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: February 23, 2022

SUBJ: **AR Medicaid Prior Authorization Edits approved at the AR Medicaid DUR Board January 19, 2022 meeting for the following:**
Manual review criteria for: Palforzia® (peanut powder), Kerendia® (finerenone), Tavneos™ (avacopan), Exkivity™ (mobocertinib), Opzelura™ (ruxolitinib), Scemblix® (asciminib), Vuity™ (pilocarpine hydrochloride), Voxzogo™ (vosoritide), and Carbaglu® (carglumic acid)

Point-of-Sale edits for: Seroquel® **(**Quetiapine) and rescue seizure medications (Nayzilam®, Valtoco® and Diastat®)

Preferred Drug List (PDL) therapeutic classes: (February 9, 2022 Drug Review Committee meeting)
Anticonvulsants and immune globulins

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I. ANNOUNCEMENTS

A. POLYPHARMACY EDITS

Effective April 18, 2022, concomitant fills for any of the following will prompt a severity level 3 drug to drug interaction message at point-of-sale requiring the pharmacy to override the DUR rejection with approved DUR codes.

- Opioid and antipsychotics
- Opioid and gabapentin
- Opioid and muscle relaxers
- Opioid and sedative hypnotics

PA restrictions will remain in place.

The following codes can be used to override the DUE rejection.
Response for Service Code: Drug-Drug (DD)
Professional Service Code: M0, P0, or R0
Result of Service: 1A, 1B, 1C, 1D, 1E, 1F, 1G, 2A, or 2B

B. COVID-19 VACCINATION UPDATES

***Review the Department of Human Services COVID response page for updates to any new billing guidance. Updates for Providers - Arkansas Department of Human Services**

C. MEDICAID SLOT UPDATE

Act 758 is scheduled to go into effect Jan. 1, 2022. All adult Medicaid clients age 21 and older who are in the fee-for-service Medicaid program will be able to get up to six (6) prescriptions paid for by Medicaid, with five (5) classes of medication that will not count toward that limit. Extension of benefits will no longer be needed. The previous exceptions that do not count towards the limit still apply, which are birth control pills, contraceptives, medications used to treat opioid use disorder, and smoking cessation products. The new medication types that do not count toward the limit of six (6) are:

- High blood pressure agents
- High cholesterol agents
- Bleeding disorder agents
- Diabetes drugs
- Inhalers for breathing disorders

The previous prescription limit of five (5) times filled or not allowed to be filled beyond six (6) months after the date of the original issue is also no longer in effect. All prescription refill allowances will be in accordance with State and Federal guidelines.

EFFECTIVE APRIL 1, 2022:

II. PREFERRED DRUG LIST (PDL):

1. ANTICONVULSANTS (new PDL class)

NOTE: Patients compliant on a non-preferred agent will be able to continue that medication without a PA if there is a claim in their Medicaid profile in the previous 60 days.

Many anticonvulsants have criteria established. See the notations below for clarification. Anticonvulsants have quantity limits as well based on the manufacturer's package inserts and support in MicroMedex.

***Point-of-sale criteria**
****Follows NPO rules (**either <7 years of age **OR** NPO within the past 365 days**)**
*****Manual review criteria**

PREFERRED AGENTS

- Carbamazepine chew tablet (generic for Tegretol®) **
- Carbamazepine tablet (generic for Tegretol®)
- Clobazam suspension (generic for Onfi®) **
- Clobazam tablet (generic for Onfi®)
- Diastat Acudial® (diazepam) **BRAND ONLY***
- Diastat® Rectal Gel (diazepam) **BRAND ONLY***
- Divalproex DR tablet (generic for Depakote DR®)
- Divalproex ER tablet (generic for Depakote ER®)
- Ethosuximide capsule (generic for Zarontin®)
- Gabapentin capsule/tablet (generic for Neurontin®)
- Lamictal® tablet (lamotrigine) **BRAND ONLY**
- Levetiracetam solution (generic for Keppra®) **
- Levetiracetam tablet (generic for Keppra®)
- Nayzilam® nasal spray (midazolam) *
- Oxcarbazepine tablet (generic for Trileptal®)
- Phenytoin capsule (generic for Dilantin®)
- Pregabalin capsule (generic for Lyrica®)
- Primidone tablet (generic for Mysoline®)
- Qudexy XR® capsule (topiramate)
- Sabril® Powder Packet (vigabatrin) **BRAND ONLY**
- Sabril® tablet (vigabatrin) **BRAND ONLY**
- Tegretol® suspension (carbamazepine) **BRAND ONLY****
- Topiramate tablet (generic for Topamax®)
- Trileptal® suspension (oxcarbazepine) **BRAND ONLY****
- Valproic Acid capsule (generic for Depakene®)
- Valproic acid solution (generic for Depakene®) **
- Valtoco® nasal spray (diazepam) *
- Zonisamide capsule (generic for Zonegran®)

