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# Provider Memorandum

TO: Arkansas Medicaid Enrolled Prescribing Providers and Pharmacy Providers
FROM: Cynthia Neuhofel, Pharm.D. Division of Medical Services Pharmacy Program
DATE: May 13, 2026
SUBJ: AR Medicaid Prior Authorization Edits and Preferred Drug List updates approved at the AR Medicaid DUR Board April 15, 2026 meeting for the following:

**Preferred Drug List Full Review:** $H_2$ Receptor Blockers, Thyroid Products, Octreotide and Related Agents, Diuretics, and Bone Resorption Suppression and Related Agents (osteoporosis)

**Preferred Drug List Abbreviated Review:** Antidepressants, Pituitary Suppressive Agents, CII Stimulants, and Lipotropics Excluding Statins

**Manual Review PA Criteria:** Allergic Fungal Rhinosinusitis (AFRS), Cardamyst™ (etripamil), Voyxact® (sibeprenlimab), Aqvesme™ (mitapivat), MyQorzo™ (aficamten), Forzinity™ (elamipretide hydrochloride), Zycubo® (copper histidinate), Pivya™ (pivmecillinam), and Loargys® (pegzilarginase-nbln)

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# I. ANNOUNCEMENTS

## 1. QUARTERLY NEWSLETTER

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

The April 2026 quarterly newsletter can be found with the following link.
**https://ar.primetherapeutics.com/documents/d/arkansas/armquarterlynewsletterapril2026**

## 2. INFORMATIONAL DRUG UPDATES

### a. LIFYORLI (relacorilant) 25 mg and 100 mg capsules

This medication has been added to the oncology policy.

**https://ar.primetherapeutics.com/documents/d/arkansas/oncology_policy_04172024**
LIFYORLI is indicated in combination with nab-paclitaxel for the treatment of adults with platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer who have received one to three prior systemic treatment regimens, at least one of which included bevacizumab.

The recommended dosage of LIFYORLI is 150 mg orally once on the day before, the day of, and the day after each nab-paclitaxel infusion until disease progression or unacceptable toxicity. The recommended dosage for nab-paclitaxel is 80 $mg/m^2$ administered as an intravenous infusion on Days 1, 8 and 15 of each 28-day cycle until disease progression or unacceptable toxicity.

### b. WEGOVY (semaglutide) tablets

INDICATIONS:
WEGOVY tablets are indicated in combination with a reduced calorie diet and increased physical activity:

- To reduce the risk of major adverse CV events (CV death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established CV disease and either obesity or overweight.
- To reduce excess body weight and maintain weight reduction long term in adults with obesity, or in adults with overweight in the presence of at least one weight-related comorbid condition.

**NOTE: Wegovy tablets have been added to the Wegovy injection page in the PA criteria document concerning the MACE indication. The tablets will follow the same criteria as the injection. The Arkansas Medicaid Pharmacy Program does not cover medications for weight loss.**

## 3. NCPDP VERSION F6 INFORMATION

- National Council for Prescription Drug Programs (NCPDP) Version D.0 will be converted to version F6 based on a final CMS rule 0056-P which was published 12/13/2024.
- The rule requires modifications to:
    - Standards of pharmacy claims
    - Pharmacy batch claims
    - Medicaid subrogation
- Version F6 enables the following:
    - Modernization to adapt transactions to health care industry needs
    - Support transparency by improving clarity and reducing data exceptions
    - Readiness for future regulatory and industry changes
    - Improved member experience by reducing medication access delays
        - Reduces false rejections
        - Improves clarity to avoid false positives for prior authorization
        - Clarifies cost-share responses
        - Provides better support for utilization management and refill too soon
- Version F6 Transaction Changes:
    - New and updated claim segments, fields, and values, including retirement of select fields
    - Expanded dollar fields to support 11- and 14-digit values
    - Expanded Product Service ID (NDC) fields to 40 characters
    - Field name and size changes across multiple transaction elements
    - Changes to claim segment counts affecting transaction structure
    - 400+ external code list updates impacting validation and processing
    - Issuer Identification Number (IIN) replaces BIN and expands to 8 digits
    - New adjudicated program type field enabling more granular plan identification during adjudication
- Early option start with transition from D.0 to F6 begins 8/14/2027 with compliance required by 4/14/2028.
- More communication will come when Medicaid is ready to accept the new layouts.
- References
    - Federal Register :: Administrative Simplification: Modifications of Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Council for Prescription Drug Programs (NCPDP) Retail Pharmacy Standards; and Modification of the Medicaid Pharmacy Subrogation Standard
    - Proposed Modifications to the National Council for Prescription Drug Programs Retail Pharmacy Standards and Adoption of a New Pharmacy Subrogation Standard (CMS-0056-P)

