ARKANSAS DEPARTMENT OF HUMAN SERVICES

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MEMORANDUM

TO: Arkansas Medicaid Enrolled Prescribing Providers and Pharmacy Providers

FROM: Cynthia Neuhofel, Pharm.D. Division of Medical Services Pharmacy Program

DATE: November 12, 2025

SUBJ: **AR Medicaid Prior Authorization Edits and Preferred Drug List updates approved at the AR Medicaid DUR Board October 15, 2025 meeting for the following:**

Preferred Drug List Full Review: tetracycline agents, topical antibiotics, butalbital agents without codeine, androgenic agents

Preferred Drug List Abbreviated Review: targeted immunomodulators, Alzheimer's agents, anti-Parkinson's agents, bowel prep agents, hepatitis C medications, HMG-CoA reductase inhibitors, immune globulins, neuropathic pain agents, penicillamine/cystine-depleting agents, phosphate removing agents, platelet aggregation inhibitors, proton pump inhibitors, sedative hypnotics

Manual Review PA Criteria: Empaveli® (pegcetacoplan), Wegovy® (semaglutide), Rezdiffra® (resmetirom), Sephience™ (sepiapterin), Harliku™ (nitisinone), Ekterly® (sebetralstat), Andembry® (garadacimab), Dawnzera™ (donidalorsen), Anzupgo® (delgocitinib), Egrifta WR™ (tesamorelin), Egrifta SV® (tesamorelin), Brinsupri™ (brensocatib), Zelsuvmi™ (berdazimer)

Table of Contents

I. ANNOUNCEMENTS

A. QUARTERLY NEWSLETTER

As a service to our providers, we publish a quarterly provider newsletter with some updates for the Medicaid program and educational materials. The quarterly newsletter is in addition to this DUR Board provider memorandum. Archived newsletters can be found on the Prime Therapeutics State Government Solutions portal under the pharmacy tab. https://ar.primetherapeutics.com/provider-documents

The October 2025 quarterly newsletter can be found with the following link.
https://ar.primetherapeutics.com/documents/d/arkansas/arkansas-medicaid-quarterly-newsletter-october-2025-final

B. PRIOR AUTHORIZATION PROCESS FOR PHYSICIAN-ADMINISTERED DRUGS

Beginning **January 1, 2026**, Arkansas Medicaid will implement a new **prior authorization (PA) process** for **Physician-Administered Drug (PAD)**. This change is part of a broader effort to align with evidence-based clinical guidelines and streamline specialty drug management.

What's Changing?

- **Prime Therapeutics**, the existing Pharmacy vendor, will now also be managing prior authorization reviews for drugs covered under the medical benefit for all Arkansas Medicaid members. This will streamline the prior authorization process for more consistent processes for all drug prior authorizations with faster clinical reviews.
- Providers must submit PAD PA requests to **Prime Therapeutics** by initiating an electronic request through CoverMyMeds at https://www.covermymeds.health/. Requests can also be faxed to 800-424-7976.
- The new process applies to **dates of service on or after January 1, 2026**.
- Providers may begin submitting PA requests to Prime Therapeutics beginning on **January 1, 2026**.

What You Need to Do:

- Ensure your staff is aware that **as of January 1, 2026, PAD PA requests will be submitted to Prime Therapeutics**.
- If you are not yet registered for CoverMyMeds and plan to submit electronic PAD PA requests, please register before January 1, 2026. CoverMyMeds Frequently Asked Questions (FAQs) can be found here and the CoverMyMeds Help Desk can be reached at 1-866-452-5017.

Additional Information:

- This change affects providers who request PAD PAs for medical claims.
- This change does not apply to PAD PAs with dates of service prior to January 1, 2026.
- Contact information for **billing issues only** does not change.
- The process for billing submissions does not change.

For inquiries regarding this change, please visit the Arkansas Medicaid Pharmacy Portal at https://ar.primetherapeutics.com/home, or call 800-424-7895.

Please note you will receive additional communication leading up to January 1, 2026, including links to resources and general support.

C. ELECTRONIC PA (ePA) and CoverMyMeds

Beginning 8/1/2025, the Arkansas Medicaid Prescription Drug Program added a new functionality that accepts electronic prior authorization (ePA) requests via CoverMyMeds, in addition to fax requests.

The CoverMyMeds tool simplifies the prior authorization process by prompting prescribers to answer required clinical questions and can offer real-time approval if clinical criteria are met. This update allows prescribers to submit prior authorization requests electronically, with the ability to upload supporting documents, and track the request in real time.

Additionally, pharmacy providers who utilize CoverMyMeds have the opportunity to initiate medication ePA requests on behalf of the member for completion by the prescriber. CoverMyMeds directs the case to the prescriber's queue and prompts them to complete and submit the ePA to Arkansas Medicaid.

Please refer to the Arkansas Medicaid Pharmacy Website at https://ar.primetherapeutics.com/provider-documents#tab6-rncs for additional information on ePA and CoverMyMeds.

Resources:
• https://ar.primetherapeutics.com/documents/d/arkansas/arkansas-medicaid-two-ways-to-submit-a-prior-authorization
• https://ar.primetherapeutics.com/documents/d/arkansas/arkansas-medicaid-covermymeds-faqs

D. INFORMATIONAL DRUG UPDATES

1. Medications added to the oncology policy

a. IBTROZI (taletrectinib) capsule
IBTROZI™ (taletrectinib) is indicated for the treatment of adult patients with locally advanced or metastatic *ROS1*-positive non-small cell lung cancer (NSCLC)

b. MODEYSO (dordaviprone) capsule
MODEYSO is indicated for the treatment of adult and pediatric patients 1 year of age and older with diffuse midline glioma harboring an H3 K27M mutation with progressive disease following prior therapy.

This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

c. HERNEXEOS (zongertinib) tablet
HERNEXEOS is indicated for the treatment of adult patients with unresectable or metastatic non-squamous non-small cell lung cancer (NSCLC) whose tumors have HER2 (ERBB2) tyrosine kinase domain activating mutations, as detected by an FDA-approved test, and who have received prior systemic therapy.

This indication is approved under accelerated approval based on objective response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

d. FASLODEX (fulvestrant) injection
This medication has been listed as included without PA in pharmacy. We are updating to manual review and adding it to the oncology policy review.

2. **KHINDIVI (hydrocortisone) solution**
ALKINDI has the same indication as KHINDIVI. Since ALKINDI has Board approved criteria, we have added KNINDIVI to the same page in the PA criteria document. The only update made was to remove the specific age listed previously and replaced with our typical language to consult the PI for age limitations.

Hydrocortisone sprinkle (Alkindi®) and hydrocortisone solution (Khindivi™)
Approval Criteria
- Beneficiary does not exceed the maximum age recommended in the manufacturer's package insert
- Beneficiary must be diagnosed with adrenocortical insufficiency
- Prescriber must submit the following:
  - Current chart notes
  - Dose requested
  - Medical necessity over hydrocortisone tablets or prednisolone solution which are available without prior authorization

Renewal Requirements
Beneficiary continues to demonstrate the medical necessity of the sprinkle or solution formulation

E. PREFERRED DRUG LIST
PDL UPDATE EFFECTIVE JANUARY 1, 2026

NOTE: Bolded medications indicate a change from the previous preferred drug list or PA status.

Non-preferred agents require prior authorization submission. Prescribers with questions on how to obtain a PA should call the Prime Therapeutics State Government Solutions Help Desk at 1-800-424-7895. All PA requests must be submitted in writing with appropriate supporting documentation. PA requests for PDL products may be faxed to the Prime Therapeutics State Government Solutions Help Desk at 1-800-424-7976. Any PA request for off-label use will be reviewed on a case-by-case basis.

1. Classes with full review without criteria

a. TETRACYCLINES
Preferred Agents
- Doxycycline hyclate 50 mg and 100 mg capsule (generic for Vibramycin®)
- Doxycycline hyclate 100 mg tablet (generic for Vibra-tab®)
- Doxycycline hyclate 75 mg and 150 mg tablet (generic for Acticlate®)
- Doxycycline hyclate 20 mg tablet (generic for Periostat®)
- Doxycycline monohydrate 50 mg and 100 mg capsule (generic for Monodox®)
- Doxycycline monohydrate 50 mg, 75 mg, 100 mg and 150 mg tablet (generic for Adoxa®)
- Minocycline HCl 50 mg and 100 mg capsule (generic for Minocin®)
- Minocycline HCl 75 mg capsule (generic for Dynacin®)

Non-preferred Agents
- Demeclocycline HCl tablet (generic for Declomycin®)
- Doryx® (doxycycline hyclate) 80 mg and 200 mg delayed-release tablet
- Doryx MPC® (doxycycline hyclate) 60 mg delayed-release tablet
- Doxycycline hyclate 50 mg, 75 mg, 80 mg, 100 mg, 150 mg, and 200 mg delayed-release tablet (generic for Doryx®)
- Doxycycline monohydrate 150 mg capsule (generic for Adoxa®)
- Doxycycline monohydrate 25 mg/5 mL suspension (generic for Vibramycin®)
- Doxycycline monohydrate 75 mg capsule (generic for Monodox®)
- Doxycycline monohydrate IR/DR 40 capsule (generic for Oracea®)
- Minocycline HCl 50 mg, 75 mg, and 100 mg tablet (generic for Dynacin®)

- Morgidox® (doxycycline hyclate) 50 mg capsule
- Nuzyra® (omadacycline tosylate) 150 mg tablet see criteria for Nuzyra®
- Oracea® (doxycycline monohydrate) 40 mg IR/DR capsule
- Tetracycline capsule (generic for Sumycin®)
- Tetracycline tablet (generic for Sumycin®)

b. TOPICAL ANTIBIOTICS

Preferred Agents

- Bacitracin OTC ointment
- Bacitracin zinc/neomycin/polymyxin B OTC ointment
- Gentamicin 0.1% ointment
- Gentamicin 0.1% cream
- Mupirocin 2% ointment

Non-preferred Agents

- Bacitracin OTC packets
- Centany® (mupirocin) 2% ointment
- Mupirocin 2% cream

NOTE: OTC topical antibiotics excluded from the list above are not covered by Arkansas Medicaid. Topical antibiotics only indicated for the treatment of acne are not covered by Arkansas Medicaid.

