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

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

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

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

Product Name	Dose(s)	Notes – If Applicable
Advair® HFA Aerosol	45-21 MCG, 115-21 MCG, 230-21 MCG	Preferred with prior authorization required • Quantity limit of 1 inhaler per month
Aimovig® Autoinjector	70 MG/ML, 140 MG/ML	Preferred with prior authorization required
Ambrisentan Tablet	5 MG, 10 MG	Preferred with criteria
Anoro Ellipta® Inhaler	62.5-25 MCG	Preferred with criteria
Dimethyl Fumarate Capsule	120 MG, 240 MG	Preferred without criteria
Flovent Diskus® Inhaler	50 MCG, 100 MCG, 250 MCG	Preferred without criteria
Ipratropium/Albuterol sulfate Ampule (Generic Duoneb® inhalation)	0.5-3(2.5) MG/3 ML	Preferred with criteria
Norditropin® Pen Injector	5 MG/1.5 ML,	Preferred with prior authorization

	10 MG/1.5 ML, 15 MG/1.5 ML, 30 MG/3 ML	required
Nurtec® ODT Tablet	75 MG	Preferred with prior authorization required
Pulmicort Flexhaler® Aerosol Powder	90 MCG, 180 MCG	Preferred without criteria
Stiolto Respimat® Mist Inhaler	2.5-2.5 MCG	Preferred with criteria
Tobramycin Ampule	300 MG/5 ML	Preferred with criteria
Veletri® Vial	0.5 MG, 1.5 MG	Preferred without criteria

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

Product Name	Dose(s)	Notes – If Applicable
Letairis® Tablet	5 MG, 10 MG	Non-Preferred • Generic ambrisentan is preferred
Tecfidera® Capsule	120 MG, 240 MG, Starter Pack	Non-Preferred • Generic dimethyl fumarate is preferred

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

Product Name	Dose(s)	Notes – If Applicable
Advair Diskus® Inhaler	All	Quantity limit of 1 inhaler per month
Attention Deficit Hyperactivity Disorder (ADHD) CII Stimulants, Select Non-Stimulants	All	Updated criteria for adults
Cosentyx® Pen, Syringe	All	Updated criteria
Dupixent® Pen, Syringe	All	Updated criteria
Enbrel® Cartridge, Kit, Sureclick, Syringe, Vial	All	Updated criteria
Fasenra® Pen, Syringe	All	Updated criteria
Humira® Pen, Syringe	All	Updated criteria
Ilumya® Syringe	All	Updated criteria
Nucala® Injector, Syringe, Vial	All	Updated criteria
Otezla® Tablet	All	Updated criteria
Siliq® Syringe	All	Updated criteria
Skyrizi® Kit, On-Body, Pen, Syringe, Vial	All	Updated criteria
Stelara® Syringe, Vial	All	Updated criteria
Taltz® Injector, Syringe	All	Updated criteria
Tezspire® Syringe	All	Updated criteria

Tremfya® Injector, Syringe	All	Updated criteria
Xolair® Vial	All	Updated criteria

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

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

Product Name	Dose(s)	Notes – If Applicable
Amvuttra® Syringe	25 MG/0.5 ML	New criteria
Vtama ® Cream	1%	New criteria
Xaciato® Gel	2%	New criteria
Zoryve® Cream	0.3%	New criteria
Ztalmy® Oral Suspension	50 MG/ML	New criteria

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 click 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