NON-PREFERRED AGENTS

- Aptiom® (eslicarbazepine acetate)
- Banzel® suspension (rufinamide)
- Banzel® tablet (rufinamide)
- Briviact® solution (brivaracetam)
- Briviact® tablet (brivaracetam)
- Carbamazepine ER capsule (generic for Carbatrol®)
- Carbamazepine ER tablet (generic for Tegretol XR®)
- Carbamazepine suspension (generic for Tegretol®)
- Carbatrol ER® capsule (carbamazepine)
- Celontin® capsule (methsuximide)
- Depakote DR® tablet (divalproex)
- Depakote ER® tablet (divalproex)
- Depakote® sprinkle capsule (divalproex)
- Diacomit® capsule (stiripentol)
- Diacomit® powder packet (stiripentol)
- Diazepam rectal device (generic for Diastat Acudial®)
- Diazepam rectal gel (generic for Diastat®)
- Dilantin® capsule (phenytoin)
- Dilantin® Infatab tablet (phenytoin)
- Dilantin® suspension (phenytoin)
- Divalproex sprinkle capsule (generic for Depakote®)
- Elepsia XR® tablet (levetiracetam)
- Epidiolex® solution (cannabidiol)***
- Eprontia® solution (topiramate)
- Equetro® capsule (carbamazepine)
- Ethosuximide solution (generic for Zarontin®)
- Felbamate suspension (generic for Felbatol®)
- Felbamate tablet (generic for Felbatol®)
- Felbatol® suspension (felbamate)
- Felbatol® tablet (felbamate)
- Fintepla® solution (fenfluramine)***
- Fycompa® suspension (perampanel)
- Fycompa® tablet (perampanel)
- Gabitril® tablet (tiagabine)
- Keppra® solution (levetiracetam)
- Keppra® tablet (levetiracetam)
- Keppra XR® tablet (levetiracetam)
- Lamictal® dispersible tablet (lamotrigine)
- Lamictal® dose pack (lamotrigine)
- Lamictal® ODT dose pack (lamotrigine)
- Lamictal® ODT tablet (lamotrigine)
- Lamictal® XR tablet (lamotrigine ER)
- Lamictal® XR dose pack (lamotrigine)
- Lamotrigine dispersible tablet (generic for Lamictal®)
- Lamotrigine dose pack (generic for Lamictal®)
- Lamotrigine ER tablet (generic for Lamictal XR®)

- Lamotrigine ODT dose pack (generic for Lamictal®)
- Lamotrigine ODT tablet (generic for Lamictal®)
- Lamotrigine tablet (generic for Lamictal®)
- Levetiracetam ER tablet (generic for Keppra XR®)
- Mysoline® tablet (primidone)
- Onfi® suspension (clobazam)
- Onfi® tablet (clobazam)
- Oxcarbazepine suspension (generic for Trileptal®)
- Oxtellar XR® tablet (oxcarbazepine)
- Phenobarbital elixir
- Phenobarbital tablet
- Phenytek® capsule (phenytoin ER)
- Phenytoin chew tablet (generic for Dilantin Infatab®)
- Phenytoin ER capsule (generic for Phenytek®)
- Phenytoin suspension (generic for Dilantin®)
- Rufinamide suspension (generic for Banzel®)
- Rufinamide tablet (generic for Banzel®)
- Spritam® tablet (levetiracetam)
- Sympazan® film (clobazam)***
- Tegretol® tablet (carbamazepine)
- Tegretol XR® tablet (carbamazepine ER)
- Tiagabine tablet (generic for Gabitril®)
- Topamax® sprinkle (topiramate)
- Topamax® tablet (topiramate)
- Topiramate ER capsule (generic for Qudexy®)
- Topiramate sprinkle (generic for Topamax® sprinkle)
- Trileptal® tablet (oxcarbazepine)
- Trokendi XR® capsule (topiramate)
- Vigabatrin powder pack (generic for Sabril®)
- Vigabatrin tablet (generic for Sabril®)
- Vimpat® solution (lacosamide)
- Vimpat® tablet (lacosamide)
- Vimpat® tablet dose pack (lacosamide)
- Xcopri® tablet (cenobamate)
- Xcopri® titration pack (cenobamate)
- Zarontin® capsule (ethosuximide)
- Zarontin® solution (ethosuximide)

EFFECTIVE APRIL 15, 2022

2. IMMUNE GLOBULINS (new PDL class)

NOTE: Placement of the immune globulins on the PDL only impacts pharmacy claims. Medical claims may have different preferred medications and/or criteria. Patients compliant on a non-preferred agent will be able to continue that medication without a PA if there is a claim in their Medicaid profile in the previous 45 days.

