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

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

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 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 JULY 1, 2023:

THE FOLLOWING MEDICATIONS WILL BE PREFERRED ON THE PDL EFFECTIVE JULY 1, 2023.

Product Name	Strength(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 brand Novolog® Mix • Took effect 5/15/2023
Insulin Aspart cartridge, vial, FlexPen (Generic for Novolog®)	All	Preferred rapid acting insulin alongside brand 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	Preferred status does not apply to extended release or ODT formulations • 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,	Preferred with prior authorization

	11.25-3 month kit, 30mg-3 month kit, 45mg-6month kit	
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 MEDICATIONS WILL BE NON-PREFERRED ON THE PDL EFFECTIVE JULY 1, 2023.

Product Name	Strength(s)	Notes
Chlordiazepoxide-Clidinium capsule (Generic for Librax®)	5mg-2.5mg	Not reimbursable by the Arkansas PASSE program
Covaryx® Half Strength tablet	0.625mg-1.25mg	Not reimbursable by the Arkansas PASSE program
Covaryx® tablet	1.25-2.5mg	Not reimbursable by the Arkansas PASSE 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 reimbursable by the Arkansas PASSE program
EEMT Double Strength tablet	1.25mg-2.5mg	Not reimbursable by the Arkansas PASSE program
EEMT Half Strength tablet	0.625mg-1.25mg	Not reimbursable by the Arkansas PASSE 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 reimbursable by the Arkansas PASSE program
Estrogen-Methyltestosterone Half Strength tablet	0.625mg-1.25mg	Not reimbursable by the Arkansas PASSE 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 reimbursable by the Arkansas PASSE program
Triptodur® vial	22.5mg-6month	Prior authorization is required

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 JULY 1, 2023.

Product Name	Strength(s)	Notes
Amitiza® capsule	All	Age limit of ≥18 years old added
Camcevi® syringe	42mg	Medical benefit with medical necessity review for prostate cancer indication
Eligard® syringe kit	7.5 mg, 22.5 mg-3 month, 30 mg-4 month, and 45 mg-6 month	Medical benefit with medical necessity review for prostate cancer indication
Gabapentin solution (Generic for Neurontin®)	All	Prior authorization is not required if < 7 years of age or billed diagnosis of NPO in the last year • Took effect 4/17/2023
Lupron® Depot syringe kit	22.5 mg-3 month, 30 mg-4 month, 45mg-6 month	Medical benefit with medical necessity review for prostate cancer indication
Lupron 2 week kit	1mg/0.2mL	Medical benefit with medical necessity review for prostate cancer indication
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 with medical necessity review for prostate cancer indication

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

THE FOLLOWING MEDICATIONS HAVE A CHANGE IN PRIOR AUTHORIZATION/CRITERIA EFFECTIVE JULY 1, 2023.

Product Name	Strength(s)	Notes
Afinitor® tablet	All	No longer on the State Supported Brand List • Took effect 3/1/2023
Briumvi® vial	150mg/6mL	Medical benefit with medical necessity review

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 with medical necessity review** • **Preferred with prior authorization** • **Trial of Ferrlecit, Infed or Venofer is required for approval of non-preferred intravenous iron agents**
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 with medical necessity review**
Infed® vial	**100mg/2mL**	**Medical benefit with medical necessity review** • **Preferred with prior authorization** • **Trial of Ferrlecit, Infed or Venofer is required for approval of non-preferred intravenous iron agents**
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 with medical necessity review**
Nalmefene vial	**2mg/2mL**	**Medical benefit with medical necessity review**
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 with medical necessity review**
Relyvrio ® powder in packet	**3gm-1gm**	**New criteria** • **Quantity limit of 62 powder packets per 31 days**
Sunlenca® tablet	**300mg**	**New criteria**

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		• 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 with medical necessity review
Venofer® vial	200mg/10mL	Medical benefit with medical necessity review • Preferred with prior authorization • Trial of Ferrlecit, Infed or Venofer is required for approval of non-preferred intravenous iron agents

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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