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

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

Dear Health Partner,

We are dedicated to partnering with you in the most effective way to manage our members' care. CareSource PASSE complies with Arkansas Medicaid's Evidence-Based Preferred Drug List (PDL) and also routinely reviews medications not found on Arkansas Medicaid's PDL. We encourage you to actively work with your CareSource PASSE patients in advance of the effective date above to ensure a smooth transition if necessary.

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

THE FOLLOWING MEDICATIONS WILL BE PREFERRED ON THE PDL EFFECTIVE JANUARY 1, 2024.

Product Name	Strength(s)	Notes If Applicable
Austedo®, Austedo® XR tablet	All	Prior authorization criteria apply; New PDL class
Ezetimibe tablet (Generic for Zetia®)	10mg	
Fylnetra® 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 MEDICATIONS WILL BE NON-PREFERRED ON THE PDL EFFECTIVE JANUARY 1, 2024.

Product Name	Strength(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

We will provide a list of your CareSource PASSE patients who are taking any medication above upon your request. Please email your request to
PharmacyConversionProgram@CareSource.com
In your request, include the medication name(s), provider name, NPI, and your secure fax number. We will fax you a list of patients who have been prescribed these medications.

THE FOLLOWING MEDICATIONS WILL HAVE A CHANGE IN PRIOR AUTHORIZATION/CRITERIA ON THE PDL EFFECTIVE JANUARY 1, 2024.

Product Name	Strength(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 MEDICATIONS HAVE A CHANGE IN PRIOR AUTHORIZATION/CRITERIA EFFECTIVE JANUARY 1, 2024.

Product Name	Strength(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

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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
Soliris® vial	All	Updated criteria
Triferic® ampule, powder packet	All	Prior authorization is required for medical benefit: J1443 code
Ultomiris® vial	All	Updated criteria
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 you should know
We know patient care is of the utmost importance to you. We are notifying our members of this change to help ensure their treatment plan is maintained. We have asked our members to contact their prescriber if they have questions.

Additional Resources
For the most up-to-date information, please utilize the Formulary resources available at CareSourcePASSE.com. You can also access the complete PDL at **CareSourcePASSE.com** by clicking on:

- Providers
- Tools & Resources
- Drug Formulary

We recognize each patient is unique and we appreciate your partnership in making this a successful transition. We are here to help you with any questions. Call CareSource PASSE Provider Services at 1-833-230-2100 Monday through Friday, 8 a.m. to 5 p.m. CST. Thank you for being a CareSource PASSE health partner.

Sincerely,

CareSource PASSE

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