## 4. PHYSICIAN ADMINISTERED DRUGS UPDATE

https://ar.primetherapeutics.com/documents/d/arkansas/arkansas_medicaid_pad_criteria

## 5. PREFERRED DRUG LIST

**PDL UPDATE EFFECTIVE JULY 1, 2026**
**PRIOR AUTHORIZATION CRITERIA EFFECTIVE APRIL 15, 2026**

### a. CLASSES WITH FULL REVIEW WITHOUT CRITERIA

#### *i. $H_2$ RECEPTOR BLOCKERS (NEW PDL CLASS)*

**Preferred Agents**

- famotidine tablet (generic for PEPCID)
- famotidine OTC
- famotidine/calcium carbonate/magnesium hydroxide OTC

**Preferred Agents with Criteria**

- famotidine suspension (generic for PEPCID)

**Famotidine suspension point-of-sale (POS) criteria**

- < 7 years of age; OR
- NPO (Appendix A) within the past 365 days

**Non-preferred Agents**

- cimetidine (generic for TAGAMET)
- nizatidine (generic for AXID)
- ranitidine (generic for ZANTAC)

### b. CLASSES WITH FULL REVIEW WITH CRITERIA

#### *i. THYROID PRODUCTS (NEW PDL CLASS)*

**Preferred Agents**

- ARMOUR THYROID (thyroid, pork)
- levothyroxine tablet (generic for SYNTHROID)
- liothyronine tablet (generic for CYTOMEL)
- NIVA THYROID (thyroid, pork)
- NP THYROID (thyroid, pork)
- thyroid, pork

**Non-preferred Agents**

- ADTHYZA (thyroid, pork)
- CYTOMEL (liothyronine)
- ERMEZA (levothyroxine) —Manufacturer obsolete 11/14/2025
- EVEXITHROID (thyroid, pork)
- LEVO-T (levothyroxine)
- levothyroxine vial
- LEVOXYL (levothyroxine)
- LIOMNY (liothyronine)
- liothyronine vial (generic for TRIOSTAT)
- RENTHYROID (thyroid, pork)
- SYNTHROID (levothyroxine)
- THYQUIDITY (levothyroxine)
- UNITHROID (levothyroxine)

**Levothyroxine solution (Ermeza® and Thyquidity®)**
**APPROVAL CRITERIA:**

- Manual review on a case-by-case basis
- Beneficiary must be diagnosed with ONE of the following:
    - primary (thyroidal), secondary (pituitary), and tertiary (hypothalamic) congenital or acquired hypothyroidism
    - adjunct to surgery and radioiodine therapy in the management of thyrotropin-dependent well-differentiated thyroid cancer
- Prescriber must submit the following:
    - Current chart notes
    - Current labs (TSH, T4)
    - Letter of medical necessity over levothyroxine tablet

**RENEWAL REQUIREMENTS:**

- Beneficiary must be compliant with therapy (defined as 75% utilization)
- Prescriber must submit the following:
    - Current chart notes
    - Current labs (TSH, T4)
    - Continued need over levothyroxine tablet

*ii. OCTREOTIDE AND RELATED PRODUCTS (NEW PDL CLASS)*

**Preferred Agents with Criteria**

- octreotide acetate syringe (generic for SANDOSTATIN)
- SANDOSTATIN LAR DEPOT (octreotide)—**Brand only**

**Non-preferred Agents**

- octreotide acetate ampule and vial (generic for SANDOSTATIN)
- SANDOSTATIN (octreotide)
- BYNFEZIA (octreotide)
- lanreotide acetate (generic for SOMATULINE DEPOT)
- octreotide ER (generic for SANDOSTATIN LAR DEPOT)
- SOMAVERT (pegvisomant)
- SOMATULINE DEPOT (lanreotide)
- MYCAPSSA (octreotide)
- SIGNIFOR (pasireotide)
- PALSONIFY (paltusotine)

