



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

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

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

Product Name	Strength(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 <ul style="list-style-type: none"> <li>Will take effect on 10/17/2023</li> </ul> *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 <ul style="list-style-type: none"> <li>Will take effect on 12/1/2023</li> </ul> *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) <ul style="list-style-type: none"> <li>Will take effect on 10/17/2023</li> </ul> *Preferred status starts 10/1/2023. New criteria will start on date cited

Product Name	Strength(s)	Notes If Applicable
Dexmethylphenidate IR tablet (Generic for Focalin®)	All	Preferred with prior authorization criteria (Brand name Focalin® is also preferred) <ul style="list-style-type: none"> <li>Will take effect on 10/17/2023</li> </ul> *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 <ul style="list-style-type: none"> <li>Will take effect on 12/1/2023</li> </ul> *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 <ul style="list-style-type: none"> <li>Took effect 8/1/2023</li> </ul>
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	



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

THE FOLLOWING MEDICATIONS WILL BE NON-PREFERRED ON THE PDL EFFECTIVE OCTOBER 1, 2023.

Product Name	Strength(s)	Notes If Applicable
Albuterol HFA aerosol	All	Brand name Proventil HFA <sup>®</sup> & Ventolin HFA <sup>®</sup> are preferred
Apretude <sup>®</sup> vial	All	Non-Preferred with prior authorization criteria
Aptivus <sup>®</sup> capsule	All	
Atripla <sup>®</sup> tablet	All	
Azstarys <sup>®</sup> capsule	All	Updated criteria <ul style="list-style-type: none"> <li>Will take effect on 12/1/2023</li> </ul>
Cabenuva <sup>®</sup> vial	All	Non-Preferred with prior authorization criteria
Combivir <sup>®</sup> tablet	All	
Darunavir ethanolate tablet (Generic for Prezista <sup>®</sup> )	All	

Product Name	Strength(s)	Notes If Applicable
Didanosine capsule (Generic for Videx® EC)	All	
Efavirenz capsule (Generic for Sustiva®)	All	
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 <ul style="list-style-type: none"> <li>Will take effect on 12/1/2023</li> </ul>
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 <ul style="list-style-type: none"> <li>Will take effect on 12/1/2023</li> </ul>
Nardil® tablet	15mg	Updated criteria <ul style="list-style-type: none"> <li>Will take effect on 12/1/2023</li> </ul>
Norvir® tablet	All	
Opzelura® cream	All	Non-Preferred with prior authorization criteria
Phenelzine tablet	15mg	Updated criteria <ul style="list-style-type: none"> <li>Will take effect on 12/1/2023</li> </ul>
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 <ul style="list-style-type: none"> <li>Will take effect on 10/17/2023</li> </ul>
Retrovir® syrup	All	
Reyataz® capsule	All	
Rukobia® tablet	All	



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Product Name	Strength(s)	Notes If Applicable
Selzentry <sup>®</sup> solution, tablet	All	Non-Preferred with prior authorization criteria
Sodium oxybate solution (Generic for Xyrem <sup>®</sup> )	500mg/mL	
Spravato <sup>®</sup> nasal spray	All	Updated criteria <ul style="list-style-type: none"> <li>Will take effect on 12/1/2023</li> </ul>
Stavudine capsule (Generic for Zerit <sup>®</sup> )	All	
Sunlenca <sup>®</sup> tablet, vial	All	Non-Preferred with prior authorization criteria
Sunosi <sup>®</sup> tablet	All	
Sustiva <sup>®</sup> capsule	All	
Temixys <sup>®</sup> tablet	All	
Trizivir <sup>®</sup> tablet	All	
Truvada <sup>®</sup> tablet	All	
Viracept <sup>®</sup> tablet	All	
Viramune <sup>®</sup> XR tablet	All	
Viread <sup>®</sup> tablet, powder	All	
Wakix <sup>®</sup> tablet	All	
Xywav <sup>®</sup> solution	0.5gm/mL	
Ziagen <sup>®</sup> solution, tablet	All	
Zidovudine capsule (Generic for Retrovir <sup>®</sup> )	All	

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](mailto: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 OCTOBER 1, 2023**

Product Name	Strength(s)	Notes If Applicable
Asceniv <sup>®</sup> vial	10%	New medical benefit criteria for J1554 code
Cibinqo <sup>®</sup> tablet	All	Updated atopic dermatitis criteria
Nexium <sup>®</sup> packet	All	Updated criteria
Proton Pump Inhibitors (PPIs): Aciphex <sup>®</sup> , Dexilant <sup>®</sup> , Konvomep <sup>®</sup> , Nexium <sup>®</sup> , Prevacid <sup>®</sup> , Prilosec <sup>®</sup> , Protonix <sup>®</sup> , Zegerid <sup>®</sup>	All	Updated criteria <ul style="list-style-type: none"> <li>Applies to brand and generic products</li> </ul>

Rinvoq® tablet	All	Updated atopic dermatitis criteria
Xelstrym® patch	All	Updated criteria <ul style="list-style-type: none"> <li>Will take effect on 10/17/2023</li> </ul>

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

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

Product Name	Strength(s)	Notes If Applicable
Altuviiiio® 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 <ul style="list-style-type: none"> <li>Updated criteria</li> </ul>
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 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](http://CareSourcePASSE.com). You can also access the complete PDL at [CareSourcePASSE.com](http://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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