2. Classes with full review with criteria

a. BUTALBITAL AGENTS WITHOUT CODEINE

Preferred Agents

- Butalbital-Acetaminophen-Caffeine 50-325-40 mg tablet (generic for Esgic®)

Non-preferred Agents

- **Butalbital-Acetaminophen 50-325 mg tablet (generic for Marten-Tab®)**
- Butalbital-Acetaminophen 50-300 mg tablet (generic for Bupap®)
- Butalbital-Acetaminophen-Caffeine 50-300-40 mg capsule (generic for Fioricet®)
- Butalbital-Acetaminophen-Caffeine 50-325-40 mg capsule (generic for Esgic®)
- Butalbital-Aspirin-Caffeine 50-325-40 mg capsule (generic for Fiorinal®)
- Butalbital-Aspirin-Caffeine 50-325-40 mg tablet (generic for Fiorinal®)
- Butalbital-Acetaminophen 50-300 mg capsule
- Butalbital-Acetaminophen-Caffeine 50-325/ 15 mL solution (generic for Vanatol®)
- Fioricet® 50-300-40 capsule (Butalbital-Acetaminophen-Caffeine)

Age Edit

- Beneficiary must be at least 12 years of age or greater

Quantity Edits

- Solid Oral dosage forms of butalbital products will be limited up to a maximum of 6 units per day
- Solid Oral dosage forms of butalbital products will have a cumulative quantity limit of 124 units per 31 days' supply
- Oral liquid forms of butalbital will be limited to 60ml per day or up to 240ml per Prescription

b. ANDROGEN AGENTS

Preferred Agents with Criteria

- Testosterone cypionate 100 mg/ml vial (generic for Depo-Testosterone®)
- Testosterone cypionate 200 mg/ml vial (generic for Depo-Testosterone®)
- Testosterone gel pump (generic for Androgel®)

Non-preferred Agents

- Androgel® pump (testosterone)
- Aveed® vial (testosterone undecanoate)
- Azmiro® 200 mg/ml syringe (testosterone cypionate)
- Depo-Testosterone® vial (testosterone cypionate)
- **Jatenzo® capsule (testosterone undecanoate)**
- **Methitest™ tablet (methyltestosterone)**
- **Methyltestosterone capsule (generic for Android®, Testred®)**
- Natesto® nasal gel (testosterone)
- Testim® gel tube (testosterone)
- **Testosterone enanthate 200 mg/ml vial (generic for Delatestryl®)**
- Testosterone gel packet (generic for Androgel®, Vogelxo®)
- Testosterone gel pump (generic for Fortesta®)
- Testosterone gel pump (generic for Vogelxo®)
- Testosterone gel tube (generic for Testim®, Vogelxo®)
- Testosterone solution pump (generic for Axiron®)
- Tlando® capsule (testosterone undecanoate)
- Undecatrex™ capsule (testosterone undecanoate)
- Vogelxo® gel packet and pump (testosterone)
- Xyosted® autoinjector (testosterone enanthate)

Criteria for Preferred Agents with Criteria

- Male
- Diagnosis of one of the following diagnoses in the previous 3 years:
    - Hypospadias
    - Klinefelter Syndrome
    - Kallmann Syndrome
    - Orchiectomy
    - Panhypopituitarism
    - Prader-Willi Syndrome
    - Testicular cancer

**If the above criteria is not met, prior authorization is required.

Denial Criteria

- Diagnosis of one of the following diagnoses in the previous 3 years:
    - Decreased libido
    - Impotence
    - Any other sexual dysfunction diagnoses

3. **Classes with abbreviated review without criteria**

a. TARGETED IMMUNOMODULATORS

Preferred Agents with Criteria

- ENBREL (etanercept) syringe/pen/cartridge/vial
- HUMIRA (adalimumab) syringe/pen
- OTEZLA (apremilast) tablet
- **PYZCHIVA (ustekinumab-ttwe)* 90 mg syringe and 45 mg vial/syringe ****
- **STEQEYMA (ustekinumab-stba)* syringe****
- TALTZ (ixekizumab) syringe/autoinjector**
- XELJANZ, XELJANZ XR (tofacitinib) tablet**

****PYZCHIVA, STEQEYMA, TALTZ and XELJANZ IR/XR must have trial and failure of at least ONE preferred tumor necrosis factor (TNF) blocker (i.e., Humira® or Enbrel®) unless there is a contraindication to the use of a TNF blocker.**

Continuation Criteria:

- Enbrel: Look back in pharmacy claims history 45 days for 1 or more paid claims for Enbrel
- Humira: Look back in pharmacy claims history 45 days for 1 or more paid claims for Humira
- Otezla: Look back in pharmacy claims history 45 days for 1 or more paid claims for Otezla
- Taltz: Look back in pharmacy claims history 45 days for 1 or more paid claims for Taltz
- Xeljanz or Xeljanz XR: Look back in pharmacy claims history 45 days for 1 or more paid claims for Xeljanz or Xeljanz XR
- **Pyzchiva: Look back in pharmacy claims history 120 days for 1 or more paid claims for Pyzchiva**
- **Steqeyma: Look back in pharmacy claims history 120 days for 1 or more paid claims for Steqeyma**

Non-Preferred Agents (*Designates biosimilar)

- ABRILADA (adalimumab-afzb)* syringe/pen
- ACTEMRA (tocilizumab) syringe/autoinjector
- ADALIMUMAB-AACF (generic for Idacio)* syringe/pen
- ADALIMUMAB-AATY (generic for Yuflyma)* syringe/autoinjector
- ADALIMUMAB-ADAZ (generic for Hyrimoz)* syringe/pen
- ADALIMUMAB-ADBM (generic for Cyltezo)* syringe/pen
- ADALIMUMAB-FKJP (generic for Hulio)* syringe/pen
- ADALIMUMAB-RYVK (generic for Simlandi)* syringe/autoinjector
- AMJEVITA (adalimumab-atto)* syringe/autoinjector
- ARCALYST (rilonacept) vial
- BIMZELX (bimekizumab-bkzx) syringe/autoinjector
- CIMZIA (certolizumab) syringe
- COSENTYX (secukinumab) syringe/pen
- CYLTEZO (adalimumab-adbm)* syringe/pen
- ENSPRYNG (satralizumab-mwge) syringe
- ENTYVIO (vedolizumab) pen
- HADLIMA (adalimumab-bwwd)* syringe/autoinjector
- HULIO (adalimumab-fkjp)* syringe/pen
- HYRIMOZ (adalimumab-adaz)* syringe/pen
- IDACIO (adalimumab-aacf)* syringe/pen
- ILARIS (canakinumab) vial
- KEVZARA (sarilumab) syringe/pen
- KINERET (anakinra)

- LITFULO (ritlecitinib) capsule
- OLUMIANT (baricitinib) tablet
- OMVOH (mirikizumab-mrkz) syringe/pen
- ORENCIA (abatacept) syringe/autoinjector
- **OTEZLA XR (apremilast) tablet**
- OTULFI (ustekinumab-aauz)* syringe
- RINVOQ (upadacitinib) tablet/solution
- SELARSDI (ustekinumab-aekn)* syringe
- SILIQ (brodalumab) syringe
- SIMLANDI (adalimumab-ryvk)* syringe/autoinjector
- SIMPONI (golimumab) syringe/pen
- SKYRIZI (risankizumab-rzaa) syringe/on-body injector/pen
- SOTYKTU (deucravacitinib) tablet
- SPEVIGO (spesolimab-sbzo) syringe
- STELARA (ustekinumab) syringe and 45 mg vial
- TREMFYA (guselkumab) syringe/pen/autoinjector
- TYENNE (tocilizumab-aazg)* syringe/autoinjector
- VELSIPITY (etrasimod) tablet
- XELJANZ (tofacitinib) solution
- YESINTEK (ustekinumab-kfce)* syringe/45 mg vial
- YUFLYMA (adalimumab-aaty)* syringe/autoinjector
- YUSIMRY (adalimumab-aqvh)* pen
- ZYMFENTRA (infliximab-dyyb)* syringe/pen

Agents Covered Under Medical Claims Only- Please refer to AFMC for PA criteria until 1/1/2026 when Prime Therapeutics will begin Medical Claim PA reviews.

