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Asunto: Resumen de cambios al Formulario/a la Autorización previa en vigor desde el JULY 1, 2023

Su atención médica es nuestra prioridad. Po ello le escribimos para informarle que el July 1, 2023, habrá cambios en la Lista de medicamentos preferidos (PDL) de Medicaid de Arkansas o en la administración de productos que no están en la PDL de Medicaid de Arkansas de parte de CareSource PASSE. Una PDL es una lista de medicamentos preferidos.

RESUMEN DE CAMBIOS A LA PDL DE MEDICAID DE MEDICAID EN VIGOR A PARTIR DEL JULY 1, 2023:

LOS SIGUIENTES MEDICAMENTOS SE INCLUIRÁN COMO PREFERIDOS EN LA PDL A PARTIR DEL JULY 1, 2023.

Nombre del producto	Dosis	Notas
Baqsimi® nasal spray	3mg	Preferred without prior authorization
Clonidine extended release tablet (Generic for Kapvay®)	0.1mg	Preferred with prior authorization <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Took effect 5/15/2023
Insulin Aspart cartridge, vial, FlexPen (Generic for Novolog®)	All	Preferred rapid acting insulin alongside brand Novolog® <ul style="list-style-type: none"> • Took effect 5/15/2023
Ketorolac vial	All	Preferred with criteria <ul style="list-style-type: none"> • Took effect 4/11/2023
Lamotrigine tablet (Generic for Lamictal®)	25mg, 100mg, 150mg, 200mg	Extended release or ODT preparations are not preferred <ul style="list-style-type: none"> • 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, 11.25-3 month kit, 30mg-3 month kit,	Preferred with prior authorization

	45mg-6month kit	
Proglycem® oral suspension	5mg/mL	Preferred without prior authorization
Riluzole tablet (Generic for Rilutek®)	50mg	Prior authorization is not required <ul style="list-style-type: none"> Quantity limit of 62 tablets per 31 days
Synarel® spray	2mg/mL	Preferred with prior authorization

LOS SIGUIENTES MEDICAMENTOS SE INCLUIRÁN COMO NO PREFERIDOS EN LA PDL A PARTIR DEL JULY 1, 2023.

Nombre del producto	Dosis	Notas
Chlordiazepoxide-Clidinium capsule (Generic for Librax®)	5mg-2.5mg	Not paid for by the Arkansas PASSE Medicaid program
Covaryx® Half Strength tablet	0.625mg-1.25mg	Not paid for by the Arkansas PASSE Medicaid program
Covaryx® tablet	1.25-2.5mg	Not paid for by the Arkansas PASSE Medicaid program
Diazoxide suspension (generic for Proglycem®)	5mg/mL	Prior authorization is required <ul style="list-style-type: none"> Brand name Proglycem® is preferred without prior authorization
ED-Spaz® oral disintegrating tablet	0.125mg	Not paid for by the Arkansas PASSE Medicaid program
EEMT Double Strength tablet	1.25mg-2.5mg	Not paid for by the Arkansas PASSE Medicaid program
EEMT Half Strength tablet	0.625mg-1.25mg	Not paid for by the Arkansas PASSE Medicaid program
Epinephrine auto-injector (Generic for EpiPen® and EpiPen Jr®)	All	Prior authorization is required <ul style="list-style-type: none"> Brand name EpiPen®/ EpiPen Jr® are preferred without prior authorization
Estrogen-Methyltestosterone Full Strength tablet	1.25mg-2.5mg	Not paid for by the Arkansas PASSE Medicaid program
Estrogen-Methyltestosterone Half Strength tablet	0.625mg-1.25mg	Not paid for by the Arkansas PASSE Medicaid program
Glucagon Emergency Kit	1mg	Prior authorization is required
Lamictal® tablet	25mg, 100mg, 150mg, 200mg	Generic lamotrigine tablet is preferred <ul style="list-style-type: none"> Took effect 5/15/2023
Latuda® tablet	All	Generic lurasidone remains preferred with criteria <ul style="list-style-type: none"> Took effect 5/19/2023
Nitro-Time® extended release capsule	2.5mg, 6.5mg	Not paid for by the Arkansas PASSE Medicaid program
Triptodur® vial	22.5mg-6month	Prior authorization is required

LOS SIGUIENTES MEDICAMENTOS TIENEN CAMBIOS EN LA AUTORIZACIÓN PREVIA/CRITERIOS DE AUTORIZACIÓN PREVIA EN LA PDL EN VIGOR A PARTIR DEL JULY 1, 2023.