PREFERRED AGENTS

- Gammagard® Liquid vial
- Gamunex-C® vial
- Hizentra® vial **(NOT SYRINGE)**

NON-PREFERRED AGENTS

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

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

1. PALFORZIA® (peanut powder)

PALFORZIA is a type of oral immunotherapy that is approved for use in treating peanut allergies. It is a daily medication that may reduce symptoms in some people who have a peanut allergy. There is no sufficient new data to warrant changing the current criteria. The criteria will remain as below:

APPROVAL CRITERIA:

- Recipient must be ≥ 4 years of age and ≤ 17 years of age to initiate treatment; **AND**
- Recipient must have a confirmed diagnosis of a peanut allergy; **AND**
- Prescriber must be an Allergy and Immunology specialist; **AND**
- Prescriber, clinic, pharmacy, and recipient must be enrolled in the Risk Evaluation and Mitigation Strategy (REMS) program and remain compliant with program requirements; **AND**
- Prescriber must attest that the recipient has been counseled to continue a peanut-avoiding diet as this medication is for accidental exposure to peanuts; **AND**

- Recipient must continue to have injectable epinephrine on hand with a pharmacy claim within the last year; **AND**
- Prescriber must require Initial Dose Escalation and first dose of each up-dosing stage to occur in the office to monitor for anaphylaxis for at least 60 minutes and provide a plan on how to manage potential anaphylaxis reactions while in the office; **AND**
- Prescriber should provide the following:
  - Current chart notes; **AND**
  - Documentation of a systemic reaction to peanuts AND at least one of the following:
    - Positive serum immunoglobulin E (IgE) to peanuts within the past 12 months; **OR**
    - Skin prick test (SPT) to peanut with a mean wheal diameter of ≥ 8mm compared to control; **OR**
    - Documented reaction to peanut upon supervised oral food challenge at a dose of ≤ 100 mg peanut protein (≤ 200 mg peanut flour).
- PAs will be approved for 2 months at a time with correct dosages per the taper. Compliance, response to therapy, and tolerance will be reviewed on renewal request.

DENIAL CRITERIA:

- Recipient does not meet the FDA approved indication **OR** have a diagnosis supported in the official Compendia; **OR**
- Recipient has uncontrolled asthma, markedly compromised lung function, severe mast cell disorder or cardiovascular disease (decreased ability to survive anaphylaxis); **OR**
  - Uncontrolled asthma is defined per the 2007 NHLBI, and involves: asthma symptoms throughout the day, nighttime awakenings often (7x/week), poor lung function (FEV1 < 60% predicted; FEV1/FVC reduced > 5%), extreme limitation on normal activity, and the need to use a short-acting beta agonist (rescue inhaler) several times a day.
- Recipient has suspected eosinophilic esophagitis and/or other eosinophilic gastrointestinal disease; **OR**
- Recipient cannot tolerate doses up to and including the 3 mg dose during Initial Dose Escalation; **OR**
- Recipient had a severe or life-threatening anaphylaxis within the previous 60 days.

CONTINUATION CRITERIA:

- Recipient's Medicaid profile will be reviewed for compliance for PA renewal; **AND**
- Prescriber should submit current chart notes with response/tolerance to medication; **AND**
- PA renewals for maintenance dosing may be approved for 3-6 months depending on length of proven tolerance.

EFFECTIVE APRIL 18, 2022:

2. QUETIAPINE POINT-OF-SALE EDIT

CURRENT INDICATIONS (as of 2/23/2022):

- Acute treatment of schizophrenia in patients ≥13 years of age
- Bipolar I disorder
  - Acute treatment of manic episodes in patients ≥10 years of age
    - Monotherapy
    - Adjunct to lithium or divalproex

  - Monotherapy for acute treatment of depressive episodes in adults
  - Maintenance treatment as adjunct to lithium or divalproex in adults
- Bipolar II disorder—Monotherapy for acute treatment of depressive episodes in adults

POINT-OF-SALE CRITERIA:

- Recipients <18 years of age will not be included in this POS edit
- If the recipient does not meet one of the POS criteria, a prior authorization request must be submitted including the following:
  - Current chart notes
  - Previous medication therapies
  - Medical necessity for the off-label use (If the request is for sedation, provide the medical necessity over other medications that can be used for sleep such as melatonin, trazodone, and alpha blockers.)

Criterion 1: Recipient has a billed diagnosis in the past two years for one of the following:

- Schizoaffective disorder
- Schizophrenia
- Bipolar I disorder
- Bipolar II disorder
- Unspecified bipolar and related disorder
- Unspecified schizophrenia spectrum and other psychotic disorders
- Delusional disorder

Criterion 2: Recipient has a paid pharmacy claim in their Medicaid drug history for quetiapine in the last 120 days

EFFECTIVE APRIL 1, 2022:

3. RESCUE SEIZURE MEDICATIONS

INDICATIONS:

VALTOCO® is indicated for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern in patients with epilepsy 6 years of age and older.

NAYZILAM® is indicated for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern in patients with epilepsy 12 years of age and older.

DIASTAT® rectal gel is intended for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern in patients with epilepsy 2 years of age and older.

UPDATED CRITERIA: (Criteria was changed slightly to incorporate the PDL preferred agents.)

