ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Pharmacy Program

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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 Cynthia Neuhofel

DATE: **February 14, 2019**

SUBJ: **AR Medicaid Prior Authorization Edits Approved at the AR Medicaid DUR Board January 16, 2019 meeting for the following:** Manual review criteria for JAKAFI® (ruxolitinib); New clinical point of sale criteria: ZORTRESS® (everolimus); ZORTRESS® (everolimus); New drugs manual review criteria: XOFLUZA™ (baloxavir marboxil); RYCLORA™ (dexchlorpheniramine maleate); COPIKTRA™ (duvelisib); VIZIMPRO® (dacomitinib; EPIDIOLEX® ORAL SOLUTION; NOCDURNA® (desmopressin acetate tablet); LORBRENA® (Lorlatinib); GALAFOLD™ (migalastat); ABILIFY MYCITE® (aripiprazole) Tablet

Preferred Drug List (PDL) Drugs from the February 13, 2019 Drug Review Committee Meeting for the following: Long-Acting Opioids

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All criteria for the point of sale (POS) clinical edits and claim edits can be viewed on the Medicaid website at https://arkansas.magellanrx.com/provider/documents/ Select "Resources" tab at the top right, then select "Documents" from the drop-down box. All Provider Memos are under the "Pharmacy" tab at the top.

Medicaid Pharmacy Program drug reimbursement rate methodology changed April 1, 2017; reimbursement rates stated in this memo are informational only and are only current as of the date the memo was drafted; the rates stated are approximate as they may have been rounded.

ANNOUNCEMENTS

1) **REMINDER: Morphine Milligram Equivalents (MME) Final Reduction November 14, 2018:**
The final MME was reduced to **≤90 MME/day** on **November 14, 2018**. This is an additive edit for all opioid drug claims with overlapping days' supply. The beneficiaries with certain cancer diagnoses in Medicaid medical diagnosis history are exempted from the MME edit.

2) **ELECTRONIC PROVIDER MEMO**:
To reduce paper waste, only the Table of Contents section of the January/February 2019 Medicaid Pharmacy Program Provider Memo will be mailed to enrolled prescribing providers and pharmacy providers with the full memo available on the Medicaid Pharmacy Program website (see hyperlinks below). 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.

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.

EFFECTIVE APRIL 1, 2019:

PREFERRED DRUGS LIST (PDL):

Long-acting opioids were reviewed at the February 13, 2019 PDL meeting. The Preferred status and Non-preferred status drugs were selected based on a review of comparative effectiveness as well as cost-effectiveness for the state Medicaid program and are listed below. *Prior Authorization criteria* and quantity limits will remain in place for Preferred-status drugs unless otherwise noted below. Agents in **bold** font indicate a change in designation on the PDL.

LONG-ACTING OPIOIDS

Preferred agents with criteria

- Buprenorphine patch (Butrans)- Brand Only
- Morphine sulfate/naltrexone (Embeda ER)

- Morphine sulfate long-acting tablet (MS Contin, Oramorph)
- Tramadol ER Tablet

Nonpreferred agents with criteria

- Buprenorphine (Belbuca)
- Fentanyl patch (Duragesic)
- **Hydrocodone ER (Hysingla ER)**
- Hydrocodone ER Capsule (Zohydro ER)
- Hydromorphone HCl extended-release tablet (Exalgo ER)
- Methadone HCl (Dolophine)
- Morphine sulfate extended-release capsule (Avinza, Kadian)
- Morphine sulfate extended-release tablets (Morphabond ER)
- Oxycodone-Acetaminophen extended-release tablet (Xartemis XR)
- Oxycodone extended-release tablet (Oxycontin)
- Oxycodone extended-release capsule (Xtampza ER)
- Oxymorphone HCl extended-release tablet (Opana ER)
- Tapentadol HCl extended-release tablet (Nucynta

PRIOR AUTHORIZATION DRUG CRITERIA, NEW OR REVISED, FOR THE FOLLOWING DRUGS:

EFFECTIVE APRIL 10, 2019:

1. ZORTRESS® (everolimus) Tablet 0.25mg, 0.5mg, 0.75mg, 1mg

   NOVARTIS

MEDICAID estimated reimbursement rates:

0.25 mg = $8.45 each
0.50 mg = $16.31 each
0.75 mg = $24.65 each
1.0 mg = $33.81 each

PROPOSAL:

Point of Sale (POS) criteria algorithm with quantity limits:

- Beneficiary is age 18 years or greater; *AND*
- Diagnosis in Medicaid history of kidney transplant (Z94.0) ***OR*** liver transplant (Z94.4) in previous 2 years; *AND*
- No therapeutic duplication between different strengths of ZORTRESS® or between other brand names of everolimus (e.g., AFINITOR®); *AND*
- Quantity limit of 2 tablets per day, #60 for 30-day supply; standard early refill allowances apply;

Magellan Medicaid Administration (MMA) Help Desk 1-800-424-7895; fax letter of medical Necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-7976.

