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

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

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

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

Product Name	Dose(s)	Notes – If Applicable
Abacavir tablet, solution (Generic for Ziagen®)	All	
Abacavir/lamivudine tablet (Generic for Epzicom®)	All	
Abilify Asimtufii® ER syringe	All	Preferred with prior authorization criteria
Adbry® syringe	All	Preferred with prior authorization criteria
Atazanavir capsule (Generic for Reyataz®)	All	
Biktarvy® tablet	All	
Cimduo® tablet	All	
Complera® tablet	All	
Daytrana® patch	All	Preferred with prior authorization criteria • Will start on 10/17/2023 *Preferred status starts 10/1/2023. New criteria will start on date cited
Delstrigo® tablet	All	
Descovy® tablet	All	
Desvenlafaxine succinate ER tablet (Generic for Pristiq® ER)	All	Preferred with prior authorization criteria • Will start on 12/1/2023 *Preferred status starts 10/1/2023. New criteria will start on date cited
Dexmethylphenidate ER capsule (Generic for Focalin® XR)	All	Preferred with prior authorization criteria (Brand name Focalin® XR is also preferred) • Will start on 10/17/2023 *Preferred status starts 10/1/2023. New criteria will start on date cited

Product Name	Dose(s)	Notes – If Applicable
Dexmethylphenidate IR tablet (Generic for Focalin®)	All	Preferred with prior authorization criteria (Brand name Focalin® is also preferred) • Will start on 10/17/2023 *Preferred status starts 10/1/2023. New criteria will start on date cited
Dovato® tablet	All	
Dupixent® pen, syringe	All	Preferred with prior authorization criteria
Edurant® tablet	All	
Efavirenz tablet (Generic for Sustiva®)	All	
Efavirenz/emtricitabine/tenofovir disoproxil fumarate tablet (Generic for Atripla®)	All	
Emtricitabine/tenofovir disoproxil fumarate tablet (Generic for Truvada®)	All	
Emtriva® solution	All	
Evotaz® tablet	All	
Fluoxetine hydrochloride capsule (Generic for Prozac®)	40mg	Preferred with prior authorization criteria • Will start on 12/1/2023 *Preferred status starts 10/1/2023. New criteria will start on date cited
Fosamprenavir tablet (Generic for Lexiva®)	All	
Freestyle Libre® 2 & Freestyle Libre® 3 Continuous Glucose Monitors	All	Preferred with prior authorization criteria • Was started 8/1/2023
Genvoya® tablet	All	
Invega Hafyera® syringe	All	Preferred with prior authorization criteria
Isentress® powder, chew, tablet, HD tablet	All	
Juluca® tablet	All	
Lamivudine solution, tablet (Generic for Epivir®)	All	
Lamivudine/zidovudine tablet (Generic for Combivir®)	All	
Lexiva® suspension	All	
Lopinavir/ritonavir solution, tablet (Generic for Kaletra®)	All	
Nevirapine tablet, suspension, ER tablet (Generic for Viramune®)	All	
Norvir® powder	All	
Odefsey® tablet	All	
Perseris® ER syringe	All	Preferred with prior authorization criteria
Pifeltro® tablet	All	
Prezcobix® tablet	All	

Product Name	Dose(s)	Notes – If Applicable
Prezista® suspension, tablet	All	
ProAir RespiClick® aerosol powder	90mcg	Preferred without prior authorization criteria
Reyataz® powder	All	
Ritonavir tablet (Generic for Norvir®)	All	
Stribild® tablet	All	
Symfi® tablet	All	
Symfi Lo® tablet	All	
Symtuza® tablet	All	
Tacrolimus ointment (Generic for Protopic®)	All	
Tenofovir disoproxil fumarate tablet (Generic for Viread®)	All	
Tivicay® PD tablet for suspension, Tivicay®) tablet	All	
Triumeq® PD tablet for suspension, Triumeq® tablet	All	
Tybost® tablet	All	
Xolair® syringe	All	Preferred with prior authorization criteria
Xopenex® HFA aerosol	45mcg	Preferred without prior authorization criteria
Xyrem® oral solution	500mg/mL	Preferred with prior authorization criteria
Zidovudine tablet, syrup (Generic for Retrovir®)	All	

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

Product Name	Dose(s)	Notes – If Applicable
Albuterol HFA aerosol	All	Brand name Proventil HFA® & Ventolin HFA® are preferred
Apretude® vial	All	Non-Preferred with prior authorization criteria
Aptivus® capsule	All	
Atripla® tablet	All	
Azstarys® capsule	All	Updated criteria • Will start on 12/1/2023
Cabenuva® vial	All	Non-Preferred with prior authorization criteria
Combivir® tablet	All	
Darunavir ethanolate tablet (Generic for Prezista®)	All	
Didanosine capsule (Generic for Videx® EC)	All	
Efavirenz capsule (Generic for Sustiva®)	All	