**PHARMACY PRIOR AUTHORIZATION CRITERIA:**

**1. MYCAPSSA capsule (octreotide)**

**(Pharmacy claim only)**

**APPROVAL CRITERIA:**

- Manual review on a case-by-case basis
- Beneficiary is diagnosed with acromegaly and has responded to and tolerated treatment with octreotide or lanreotide
- Beneficiary has elevated insulin-like growth factor-1 (IGF-1) levels for age and/or gender
- Must be prescribed by, or in consultation with, an endocrinologist or oncologist
- Beneficiary should not be approved or continue this therapy with any of the following:
    - Has not tried either octreotide or lanreotide injections
    - Has end stage renal disease (must start at 20 mg daily)
- Prescriber must submit the following:
    - Current chart notes
    - Previous therapies tried
    - Baseline IGF-1 level
    - Documentation that beneficiary has had an inadequate response to surgery or is not a candidate for surgery
    - Letter of medical necessity with clinically significant reason the beneficiary cannot continue their current injectable medication or start therapy on a preferred product

**RENEWAL REQUIREMENTS:**

- Beneficiary has been compliant with therapy (defined as 75% utilization)
- Beneficiary has a positive response to treatment similar to the injection somatostatin product with decrease or normalized IGF-1 level
- Prescriber must submit the following:
    - Current chart notes
    - Current IGF-1 level

2. **SANDOSTATIN LAR DEPOT (octreotide acetate)/octreotide ER vial AND octreotide vial, syringe, and ampule/Sandostatin ampule/Bynfezia pen**

**(Available as pharmacy and medical claim)**

- **J2353 for Sandostatin LAR Depot/octreotide ER vial**
- **J2354 for octreotide ampule, vial and syringe, Sandostatin ampule, or Bynfezia pen**

**APPROVAL CRITERIA:**

- Manual review on a case-by-case basis
- Beneficiary must be diagnosed with one of the following:
    - Acromegaly confirmed by elevated IGFF-1 and inadequate suppression of growth hormone (GH) after a glucose load with an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy, is not an option.
    - Severe diarrhea and flushing episodes associated with metastatic carcinoid /neuroendocrine tumors
    - Profuse watery diarrhea associated with vasoactive intestinal peptide tumors (VIPomas)
- Prescribed by or in consultation with an endocrinologist, oncologist, hematologist or palliative care specialist
- Beneficiary should not be approved or continue this therapy with any of the following:
    - Develops complications of cholelithiasis
    - If request is for LAR Depot and has not tried regular octreotide injection to ensure tolerability
- Prescriber must submit the following:
    - Current chart notes with documentation of diagnosis
    - Previous therapies tried with response
    - If no surgery or radiation, provide rationale for requesting in acromegaly patients
    - Baseline labs--Monitor the following at baseline and throughout treatment
        - Acromegaly: Growth Hormone, IGF-1 (somatomedin C)
        - Carcinoid: 5-HIAA (urinary 5-hydroxyindole acetic acid), plasma serotonin, plasma Substance P
        - VIPoma: VIP (plasma vasoactive intestinal peptide) baseline and periodic total and/or free T4 measurements should be performed during chronic therapy
        - Additional monitoring—blood glucose, TSH, total and/or free T4, vitamin B12, zinc

**RENEWAL REQUIREMENTS:**

- Beneficiary must be compliant on therapy (defined as 75% utilization)
- Beneficiary must demonstrate a positive response to treatment with an improvement in beneficiary's symptoms, including reduction in symptomatic episodes (e.g., diarrhea, rapid gastric dumping, flushing, bleeding, etc.), stabilization of glucose levels, or decrease in size of tumor or tumor spread
- Beneficiary must have an absence of unacceptable toxicity from the drug (e.g., biliary tract abnormalities, hypothyroidism, goiter, sinus bradycardia, cardiac arrhythmias, cardiac conduction abnormalities, pancreatitis, etc.)
- Prescriber must submit the following:
    - Current chart notes
    - Provide current labs as listed below
        - Acromegaly: Growth Hormone, IGF-1 (somatomedin C)
        - Carcinoid: 5-HIAA (urinary 5-hydroxyindole acetic acid), plasma serotonin, plasma Substance P
        - VIPoma: VIP (plasma vasoactive intestinal peptide) baseline and periodic total and/or free T4 measurements should be performed during chronic therapy
        - Additional monitoring—blood glucose, TSH, total and/or free T4, vitamin B12, zinc