EFFECTIVE IMMEDIATELY:

2. JAKAFI® (ruxolitinib) Tablets 5mg, 10mg, 15mg, 20mg, 25mg
   INCYTE CORPORATION

MEDICAID estimated reimbursement rate: $210.12 each tablet for any strength; twice daily dosing, **#60 = $12,607.20 per 30-day supply**

JAKAFI® (ruxolitinib) tablet will require manual review PA on a case-by-case basis using all of the following:

APPROVAL CRITERIA, requires all of the following:

- Beneficiary is ≥ 18 years of age;
- Beneficiary must have a diagnosis of intermediate or high-risk myelofibrosis (MF), including primary MF, post-polycythemia vera MF or post-essential thrombocythemia MF, or polycythemia vera (PV);
- Beneficiary must have at least 2 hydroxyurea drug claims in Medicaid drug history in previous 3 months in those with diagnoses of post-essential thrombocythemia MF or polycythemia vera (PV); If no hydroxyurea drug claims in Medicaid drug history, provider must submit documentation to substantiate that beneficiary had an inadequate response to or was intolerant of hydroxyurea;
- Provider must submit results of a current complete blood count (CBC) and platelet count before initiating therapy;
- Provider must submit Child-Pugh Class score or all LFTs to calculate (Class A, B, or C);
- Provider must submit baseline lipid panel;
- Approved starting dose will be based on the platelet count and follow all FDA approved dosing recommendations in the package insert;
- Initial PA will be for the specific strength required for dose; approval time will be for 1 month;

CONTINUATION CRITERIA require all of the following:

- Provider must submit results of a complete blood count (CBC) and platelet count at least every 4 weeks with each PA request until doses are stabilized; submit blood counts with every PA request thereafter;
- Beneficiary must show positive response to Jakafi® by spleen size reduction (using CT or MRI) or symptom improvement within 6 months of therapy;
- Provider must submit follow-up lipid panel 12 weeks after initiating JAKAFI therapy for possible management of hyperlipidemia;
- Approval criteria for dose increases must meet *all* of the following conditions:
    - Inadequate efficacy as demonstrated by one or more of the following: AND
        - Continued need for phlebotomy; or
        - WBC greater than the upper limit of normal range; or
        - Platelet count greater than the upper limit of normal range; or

        - Palpable spleen that is reduced by less than 25% from Baseline; AND
    - Platelet count greater than or equal to 140 X 10^9/L; AND
    - Hemoglobin greater than or equal to 12 g/dL; AND
    - ANC greater than or equal to 1.5 X 10^9/L;
- Continuation PA will be monthly until dose stabilized, then approval PA may be for 3 months at a time;

DENIAL CRITERIA, any one of the following:

- Beneficiary is <18 years of age;
- Beneficiary does not have appropriate diagnosis;
- Dose increase requested during 1st 4 weeks of therapy;
- After the 1st month of therapy, the dose increase is requested more frequently than every 2 weeks;
- Provider did not submit current lab data – CBC w/ differential, AST/ALT, fasting lipids;
- There is no spleen size reduction (w/ CT or MRI) or symptom improvement after 6 months of therapy;
- Beneficiary has current active bleed requiring intervention;
- For polycythemia vera:
    - Interrupt treatment for hemoglobin less than 8 g/dL, platelet counts less than 50 X 10^9/L or ANC less than 1.0 X 10^9/L.
    - After recovery of the hematologic parameter(s) to acceptable levels, dosing may be restarted.
    - Restart dose will not exceed drug package insert dose in restarting Jakafi® after a previous interruption;
- Renal impairment:
    - Moderate-severe renal impairment PLUS PLT < 50 X 10^9/L – avoid use for MF;
    - Patients on hemodialysis, regardless of PLT count, may use Jakafi® for either MF or PV;
    - For ESRD without hemodialysis, use is not recommended for either PV or MF;
- Hepatic impairment:
    - PV permits use with any PLT count and Child-Pugh class A, B, or C
    - For MF, avoid use with PLT Less than 50 X 10^9/L and Child-Pugh class A, B, C
- Beneficiary has active serious infection(s);
- Beneficiary has positive TB test for either active TB or latent TB;
- Beneficiary currently receiving fluconazole doses of greater than 200 mg daily;

QUANTITY LIMIT:

- Not to exceed 2 tablets per day for each strength tablet;
- Quantity limit of #60/30 days' supply;

3. QBREXZA® (glycopryrronium) cloth

DERMIRA, INC.

MEDICAID Estimated Reimbursement Rate: package of 30 cloths = $550.00

PROPOSAL:

Manual Review:

- Age edit ≥9 years; AND
- The ICD-10 code for Primary focal hyperhidrosis, axilla (L74.510) is in Medicaid medical diagnosis history in the previous 365 days; AND
- Must have documentation of a trial or intolerance to an aluminum based antiperspirant such as Drysol, Certain Dri,, Xerac AC, and Hypercare ;
- Quantity limit 1 per day; 30 cloths /30 days; standard refill allowance;

Continuation Criteria:

- 90 days of therapy in previous 120 days;

Denial Criteria:

- Absence of approval criteria;
- Denial if either of these 2 codes are found in Medicaid medical diagnosis history regardless of if the diagnosis of Primary focal hyperhidrosis, axilla is found in Medicaid medical diagnosis history:
    - Diagnosis in Medicaid medical diagnosis history for Secondary focal hyperhidrosis or Frey's Syndrome (L74.52); OR
    - Diagnosis in Medicaid medical diagnosis history for Generalized hyperhidrosis, night sweats, excessive sweating, (R61);

4. XOFLUZA ™ (baloxavir marboxil)

GENENTECH, INC.

