition to the medical benefit • Took effect 5/22/2023
Trelstar® vial	3.75 mg, 11.25 mg, 22.5 mg	Medical benefit review to determine if treatment is essential for prostate cancer diagnosis

SUMMARY OF CHANGES TO PRODUCTS NOT ON THE ARKANSAS MEDICAID PDL EFFECTIVE JULY 1, 2023:

THE FOLLOWING MEDICATION(S) HAVE A CHANGE IN PRIOR AUTHORIZATION/CRITERIA EFFECTIVE JULY 1, 2023.

Product Name	Strength(s)	Notes
Afinitor® tablet	All	No longer preferred by Arkansas PASSE Medicaid program • Took effect 3/1/2023
Briumvi® vial	150mg/6mL	Medical benefit review to determine if treatment is essential
Dartisla® orally disintegrating tablet	1.7mg	New criteria • Quantity limit of 124 tablets per 31 days
Exservan® film	50mg	New criteria • Quantity limit of 62 films per 31 days
Ferrlecit® vial	62.5mg/5mL	Medical benefit review to determine if treatment is essential • Preferred with prior authorization • Trial of Ferrlecit, Infed or

		Venofer is required before a non-preferred iron injection product is approved
Filspari® tablet	200mg, 400mg	New criteria • Quantity limit of 31 tablets per 31 days
Glycate® tablet	1.5mg	New criteria
Hemgenix® kit	All	Medical benefit review to determine if treatment is essential
Infed® vial	100mg/2mL	Medical benefit review to determine if treatment is essential • Preferred with prior authorization • Trial of Ferrlecit, Infed or Venofer is required before a non-preferred iron injection product is approved
Jaypirca® tablet	50mg, 100mg	New criteria • Quantity limit of 31 tablets per 31 days of 50mg and 62 tablets per 31 days of 100mg
Kalydeco® granule packet, tablet	All	Updated criteria
Kevzara® pen, syringe	All	New criteria for polymyalgia rheumatica
Krazati® tablet	200mg	New criteria • Quantity limit of 180 tablets per 30 days
Leqembi® vial	All	Medical benefit review to determine if treatment is essential
Nalmefene vial	2mg/2mL	Medical benefit review to determine if treatment is essential
Orkambi® granule packet, tablet	All	Updated criteria
Orserdu® tablet	86mg, 345mg	New criteria • Quantity limit of 93 tablets per 31 days of 86mg and 31 tablets per 31 days of 345mg
Radicava® oral suspension	105mg/5mL	New criteria • Quantity limit of one 50 mL or 70mL bottle per 28 days
Rebyota® rectal suspension	500mL	Medical benefit review to determine if treatment is essential
Relyvrio ® powder in packet	3gm-1gm	New criteria • Quantity limit of 62 powder packets per 31 days
Sunlenca® tablet	300mg	New criteria • Quantity limit of 1 oral tablet pack per year (qty 4 or 5 depending on regimen chosen)

Sunlenca® vial	**463.5mg/1.5mL**	**New criteria** • **Quantity limit of 1 injection kit (2 vials) every 6 months**
Symdeko® tablet	**All**	**Updated criteria**
Tiglutik® oral suspension	**50mg/10mL**	**New criteria** • **Quantity limit of 620 mL per 31 days**
Trikafta® tablet	**All**	**Updated criteria**
Tzield® vial	**2mg/2mL**	**Medical benefit review to determine if treatment is essential**
Venofer® vial	**200mg/10mL**	**Medical benefit review to determine if treatment is essential** • **Preferred with prior authorization** • **Trial of Ferrlecit, Infed or Venofer is required before a non-preferred iron injection product is approved**

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 c**lick 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