**3. PALSONIFY (paltusotine) tablet**

**(Pharmacy claim only)**

**APPROVAL CRITERIA:**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must have a diagnosis of acromegaly with ONE of the following:
    - Had an inadequate response to surgical resection as indicated by growth hormone and serum insulin-like growth factor 1 (IGF-1) are above the reference ranges
    - Not a candidate for surgical resection
- Prescribed by, or in consultation with, a specialist knowledgeable in acromegaly (e.g., endocrinologist, oncologist)

- Beneficiary with concomitant moderate or strong CYP3A4 inducers or proton pump inhibitors may require a dose modification for PALSONIFY
- Prescriber must submit the following:
    - Current chart notes
    - Previous therapies tried with response
    - Rationale for prescribing if patient has not had surgery
    - Current labs including baseline IGF-1 level, growth hormone
    - Letter of medical necessity with clinically significant reason the beneficiary cannot continue their current injectable medication or start therapy on a preferred product

**RENEWAL REQUIREMENTS:**

- Beneficiary must remain compliant on therapy (defined as 75% utilization)
- Beneficiary must have a positive clinical response (e.g., decrease in symptom severity/frequency, reduction in adenoma size, reduction in IGF-1 and/or growth hormone levels)
- Beneficiary that develops cholelithiasis should discontinue
- Prescriber must submit the following:
    - Current chart notes
    - Documentation of response to therapy
    - Current labs including baseline IGF-1, growth hormone

**4. SOMAVERT injection (pegvisomant)**

**(Pharmacy claim only)**

**APPROVAL CRITERIA:**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with elevated serum insulin-like growth factor-1 (IGF-1) due to acromegaly with an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy, is not an option.
- Prescribed by or in consultation with an endocrinologist or oncologist
- Beneficiary's dose should not be based on growth hormone concentrations or sign/symptoms. The dose should be titrated to normalize serum IGF-1 concentration.

- Prescriber must submit the following:
    - Current chart notes with documentation of diagnosis
    - Previous therapies tried with response
    - If no surgery or radiation, provide rationale for requesting in acromegaly patients
    - Baseline labs--Monitor the following at baseline and throughout treatment IGF-1
    - Baseline liver function tests

**RENEWAL REQUIREMENTS:**

- Beneficiary must remain compliant on therapy (defined as 75% utilization)
- Beneficiary must have a positive response to therapy with a decrease in serum IGF-1
- Prescriber must submit the following:
    - Current chart notes
    - Updated labs including IGF-1 and liver function tests

**5. SIGNIFOR ampule (pasireotide)**

**(Pharmacy claim only)**

**APPROVAL CRITERIA:**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with Cushing's disease and pituitary surgery is not an option or has not been curative
- Must be prescribed by, or in consultation with, an endocrinologist
- Beneficiary should be monitored and therapy adjusted with the following:
    - Consider interrupting therapy if beneficiary develops hypocortisolism
    - Consider discontinuing if beneficiary develops uncontrolled hyperglycemia
    - If cholelithiasis is suspected, discontinue therapy
    - Consider altering other therapy if bradycardia or QT prolongation develops
    - Moderate hepatic impairment (Child-Pugh B) requires dose adjustment

- Beneficiary should not be approved or continue this therapy with any of the following:
    - Has severe hepatic impairment (Child-Pugh C)
- Prescriber must submit the following:
    - Current chart notes with patient specific symptoms of Cushing's syndrome
    - Baseline labs--Monitor the following at baseline and throughout treatment
        - Urinary free cortisol (UFC) level
        - Fasting plasma glucose, hemoglobin A1c, liver tests, serum potassium and magnesium level
        - Pituitary function (TSH/free T4, GH/IGF-1)
    - Baseline ECG

**RENEWAL REQUIREMENTS:**

- Beneficiary must remain compliant on therapy (defined as 75% utilization)
- Beneficiary must have a positive response from therapy with decrease in urine free cortisol (UFC) compared to baseline after 6 months of therapy
- Prescriber must submit the following:
    - Current chart notes with updated patient specific symptoms of Cushing's syndrome
    - Current labs
        - Urinary free cortisol (UFC) level
        - Fasting plasma glucose, hemoglobin A1c, liver tests, serum potassium and magnesium level
        - Pituitary function (TSH/free T4, GH/IGF-1)