- Point-of-sale criteria for VALTOCO, DIASTAT, and NAYZILAM
  - Recipient must have a billed diagnosis of seizures in the last 2 years; **AND**
  - Recipient must have a Medicaid paid pharmacy claim for an antiepileptic in the previous 2 months; **AND**

  - Recipients must be ≥6 years of age to receive VALTOCO; ≥2 years of age to receive DIASTAT rectal gel; ≥12 years of age to receive NAYZILAM; **AND**
  - If the recipient has >2 consecutive months of paid pharmacy claims for NAYZILAM, VALTOCO, and/or DIASTAT rectal gel, a prior authorization will be required.
- Recipients that do not meet the above criteria will require a prior authorization
  - Prescriber must be a neurologist or in consultation with a neurologist and must submit the following:
    - Current chart notes with documentation of seizure diagnosis with seizure clusters or acute repetitive seizures that are distinct from the usual seizure pattern; **AND**
    - Documentation of current medication list; **AND**
    - Updated treatment plan if requiring >2 consecutive months of rescue medication; **AND**
  - PA request may be denied if the recipient has any of the following:
    - Severe chronic cardio-respiratory disease (NAYZILAM request only); **OR**
    - History of acute narrow-angle glaucoma; **OR**
    - Taking moderate or strong CYP3A4 inhibitors
- Quantity edits: NAYZILAM—10 doses per month; VALTOCO—10 doses per month; DIASTAT—3 doses per claim

EFFECTIVE IMMEDIATELY:

4. KERENDIA® (finerenone) tablet

INDICATION:
KERENDIA is indicated to reduce the risk of sustained eGFR decline, end-stage kidney disease, cardiovascular death, non-fatal myocardial infarction, and hospitalization for heart failure in adult patients with chronic kidney disease (CKD) associated with type 2 diabetes (T2D).

APPROVAL CRITERIA:
- Recipient must be ≥ 18 years of age; **AND**
- Recipient must have a diagnosis of Type 2 diabetes mellitus and chronic kidney disease **OR** a diagnosis consistent with FDA indications; **AND**
- Recipient must have one of the following to confirm the diagnosis of CKD with T2D:
  - UACR of 30-300 mg/g, eGFR 25-60 mL/min/1.73m^2, and diabetic retinopathy **OR**
  - UACR of ≥ 300 mg/g and eGFR 25-75 mL/min/1.73m^2
- Recipient must have been treated with an angiotensin-converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) unless contraindicated and receiving treatment for diabetes based on treatment guidelines; **AND**
- Recipient must have tried and failed an aldosterone inhibitor unless contraindicated; **AND**
- Recipient must be a non-smoker or participating in a tobacco cessation program**; AND**
- Recipient must have controlled diabetes (HbA1c <9%) and blood pressure (BP < 130/85); **AND**
- Prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of previous therapies; **AND**
  - Current labs including Urinary Albumin-to-Creatinine Ratio (UACR), eGFR, and potassium level; **AND**
  - Medical necessity over other mineralocorticoid receptor antagonists available without a PA

- Initial approval for 3 months

DENIAL CRITERIA:

- Recipient does not meet approval criteria **OR** have a diagnosis supported on the official Compendia; **OR**
- Recipient has eGFR < 25 mL/min/1.73m^2; **OR**
- Recipient's baseline serum potassium is > 5 mEq/L; **OR**
- Recipient is receiving concomitant strong CYP3A4 inhibitors (e.g., fluconazole) and strong or moderate CYP3A4 inducers (e.g., efavirenz, rifampicin); **OR**
- Recipient has been diagnosed with adrenal insufficiency (Addison's disease)

CONTINUATION CRITERIA:

- Recipient must demonstrate a decrease in UACR and sustained or improved eGFR after dose titration; **AND**
- Recipient must be a non-smoker; **AND**
- Recipient must have a potassium level that remains < 5.5 mEq/L; **AND**
- Prescriber must submit the following:
  - Current chart notes; **AND**
  - Current labs including UACR, eGFR, and potassium
- Approval for 6 months

QUANTITY EDITS:

- 20 mg--#31/ 31 days
- 10 mg--#31/ 31 days

EFFECTIVE IMMEDIATELY:

5. TAVNEOS™ (avacopan) capsule

INDICATION:

TAVNEOS is indicated as an adjunctive treatment of adult patients with severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA]) in combination with standard therapy including glucocorticoids. TAVNEOS does not eliminate glucocorticoid use.