Nombre del producto	Dosis	Notas
Amitiza® capsule	All	Prior authorization is required if under 18 years of age
Camcevi® syringe	42mg	Medical benefit review to determine if treatment is essential for prostate cancer diagnosis
Eligard® syringe kit	7.5 mg, 22.5 mg-3 month, 30 mg-4 month, and 45 mg-6 month	Medical benefit review to determine if treatment is essential for prostate cancer diagnosis
Gabapentin solution (Generic for Neurontin®)	All	Prior authorization is not required if under 7 years of age or if you have had a medical condition called NPO (nothing by mouth) and it was billed as a diagnosis within the past year <ul style="list-style-type: none"> • Took effect 4/17/2023
Lupron® Depot syringe kit	22.5 mg-3 month, 30 mg-4 month, 45mg-6 month	Medical benefit review to determine if treatment is essential for prostate cancer diagnosis
Lupron 2 week kit	1mg/0.2mL	Medical benefit review to determine if treatment is essential for prostate cancer diagnosis
Sublocade® syringe	All	Now accepted on the pharmacy benefit in addition to the medical benefit <ul style="list-style-type: none"> • Took effect 5/22/2023
Trelstar® vial	3.75 mg, 11.25 mg, 22.5 mg	Medical benefit review to determine if treatment is essential for prostate cancer diagnosis

RESUMEN DE CAMBIOS A LOS PRODUCTOS QUE NO ESTÁN EN LA PDL DE MEDICAID DE ARKANSAS EN VIGOR A PARTIR DEL JULY 1, 2023:

LOS SIGUIENTES MEDICAMENTOS TIENEN CAMBIOS EN LA AUTORIZACIÓN PREVIA/CRITERIOS DE AUTORIZACIÓN PREVIA EN VIGOR A PARTIR DEL JULY 1, 2023.

Nombre del producto	Dosis	Notas
Afinitor® tablet	All	No longer preferred by Arkansas PASSE Medicaid program <ul style="list-style-type: none"> • Took effect 3/1/2023

Briumvi® vial	150mg/6mL	Medical benefit review to determine if treatment is essential
Dartisla® orally disintegrating tablet	1.7mg	New criteria <ul style="list-style-type: none"> Quantity limit of 124 tablets per 31 days
Exservan® film	50mg	New criteria <ul style="list-style-type: none"> Quantity limit of 62 films per 31 days
Ferrlecit® vial	62.5mg/5mL	Medical benefit review to determine if treatment is essential <ul style="list-style-type: none"> Preferred with prior authorization Trial of Ferrlecit, Infed or Venofer is required before a non-preferred iron injection product is approved
Filspari® tablet	200mg, 400mg	New criteria <ul style="list-style-type: none"> Quantity limit of 31 tablets per 31 days
Glycate® tablet	1.5mg	New criteria
Hemgenix® kit	All	Medical benefit review to determine if treatment is essential
Infed® vial	100mg/2mL	Medical benefit review to determine if treatment is essential <ul style="list-style-type: none"> Preferred with prior authorization Trial of Ferrlecit, Infed or Venofer is required before a non-preferred iron injection product is approved
Jaypirca® tablet	50mg, 100mg	New criteria <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Quantity limit of 180 tablets per 30 days
Leqembi® vial	All	Medical benefit review to determine if treatment is essential
Nalmefene vial	2mg/2mL	Medical benefit review to determine if treatment is essential
Orkambi® granule packet, tablet	All	Updated criteria

Orserdu® tablet	86mg, 345mg	New criteria <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Quantity limit of one 50 mL or 70mL bottle per 28 days
Rebyota® rectal suspension	500mL	Medical benefit review to determine if treatment is essential
Relyvrio ® powder in packet	3gm-1gm	New criteria <ul style="list-style-type: none"> Quantity limit of 62 powder packets per 31 days
Sunlenca® tablet	300mg	New criteria <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Quantity limit of 1 injection kit (2 vials) every 6 months
Symdeko® tablet	All	Updated criteria
Tiglutik® oral suspension	50mg/10mL	New criteria <ul style="list-style-type: none"> Quantity limit of 620 mL per 31 days
Trikafta® tablet	All	Updated criteria
Tzield® vial	2mg/2mL	Medical benefit review to determine if treatment is essential
Venofer® vial	200mg/10mL	Medical benefit review to determine if treatment is essential <ul style="list-style-type: none"> Preferred with prior authorization Trial of Ferlecit, Infed or Venofer is required before a non-preferred iron injection product is approved

¿Qué debe hacer?

Primero, hable con la persona que le receta. Hay distintas formas en que usted y la persona que receta pueden encontrar información sobre medicamentos:

- Puede buscar en nuestro sitio web, en CareSourcePASSE.com. En la página “Afiliados”, vaya a “Herramientas y Recursos” y haga clic en “Encontrar mis medicamentos con receta”.

- O llame al Departamento de Servicios para Afiliados, al 1-833-230-2005 (TDD/TTY: 711).

Estamos aquí para ayudarle. El Departamento de Servicios para Afiliados a CareSource PASSE está abierto de lunes a viernes, de 8 a. m. a 5 p. m. hora del centro.

Atentamente,

CareSource PASSE

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Aprobado por DHS: 3/18/2022