**6. SOMATULINE DEPOT (lanreotide acetate) and generic**

**(Available as pharmacy and medical claim)—J1930**

**APPROVAL CRITERIA:**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with **ONE** of the following:
    - Acromegaly confirmed by elevated IGF-1 and inadequate suppression of growth hormone (GH) after a glucose load with

an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy, is not an option.
    - Gastroenteropancreatic Neuroendocrine Tumors (GEP-NETs) that are unresectable, well or moderately differentiated, and locally advanced or metastatic
    - Carcinoid Syndrome (flushing or diarrhea) to reduce the frequency of short-acting somatostatin analog rescue therapy
- Must be prescribed by, or in consultation with an endocrinologist or oncologist
- Prescriber must submit the following:
    - Current chart notes
    - Previous therapies tried with response
    - If no surgery or radiation, provide rationale for requesting in acromegaly patients
    - Baseline labs including Growth Hormone, IGF-1 (somatomedin C) for acromegaly patients

**RENEWAL REQUIREMENTS:**

- Authorizations can be renewed based on the following:
    - Absence of unacceptable toxicity from the drug (e.g., formation of gallstones, cardiovascular abnormalities [bradycardia, sinus bradycardia, and hypertension], uncontrolled blood glucose abnormalities [hyperglycemia or hypoglycemia], thyroid disorders [hypothyroidism], etc.)
    - **Acromegaly:**
        - Disease response, as indicated by an improvement in signs and symptoms compared to baseline:
            - Reduction of growth hormone
            - Age-adjusted normalization of serum IGF-1
    - **Gastroenteropancreatic neuroendocrine tumors (GEP-NETs):**
        - Disease response with treatment, as indicated by an improvement in symptoms, including reduction in symptomatic episodes (e.g., diarrhea, rapid gastric dumping, flushing, bleeding, etc.), stabilization of glucose levels, or decrease in tumor size or tumor spread.
    - **Carcinoid syndrome:**
        - Disease response with treatment, as indicated by reduction in use of short-acting somatostatin analog rescue medication (e.g., octreotide), an improvement in symptoms, including reduction in symptomatic episodes

(such as diarrhea, flushing), or decrease in tumor size or tumor spread.

- Prescriber must submit the following:
  - Current chart notes
  - Provide current labs

iii. DIURETICS (NEW PDL CLASS)

**Preferred Agents**

- amiloride (generic for MIDAMOR)
- bumetanide tablet (generic for BUMEX)
- chlorthalidone (generic for HEMICLOR)
- eplerenone (generic for INSPRA)
- furosemide oral solution and tablet (generic for LASIX)
- hydrochlorothiazide (generic for HYDRODIURIL)
- indapamide (generic for LOZOL)
- metolazone (generic for ZAROXOLYN)
- spironolactone tablet (generic for ALDACTONE)
- spironolactone/HCTZ (generic for ALDACTAZIDE)
- torsemide (generic for DEMADEX)
- triamterene/HCTZ capsule (generic for DYAZIDE)
- triamterene/HCTZ tablet (generic for MAXZIDE)

**Preferred Agent with Criteria**

- LASIX ONYU (furosemide) kit—see manual review criteria

**Non-Preferred Agents**

- ALDACTONE (spironolactone)
- amiloride/HCTZ (generic for MODURETIC)
- CAROSPIR (spironolactone)—see manual review criteria
- ENBUMYST (bumetanide)—see manual review criteria
- ethacrynic acid tablet (generic for EDECRIN)
- FUROSCIX (furosemide) kit—see manual review criteria
- HEMICLOR (chlorthalidone)
- INSPRA (eplerenone)—manufacturer obsolete 02/04/2026
- INZIRQO (hydrochlorothiazide)—see manual review criteria
- KERENDIA (finerenone)—see manual review criteria
- LASIX (furosemide)
- spironolactone susp (generic for CAROSPIR) —see manual review criteria
- THALITONE (chlorthalidone)
- triamterene (generic for DYRENIUM)