- ACTEMRA (tocilizumab) vial
- AVSOLA (infliximab-axxq)* vial
- **CIMZIA (certolizumab) vial**
- COSENTYX (secukinumab) vial
- ENTYVIO (vedolizumab) vial
- **ILUMYA (tildrakizumab-asmm) syringe**
- INFLECTRA (infliximab-dyyb)* vial
- INFLIXIMAB (generic for Remicade®) vial
- OMVOH (mirikizumab-mrkz) vial
- ORENCIA (abatacept) vial
- OTULFI (ustekinumab-aauz)* vial
- PYZCHIVA (ustekinumab-ttwe)* 130 mg vial
- REMICADE (infliximab) vial
- RENFLEXIS (infliximab-abda)* vial
- SELARSDI (ustekinumab-aekn)* vial
- SIMPONI ARIA (golimumab) vial
- SKYRIZI (risankizumab-rzaa) vial
- SPEVIGO (spesolimab-sbzo) vial
- STELARA (ustekinumab) 130 mg vial
- STEQEYMA (ustekinumab-stba)* 130 mg vial
- TOFIDENCE (tocilizumab-bavi)* vial
- TREMFYA (guselkumab) vial
- TYENNE (tocilizumab-aazg)* vial

b. ALZHEIMER'S AGENTS

Preferred Agents

- Donepezil 5mg and 10 mg tablet (generic for Aricept®)
- Exelon® patch (rivastigmine) – BRAND ONLY
- Memantine tablet (generic for Namenda®)

Non-Preferred Agents with Criteria

- Leqembi® Iqlik (lecanemab-irmb)—Criteria is pending review

Non-Preferred Agents

- Adlarity® (donepezil patch)
- Aricept® tablet (donepezil)
- Donepezil ODT (generic for Aricept® ODT)
- Donepezil 23 mg tablet (generic for Aricept®)
- Galantamine tablet (generic for Razadyne®)
- Galantamine ER capsule (generic for Razadyne® ER)
- Galantamine solution (generic for Razadyne®)
- Memantine ER capsule (generic for Namenda® XR)
- Memantine solution (generic for Namenda®)
- Memantine/donepezil capsule (generic for Namzaric®)
- Namenda® XR Titration Pack (memantine)
- Namenda® XR capsule (memantine ER)
- Namzaric® capsule (memantine/donepezil)
- Rivastigmine patch (generic for Exelon®)
- Rivastigmine capsule (generic for Exelon®)
- Zunveyl® DR tablet (benzgalantamine)

c. ANTI-PARKINSON'S AGENTS

Preferred Agents

- Amantadine capsule (generic for Symmetrel®)
- Amantadine syrup (generic for Symmetrel®)
- Benztropine (generic for Cogentin®) tablet
- Carbidopa/levodopa ER (generic for Sinemet CR®) tablet
- Carbidopa/levodopa (generic for Sinemet®) tablet
- Pramipexole (generic for Mirapex®) tablet
- Ropinirole (generic for Requip®) tablet
- Trihexyphenidyl (generic for Artane®) tablet
- Trihexyphenidyl elixir (generic for Artane®)

Non-Preferred Agents

- Amantadine tablet (generic for Symmetrel®)
- Apokyn® (apomorphine) cartridge
- **Apomorphine cartridge (generic for Apokyn®)**
- Azilect® (rasagiline) tablet
- Bromocriptine (generic for Parlodel®) tablet and capsule
- Carbidopa (generic for Lodosyn®) tablet
- **Carbidopa/levodopa ER capsule (generic for Rytary®)**
- Carbidopa/levodopa ODT (generic for Parcopa®)
- Carbidopa/levodopa/entacapone (generic for Stalevo®) tablet
- Crexont ER® capsule (carbidopa/levodopa)

- **Dhivy™ (carbidopa/levodopa) tablet**
- Duopa® suspension (carbidopa/levodopa)
- Entacapone (generic for Comtan®) tablet
- Gocovri® capsule (amantadine)
- Neupro® patch (rotigotine)
- Pramipexole ER (generic for Mirapex ER®) tablet
- Rasagiline (generic for Azilect®) tablet
- Ropinirole ER (generic for Requip XL®) tablet
- Rytary® (carbidopa/levodopa ER) capsule—**Brand Preferred**
- Selegiline capsule (generic for Eldepryl®)
- Selegiline tablet (generic for Zelapar®)
- Sinemet® (carbidopa/levodopa) tablet
- Tolcapone (generic for Tasmar®) tablet
- Xadago® (safinamide) tablet

Non-Preferred Agents with Criteria

- Inbrija® (levodopa) capsule See Criteria for Inbrija
- Nourianz® (istradefylline) tablet See Criteria for Nourianz
- **Onapgo™ (apomorphine) injection** See Criteria for Onapgo
- Ongentys® (opicapone) capsule See Criteria for Ongentys
- **Vyalev™ (foscarbidopa/foslevodopa) injection** See Criteria for Vyalev

d. BOWEL PREP AGENTS AND KITS

Preferred Agents

- Gavilyte™-C solution
- Gavilyte™-G solution
- Gavilyte™-N solution
- PEG-3350 with electrolytes solution (generic for GoLYTELY® and NuLYTELY®)

Non-Preferred Agents

- Clenpiq® solution
- **GoLYTELY® solution**
- PEG-3350 with electrolytes powder pack (generic for Moviprep®)
- Sodium sulfate-potassium sulfate-magnesium sulfate (generic for Suprep®)
- Suflave® solution
- Suprep® solution
- Sutab® tablets

e. HEPATITIS C MEDICATIONS

Preferred Agents that require manual review for prior authorization

- Mavyret® tablet (glecaprevir and pibrentasvir)
- **Mavyret® pellet packet (glecaprevir and pibrentasvir)**
- Sofosbuvir/velpatasvir tablet (generic for Epclusa®)
- Zepatier® tablet (elbasvir/grazoprevir)
- Ribavirin capsule 200 mg
- Ribavirin tablet 200 mg

Non-Preferred Agents

- Epclusa® tablet and **pellet pack (**sofosbuvir/velpatasvir)
- Harvoni® tablet and **pellet pack** (ledipasvir-sofosbuvir)
- **Ledipasvir/sofosbuvir tablet (generic for Harvoni®)**
- Pegasys® pen, vial (peginterferon alpha-2a)
- Sovaldi® tablet and **pellet pack** (sofosbuvir)
- Vosevi® tablet, film-coated (sofosbuvir, velpatasvir, and voxilaprevir)

f. HMG-COA REDUCTASE INHIBITORS

Preferred Agents

- Atorvastatin calcium (generic for Lipitor®)
- Lovastatin (generic for Mevacor®) tablet
- Pravastatin (generic for Pravachol®) tablet
- Rosuvastatin (generic for Crestor®) tablet
- Simvastatin (generic for Zocor®) tablet

Non-Preferred Agents

- Altoprev® (lovastatin ER) tablet
- Atorvaliq® suspension (atorvastatin)
- Atorvastatin/amlodipine (generic for Caduet®) tablet
- Caduet® (atorvastatin/amlodipine) tablet
- Crestor® (rosuvastatin) tablet
- Fluvastatin (generic for Lescol®) capsule
- **Fluvastatin ER tablet (generic for Lescol® XL)**
- **Lescol® XL tablet (fluvastatin)**
- Lipitor® (atorvastatin) tablet
- Livalo® (pitavastatin) tablet
- Pitavastatin (generic for Livalo®) tablet
- Simvastatin/ezetimibe (generic for Vytorin®) tablet
- Vytorin® (simvastatin/ezetimibe) tablet
- Zocor® (simvastatin) tablet
- **Zypitamag® (pitavastatin) tablet**

g. IMMUNE GLOBULINS

Preferred Agents with Criteria

- Gammagard® liquid vial
- Gamunex-C® vial
- Hizentra® vial/syringe

Point-of-Sale (POS) Approval Criteria for Preferred Agents

- All IVIG and SCIG products will be subject to point-of-sale edits
- For a claim to process at POS, the beneficiary must have a billed diagnosis for an indication found in Table A in the last 2 years
- Beneficiaries without a billed diagnosis from Table A will require a prior authorization request to be submitted by the prescriber. Each PA request will be reviewed on a case-by-case basis. The prescriber must submit the following:
    - Current chart notes
    - Diagnosis requiring immune globulin
    - Criteria does not pertain to medically billed claims; only pertains to pharmacy claims

Non-Preferred Agents

- Alyglo™ vial
- Asceniv™ vial
- Bivigam® vial
- Cutaquig® vial
- Cuvitru® vial
- Cytogam® vial
- Flebogamma Dif® vial
- Gamastan® vial
- Gammagard® S-D vial
- Gammaked™ vial
- Gammaplex® vial
- HyperRHO® S-D syringe
- Hyqvia® vial
- Octagam® vial
- Panzyga® vial
- Privigen® vial
- RhoGAM® Ultra-filtered plus syringe
- Rhophylac® syringe
- WinRho® SDF vial
- Xembify® vial

h. NEUROPATHIC PAIN AGENTS

Preferred Agents

- Duloxetine 20 mg, 30 mg and 60 mg (generic for Cymbalta®) capsule
- Gabapentin capsule and tablet (generic for Neurontin®)
- Pregabalin capsule (generic for Lyrica®)