Medicaid Estimated Reimbursement Rate:

XOFLUZA™ 20 mg tablet, packaged as 2 tablets for single dose of 40 mg, = **$150.00**;
XOFLUZA™ 40 mg tablet, packaged as 2 tablets for single dose of 80 mg, = **$150.00**;
NOTE: XOFLUZA™ is not indicated for children < 12 years of age; not indicated for prophylaxis treatment;

Medicaid Price Comparison to Tamiflu® (oseltamivir phosphate) by Genentech, Inc:

30 mg capsule x 10 capsules (5-day supply) = $53.46
45 mg capsule x 10 capsules (5-day supply) = $56.17
75 mg capsule x 10 capsules (5-day supply) = $55.73
6 mg/ml oral suspension, 60 ml bottle = $89.90

Note: pricing listed is the generic pricing as the drug is available as a generic;

PROPOSAL:

XOFLUZA™ will require manual review PA on a case-by-case basis using all of the following:

APPROVAL CRITERIA, require all of the following:

- Beneficiary is age 12 years or older;
- Beneficiary has positive flu test who have been symptomatic for no more than 48 hours;
- Prescriber to submit beneficiary's weight at time of PA request;
- Prescriber to submit documentation to substantiate medical necessity of beneficiary receiving XOFLUZA™ over TAMIFLU® (oseltamivir) that does not require a PA;

CONTINUATION CRITERIA require all of the following:

- No continuation criteria; Provider must submit request every time;

DENIAL CRITERIA, any one of the following:

- Beneficiary does not have active flu;
- Beneficiary is < 12 years of age;
- Quantity requested is greater than one dose;

QUANTITY LIMIT:

- Quantity limited to one dose, PA for NDC entered at time of approval
    - XOFLUZA™ 20 mg tablet, packaged as 2 tablets for single dose of 40 mg, or
    - XOFLUZA™ 40 mg tablet, packaged as 2 tablets for single dose of 80 mg;

5. RYCLORA™ (dexchlorpheniramine maleate) 2mg/5ml oral liquid
   CARWIN PHARMACEUTICAL ASSOCIATES, LLC

MEDICAID estimated reimbursement rate = **$192.99 for 118 mL bottle**

MEDICAID reimbursement rate price comparison (dispensing fee not included in prices below):

- Carbinoxamine 4 mg/5mL Liquid, **118 ml bottle $11.45**
- Chlorpheniramine 2 mg/5 ml syrup (e.g. ED Chlorped Jr), **118 ml bottle $2.55**
- Diphenhydramine Liquid 12.5 mg/5 ml, **118 mL bottle $1.35**

PROPOSAL:

RYCLORA™ LIQUID will require manual review PA on a case-by-case basis using all of the following:

APPROVAL CRITERIA, require all of the following:

- Provider must submit explanation and documentation of medical necessity of beneficiary receiving this antihistamine over other antihistamines with anticholinergic (drying) and sedative side effects, OTC or legend, (e.g., chlorpheniramine syrup, carbinoxamine liquid, or diphenhydramine liquid) that are covered by AR Medicaid without prior authorization criteria AND over the preferred status non-sedating antihistamines listed on the Medicaid PDL;
- Beneficiary is ≥2 years of age and ≤ 6 years of age;
- Length of PA approval determined at the time of PA approval;

CONTINUATION CRITERIA require all of the following:

- No continuation criteria; Prescriber must submit PA request each time;

DENIAL CRITERIA, any one of the following:

- Beneficiary is < 2 years of age or > 6 years of age;
- Beneficiary has not tried other sedating antihistamines covered by AR Medicaid without prior authorization and available in liquid form;
- Beneficiary has not tried the preferred non-sedating antihistamines on the PDL;

QUANTITY LIMIT:

- One 118 ml bottle per 30 days;

6. COPIKTRA™ (duvelisib) Capsule, 15mg and 25mg

VERASTEM, INC.

MEDICAID Estimated Reimbursement Rate: either strength capsule = **$210.71 each capsule**; twice daily dosing;
#56 Capsules = $11,799.76 per 28-day supply;

The recommended dose of COPIKTRA™ is 25 mg administered as oral capsules twice daily (BID). A cycle consists of 28 days.