APPROVAL CRITERIA:

- Recipient must be ≥18 years of age; **AND**
- Recipient must have a diagnosis of severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis with granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA) **OR** a diagnosis consistent with FDA indications; **AND**
- Recipient had previous therapy with an immunosuppressant (i.e., rituximab or cyclophosphamide) and corticosteroids based on treatment guidelines; **AND**
- Recipient must be concomitantly prescribed standard therapy; **AND**
- Prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of previous therapy; **AND**

- Current labs including positive ANCA test results, anti-PR3 and anti-MPO if available, baseline LFTs, and Hepatitis B serology (HBsAg and anti-HBc); **AND**
- If available, chest x-ray or CT scan results used for diagnosis confirmation; **AND**
- If available, biopsy reports used for diagnosis confirmation

DENIAL CRITERIA:

- Recipient does not meet approval criteria **OR** have a diagnosis supported on the official Compendia; **OR**
- Recipient has severe hepatic impairment OR AST/ALT >5X ULN OR AST/ALT >3X ULN with bilirubin >2X ULN; **OR**
- Recipient should avoid the use of CYP3A4 inhibitors (e.g., ketoconazole, cyclosporine, erythromycin) if possible. If concomitant use is required, TAVNEOS dose should be decreased to 30 mg once daily; **OR**
- Recipient develops reactivation of HBV while on TAVNEOS; **OR**
- Recipient has an active, serious infection including localized infections; **OR**
- Recipient is pregnant or breastfeeding

CONTINUATION CRITERIA:

- Recipient demonstrates a therapeutic response with disease stability and/or improvement; **AND**
- Recipient has achieved remission by week 52 of therapy (based on length of the clinical trial); **AND**
- Recipient is compliant on TAVNEOS and standard therapy**; AND**
- Prescriber must submit the following:
  - Current chart notes; **AND**
  - Current labs including LFTs; **AND**
  - Documentation of response to therapy

QUANTITY EDITS:
#180 capsules/ 30 days

EFFECTIVE IMMEDIATELY:

6. EXKIVITY™ (mobocertinib) capsule

INDICATION:
EXKIVITY is indicated for the treatment of adult patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 20 insertion mutations whose disease has progressed on or after platinum-based chemotherapy.

APPROVAL CRITERIA:

- Recipient must be ≥18 years of age; **AND**
- Recipient must have a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) (Stage IIIB or IV) with epidermal growth factor receptor (EGFR) exon 20 insertion mutations **OR** a diagnosis consistent with FDA indications; **AND**
- Recipient must have disease progression on or after platinum-based chemotherapy; **AND**
- Female recipients of reproductive potential must use effective non-hormonal contraception; **AND**

- Recipient must have normal lab values for electrolytes (i.e., sodium, potassium, calcium, and magnesium). Prior to beginning medication, electrolyte abnormalities must be corrected; **AND**
- Prescriber must submit the following:
    - Current chart notes; **AND**
    - Documentation of previous therapy; **AND**
    - Baseline QTc interval; **AND**
    - Baseline left ventricular ejection fraction; **AND**
    - Baseline labs including CBC and CMP; **AND**
    - Documentation of treatment plan for possible diarrhea

DENIAL CRITERIA:

- Recipient does not meet approval criteria **OR** have a diagnosis supported on the official Compendia; **OR**
- Recipient is pregnant; **OR**
- Recipient has severe renal impairment or severe hepatic impairment; **OR**
- Recipient requires hormonal contraceptives, strong or moderate CYP3A inducer, or strong or moderate CYP3A inhibitor (EXKIVITY dose may need to be adjusted); **OR**
- Recipient has a prolonged QTc interval (clinical trials included QT intervals of ≤ 450ms for males and ≤ 470ms for females) or being treated with medications known to cause Torsades de Pointes; **OR**
- Recipient has been diagnosed with interstitial lung disease or pneumonitis; **OR**
- Recipient has Grade 2 heart failure or Grade 3 or 4 decreased ejection fraction (EF <39%)

CONTINUATION CRITERIA:

- Recipient must not demonstrate disease progression or unacceptable toxicity; **AND**
- Female recipients of reproductive potential remain on non-hormonal contraception; **AND**
- Recipient's lab values must remain within normal limits; **AND**
- Recipient must not have Grade 2 or greater heart failure or an EF <39%; **AND**
- Prescriber must submit the following:
    - Current chart notes; **AND**
    - Documentation of disease response; **AND**
    - Current labs; **AND**
    - Current cardiac function tests if available

QUANTITY EDITS:
#124/31 days

EFFECTIVE IMMEDIATELY:

7. OPZELURA™ (ruxolitinib) cream

INDICATION:
OPZELURA is indicated for the topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised patients 12 years of age and older whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.

Limitation of Use:
Use of OPZELURA in combination with therapeutic biologics, other JAK inhibitors or potent immunosuppressants such as azathioprine or cyclosporine is not recommended.

