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

**Re: Summary of Formulary/Prior Authorization Changes Effective January 1, 2025.**

Your health care is our priority. That is why we are writing to tell you that on January 1, 2025, 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, 2025:**

**THE FOLLOWING MEDICATION(S) WILL BE PREFERRED ON THE PDL EFFECTIVE JANUARY 1, 2025.**

| Product Name | Dose(s) | Notes |
|---|---|---|
| MYRBETRIQ®ER TABLET | ALL | |
| OLANZAPINE/FLUOXETINE (GENERIC FOR SYMBYAX®) CAPSULE | ALL | Criteria applies |
| OMNIPOD 5® | G6/LIBRE 2 PLUS, INTRO G6/LIBRE 2 PLUS | Updated to preferred – Took effect 10/4/24; Updated quantity limit for OMNIPOD 5 INTRO (G6/LIBRE 2 PLUS) - Took effect 8/16/24 |
| PERFECT POINT®SAFETY LANCET | 28G, 30G | Took effect 8/16/24 |
| QULIPTA®TABLET | ALL | Criteria applies |
| UZEDY ER® SYRINGE | ALL | Criteria applies |
| VRAYLAR®CAPSULE | ALL | Criteria applies |

**THE FOLLOWING MEDICATION(S) WILL BE NON-PREFERRED ON THE PDL EFFECTIVE JANUARY 1, 2025.**

| Product Name | Dose(s) | Notes |
|---|---|---|
| ALLOPURINOL (GENERIC FOR ZYLOPRIM®) TABLET | 200MG | Took effect 9/4/24 |
| CELEBREX®CAPSULE | 50MG, 200 MG, 400MG | Took effect 9/27/24 |
| COSOPT®OPHTHALMIC DROPS | 22.3MG-6.8MG/ML | Took effect 9/27/24 |
| COZAAR®TABLET | 25MG, 50MG | Updated to non-preferred - 25MG tablet - Took effect 9/13/24; 50MG took effect 10/16/24 |
| HYDROCORTISONE CREAM | 1% (453.6GM) | Took effect 11/13/24 |
| HYZAAR® TABLET | 50-12.5MG | Took effect 10/16/24 |
| LIPITOR®TABLET | ALL | Took effect 9/13/24 |

| | | |
|---|---|---|
| MAXITROL®OPHTHALMIC DROPS | 0.1 % | Took effect 9/27/24 |
| NORVASC®TABLET | 10MG | Took effect 9/13/24 |
| OXCARBAZEPINE (GENERIC FOR TRILEPTAL®) SUSPENSION | 300 MG/5 ML | Took effect 12/1/24 |
| SEROQUEL® TABLET | ALL | Took effect 9/27/24 |
| TENORETIC® TABLET | ALL | Took effect 9/16/24 |

**THE FOLLOWING MEDICATION(S) HAVE A CHANGE IN PRIOR AUTHORIZATION/CRITERIA ON THE PDL EFFECTIVE JANUARY 1, 2025.**

| Product Name | Dose(s) | Notes |
|---|---|---|
| ADALIMUMAB-AACF (CF) CROHN PEN INJECTOR KIT | 40MG/0.8ML | Updated quantity limit; Took effect 9/10/24 |
| AUGTYRO® CAPSULE | 160 MG | Updated age and quantity limit; Took effect 11/1/24 |
| COBENFY® CAPSULE | 100MG-20MG | Updated quantity limit; Took effect 9/27/24 |
| CREXONT® ER CAPSULE | ALL | Updated quantity limit; Took effect 8/14/24 |
| EBGLYSS® PEN INJECTOR | 250MG/2ML | Updated age limit; Took effect 8/14/24 |
| ERZOFRI® SYRINGE | ALL | Updated age limit; Took effect 10/24/24 |
| ESTRADIOL GEL (GENERIC for ESTROGEL®) PUMP | 0.06% | Updated age limit; Took effect 10/23/24 |
| FEMLYV®ODT TABLET | 1MG-0.02MG | Updated age and quantity limit; Took effect 9/11/24 |
| FRAICHE®5000 DENTAL GEL | 1.1% | Removed quantity limit; Took effect 8/12/24 |
| GRASTEK®SL TABLET | 2,800 BAU | Updated quantity limit; Took effect 9/20/24 |
| HYDROCODONE-ACETAMINOPHEN ORAL SOLUTION | 10-325MG/15ML | Updated quantity limit; Took effect 8/22/24 |
| LAZCLUZE®TABLET | ALL | Updated quantity limit; Took effect 8/24/24 |
| NALOXONE VIAL | 0.4 MG/ML | Updated age limit; Took effect 9/23/24 |
| NYSTATIN (GENERIC for NYSTOP®) POWDER | 100,000 UNIT/GM | Updated quantity limit; Took effect 10/2/24 |
| OFLOXACIN (GENERIC for OCUFLOX®) OPHTHALMIC DROPS | 0.3% | Updated quantity limit; Took effect 11/6/24 |
| ONYDA®XR SUSPENSION | 0.1MG/ML | Updated quantity limit; Took effect 8/23/24 |
| ORALAIR®SUBLINGUAL TABLET | 300IR | Updated quantity limit; Took effect 7/17/24 |
| OTEZLA®DOSE PACK, TABLET | 10-20-30MG, 30MG | Updated age limit; Took effect 9/6/24 |
| OXYCODONE HCL IR (GENERIC for ROXICODONE®) TABLET | 5MG, 15MG, 20MG, 30MG | Updated criteria; Took effect 9/20/24 |

| Product Name | Dose(s) | Notes |
|---|---|---|
| PENCICLOVIR (GENERIC for DENAVIR®) CREAM | 1% | Updated to require prior authorization. Took effect 11/5/24 |
| PENICILLIN G (GENERIC for BICILLIN L-A®) SYRINGE | 1.2 MILLION UNIT/2 ML | Updated quantity limit; Took effect 9/13/24 |
| RAGWITEK®SUBLINGUAL TABLET | 12 UNITS | Updated quantity limit; Took effect 9/20/24 |
| TWIIST®REFILL KIT | N/A | Updated quantity limit; Took effect 7/3/24 |
| VOYDEYA® TABLET | ALL | Updated quantity limit; Took effect 7/17/24 |
| WINREVAIR®KIT | ALL | Updated quantity limit; Took effect 10/16/24 |
| YORVIPATH® PEN | ALL | Updated quantity limit - Took effect 9/9/24; Updated criteria - Took effect 9/20/24 |
| ZITUVIMET®XR TABLET | 100-1,000MG, 50-1000MG | Updated quantity limit; Took effect 10/14/24 |
| ZOLPIDEM TARTRATE (GENERIC for AMBIEN®) TABLET | 5MG, 10MG | Updated quantity limit; Took effect 8/30/24 |

**SUMMARY OF CHANGES TO PRODUCTS NOT ON THE ARKANSAS MEDICAID PDL EFFECTIVE JANUARY 1, 2025:**

**THE FOLLOWING MEDICATION(S) HAVE A CHANGE IN PRIOR AUTHORIZATION/CRITERIA EFFECTIVE JANUARY 1, 2025.**

| Product Name | Dose(s) | Notes |
|---|---|---|
| KISUNLA®VIAL | 350MG/20ML | Prior authorization is required for medical benefit code: J0175 |
| PIASKY®VIAL | 340 MG/2ML | Prior authorization is required for medical benefit |

**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

AR-PAS-M-1135300-V.13 DHS Approved: 2/23/2022