PROPOSAL:

COPIKTRA™ (duvelisib) Capsule will require manual review PA on a case-by-case basis using all of the following:

APPROVAL CRITERIA, require all of the following:

- Age ≥ 18 years old;
- Beneficiary has diagnosis of chronic lymphocytic leukemia (CLL), small lymphocytic lymphoma (SLL), OR follicular lymphoma (FL), AND has relapsed or has refractory disease, AND has had at least two prior CLL/SLL therapies or two prior FL systemic therapies;

- Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2;
- Must meet the following laboratory parameters:
    1. Serum aspartate transaminase (AST/SGOT) or alanine transaminase (ALT/SGPT) ≤ 3 x upper limit of normal (ULN)
    2. Total bilirubin ≤ 1.5 x ULN
    3. Serum creatinine ≤ 2.0 x ULN
    4. Hemoglobin ≥ 8.0 g/dL with or without transfusion support
    5. Platelet count ≥ 10,000 µL with or without transfusion support
- Female beneficiary of childbearing potential must have a current negative pregnancy test at the time of PA request;
- Female beneficiary is not lactating;
- Prescriber has prescribed Trimethoprim-sulfamethoxazole (TMP-SMX), or other appropriate agent, as prophylaxis for jiroveci pneumonia (PJP), formerly known as Pneumocystis carinii pneumonia (PCP);
- Prescriber has prescribed prophylactic antiviral treatment for prevention of cytomegalovirus (CMV) infection or reactivation;
- Initial PA will be approved for 1 month;

CONTINUATION CRITERIA require all of the following:

- No disease progression;
- Beneficiary is adherent to prescribed COPIKTRA™ therapy;
- Beneficiary is adherent to CMV antiviral therapy;
- Beneficiary is adherent to PJP prophylaxis therapy;
- Beneficiary is able to tolerate COPIKTRA™ minimum dose of 15 mg twice daily;
- Beneficiary does not have unacceptable toxicities;
- Female beneficiary is not pregnant;
- Provider must submit current blood counts and LFT results with every PA request;
- Due to high adverse event rate, the PA approval will be monthly for first six months, then up to 3 months at a time thereafter;

DENIAL CRITERIA, any one of the following:

- Disease progression;
- Beneficiary is unable to tolerate a minimum dose of 15 mg twice daily;
- Beneficiary does not have a diagnosis of CLL, SLL, or FL;
- Beneficiary has not received 2 previous treatments for CLL, SLL, or FL;
- Beneficiary has Richter syndrome (RS), also called Richter transformation;
- Beneficiary has prolymphocytic leukemia;
- Beneficiary has •Uncontrolled autoimmune hemolytic anemia (AIHA) or idiopathic thrombocytopenia purpura (ITP) that is uncontrolled or requiring > 20 mg once daily (QD) of prednisone (or equivalent) to maintain hemoglobin > 8.0 g/dL or platelets > 10,000 µL without transfusion support;
- Beneficiary has diagnosis of FL grade 3b;
- Beneficiary has a history of tuberculosis treatment within the preceding two years;

- Beneficiary is pregnant, planning to become pregnant, or breastfeeding;
- Beneficiary does not meet laboratory requirements listed under approval criteria;
- Beneficiary has an ECOG score >2;
- Prior allogenic transplant
- Prior treatment with PI3K or BTK inhibitors
- Ongoing treatment with chronic immunosuppressants (i.e. cyclosporine, prednisone ≥ 20 mg daily, etc.)
- Patient has or has a history of or current HIV, Hepatitis B or C, or history of alcohol abuse or liver disease;
- QTc > 480 msec;
- Beneficiary is unable to receive prophylactic treatment for jiroveci pneumonia (PJP), formerly known as Pneumocystis carinii pneumonia (PCP);

QUANTITY LIMIT:

- Strength of capsule will be entered at the time of PA approval;
- Quantity limit of both strengths not to exceed 2 per day and 56 capsules per 28-day supply;

7. VIZIMPRO® (dacomitinib) Tablet, 15mg, 30mg, 45mg
   PFIZER

MEDICAID estimated reimbursement rate: **$413.33 each tablet** for any strength; **#30 = $12,399.90;**
Recommended dose is 45 mg once daily;

PROPOSAL

VIZIMPRO® (dacomitinib) will require manual review PA on a case-by-case basis using all of the following:

APPROVAL CRITERIA, require all of the following:

- Beneficiary is ≥ 18 years old;
- Beneficiary has diagnosis metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test;
- Female beneficiary is not pregnant or breastfeeding;
- Beneficiary has at least 12-month disease free interval between previous systemic therapy and recurrence of disease;
- Provider must submit baseline lab documentation to show beneficiary has adequate renal, hematologic, and liver function;
- ECOG score is 0-2;
- PA approval one month;

CONTINUATION CRITERIA require all of the following:

- No disease progression;
- Adherent with current treatment;
- PA approval will be month to month due to high level of adverse events that require doses reduction;

DENIAL CRITERIA, any one of the following:

- No diagnosis of NSCLC with approved mutation;
- Disease progression;
- Interstitial Lung Disease (ILD);
- Use of PPIs concomitantly
- CrCl ≤ 30 mL/min;
- ECOG 3 or 4;
- History of brain mets or leptomeningeal mets;
- Concomitant use of CYP2D6 substrates;

QUANTITY LIMIT:

- 1 tablet daily;
- 30 tablets per 30-day supply;

8. EPIDIOLEX® ORAL SOLUTION 100mg/mL; 100ml bottle
GREENWICH BIOSCIENCE

MEDICAID estimated reimbursement rate = $12.35 per mL; **price for one 100 mL bottle = $1,235.00**

Weight-based dose is up to a **maximum dose is 20 mg/kg/day**.