Non-Preferred Agents

- Cymbalta® (duloxetine) capsule (obsolete effective 6/19/2025)
- Drizalma™ sprinkle (duloxetine)
- Duloxetine 40 mg (generic for Cymbalta®) capsule
- Gabapentin 250mg/5ml solution (generic for Neurontin®)*
- Gabapentin ER tablet (generic for Gralise®)
- Gabarone™ tablet (gabapentin)
- Gralise® tablet (gabapentin ER)
- Horizant® tablet (gabapentin ER)
- Lidoderm® patch (lidocaine) (obsolete effective 3/31/2025)
- Lyrica® (pregabalin) capsule
- Lyrica CR® (pregabalin) tablet
- Lyrica® solution (pregabalin)
- Neurontin® capsule, tablet, solution (gabapentin)
- Pregabalin solution (generic for Lyrica® solution)
- Pregabalin ER (generic for Lyrica CR®) tablet
- Savella® (milnacipran) tablet see criteria for Savella®
- Ztlido® patch (lidocaine)

***Follows NPO rules (either <7 years of age OR NPO within the past 365 days)**

Non-Preferred Agents with Criteria

- Lidocaine patch (generic for Lidoderm®)

Approval Criteria for generic Lidoderm® patch:

- Submitted diagnosis post-herpetic neuralgia (ICD-10 codes: B0222 POSTHERPETIC TRIGEMINAL NEURALGIA and B0223 POSTHERPETIC POLYNEUROPATHY) within the past 12 months; OR
- Paid claim in history identifying appropriate antiviral medication (Table 4) for post- herpetic neuralgia within the past 30 days

Table 4 – Antivirals

- Acyclovir 200mg
- Acyclovir 400mg
- Acyclovir 800mg
- Famciclovir 125mg
- Famciclovir 250mg
- Famciclovir 500mg
- Valacyclovir 500mg caplet
- Valacyclovir 1g caplet

i. PENICILLAMINE/CYSTINE-DEPLETING AGENTS

Preferred Agents

- Depen® tablet (penicillamine) - BRAND NAME ONLY
- Potassium citrate tablet (generic for Urocit-K®)
- Thiola® tablet (tiopronin) - BRAND NAME ONLY
- Thiola® EC tablet (tiopronin) - BRAND NAME ONLY

Non-Preferred Agents

- Penicillamine capsule (generic for Cuprimine®)
- Penicillamine tablet (generic for Depen®)
- Tiopronin tablet (generic for Thiola®)
- Tiopronin DR tablet (generic for Thiola® EC)
- Urocit-K® ER tablet (potassium citrate)
- **Venxxiva™ DR tablet (generic for Thiola® EC)**

j. PHOSPHATE REMOVING AGENTS

Preferred Agents

- Calcium acetate capsule
- Calcium acetate tablet
- Sevelamer carbonate tablet (generic for Renvela®)

Non-Preferred Agents

- Auryxia® tablet (ferric citrate)
- Ferric citrate tablet (generic for Auryxia®)
- Fosrenol® chewable tablet (lanthanum carbonate)
- **Fosrenol® powder pack (lanthanum carbonate)**
- Lanthanum carbonate chewable tablet (generic for Fosrenol®)
- Renvela® powder pack (sevelamer carbonate) (obsolete effective 10/7/2025)
- Renvela® tablet (sevelamer carbonate)
- Sevelamer HCl tablet (generic for Renagel®)
- Sevelamer carbonate powder pack (generic for Renvela®)
- Velphoro® chewable tablet (sucroferric oxyhydroxide)
- Xphozah® tablet (tenapanor)

k. PLATELET AGGREGATION INHIBITORS

Preferred Agents

- Aspirin/dipyridamole capsule (generic for Aggrenox®)
- Clopidogrel tablet (generic for Plavix®)
- Dipyridamole tablet (generic for Persantine®)
- Prasugrel tablet (generic for Effient®)
- **Ticagrelor tablet (generic for Brilinta®)**

Non-Preferred Agents

- **Brilinta® tablet (ticagrelor)**
- Effient® tablet (prasugrel)
- Plavix® tablet (clopidogrel)

l. PROTON PUMP INHIBITORS

Preferred Agents with Criteria

- Omeprazole capsule (generic for Prilosec® (Rx only))
- Pantoprazole sodium tablet (generic for Protonix®)

Non-Preferred Agents

- Dexilant® capsule (dexlansoprazole)
- Dexlansoprazole capsule (generic for Dexilant®)
- Esomeprazole magnesium capsule (generic for Nexium®)
- Esomeprazole magnesium packet (generic for Nexium® Packet)
- Esomeprazole magnesium/naproxen tablet (generic for Vimovo®)
- Konvomep® suspension (omeprazole/sodium bicarbonate)
- Lansoprazole capsule (generic for Prevacid®)
- Lansoprazole ODT (generic for Prevacid® solutab)
- Nexium® capsule (esomeprazole)
- Omeprazole/sodium bicarbonate capsule and packet (generic for Zegerid®)
- Pantoprazole suspension (generic for Protonix®)
- Prevacid® capsule (lansoprazole)
- Prevacid® Solutab (lansoprazole)
- Prilosec® Suspension (omeprazole)
- Protonix® tablet (pantoprazole)
- Rabeprazole sodium tablet (generic for Aciphex®)

Non-Preferred Agents with Criteria

- Nexium® packets for suspension (esomeprazole) - **BRAND NAME ONLY**
- Protonix® suspension (pantoprazole) - **BRAND NAME ONLY**

Approval Criteria for Preferred Agents with Criteria

- Approve up to 93 days of proton pump inhibitor therapy per year for all beneficiaries age 24 months or older
- Approve treatment beyond 93 days for beneficiaries 24 months or older who have a diagnosis in history for Zollinger-Ellison Syndrome, Barrett's esophagus, esophageal varices, or an endoscopy (Appendix I) in the past 24 months
- Approve treatment beyond 93 days for beneficiaries 24 months or older who have a diagnosis in history for Cystic Fibrosis, pancreatic insufficiency, or pancreatic disease in the past 24 months

Approval Criteria for Non-Preferred Agents with Criteria
Nexium® packet
- Beneficiary ≤ 4 years of age

Protonix® suspension
- Beneficiary < 7 years of age; OR
- History of NPO (Appendix A) within the past 365 days

Denial Criteria
Nexium packet
- Beneficiary Age > 4

Protonix suspension
- No documented history of NPO (Appendix A) within past 365 days
- Beneficiary age ≥ 7

All Proton Pump Inhibitors
93 days of PPI therapy in the past 365 days for beneficiaries 24 months or older, unless there is a diagnosis in history for Zollinger- Ellison Syndrome, Barrett's esophagus, Cystic Fibrosis, pancreatic insufficiency, pancreatic disease, or an endoscopy (Appendix I) in the past 24 months

m. SEDATIVE HYPNOTICS (BENZO AND NON-BENZO)
Preferred Agents with Criteria in Benzodiazepine Class
- Temazepam 15 mg and 30 mg capsule (generic for Restoril®)
- Triazolam tablet (generic for Halcion®)

Non-Preferred Agents in Benzodiazepine Class
- **Doral® tablet (quazepam)**
- Estazolam tablet (generic for Prosom®)
- Flurazepam capsule (generic for Dalmane®)
- Halcion® tablet (triazolam)
- **Quazepam tablet (generic for Doral®)**
- Restoril® capsule (temazepam)
- Temazepam 7.5 and 22.5 mg (generic for Restoril®)

Preferred Agents with Criteria in Non-Benzodiazepine Class
- Eszopiclone tablet (generic for Lunesta®)
- Zaleplon capsule (generic for Sonata®)
- Zolpidem tablet (generic for Ambien®)

Non-Preferred Agents in Non-Benzodiazepine Class
- Ambien® tablet (zolpidem)
- Ambien® CR tablet (zolpidem ER)
- Belsomra® tablet (suvorexant)
- Dayvigo® tablet (lemborexant)
- Doxepin tablet (generic for Silenor®)
- Edluar® tablet (zolpidem SL)
- Hetlioz® capsule and suspension (tasimelteon)- See Hetlioz Criteria
- Quviviq® tablet (daridorexant)
- Ramelteon tablet (generic for Rozerem®)
- Rozerem® tablet (ramelteon)
- Tasimelteon capsule (generic for Hetlioz®) – See Hetlioz Criteria
- Zolpidem 7.5mg capsule

- Zolpidem ER tablet (generic for Ambien CR®)
- Zolpidem SL tablet (generic for Intermezzo®)

Additional Criteria

- Quantity limits apply

Age Edits

Product	Minimum Age	Product	Minimum Age
DARIDOREXANT (QUVIVIQ®)	18	SUVOREXANT (BELSOMRA®)	18
DOXEPIN (SILENOR®)	18	TEMAZEPAM (RESTORIL®)	18
ESTAZOLAM (PROSOM®)	18	TRIAZOLAM (HALCION®)	N/A
ESZOPICLONE (LUNESTA®)	18	ZALEPLON (SONATA®)	18
FLURAZEPAM (DALMANE®)	18	ZOLPIDEM (AMBIEN®)	18
LEMBOREXANT (DAYVIGO®)	18	ZOLPIDEM ER (AMBIEN CR®)	18
RAMELTEON (ROZEREM®)	18	ZOLPIDEM SL (EDLUAR®)	18

II. PRIOR AUTHORIZATION DRUG CRITERIA (NEW OR REVISED):

CRITERIA EFFECTIVE OCTOBER 15, 2025

A. BULLOUS PEMPHIGOID

Approval Criteria for Bullous Pemphigoid (Dupixent®)

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed a dose that meets the package insert requirements for indication, age, and weight or supported in MicroMedex®
- Beneficiary must have a diagnosis of bullous pemphigoid with confirmation from tissue biopsy results
- Beneficiary must have tried and failed oral corticosteroids (e.g., prednisone or prednisolone)
- Beneficiary must use the requested biologic in combination with a tapering course of oral corticosteroids
- If the request is for a non-preferred medication, the beneficiary must have tried and failed the preferred biologic(s) with this indication before non-preferred options can be approved unless there is a patient specific contraindication to the preferred options(s)
- Prescriber must submit the following:
  - Current chart notes
  - Tissue biopsy report confirming diagnosis read
  - Documentation of current status at baseline (e.g., location of lesions, estimated BSA of lesions, description of lesions)
  - Previous therapies tried (e.g., topical corticosteroids, oral corticosteroids, doxycycline, dapsone, methotrexate, mycophenolate, azathioprine)
  - Plan for corticosteroid taper
- Initial PA approved for 3 months. If responsive, renewal PAs can be approved for 6 months.