APPROVAL CRITERIA:

- Recipient must be ≥12 years of age; **AND**
- Recipient should have mild or moderate atopic dermatitis defined by an Investigator's Global Assessment (IGA) score of 2-3 out of a 0-4 scale **OR** a diagnosis consistent with FDA indications; **AND**
- Recipient must have uncontrolled mild to moderate atopic dermatitis with recent claims for topical corticosteroids and topical calcineurin inhibitors (TCI); **AND**
    - 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 superpotent (Class-1) depending on location of atopic dermatitis; **AND**
    - At least one trial of a TCI over a minimum of 30 days (i.e., tacrolimus, pimecrolimus); **AND**
- Prescriber must submit the following:
    - Current chart notes; **AND**
    - Documentation of previous therapies; **AND**
    - Current IGA score; **AND**
    - Current baseline Itch Numerical Rating Scale (Itch NRS); **AND**
- If approved, PA will be approved for 2 months

DENIAL CRITERIA:

- Recipient does not meet approval criteria **OR** have a diagnosis supported on the official Compendia; **OR**
- Recipient has a history of skin cancer; **OR**
- Recipient has severe atopic dermatitis; **OR**
- Recipient's atopic dermatitis affects greater than 20% of BSA; **OR**
- Prescriber requests continuance beyond 8 weeks without improvement; **OR**
- Recipient has been approved for biologics, JAK inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine

CONTINUATION CRITERIA:

- After 8 weeks, recipient has an improvement of IGA score to 0-1 **OR** ≥ 4 point improvement in itch NRS; **AND**
- Prescriber must submit the following:
    - Current chart notes; **AND**
    - Documentation of current IGA score and Itch NRS; **AND**
    - Medical necessity to continue beyond 8 weeks

QUANTITY EDITS:

2 tubes (120 gm)/ 30 days

EFFECTIVE IMMEDIATELY:

8. SCEMBLIX® (asciminib) tablet

INDICATION:
SCEMBLIX is indicated for the treatment of adult patients with:

- Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP), previously treated with two or more tyrosine kinase inhibitors (TKIs).

- Ph+ CML in CP with the T315I mutation.

APPROVAL CRITERIA:

- Recipient must be ≥18 years of age; **AND**
- Recipient must have a diagnosis of Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP) with one of the following:
    - Recipients without the T315I mutation must previously have been treated with two or more tyrosine kinase inhibitors (TKIs) (e.g., imatinib, nilotinib, dasatinib, radotinib or ponatinib); **OR**
    - Recipients with the T315I mutation must have a trial and failure of ponatinib unless the development of the T315I mutation was determined after the ponatinib trial; **AND**
- Prescriber must submit the following:
    - Current chart notes; **AND**
    - Current labs including CBC, serum lipase, and amylase levels; **AND**
    - Genetic test results with confirmation of the Philadelphia chromosome and/or the BCR-ABL gene; **AND**
    - Test results for the T315I mutation, if applicable; **AND**
    - Previous therapy; **AND**
    - Current blood pressure; **AND**
- Initial PA will be approved for 1 month to determine tolerability

DENIAL CRITERIA:

- Recipient does not meet approval criteria **OR** have a diagnosis supported on the official Compendia; **OR**
- Recipient without the T315I mutation must be able to tolerate the minimum dose of 40 mg daily (or 20 mg twice daily); Recipient with the T315I mutation must be able to tolerate the minimum dose of 160 mg twice daily; **OR**
- Recipient has uncontrolled hypertension; **OR**
- Recipient has baseline platelets <50 X 10^9/L; **OR**
- Recipient has recent history of pancreatitis; **OR**
- Recipient is pregnant

CONTINUATION CRITERIA:

- Recipient has continued response without unacceptable toxicity; **AND**
- Prescriber must submit the following:
    - Current chart notes; **AND**
    - Current labs including CBC (CBCs should be reviewed every 2 weeks for the first 3 months then monthly.), serum lipase and amylase levels (Labs must be checked at least monthly for monitoring pancreatitis.) Dosing should be based on these labs per the package insert.; **AND**
    - Requested dose

QUANTITY EDITS:
20 mg--#60/ 30 days
40 mg--#60/ 30 days
PA required for quantity override on patients with T315I mutation

EFFECTIVE IMMEDIATELY:

9. VUITY™ (pilocarpine) drops

INDICATION:
VUITY is indicated for the treatment of presbyopia in adults.

APPROVAL CRITERIA:
- Recipient must be ≥18 years of age; **AND**
- Recipient must have a diagnosis of presbyopia **OR** a diagnosis consistent with FDA approved indication; **AND**
- Prescriber must submit the following:
  - Current chart notes; **AND**
  - Medical necessity over other treatment options for presbyopia

DENIAL CRITERIA:
- Recipient does not meet approval criteria **OR** have a diagnosis supported on the official Compendia; **OR**
- Recipient has a history of glaucoma or ocular hypertension; **OR**
- Recipient has a history of cataract surgery, phakic intraocular lens surgery, corneal inlay surgery, radial keratotomy, or any intraocular surgery

CONTINUATION CRITERIA:
- Recipient has documented improvement in presbyopia defined as the patients gained 3 lines or more in mesopic, high contrast, binocular distance corrected near visual acuity (DCNVA)

QUANTITY EDITS:
1 bottle per 22 days

EFFECTIVE IMMEDIATELY:

10. VOXZOGO™ (vosoritide) vial

INDICATION:
VOXZOGO is indicated to increase linear growth in pediatric patients with achondroplasia who are 5 years of age and older with open epiphyses.