- Example at max daily dose for **20 kg weight** = **400 mg/day**; 4 mL/day, **100 ml bottle will last 25 days**;
- Example at max dose for **50 kg weight** = **1,000 mg/day**; 10 mL/day, **100 mL bottle will last 10 days**;
- Example at max dose for **100 kg weight** = **2,000 mg/day**; 20 mL/day, **100 mL bottle will last 5 days**;

PROPOSAL:
EPIDIOLEX® oral solution will require manual review PA on a case-by-case basis using all of the following:

APPROVAL CRITERIA, require all of the following:

- Beneficiary is ≥ 2 years of age;
- Beneficiary has documented history of seizures associated with Lennox-Gastaut syndrome or Dravet syndrome:

  - For Lennox-Gastaut Syndrome: Provider must submit written documentation of electroencephalogram (EEG) showing slow (<3.0 hertz [Hz]) spike-and-wave pattern;
  - For Dravet Syndrome: Provider must submit written documentation showing convulsive status epilepticus, alternating hemiconvulsions, OR myoclonic seizures and include genetic testing results for Dravet Syndrome that shows mutations within SCN1A gene.
- Beneficiary has 2 drop seizures each week (NOTE: SEE DRUG TRIAL *INCLUSION* CRITERIA that stated "Participant had at least 2 drop seizures each week during the first 28 days of the baseline period");
- Beneficiary is currently adherent to prescribed dose and frequency of antiepileptic drugs and was on stable dose(s) for at least 4 weeks;
- Provider must submit chart notes and documentation that beneficiary is refractory to antiepileptic drugs with documented failures on more than 1 anticonvulsant drug (≥2 antiepileptic drugs);
- Provider must submit baseline liver function tests including liver enzyme test results (ALT AST) and total bilirubin;
- Initial approval will be for 1 month;
- For adult beneficiaries, provider must submit results for urine drug screen (UDS) testing for marijuana and beneficiary must test negative for THC every 3 months;
- Beneficiary is not pregnant, planning to become pregnant, or lactating;

CONTINUATION CRITERIA require all of the following:

- Prescriber must submit liver enzyme test results (ALT AST) and total bilirubin at month-1, month 3, and month 6 after initiation of treatment, and if results are all normal, then submit test results yearly thereafter; and provider must submit the LFTs within 1 month of EPIDIOLEX® dose changes or additions of or changes to other drugs that are known to impact the liver and continue follow-up at month 3 and month 6. For those receiving concomitant valproate or who have elevated liver enzymes at baseline, prescriber must submit test results every 3 months ongoing;
- Beneficiary is adherent to prescribed dose;
- Beneficiary must show positive improvement by a reduction from baseline in seizure frequency;

DENIAL CRITERIA, any one of the following:

- Beneficiary does not meet approval criteria;
- Beneficiary does not have seizures associated with Lennox-Gastaut syndrome or Dravet syndrome;
- Etiology of beneficiary's seizures is a progressive neurologic disease;

- Beneficiary has significantly impaired hepatic function, defined as any of the following: alanine aminotransferase (ALT) or aspartate aminotransferase (AST) > 5 × upper limit of normal (ULN); ALT or AST > 3 × ULN and total bilirubin > 2 × ULN or international normalized ratio (INR) > 1.5; ALT or AST > 3 × ULN with the presence of fatigue, nausea, vomiting, right upper quadrant pain or tenderness, fever, rash, and/or eosinophilia (>5%).
- Female beneficiary is pregnant (positive pregnancy test), lactating or planning pregnancy for 3 months thereafter;

QUANTITY LIMIT:

- The starting dosage is 2.5 mg/kg twice daily (5 mg/kg/day). After one week, the dosage can be increased to a maintenance dosage of 5 mg/kg twice daily (10 mg/kg/day);
- If further reduction of seizures is necessary, dose may be increased to a maximum of 10 mg/kg twice daily (20 mg/kg/day);
- Prescriber must submit beneficiary's weight and prescribed dose at every PA request;
- Calculating the dose and the quantity limit for the number of 100 mL bottles per month will be entered at the time of PA approval;
- Dose adjustment is recommended in patients with moderate (Child-Pugh B) hepatic impairment or severe (Child-Pugh C) hepatic impairment and the quantity limit of 100 ml bottles will be implemented at the time of PA approval;
- Per the package insert, it may be necessary to have slower dose titration in patients with moderate or severe hepatic impairment than in patients without hepatic impairment, so quantity limit will be adjusted accordingly;

9. NOCDURNA® (desmopressin acetate) SL Tablet, 27.7mcg, 55.3mcg
FERRING PARMACEUTICALS INC

MEDICAID estimated reimbursement rate: **$14 each tablet** for either strength; **#30 = $420.00 for a 30-day supply**
Dose is gender-based: 27.7 mcg for women; 55.3 mcg for men; Women are more sensitive to the effects of Nocdurna® and have a higher risk of hyponatremia.