Renewal Requirements:

- Beneficiary is compliant on therapy (defined as 75% utilization)
- Beneficiary must demonstrate a positive response with decrease in quantity and severity of BP lesions compared to baseline
- Prescriber must submit the following:
  - Current chart notes
  - Documentation of current status to compare to baseline e.g., location of lesions, estimated BSA of lesions, description of lesions)
  - Status of corticosteroid taper

B. EMPAVELI (pegcetacoplan) injection

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert
- Beneficiary is prescribed no more than the maximum dose or treatment duration from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with **ONE** of the following:
  - Paroxysmal Nocturnal Hemoglobinuria (PNH)
  - Proteinuria with Complement 3 Glomerulopathy (C3G)
  - Proteinuria with Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN)
- Beneficiary must be vaccinated against encapsulated bacteria, including *Streptococcus pneumoniae* and *Neisseria meningitidis* types A, C, W, Y, and B at least 2 weeks prior to initiation of EMPAVELI, and beneficiary must be provided antibiotics if vaccines were administered less than 2 weeks before starting therapy
- Prescriber and pharmacy must be enrolled in the REMS program
- This medication must be prescribed by or in consultation with the following:
  - For PNH patients—hematologist or oncologist
  - For C3G patients—nephrologist
  - For IC-MPGN—nephrologist
- Beneficiary with PNH
  - Beneficiary currently taking eculizumab (Soliris®) or ravulizumab (Ultomiris®) must follow the required dose initiation per the package insert
  - Beneficiary must be clinically symptomatic (e.g., fatigue, dyspnea, pain, thrombosis, etc.) and have abnormal labs (e.g., low hemoglobin (Hgb), high lactate dehydrogenase (LDH), etc.)
  - Beneficiary has baseline Hgb level < 10 g/dL with or without previous C5 inhibitors
  - Beneficiary must not be receiving Empaveli® in combination with other complement inhibitors used to treat PNH (i.e., Fabhalta®, Piasky®, Soliris®, Ultomiris®, Voydeya™)
  - Prescribers must submit the following
    - Current chart notes
    - Documented symptoms as a baseline
    - Previous therapies
    - Current labs including complete blood count (CBD), comprehensive metabolic panel, and lactate dehydrogenase
    - Recent history of blood transfusions
- Beneficiary with C3G
  - Beneficiary must have tried and failed mycophenolate and/or cyclophosphamide and oral glucocorticoids unless there is a contraindication for this specific patient
  - Beneficiary should have tried and failed an angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blocker (ARB) at maximally tolerated doses unless contraindicated
  - Prescribers must submit the following:
    - Current chart notes
    - Previous therapies (e.g., RAS inhibitors, corticosteroids, mycophenolate)
    - Documented symptoms
    - Current labs including LFTs, eGFR, lipid panel, and urine protein or UPCR
    - Confirmation of C3G diagnosis with renal biopsy results and labs (protein-to-creatinine ratio (UPCR) ≥ 1 g/g and eGFR ≥ 30 mL/min/1.73 m^2)
    - Medical necessity over immunosuppressants and glucocorticoids

- Beneficiary with IC-MPGN
    - Beneficiary should have tried and failed an angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blocker (ARB) at maximally tolerated doses unless contraindicated
    - Beneficiary must be treated with immunosuppressants if underlying cause is an autoimmune disorder, nephrotic syndrome with normal kidney function, and patients with active glomerulonephritis but no significant chronic changes
    - Prescribers must submit the following:
        - Current chart notes
        - Previous therapies (e.g., RAS inhibitors, immunosuppressants, steroids)
        - Documented symptoms
        - Current labs including LFTs, eGFR, lipid panel, and urine protein or UPCR
        - Confirmation of IC-MPGN diagnosis with renal biopsy results

RENEWAL REQUIREMENTS:

- Beneficiary is compliant on therapy (defined as 75% utilization)
- Beneficiary with PNH
    - Beneficiary has an improvement in hemoglobin and/or LDH levels compared to baseline
    - Beneficiary has an improvement in overall clinical presentation (e.g., fatigue, dyspnea, reduction in transfusions)
    - Prescribers must submit the following:
        - Current chart notes
        - Current labs including CBC, CMP, and LDH
- Beneficiary with C3G and IC-MPGN
    - Beneficiary has documented improvement of proteinuria with a reduction in UPCR or urine protein
    - Prescribers must submit the following:
        - Current chart notes
        - Current labs including LFTs, eGFR, lipid panel, and urine protein or UPCR

QUANTITY EDITS:

10 vials/ 30 days

C. WEGOVY (semaglutide) injection

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert
- Beneficiary is prescribed no more than the maximum dose or treatment duration from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis)
- Fibrosis staging documentation requires the following:
    - Liver biopsy results; **OR**
    - Fibrosis score results from **TWO** (2) testing modalities with at least **ONE** (1) blood-based non-invasive test (NITs) **AND** at least **ONE** (1) imaging test from the lists below:
        - NITs
            - Fibrosis-4 index (FIB-4)
            - AST to platelet ratio index (APRI)
            - NAFLD fibrosis score (NFS)

        - Enhanced liver fibrosis (ELF) or simplified ELF index
        - FibroSure®
      - Imaging tests
        - Vibration-controlled transient elastography (VCTE) (e.g., FibroScan®)
        - Two-dimensional shear weave elastography
        - Point shear wave elastography
        - Magnetic Resonance Elastography (MRE)
- Must be prescribed by on in consultation with an endocrinologist, gastroenterologist or hepatologist
- Beneficiary must be considered either overweight or obese (defined as baseline BMI of ≥ 27 kg/m^2)
- Beneficiary must receive standard of care treatment for cardiometabolic comorbidities and healthy lifestyle counseling with an appropriate diet and exercise plan
- Prescriber must rule out any other causes for fibrosis (e.g., alcohol, hepatitis C)
- Beneficiary must not have a personal or family history of medullary thyroid carcinoma (MTC) or should not be diagnosed with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)
- Beneficiary with Type 2 diabetes mellitus and MASH must utilize a GLP-1 agonist indicated for diabetes
- Prior authorization request should not be for weight loss only
- Prescriber must submit the following:
  - Current chart notes
  - Current labs including HbA1c and lipid panel
  - Fibrosis staging documentation as listed above and baseline non-alcoholic fatty liver disease (NAFLD) Activity Score (NAS) if biopsy was done
  - Current and previous therapy for MASH
  - Baseline BMI and weight
  - Documentation of past and current alcohol intake
  - Current treatment plan including medication therapy, reduced calorie diet, and physical activity plan along with attestation that beneficiary has been counseled on lifestyle modifications needed to assist with weight loss and metabolic syndrome
- Initial PA will be for 6 months to monitor for compliance. Renewal PAs may be for 12 months if approved.

RENEWAL REQUIREMENTS:

- Beneficiary has been compliant with therapy (defined as 75% utilization)
- Beneficiary must have a positive response defined as one of the following:
  - Reduction in steatohepatitis without worsening liver fibrosis; **OR**
  - At least one stage improvement in liver fibrosis without worsening steatohepatitis
- Prescriber must submit the following:
  - Current chart notes
  - Current BMI and weight
  - Current labs
  - Attestation that beneficiary continues with diet and exercise plan
  - Current non-alcoholic fatty liver disease (NAFLD) Activity Score (NAS) if new biopsy was done
  - Current fibrosis staging documentation requires the following:
    - Liver biopsy results; **OR**
    - Fibrosis score results from **TWO** (2) testing modalities with at least **ONE** (1) blood-based non-invasive test (NITs) **AND** at least **ONE** (1) imaging test from the lists below:

- NITs
  - Fibrosis-4 index (FIB-4)
  - AST to platelet ratio index (APRI)
  - NAFLD fibrosis score (NFS)
  - Enhanced liver fibrosis (ELF) or simplified ELF index
  - FibroSure®
- Imaging tests
  - Vibration-controlled transient elastography (VCTE) (e.g., FibroScan®)
  - Two-dimensional shear weave elastography
  - Point shear wave elastography
  - Magnetic Resonance Elastography (MRE)

QUANTITY EDITS:

- Each strength: 4 injections/ month

D. REZDIFFRA (resmetirom) tablet

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert
- Beneficiary is prescribed no more than the maximum dose or treatment duration from the manufacturer's package insert or based on support from the official Compendia
- Must be prescribed by on in consultation with an endocrinologist, gastroenterologist or hepatologist
- Beneficiary must be diagnosed with metabolic-associated steatohepatitis (MASH) [formerly known as noncirrhotic nonalcoholic steatohepatitis (NASH)] with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) **OR** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- Fibrosis staging documentation requires the following:
  - Liver biopsy results; **OR**
  - Fibrosis score results from **TWO** (2) testing modalities with at least **ONE** (1) blood-based non-invasive test (NITs) **AND** at least **ONE** (1) imaging test from the lists below:
    - NITs
      - Fibrosis-4 index (FIB-4)
      - AST to platelet ratio index (APRI)
      - NAFLD fibrosis score (NFS)
      - Enhanced liver fibrosis (ELF) or simplified ELF index
      - FibroSure®
    - Imaging tests
      - Vibration-controlled transient elastography (VCTE) (e.g., FibroScan®)
      - Two-dimensional shear weave elastography
      - Point shear wave elastography
      - Magnetic Resonance Elastography (MRE)
- Beneficiary must use this medication in conjunction with appropriate diet and exercise
- Prescriber must rule out any other cause for fibrosis (e.g., alcohol, hepatitis C)
- Beneficiary should not be prescribed concomitant use with a strong CYP2C8 inhibitor (e.g., gemfibrozil) **OR** moderate CYP2C8 inhibitor (e.g., clopidogrel) without a REZDIFFRA dose adjustment
- Beneficiary must not have severe renal impairment or decompensated cirrhosis

- Prescriber must submit the following:
    - Current chart notes
    - Fibrosis staging documentation as listed above and baseline non-alcoholic fatty liver disease (NAFLD) Activity Score (NAS) if biopsy was done
    - Current treatment plan including medication therapy, reduced calorie diet, and physical activity plan along with attestation that beneficiary has been counseled on lifestyle modifications needed
    - Current labs including comprehensive metabolic panel
    - Documentation of past and current alcohol intake
    - Attestation that metabolic comorbidities are being appropriately managed, including treatment of Type 2 diabetes, dyslipidemia, and hypertension if applicable
    - Medical necessity over the use of a GLP-1 agonist if patient has type 2 diabetes
    - Current weight for dose verification
        - < 100 kg, the recommended dosage is 80 mg orally once daily.
        - ≥ 100 kg, the recommended dosage is 100 mg orally once daily.
- Initial PA will be for 6 months to monitor for compliance. Renewal PAs may be for 12 months if approved.

RENEWAL REQUIREMENTS:

- Beneficiary must remain compliant on therapy (defined as 75% utilization)
- To continue the medication after 12 months of therapy, the beneficiary should demonstrate a positive response to the medication as defined by:
    - Reduction in steatohepatitis without worsening liver fibrosis; **OR**
    - At least one stage improvement in liver fibrosis without worsening steatohepatitis
- Beneficiary must continue to refrain from excessive alcohol use
- Prescriber must submit the following:
    - Current chart notes
    - Current weight
    - Current labs
    - Attestation that patient continues with diet and exercise plan
    - Current non-alcoholic fatty liver disease (NAFLD) Activity Score (NAS) if new biopsy was done
    - Current fibrosis staging documentation requires the following:
        - Liver biopsy results; **OR**
        - Fibrosis score results from **TWO** (2) testing modalities with at least **ONE** (1) blood-based non-invasive test (NITs) **AND** at least **ONE** (1) imaging test from the lists below:
            - NITs
                - Fibrosis-4 index (FIB-4)
                - AST to platelet ratio index (APRI)
                - NAFLD fibrosis score (NFS)
                - Enhanced liver fibrosis (ELF) or simplified ELF index
                - FibroSure®
            - Imaging results
                - Vibration-controlled transient elastography (VCTE) (e.g., FibroScan®)
                - Two-dimensional shear weave elastography
                - Point shear wave elastography
                - Magnetic Resonance Elastography (MRE)

QUANTITY EDITS:

- Each strength: #31/31 days

E. SEPHIENCE (sepiapterin) oral powder

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with sepiapterin-responsive phenylketonuria (PKU) with elevated blood phenylalanine (Phe) levels despite a Phe-restricted diet
- Must be prescribed by, or in consultation with, an endocrinologist, geneticist, or other specialist knowledgeable in treating PKU
- Beneficiary must use a Phe-restricted diet during treatment
- Beneficiary must meet **ONE** of the following:
    - Tried and had an inadequate response to sapropterin despite compliance on therapy (i.e., considered a non-responder); **OR**
    - Had intolerance or hypersensitivity to sapropterin that is not expected with Sephience™; **OR**
    - Medical necessity over the use of sapropterin is supported in literature (provide supporting literature)
- Beneficiary may not use concomitantly with other medications used to treat PKU (e.g., sapropterin [Kuvan®, Javygtor™] or pegvaliase-pqpz [Palynziq®])
- Beneficiary should not exceed a maximum dose of 60 mg/kg/day
- Prescriber must submit the following:
    - Current chart notes
    - Previous therapies tried with response
    - Current blood phenylalanine (Phe) level drawn within 30 days of prior authorization request
    - Attestation that the beneficiary has been ordered a Phe-restricted diet
- Initial approvals will be for 90 days. After 90 days, the prescriber must verify that the beneficiary responded to treatment as defined as ≥30% decrease in blood phenylalanine levels from baseline.

RENEWAL REQUIREMENTS:

- Beneficiary has been compliant with therapy (defined as: 75% utilization)
- Beneficiary has documented improvement with a decrease in PHE level by at least 30% compared to baseline without intolerable side effects
- Prescriber must submit the following:
    - Current chart notes
    - Current blood phenylalanine (Phe) level
    - Attestation that beneficiary remains on a Phe-restricted diet

QUANTITY EDITS:

- 250 mg: #93/31 days
- 1000 mg: #186/31 days

F. HARLIKU (nitisinone) tablet

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert
- Beneficiary is prescribed no more than the maximum dose or treatment duration from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with alkaptonuria and have increased urine homogentisic acid (HGA) excretion (>0.4 g/24h)
- Prescriber must submit the following:
  - Current chart notes
  - Current labs including CBC to check for leukopenia and thrombocytopenia
  - Baseline urine HGA level
  - Baseline patient specific symptoms
- Initial approvals will be for 90 days

RENEWAL REQUIREMENTS:

- Beneficiary has been compliant with therapy (defined as: 75% utilization)
- Beneficiary has documented improvement with a decrease in urine homogentisic acid (HGA) excretion compared to baseline
- Beneficiary who develops keratopathies during treatment will need plasma tyrosine levels monitored and implement a diet restricted in tyrosine and phenylalanine
- Prescriber must submit the following:
  - Current chart notes
  - Current labs including CBC to check for leukopenia and thrombocytopenia
  - Documentation if beneficiary has keratopathy development; and plasma tyrosine levels if patient does develop keratopathies (Goal is to get tyrosine level <500 micromol/L)
  - Current patient specific symptoms

QUANTITY EDITS:

- #31 tablets/31 days

G. EKTERLY (sebetralstat) tablet

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with hereditary angioedema (HAE) Type 1 or Type 2 due to C1-esterase inhibitor (C1-INH) deficiency with diagnosis confirmed by a mutation in the C1-INH gene. HAE with normal C1-INH (HAE Type III) will be reviewed on a case-by-case basis. Type 1 and Type 2 HAE are defined as followed:
  - Type 1 HAE: Decreased quantities of C4 level, C1-INH protein level and C1-INH function level; **OR**
  - Type 2 HAE: Decreased quantities of C4 level **AND** decreased C1-INH function (C1-INH protein level may be normal or elevated)
- Beneficiary must have ≥ 1 severe or life-threatening laryngeal attack or had 2-3 moderate attacks causing extremity, facial or abdominal swelling in the last year

- Beneficiary must NOT be on an ACEi, estrogens, any other medication determined to precipitate an angioedema attack
- Must be prescribed by or in consultation with an allergist, immunologist, or hematologist
- Prescriber must submit the following:
    - Current chart notes with documentation of exacerbations over the last 12 months including ER discharge summaries with history of angioedema attack severity, location, frequency, treatment and duration of attack after treatment
    - Previous therapies tried (i.e., HAE meds, antihistamines, glucocorticoids, epinephrine)
    - Proposed treatment plan for both acute and prophylaxis treatment
    - Documentation of expected angioedema triggers and plan for avoidance
    - Provide the following labs:
        - Complement C1 esterase inhibitor level
        - Complement C4 level
        - Functional C1 inhibitor activity

RENEWAL REQUIREMENTS:

- Beneficiary must have a positive response when taken for acute exacerbation
- Prescriber must submit the following:
    - Current chart notes with documentation of response to acute medication
    - Pharmacy records will be reviewed for utilization

QUANTITY EDITS:

4 tablets (2 doses)/ claim

H. ANDEMBRY (garadacimab) injection and DAWNZERA (donidalorsen) injection

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with hereditary angioedema (HAE) Type 1 or Type 2 due to C1-esterase inhibitor (C1-INH) deficiency with diagnosis confirmed by a mutation in the C1-INH gene. HAE with normal C1-INH (HAE Type III) will be reviewed on a case-by-case basis. Type 1 and Type 2 HAE are defined as followed:
    - Type 1 HAE: Decreased quantities of C4 level, C1-INH protein level and C1-INH function level; **OR**
    - Type 2 HAE: Decreased quantities of C4 level **AND** decreased C1-INH function (C1-INH protein level may be normal or elevated)
- Beneficiary must have ≥ 1 severe or life-threatening laryngeal attack per month or ≥ 4 moderate attacks causing extremity, facial or abdominal swelling despite treatment with medications for acute attacks
- Beneficiary must NOT be on an ACEi, estrogens, any other medication determined to precipitate an angioedema attack
- This medication must be used for prophylaxis only
- Prescriber must submit the following:
    - Current chart notes with documentation of exacerbations over the last 12 months including ER discharge summaries with history of angioedema attack severity, location, frequency, treatment and duration of attack after treatment
    - Previous therapies tried (i.e., HAE meds, antihistamines, glucocorticoids, epinephrine)
    - Proposed treatment plan for both acute and prophylaxis treatment

    - Documentation of expected angioedema triggers and plan for avoidance
    - Provide the following labs:
        - Complement C1 esterase inhibitor level
        - Complement C4 level
        - Functional C1 inhibitor activity
    - IF beneficiary has tried and had an insufficient response or contraindication to BOTH of the following classes of medication, provide that documentation.
        - 17α-alkylated androgens (e.g., danazol, stanozolol, oxandrolone, methyltestosterone)
        - Antifibrinolytic agents (e.g., ε-aminocaproic acid, tranexamic acid)
- Initial PA will be for 3 months with response to therapy required on renewal

RENEWAL REQUIREMENTS:

- Beneficiary must be compliant on therapy (defined as 75% utilization)
- Beneficiary must have a positive response with decrease in acute exacerbations
- Prescriber must submit the following:
    - Current chart notes with documentation of response to therapy
    - Pharmacy records will be reviewed for utilization

QUANTITY EDITS:

- Andembry #1/30 days
- Dawnzera #1/28 days

I. ANZUPGO (delgocitinib) cream

APPROVAL CRITERIA:

- Beneficiary must be ≥ 18 years of age
- Beneficiary should have moderate to severe chronic hand eczema (CHE) defined by an Investigator's Global Assessment (IGA) score of 3-4 out of a 0-4 scale **OR** Investigator's Global Assessment of Chronic Hand Eczema (IGA-CHE) score of 3-4 out of a 0-4 scale
- Beneficiary must have uncontrolled moderate to severe chronic hand eczema (CHE) with recent claims for topical corticosteroids and topical calcineurin inhibitors (TCI) and/or phosphodiesterase 4 (PDE4) inhibitors
    - Trials of at least **TWO** different topical corticosteroid entities over a minimum of 60 days use with at least **ONE** topical corticosteroid being "high" potency (Class-2) or super potent (Class-1)
    - At least one trial of a TCI (i.e., tacrolimus, pimecrolimus) **OR** PDE4 inhibitor (i.e., crisaborole) over a minimum of 30 days
- Prescriber must submit the following:
    - Current chart notes
    - Documentation of previous therapies
    - Current Investigator's Global Assessment (IGA) score **OR** Investigator's Global Assessment of Chronic Hand Eczema (IGA-CHE)
- If approved, PA will be approved for 2 months

RENEWAL REQUIREMENTS:

- Beneficiary must have documented improvement in symptoms (i.e., reduced IGA or IGA-CHE score)
- Prescriber must submit the following
    - Current chart notes

- Current Investigator's Global Assessment (IGA) score **OR** Investigator's Global Assessment of Chronic Hand Eczema (IGA-CHE) score

QUANTITY EDITS:
2 tubes (60 gm)/ 30 days

J. EGRIFTA WR and EGRIFTA SV (tesamorelin) vial

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with human immunodeficiency virus (HIV) infection and have lipodystrophy with abdominal visceral adipose tissue (VAT) defined as:
  - Males: Waist circumference of at least 95 cm (37.4 in) and waist-to-hip ratio of at least 0.94; Females: Waist circumference of at least 94 cm (37 in) and waist-to-hip ratio of at least 0.88; **OR**
  - Documentation by computed tomography (CT) scan with abdominal visceral adipose tissue
- Beneficiary must be compliant with antiretroviral therapy with 75% utilization as demonstrated by pharmacy records
- Must be prescribed by or in consultation with an infectious disease specialist or endocrinologist
- Beneficiary should not be pregnant or have active malignancy, diabetes, or hypopituitarism
- Prescriber must submit the following:
  - Current chart notes and description of physical exam documenting areas of fat loss and deposition
  - Previous therapies including antiretroviral therapy
  - Medical necessity over changing therapy to a different antiretroviral medication
  - Current labs including lipids and HbA1c
  - Provide a letter of medical necessity for the rationale for use
  - Baseline waist circumference and/or waist-to-hip ratio
  - Pregnancy status if female of child-bearing potential
- Initial PA is 6 months

RENEWAL REQUIREMENTS:

- Beneficiary has been compliant with therapy (defined as: 75% utilization)
- Beneficiary has documented improvement demonstrated by a decrease in visceral adipose tissue (VAT) with a decrease in waist circumference compared to baseline or decrease in VAT as documented in a computed tomography (CT) scan
- Beneficiary should be monitored for increase in IGF-1 or HbA1c with renewal denied if evidence of diabetes or glucose intolerance develops
- Prescriber must submit the following:
  - Current chart notes
  - Current labs including lipids and HbA1c
  - Current waist circumference and waist-to-hip ratio
  - Pregnancy status if female of child-bearing potential

QUANTITY EDITS:

- EGRIFTA WR—4 vials (1 pack) per 28 days
- EGRIFTA SV—30 vials for 30 days

K. BRINSUPRI (brensocatib) tablet

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with non-cystic fibrosis bronchiectasis confirmed by computed tomography (CT) scan and clinical history consistent with bronchiectasis with at least 2 of the following in the last 12 months
  - Cough
  - Chronic sputum production
  - Recurrent respiratory infections
- Beneficiary age 18 years of age and older must have ≥2 exacerbations requiring antibiotic treatment in the last 12 months; beneficiary age 12-17 years must have ≥1 exacerbation requiring antibiotic treatment in the last 12 months
- Must be prescribed by or in consultation with a pulmonologist
- Prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - CT scan report confirming diagnosis
  - Patient specific symptoms associated with bronchiectasis including documentation of exacerbations
  - Current pulmonary function tests
- Initial PA for 3 months

RENEWAL REQUIREMENTS:

- Beneficiary has been compliant with therapy (defined as: 75% utilization)
- Beneficiary has documented improvement demonstrated by at least **ONE** of the following:
  - Improvement in patient specific symptoms compared to baseline
  - Reduction in frequency, severity or duration of exacerbations compared to baseline
  - Improvement or stabilization of FEV_1 compared to baseline
- Prescriber must submit the following:
  - Current chart notes
  - Documentation of current patient specific symptoms
  - Current pulmonary function tests

QUANTITY EDITS:

#30/ 30 days

L. ZELSUVMI (berdazimer) gel

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with molluscum contagiosum (MC)
- Prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Medical necessity over cryotherapy and Condylox®

QUANTITY EDITS: 3 tubes per year

III. FRIENDLY REMINDERS

1. Any questions concerning various Medicaid topics (e.g., Medicaid enrollment, prescription coverage, provider manuals, and billing policies) may be researched using one of the following links.
   - **https://humanservices.arkansas.gov/divisions-shared-services/medical-services**
   - **https://humanservices.arkansas.gov/**
   - **https://ar.primetherapeutics.com/**

   Any questions about prescription drugs or drug claims for PASSE members must be directed to the specific PASSE organization taking care of that member. For more information about PASSE, please refer to the website: **https://humanservices.arkansas.gov/about-dhs/dms/passe/**

2. **For vaccine billing and updates, visit the Welcome to Arkansas webpage.**
   https://humanservices.arkansas.gov/
   https://humanservices.arkansas.gov/covid-19/dhs-response-to-covid-19/updates-for-providers/
   For adult vaccines (ages 19 and above), the following HCPCS and CPT codes are to be used in conjunction with the vaccine being administered:
   G0008 – Influenza immunization
   90471 – First vaccine administered
   90472 – Subsequent vaccines administered
   The injection administration code, **T1502,** will continue to be payable for beneficiaries of all ages. **T1502** may be used for billing the administration of subcutaneous and/or intramuscular injections only. If you have questions regarding this notice, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and out-of-state at (501) 376-2211. Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rulemaking, and remittance advice (RA) messages are available for download from the Arkansas Medicaid website:
   https://humanservices.arkansas.gov/divisions-shared-services/medical-services/
   If assistance is needed with a Medicaid vaccine or immunization billing issue, the MMIS outreach specialists are available to help. Please refer to this website to find the outreach/provider rep for your pharmacy: **https://medicaid.afmc.org/services/arkansas-medicaid-management-information-system**

3. **INCARCERATED PERSONS:**
   The Medicaid Pharmacy Program is prohibited by federal regulations, 42 C.F.R. §435.1009 and §435.1010, from paying for drug claims for Medicaid beneficiaries who, on the date the prescription is filled, is incarcerated in a correctional or holding facility, including juvenile correctional facilities, and are detained pending disposition of charges or are held under court order as material witnesses. If medications are requested for incarcerated Medicaid beneficiaries, including beneficiaries in a juvenile correctional facility, **the medications cannot be billed to Medicaid Pharmacy Program and are subject to recoupment if billed to Medicaid**. Pharmacists should contact the correctional facility regarding the facility's reimbursement procedures for the requested medications.