Product Name	Dose(s)	Notes – If Applicable
Efavirenz/lamivudine/tenofovir disoproxil fumarate tablet (Generic for Symfi® and Symfi Lo®)	All	
Elidel® cream	All	Non-Preferred with prior authorization criteria
Emsam® transdermal patch	All	Updated criteria • Will start on 12/1/2023
Emtricitabine capsule (Generic for Emtriva®)	All	
Emtriva® capsule (emtricitabine)	All	
Epivir® solution, tablet	All	
Epzicom® tablet	All	
Etravirine tablet (Generic for Intelence®)	All	
Eucrisa® ointment	All	Non-Preferred with prior authorization criteria
Fuzeon® vial	All	
Intelence® tablet	All	
Kaletra® solution, tablet	All	
Lexiva® tablet	All	
Lumryz® ER oral suspension packet	All	
Maraviroc tablet (Generic for Selzentry®)	All	Non-Preferred with prior authorization criteria
Marplan® tablet	10mg	Updated criteria • Will start on 12/1/2023
Nardil® tablet	15mg	Updated criteria • Will start on 12/1/2023
Norvir® tablet	All	
Opzelura® cream	All	Non-Preferred with prior authorization criteria
Phenelzine tablet	15mg	Updated criteria • Will start on 12/1/2023
Pimecrolimus cream (Generic for Elidel®)	All	Non-Preferred with prior authorization criteria
Protopic® ointment	All	Non-Preferred with prior authorization criteria
Qelbree® capsule	All	Updated criteria • Will start on 10/17/2023
Retrovir® syrup	All	
Reyataz® capsule	All	
Rukobia® tablet	All	
Selzentry® solution, tablet	All	Non-Preferred with prior authorization criteria
Sodium oxybate solution (Generic for Xyrem®)	500mg/mL	

Product Name	Dose(s)	Notes – If Applicable
Spravato® nasal spray	All	Updated criteria • Will start on 12/1/2023
Stavudine capsule Generic for Zerit®)	All	
Sunlenca® tablet, vial	All	Non-Preferred with prior authorization criteria
Sunosi® tablet	All	
Sustiva® capsule	All	
Temixys® tablet	All	
Trizivir® tablet	All	
Truvada® tablet	All	
Viracept® tablet	All	
Viramune® XR tablet	All	
Viread® tablet, powder	All	
Wakix® tablet	All	
Xywav® solution	0.5gm/mL	
Ziagen® solution, tablet	All	
Zidovudine capsule (Generic for Retrovir®)	All	

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

Product Name	Dose(s)	Notes – If Applicable
Asceniv® vial	10%	New medical benefit criteria for J1554 code
Cibinqo® tablet	All	Updated eczema criteria
Nexium® packet	All	Updated criteria
Proton Pump Inhibitors (PPIs): Aciphex®, Dexilant®, Konvomep®, Nexium®, Prevacid®, Prilosec®, Protonix®, Zegerid®	All	Updated criteria • Applies to brand and generic products
Rinvoq® tablet	All	Updated eczema criteria
Xelstrym® patch	All	Updated criteria • Will start on 10/17/2023

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

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

Product Name	Dose(s)	Notes – If Applicable
Altuviiio® vial	All	Medical benefit with medical necessity review
Byooviz® vial	0.5mg/0.05mL	New medical benefit criteria for Q5124 code
Daybue® oral solution	200mg/mL	New criteria
Eylea® syringe, vial	All	Updated criteria

Hydroxyprogesterone caproate vial	**250mg/mL**	**New medical benefit criteria for J1729 code**
Joenja® tablet	**70mg**	**New criteria**
Lamzede® vial	**10mg**	**Medical benefit with medical necessity review**
Qalsody® vial	**100mg/15mL**	**Medical benefit with medical necessity review**
Rebyota® rectal suspension	**150mL**	**Medical benefit with medical necessity review** • **Updated criteria**
Syfovre® vial	**15mg/0.1mL**	**Medical benefit with medical necessity review**
Vabysmo® vial	**6mg/0.05mL**	**New medical benefit criteria for J2777 code**
Veozah® tablet	**45mg**	**New criteria**
Vowst® capsule	**N/A**	**New criteria**
Zinplava® vial	**1000mg/40mL**	**New medical benefit criteria for J0565 code**

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