MEDICAID reimbursement rate price comparison to generic desmopressin tablets:
0.1 mg = $0.642 each tablet; 0.2 mg = $0.664 each tablet

PROPOSAL:

NOCDURNA® (desmopressin acetate) tablet will require manual review PA on a case-by-case basis using all of the following:

APPROVAL CRITERIA, require all of the following:

- Provider must provide documentation to explain and substantiate the medical necessity of the beneficiary receiving NOCDURNA® SL tablet over the generic desmopressin tablets that do not require prior authorization;
- Beneficiary is adult ≥18 years of age;
- Provider must submit gender of the beneficiary at birth as the dose is gender-based because for women is lower than for men because women are more sensitive to the effects of NOCDURNA® and women have a higher risk of hyponatremia with the higher dose; approval dose is 27.7 mcg for women; 55.3 mcg for men;
- Provider must submit results of confirmed diagnosis of nocturnal polyuria using data from a 24-hour urine collection;
- Provider must submit baseline serum sodium concentration;
- Beneficiary is not pregnant or lactating;
- Initial approval is 1 month;

CONTINUATION CRITERIA require all of the following:

- Provider must submit serum sodium concentration 1 month after initiating NOCDURNA®, and every 3 months thereafter;
- Beneficiary is adherent to prescribed dose;

DENIAL CRITERIA, any one of the following:

- Beneficiary has an eGFR below 50 mL/min/1.73 m^2;
- Beneficiary is < 18 years of age;
- Beneficiary does not meet approval criteria;
- Beneficiary diagnosed with heart failure;
- Beneficiary currently prescribed loop diuretics or systemic or inhaled glucocorticoids;
- Beneficiary has hyponatremia or a history of hyponatremia
- Beneficiary has syndrome of inappropriate antidiuretic hormone secretion (SIADH);
- Beneficiary has illnesses that can cause fluid or electrolyte imbalance;
- Female beneficiary is pregnant;

QUANTITY LIMIT and other claim edits:

- 1 tablet daily;

10. LORBRENA® (lorlatinib) Tablet, 25mg, 100mg
PFIZER

MEDICAID Estimated Reimbursement Rate**: $178.398 each 25 mg tablet; $535.19 each 100 mg tablet;** Recommended dose is 100 mg once daily = **$16,055.70 for 30-day supply;**

PROPOSAL:

LORBRENA® (lorlatinib) tablet will require manual review PA on a case-by-case basis using all of the following:

APPROVAL CRITERIA, requires all of the following:

- Beneficiary is an adult age 18 years or older;
- Beneficiary has a diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC);
- Beneficiary has disease that progressed on
    - crizotinib and at least one other ALK inhibitor for metastatic disease; OR
    - alectinib as the first ALK inhibitor therapy for metastatic disease; OR
    - ceritinib as the first ALK inhibitor therapy for metastatic disease;
- Beneficiary documented ALK rearrangement in tumor tissue as determined by fluorescence in situ hybridization (FISH) assay or by Immunohistochemistry (IHC);
- Beneficiary has an ECOG score of 0, 1, or 2;
- Beneficiary is not pregnant, lactating, or planning to become pregnant;
- Dose and quantity limit entered at time of PA approval;
- Beneficiary is not receiving a strong CYP3A inducer;
- Provider must submit current baseline LFTs and lipid panel;
- Beneficiary is not Child-Pugh B or C;
- Provider must submit kidney function tests and beneficiary does not have severe renal impairment;
- Initial approval 1 month;

CONTINUATION CRITERIA require all of the following:

- No disease progression;
- Continued approval will be one month at a time for the first 3 months. If stable and experiencing no adverse reaction that requires a dose reduction, the PA may be approved for 3 months;
- Provider must provide information for any dose reductions since previous PA, and provide current dose with each PA request;
- Provider must submit current LFT results and lipid panel monthly for the first 3 months. Then if stable and experiencing no adverse reaction that requires dose reduction, labs can be submitted every 3 months;
- Beneficiary must be able to tolerate 50 mg once daily dose;

- Beneficiary must be adherent to prescribed dose;

DENIAL CRITERIA, any one of the following:

- Disease progression;
- Beneficiary cannot tolerate 50 mg once daily dose;
- Beneficiary is pregnant or lactating;
- Beneficiary is Child-Pugh B or C;

QUANTITY LIMIT and other claim edits:

- Dose reviewed, and quantity limit entered at the time of PA approval;

11. GALAFOLD™ (migalastat) Capsules, 123mg
    Amicus Therapeutics U.S., Inc

MEDICAID Estimated Reimbursement Rate: **$1,732.14 PER CAPSULE**; packaged as 14 capsules for a 28-day supply. **$24,249.96 per 28 days' supply;**

PROPOSAL:

GALAFOLD™ (migalastat) will require manual review PA on a case-by-case basis using all of the following:

APPROVAL CRITERIA, requires all of the following:

- Beneficiary is an adult ≥18 years of age;
- Provider must submit documentation that beneficiary has diagnosis of Fabry disease with renal manifestations, AND has an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data, AND the amenable variant must be a disease-causing variant;
- Beneficiary is on a low protein diet;
- Provider must submit beneficiary's urine albumin, urinary creatinine, serum creatinine, glomerular filtration rate (GFR), serum BUN, serum electrolytes, plasma globotriaosylsphingosine (lyso-Gb3) for the last 12 months;
- Beneficiary must have tried Enzyme Replacement Therapy and provider must submit Medication Administration Records (MARs) and response to therapy for the last 12 months;
- Provider must submit patient specific measurable treatment goals for outcomes with GALAFOLD™ and include the treatment plan if the measurable treatment goals are not met and GALAFOLD™ is discontinued;
- Initial approval can be for 6 months;

CONTINUATION CRITERIA require all of the following:

- Provider must submit current plasma globotriaosylsphingosine (lyso-Gb_3) at 6 months, 12 months, and 18 months;

- Beneficiary shows a positive response to therapy by a reduction from baseline of plasma globotriaosylsphingosine (lyso-Gb_3);
- Beneficiary is adherent to prescribed therapy;
- Continuation PAs may be approved for 6 months at a time;

DENIAL CRITERIA, any one of the following:

- Beneficiary does not have Fabry disease with an amenable galactosidase alpha gene (*GLA*) variant;
- The *GLA* variant is not a disease-causing variant;
- Beneficiary did not show positive response to therapy;
- Requests for dose exceeding 1 capsule every other day;

QUANTITY LIMIT and other claim edits:

- Quantity limited to 1 capsule every 2 days (dose is 1 capsule every other day);
- Quantity limited to 14 capsules for a 28-day supply;

12. ABILIFY MYCITE® (aripiprazole) Tablets, a drug-sensor device combination product
Otsuka America Pharmaceutical

Abilify Mycite® was not reviewed by the committee as it is not currently on the market and has no expected release date.

FRIENDLY REMINDERS:

1. **Effective March 1, 2019,** Arkansas Medicaid will implement **PASSE** (**Provider-Led Arkansas Shared Savings Entity**), a new Medicaid program to address the needs of individuals who have intensive behavioral health and intellectual and developmental disabilities service needs. The PASSE organizations will administer all medical needs *and all pharmacy prescription drug needs* for all PASSE members. **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**. In fact, DATA 2000 stipulates that when physicians submit notification to SAMHSA to obtain the required waiver to practice opioid addiction treatment outside the OTP setting, they must attest to their capacity to refer such patients for appropriate counseling and other nonpharmacological therapies." http://lib.adai.washington.edu/clearinghouse/downloads/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction-54.pdf

Per ASAM National Practice Guideline, in Part 5: Buprenorphine, Summary of Recommendations, # (5) "**Psychosocial treatment should be implemented in conjunction with the use of buprenorphine in the treatment of opioid use disorder**." https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf

3. **Chronic Pain Patients Who Do *Not* Need Treatment for Addiction**: Per the TIP 40: *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*: *Treatment Improvement Protocol (TIP) Series 40*: "Patients who need treatment for pain *but not for addiction* should be treated within the context of their regular medical or surgical setting. *They should not be transferred to an opioid maintenance treatment program simply because they are being prescribed opioids and have become physically dependent on the opioids during their medical treatment*." Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment. http://lib.adai.washington.edu/clearinghouse/downloads/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction-54.pdf

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 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*.

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."

Per ASAM National Practice Guidelines, the bold and italics were added for emphasis, but the following statement is pulled from the "At Induction" section of "Part 5: Buprenorphine", under Dosing, "Once it has been established that the initial dose is well tolerated, the buprenorphine dose can be increased fairly rapidly to **a dose *that provides stable effects for 24 hours* and is clinically effective**". https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf

6. **CIRCUMVENTING MEDICAID LIMITS FOR OPIOIDS AND BENZODIAZEPINES:**
Beneficiaries who pay *cash* for opioids to avoid Medicaid dose and quantity limits *or* pay cash *in addition to* the opioids paid for by Medicaid, result in a much higher daily MME than what is calculated in the Medicaid system edits, are above the CDC recommendations, and could *put the patient at risk for overdose*. **According to the CDC, the number of Arkansas deaths due to drug overdose increased 10.2% from December 2016 to December 2017.**

7. **The Maximum Daily Morphine Milligram Equivalent (MME) Dose WAS DECREASED on NOVEMBER 14, 2018 to ≤ 90 MME/day for non-cancer chronic pain beneficiaries.** Incoming opioid claims that cause the total MME/day to exceed the existing limit of ≤ 90 MME/day will *deny at point of sale* whether prescription is from same prescriber or different prescriber(s).

8. **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.***

9. **"CLAIM EDITS"** referred to in this memo include quantity edits, cumulative quantity edits, monthly quantity edits, age edits, gender edits, accumulation quantity edits, and daily dose edits.

10. **CHANGE IN MANUAL REVIEW PA FOR THE AGE OF CHILDREN PRESCRIBED ANTIPSYCHOTIC AGENTS, EFFECTIVE JANUARY 1, 2017:** 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 board certified child & adolescent psychiatrist.