4. **REGARDING MANUAL REVIEW PA REQUESTS:**
   Prior authorization (PA) requests for drugs that require a clinical manual review prior approval, require a prior authorization request for a drug as an exception to established point of sale prior approval criteria algorithm, or require a request for non-preferred drugs on the PDL, are all reviewed on a case-by-case basis through a manual review process. All manual review requests for prior authorization require, at a minimum, the prescriber to provide a letter explaining the medical necessity for the requested drug along with all written documentation to substantiate the medical necessity (e.g., chart notes, pharmacy printouts for cash, printout of private insurance paid drugs, lab results, etc.). **Please note that starting the requested drug, including long-acting injectable antipsychotic agents, through either inpatient use, the use of office "samples", or by any other means, prior to a prior authorization request being reviewed and approved by the Medicaid Pharmacy Program does not necessitate Medicaid Pharmacy Program approval of the requested drug.**

5. **REGARDING EMERGENCY OVERRIDE**:
   In an emergency, for those drugs for which a five-day supply can be dispensed, an Arkansas Medicaid enrolled pharmacy provider may dispense up to a five-day supply of a drug that requires prior authorization

(e.g., a drug that requires a clinical PA or requires a PA for a non-preferred drug). **This provision applies only in an emergency when the Prime Therapeutics Help Desk and the State Medicaid Pharmacy Program offices are closed, and the pharmacist is not able to contact the prescribing provider to change the prescription.** The Emergency Supply Policy does not apply to drugs that are not covered by the State. Frequency of the emergency override is limited to once per year per drug class for non-LTC beneficiaries and once per 60 days per drug class for LTC beneficiaries.

To submit a claim using this emergency provision, the pharmacy provider must submit "03" in the Level of Service (418-DI) field. For any Schedule-II controlled substance filled using the Medicaid Emergency Override process, please refer to the Arkansas State Board of Pharmacy regulations regarding partial fill of a Schedule-II controlled substance. See information posted on the Medicaid Pharmacy Program website, **https://ar.primetherapeutics.com/provider-documents**

6. **HARD EDIT ON EARLY REFILL:**

Non-controlled drugs:
The hard edit disallowing early refills (ER) for non-controlled drugs sooner than 75% of days' supply expended was implemented on February 16, 2016. Pharmacies will no longer be able to override the ProDUR early refill edit to refill non-controlled drugs sooner than 75% of the days' supply has elapsed. Refills for non-controlled drugs sooner than 75% of the days' supply elapsed will require a manual review PA, and the pharmacy or prescriber must provide documentation to Medicaid that the dose was increased during the month which caused the prescription to run out sooner than expected/calculated. The increased dose must be within the allowed Medicaid dose edits, or an approved PA must be in the system for the beneficiary for the higher dose or an early refill PA will not be approved.

Controlled drugs:
The hard edit disallowing early refills (ER) for controlled drugs sooner than 90% of days' supply expended was implemented January 20, 2021. This change includes opioids, CII stimulants, benzodiazepines, sedative hypnotics, etc.

7. **REFILL TOO SOON ACCUMULATION LOGIC:**
When a pharmacy refills a prescription claim early, the Medicaid system began adding together the accumulated "early days" filled. Each prescription is tracked by the Generic Sequence Number (GSN), which means the drug claim is the same generic name, same strength, and same dosage form, rather than tracking by prescription number or NDC.

Non-controlled drugs:
Once the beneficiary has accumulated an ***extra*** 12 days' supply for that GSN for non-controlled drugs, any incoming claim that is early will reject at point of sale. The accumulation edit is set so that the beneficiary cannot accumulate more than an ***extra*** 12 days' supply early during a 180-day period for non-controlled drugs.

Controlled drugs:
The RTS logic with Early Refill Accumulation Limit edit for controlled drugs will only allow an ***extra*** 7-days' supply accumulation through early fills in previous 180-day period.

8. **REVERSE AND CREDIT MEDICAID PRESCRIPTIONS NOT PROVIDED TO BENEFICIARY:**
Pharmacies are required to reverse and credit back to Medicaid original prescriptions and refills if the medication was not provided to the beneficiary. Pharmacies should reverse and credit Medicaid within 14 days of the date of service for any prescription that was not provided to the beneficiary. See the Provider Manual Update Transmittal or the Pharmacy Provider Manual Section 213.200.

9. **ANTIPSYCHOTIC AGENT CRITERIA FOR CHILDREN:**

< 18 YEARS OF AGE:

Each new start of any antipsychotic agent for children < 18 years of age require a completed/signed informed consent form, current metabolic labs, and documentation of medical necessity with chart notes. Beneficiaries have an ongoing requirement for labs for metabolic monitoring every 6 months. When sending for the required metabolic labs, the provider must include the PCP's name and Medicaid ID number on the lab order request form. It does not have to be the PCP ordering the labs. Please refer to the Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual, Section II, 245.000 B.

For those providers who have not had their own version of the Informed Consent form approved for use with Medicaid PA requests and who use the Medicaid Informed Consent form for antipsychotic agents, the form may be found at the following link. **https://ar.primetherapeutics.com/provider-documents**

< 10 YEARS OF AGE:
Medicaid currently requires a manual review PA of any antipsychotic agent prescribed for children less than 10 years of age (i.e., age 9 years and under) for all new starts on an antipsychotic agent, including a change in the chemical entity for children currently on an antipsychotic agent. All documentation, chart notes, signed informed consent, and required lab work must be submitted, and the manual review will be performed by the Medicaid Pharmacy Program psychiatrist.

10. **THE AR MEDICAID PHARMACY PROGRAM REIMBURSES ENROLLED PHARMACY PROVIDERS FOR COVERED OUTPATIENT DRUGS FOR MEDICAID BENEFICIARIES WITH PRESCRIPTION DRUG BENEFITS:** Only medications prescribed to that beneficiary can be billed using the beneficiary's Medicaid ID. If medications are needed to treat remaining family members, each prescription must be billed according to each family member's Medicaid ID number. Sanctions may be imposed against a provider for engaging in conduct that defrauds or abuses the Medicaid program. This could include billing a child's medication to a parent's Medicaid ID number and vice versa.

11. **ANY REIMBURSEMENT RATES STATED IN THIS MEMORANDUM (OR ANY PREVIOUS MEMORANDUMS) ARE FOR REFERENCE PURPOSES ONLY AND SUBJECT TO CHANGE:**
AR Medicaid Pharmacy Program reimbursement methodology changed based on the requirements in the Affordable Care Act (ACA) and requirements of §447.502 of the final regulation and based on the CMS imposed final implementation date of April 1, 2017. The pricing methodology is lesser of methodology that applies to all brand or generic drugs for usual and customary charge, or NADAC, or ACA FUL, or SAAC. If the NADAC is not available, the allowed ingredient cost shall be WAC + 0%, SAAC, or ACA FUL. The Professional Dispensing Fee has been increased to $9 for Brand Drugs and $10.50 for Preferred Brand Drugs and all Generics. Reimbursement rates stated in this memo are in no way a contractual obligation by Arkansas Medicaid. NADAC pricing is subject to change and any pricing stated is only current as of the date this memo was drafted. Current Generic Upper Limits (GUL) or Maximum Allowable Cost (MAC) that have been issued at the State and or Federal level, along with State issued Capped Upper Limits (CAP), can be found on the Arkansas Medicaid website: **https://ar.primetherapeutics.com/provider-documents** A coversheet for the NADAC Help Desk Request for Medicaid Reimbursement Review form can be found on the Arkansas Medicaid website:**https://ar.primetherapeutics.com/provider-documents**

12. **OPIOID INFORMATION:**
To provide educational materials to prescribers and pharmacists on opioid dosing, opioid use disorder, medication assisted treatment and polypharmacy, an opioid information tab has been added to the Prime Therapeutics State Government Solutions website. **https://ar.primetherapeutics.com/provider-documents**

13. HEPATITIS C TREATMENT INFORMATION:

Educational information on treating Hepatitis C along with treatment consultations may be obtained through the Clinician Consultation Center.

1) Link for the Clinician Consultation Center—
   http://www.hepcap.org/hepatitis-c-consultation-warmline/
2) Hepatitis C Warmline for phone consultation—(844) HEP-INFO or (844) 437-4636

The clinical consultation staff may give advice on any of the following topics:

- HCV staging & monitoring
- Regimen selection & dosing
- Drug interactions
- HIV/HCV management strategies
- Prior HCV treatment failure, including management of complex clinical problems such as cirrhosis and renal disease
- HCV transmission & prevention
- HCV screening & diagnostic testing
- HCV in special populations (pregnancy, co-occurring substance use and/or alcohol use disorders, psychiatric disorders, post-transplant, ESRD/dialysis, pediatrics)

The Clinician Consultation Center is not affiliated with Arkansas Medicaid, but the information may be useful for providers in our state and provided only as an educational tool.

This advance notice provides you with the opportunity to contact, counsel, and change patients' prescriptions. If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

If you have questions regarding this transmittal, or you need this material in an alternative format such as large print, please contact the Prime Therapeutics State Government Solutions Help Desk at 1-800-424-7895. For copies of past Remittance Advices (RA) or Arkansas Medicaid Provider Manuals (including update transmittals), please contact the Gainwell Technologies Provider Assistance Center (PAC) at 1-800-457-4454 (Toll-Free) within Arkansas or locally and out-of-state at 1-501-376-2211.