APPROVAL CRITERIA:
- Recipient must be 5-17 years of age; **AND**
- Recipient must have a diagnosis of achondroplasia (ACH) **OR** a diagnosis consistent with FDA approved indications; **AND**
- Recipient must have open epiphyses; **AND**
- Prescriber who specializes in skeletal dysplasia (orthopedics, geneticist, or endocrinologist) must submit the following:
  - Current chart notes; **AND**
  - Genetic test results and radiologic findings confirming the diagnosis of achondroplasia; **AND**
  - Baseline standing height; **AND**
  - Current weight; **AND**

- Requested dose; **AND**
- X-ray report demonstrating epiphyses status for patients yearly

DENIAL CRITERIA:

- Recipient does not meet approval criteria **OR** have a diagnosis supported on the official Compendia; **OR**
- Recipient has closed epiphyses; **OR**
- Recipient has a diagnosis of hypochondroplasia or short stature condition other than ACH; **OR**
- Recipient has been treated with growth hormone in the previous 6 months

CONTINUATION CRITERIA:

- Recipient demonstrated a positive response with linear growth velocity after 1 year; **AND**
- Prescriber must submit the following:
  - Current chart notes; **AND**
  - Current standing height; **AND**
  - Current weight; **AND**
  - Requested dose; **AND**
  - X-ray report demonstrating epiphyses status for patients yearly

QUANTITY EDITS:
Each strength--#30 vials/30 days (packaged in 10 vials per kit)

EFFECTIVE IMMEDIATELY:

11. CARBAGLU® (carglumic acid) tablet

INDICATION:
1.1 Acute and Chronic Hyperammonemia due to N-acetylglutamate Synthase (NAGS) Deficiency
CARBAGLU is indicated in pediatric and adult patients as:

- Adjunctive therapy to standard of care for the treatment of acute hyperammonemia due to NAGS deficiency.
- Maintenance therapy for the treatment of chronic hyperammonemia due to NAGS deficiency.

1.2 Acute Hyperammonemia due to Propionic Acidemia (PA) or Methylmalonic Acidemia (MMA)
CARBAGLU is indicated in pediatric and adult patients as adjunctive therapy to standard of care for the treatment of acute hyperammonemia due to PA or MMA.

APPROVAL CRITERIA:

- Recipient must have a diagnosis of hyperammonemia due to N-acetylglutamate Synthase (NAGS) deficiency, Propionic Acidemia (PA), or Methylmalonic Acidemia (MMA) **OR** a diagnosis consistent with FDA approved indication; **AND**
- Recipient must remain on standard of care therapy for acute, severe hyperammonemia, and CARBAGLU can be used alone in chronic NAGS; **AND**
- Prescriber must order a dose consistent with diagnosis and kidney function; **AND**
- Prescriber must submit the following:
  - Current chart notes; **AND**
  - Current labs including plasma ammonia levels and eGFR; **AND**

- Current weight; **AND**
- Current BMI for recipients with PA or MMA weighing more than 15 kg; **AND**
- Daily dose requested; **AND**
- Documentation of adjunctive standard of care therapy for acute hyperammonemia; **AND**
- Number of days treated while hospitalized for PA or MMA (max of 7 days total)

DENIAL CRITERIA:

- Recipient does not meet approval criteria **OR** have a diagnosis supported on the official Compendia; **OR**
- Prescriber requests therapy for PA or MMA for longer than 7 days total which includes doses received during hospitalization; **OR**
- Prescriber requests dose outside of guidance from package insert

CONTINUATION CRITERIA:

- Recipient with chronic NAGS has a positive response with plasma ammonia levels maintained in the normal range; **AND**
- Prescriber must submit the following:
  - Current chart notes; **AND**
  - Current labs including plasma ammonia levels and eGFR; **AND**
  - Current weight; **AND**
  - Daily dose requested

12. 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://medicaid.mmis.arkansas.gov/**
- **https://humanservices.arkansas.gov/**
- **https://arkansas.magellanrx.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/
For questions about each PASSE organization, please refer to this website for contact information:
https://humanservices.arkansas.gov/about-dhs/dms/passe/contact-us

2. **MAT (Medication Assisted Treatment) with buprenorphine/naloxone and psychosocial treatment or counseling:** Per the TIP 40: *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*: *Treatment Improvement Protocol (TIP) Series 40*: "Pharmacotherapy alone is rarely sufficient treatment for drug addiction. For most patients, drug abuse counseling—individual or group—and participation in self-help programs are necessary components of comprehensive addiction care. As part of training in the treatment of opioid addiction, physicians should at a minimum obtain some knowledge about the basic principles of brief intervention in case of relapse. Physicians considering providing opioid addiction care should ensure that they are capable of providing psychosocial services, either in their own practices or through referrals to reputable behavioral health practitioners in their communities."

http://lib.adai.washington.edu/clearinghouse/downloads/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction-54.pdf

3. **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 18 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 clients 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://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx/
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://afmc.org/health-care-professionals/arkansas-medicaid-providers/mmis-outreach-specialists/

4. **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 clients 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 clients, including clients 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.