11. **SECOND GENERATION ANTIDEPRESSANTS, TRAZODONE, AND TRICYCLIC ANTIDEPRESSANTS PRESCRIBED TO CHILDREN ≤ 3 YEARS OF AGE, *EFFECTIVE MARCH 8, 2017*:** The current point of sale (POS) prior approval (PA) criteria for the second-generation antidepressants, including Trazodone, were developed based on utilization for adults, and the minimum and maximum therapeutic doses were based on adult doses. ***Second Generation Antidepressants, Trazodone, or Tricyclic Antidepressants for Children ≤ 3 years of age will require manual review prior approval (PA) by the Medicaid Pharmacy Program child psychiatrist.*** The prescriber must submit the request in writing, explain the medical necessity for the child to receive the drug requested, and include chart notes and any other documentation that will substantiate the request and the dose. Each request will be reviewed on a case-by-case basis.

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

13. **HARD EDIT ON EARLY REFILL FOR CONTROLLED AND 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.

14. **REFILL TOO SOON ACCUMULATION LOGIC for NON-CONTROLLED DRUGS:** Beginning February 16, 2016, when a pharmacy refills a prescription claim early (e.g., for a non-controlled drug or a controlled drug 1 day early to 7 days early without a PA or sooner with a PA), 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. Once the beneficiary has accumulated an "extra" 15 days' supply for that GSN, any incoming claim that is early will reject at point of sale. For example, if the prescription drug claim was for a 30-day supply and was filled 7 days early on February 16, 2016, and filled 7 days early again on March 10, 2016, the beneficiary can only refill the prescription 1 day early on the next refill date, which would be April 8, 2016 (1 day early). The accumulation edit is set so that the beneficiary cannot accumulate *more than* an *extra* 15 days' supply early during a 180-day period. In this example, the drug claim cannot be filled early again until *after* August 14, 2016, which is 180 days from the February 16, 2016 date.

    Effective August 8, 2018, the RTS logic with Early Refill Accumulation Limited edit was revised for the **non-controlled drugs** which now **allow** an **accumulation of 12 days' supply during the previous 180-day period**.

Effective February 14, 2018, the RTS logic with Early Refill Accumulation Limit edit is **revised for the controlled drugs**. The revised edit for *controlled drugs* will only allow an extra 7-days' supply accumulation through early fills in previous 180-day period rather than an accumulation of an extra 15-days' supply. The RTS logic with Early Refill Accumulation Limit edit for non-controlled drugs will remain as is. Early refills for both controlled drugs and non-controlled drugs will continue to be monitored and may be adjusted in the future to reduce misuse.

15. **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.

16. **ANTIPSYCHOTIC AGENT CRITERIA FOR CHILDREN < 18 YEARS OF AGE 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.

17. **INFORMED CONSENT FORM FOR ANTIPSYCHOTIC AGENT PA FOR CHILDREN < 18 YEARS OF AGE:** 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 has been updated (v072914) and is posted on the Medicaid website. As the form is updated and posted on the Medicaid website, providers are required to use the most current form. Effective, Dec. 10, 2013, the old versions will no longer be accepted.

18. **FOR PDL REQUESTS AND FOR REQUESTS FOR ANTIPSYCHOTIC DRUGS: Effective JULY 1, 2016**, Providers requesting a Prior Authorization (PA) for a drug on the PDL or calling to request a Prior Authorization (PA) for an antipsychotic medication should call the **PDL PA Call Center at 1-800-424-7895**. **The PDL FAX number is: 1-800- 424-5739**. Please fax a letter explaining the medical necessity and include any supporting documentation, the beneficiary ID number, beneficiary name, and Medicaid Provider ID with your request.

19. **FOR NON-PDL DRUGS AND FOR NON-ANTIPYSCHOTIC DRUG REQUESTS:** Providers requesting a Prior Authorization (PA) should call the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895. For Prior Authorization (PA) requests requiring manual review, you may fax your request to the MMA Help Desk Fax at 1-800-424-7976. Please include any supporting documentation for the request with the fax, and include beneficiary ID number, beneficiary name, and physician Medicaid provider ID with your request. An approval, denial, or request for additional information will be returned by the close of business the following business day.

20. **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 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.

21. **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

22. **AR MEDICAID PHARMACY PROGRAM IS ON FACEBOOK:** The Arkansas Medicaid Pharmacy Program is now on Facebook. Please join our group page titled "AR Medicaid Pharmacy Provider Help Group". This is a closed group for providers of Arkansas Medicaid services or those who work for a provider of Arkansas Medicaid services and join requests will be verified. The group is administered by a State of Arkansas employee and a Magellan Medicaid Administration employee on his/her own time. The purpose of the group page is to help the provider community with any issues that involve billing or prescribing covered outpatient drugs through the Arkansas Medicaid Pharmacy Program. We will not disclose any PHI and will delete any posts that contain PHI. Want to know what criteria is needed for a drug? Don't know who to call to handle your issue? Just post your questions and we will answer.

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.