5. **Suboxone Film (buprenorphine/naloxone) once daily dosing:** as stated in the Suboxone Film package insert, the FDA approved dose for treating opioid addiction is prescribing the total daily dose as one single daily dose. "After treatment induction and stabilization, the maintenance dose of SUBOXONE sublingual film is generally in the range of 4 mg/1 mg buprenorphine/naloxone to 24 mg/6 mg buprenorphine/naloxone per day depending on the individual patient and clinical response. **The recommended target dosage of SUBOXONE sublingual film during maintenance is 16 mg/4 mg buprenorphine/naloxone/day as a single daily dose**. Dosages higher than 24 mg/6 mg daily have not been demonstrated to provide a clinical advantage."

6. **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.**

7. **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 MMA Prescription Drug 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 clients and once per 60 days per drug class for LTC clients.

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://arkansas.magellanrx.com/provider/documents/.

8. 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 client 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.

9. 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 client 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 client cannot accumulate more than an *extra* 12 days' supply early during a 180-day period for non-controlled drugs.

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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.

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

11. 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. Clients have an ongoing requirement for labs for metabolic monitoring every 6 months. When any provider sends a patient, who is less than 18 years of age for the required metabolic labs for the antipsychotic agents, 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://arkansas.magellanrx.com/client/docs/rxinfo/MedInformedConsent.pdf

< 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.

12. **THE AR MEDICAID PHARMACY PROGRAM REIMBURSES ENROLLED PHARMACY PROVIDERS FOR COVERED OUTPATIENT DRUGS FOR MEDICAID CLIENTS WITH PRESCRIPTION DRUG BENEFITS:** Only medications prescribed to that client can be billed using the client's Medicaid ID. If medications are needed to treat remaining family members, each prescription must be billed accordingly 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.

13. **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://arkansas.magellanrx.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://arkansas.magellanrx.com/client/docs/rxinfo/ARRx_NADAC_Request_Medicaid_Reimbursement_Review_Form.pdf

14. **ELECTRONIC PROVIDER MEMO:** To reduce paper waste beginning April 2019, Arkansas Medicaid will no longer mail Pharmacy Program Provider Memos. An electronic message will be sent to all Medicaid enrolled prescribing providers and pharmacy providers as an alert message when the complete Provider Memo is posted on the Arkansas Medicaid Pharmacy Program website.

    NOTE: To ensure you receive the notification email, please verify that your email is correct in the Arkansas Medicaid provider portal. Department of Human Services correspondence would also be included in this effort to reduce paper waste. To ensure that all correspondence is received, we ask that each provider verify that the provider portal has the correct email address used for your business communications.

    The Arkansas Medicaid Pharmacy Program Provider Memos can be found at https://medicaid.mmis.arkansas.gov/Provider/Provider.aspx. To access the memos, select the OTHER LINKS drop-down menu in the upper-left corner of the screen, click MAGELLAN MEDICAID ADMINISTRATION, select the ADMINISTRATOR box, select the RESOURCES drop-down menu in the upper-right corner, click DOCUMENTS, select the PHARMACY tab in the top row of tabs, and then click MEMORANDUMS. The Memo can also be found at: https://arkansas.magellanrx.com/provider/documents/. To access the memos, select the PHARMACY tab and then click MEMORANDUMS.

    An added benefit of viewing the Medicaid Pharmacy Program Provider Memo online is the search feature, which will allow a more accessible and efficient user experience. To use this feature, use the shortcut by pressing the Ctrl + F keys, enabling a keyword search. Starting with the January 2018 memo, the online versions of the Provider Memos will also contain active hyperlinks in the Table of Contents. To activate these hyperlinks, open the Provider Memo, hover the mouse over the Table of Contents, press the Ctrl key until the mouse cursor ("hand") appears, then place the cursor on the item desired and click the mouse. The hyperlink in the Table of Content will then redirect to the corresponding chapter of the Provider Memo.

15. **OPIOID INFORMATION ON THE MAGELLAN WEBSITE:** 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 Magellan Health website.
    https://arkansas.magellanrx.com/client/documents

16. **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.

17. PLACE OF SERVICE

General Information

Arkansas Medicaid is updating the National Place of Service Code in the Pharmacy manual and in the billing rules to comply with the national standards, and to ensure pharmacies are billing consistently. Effective 8/1/2021, the current code of "99" will be replaced with the correct Place of Service Code for Pharmacy "01".

If you have questions regarding this notice, please contact the Provider Assistance Center at 1-800-457-4454 toll-free or locally at (501) 376-2211. If you need this material in an alternative format, such as large print, please contact the Office of Rules Promulgation at (501) 396-6428.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for download from the Division of Medical Services website.

This advance notice is to provide you 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 Magellan Medicaid Administration (MMA) 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 HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and out-of-state at 1-501-376-2211.