**PHARMACY PRIOR AUTHORIZATION CRITERIA:**

**1. CAROSPIR (spironolactone) suspension**

**APPROVAL CRITERIA:**

- The beneficiary is an adult age ≥ 18 years of age; AND

- The beneficiary has an NPO (Appendix A) diagnosis in Medicaid medical history in the previous 365 days

**DENIAL CRITERIA:**

- Hyperkalemia diagnosis in the previous 60 days
- The beneficiary has concomitant administration with potassium supplementation drug claim in previous 60 days; OR
- Addison's disease diagnosis in the previous 2 years; OR
- Concomitant use of eplerenone claim in previous 60 days; OR
- The beneficiary has lithium drug claim in history in the previous 60 days; OR
- The beneficiary is pregnant

**2. ENBUMYST (bumetanide) 0.5 mg per unit-dose spray**

**APPROVAL CRITERIA:**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with edema associated with congestive heart failure (CHF), hepatic and renal disease, including nephrotic syndrome
- Must be prescribed by, or in consultation with, a cardiologist, hepatologist, or nephrologist
- Beneficiary must be adherent to standard of care therapies including CHF therapies (i.e., ACE/ARB, beta blockers, salt restrictions) or medications for renal disease (i.e., SGLT-2 inhibitors, diuretics), if applicable
- Beneficiary must have documented recent weight gain and increased edema or other symptoms of extracellular volume expansion (e.g., jugular venous distention, pulmonary congestion or rales)
- Beneficiary must have tried and failed oral furosemide (160 mg) **AND** one of the following oral antidiuretics:
    - Torsemide (40 mg)
    - Bumetanide (4 mg)
- Prescriber must submit the following:
    - Current chart notes with diagnosis contributing to edema noted
    - Current and previous therapies tried

- Medical necessity over oral antidiuretics
- Current and baseline weight
- Confirmation that beneficiary has a history of at least one prior hospitalization or emergency department visit due to heart failure or chronic kidney disease exacerbations and/or fluid overload
- Current labs
- Attestation that ENBUMYST will be used short-term then transitioned back to oral diuretics as soon as practical.

**RENEWAL REQUIREMENTS:**

- Beneficiary continues to have episodes of edema due to underlying illness
- Beneficiary has documented positive response to the use of ENBUMYST with a decrease in edema to prevent hospitalization
- Prescriber must submit the following:
  - Current chart notes
  - Continued treatment plan for edema
  - Current weight and description of edema

### 3. FUROSCIX (furosemide) 80 mg/ml injection

**APPROVAL CRITERIA**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with fluid overload and with **ONE** of the following:
  - New York Heart Association (NYHA) Class III chronic heart failure; **OR**
  - Chronic Kidney Disease (CKD); **OR**
  - Diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- Must be prescribed by or in consultation with a cardiologist
- Beneficiary must have tried and failed oral furosemide (160 mg) **AND** one of the following:
  - Torsemide (40 mg)

    - Bumetanide (4 mg)
- Beneficiary must be adherent to CHF therapies (i.e., ACE/ARB, beta blockers, salt restrictions) or medications for CKD (i.e., SGLT-2 inhibitors, diuretics)
- Beneficiary must have documented recent weight gain and increased edema or other symptoms of extracellular volume expansion (e.g., jugular venous distention, pulmonary congestion or rales)
- Prescriber must submit ALL the following:
    - Current chart notes
    - Current and previous therapies for heart failure
    - Medical necessity over oral and IV furosemide and other preferred diuretics
    - Current and baseline weight
    - Confirmation that beneficiary has a history of at least one prior hospitalization or emergency department visit due to heart failure or chronic kidney disease exacerbations and/or fluid overload, and the beneficiary is stable enough to avoid hospitalization at the time of administration
    - Current labs
    - Attestation that FUROSCIX will be used short-term then transitioned back to oral diuretics as soon as practical.

**RENEWAL REQUIREMENTS:**

- Beneficiary continues to have fluid overload
- Prescriber must submit the following:
    - Current chart notes
    - Continued treatment plan for fluid overload
    - Current weight and description of edema

**4. INZIRQO (hydrochlorothiazide) 10 mg/mL suspension**

**APPROVAL CRITERIA (POINT-OF-SALE (POS) EDITS):**

- The beneficiary is < 7 years of age or have a diagnosis of NPO (Appendix A) in the last 365 days; AND
- Billed diagnosis of hypertension or edema in the last 2 years

**BENEFICIARY NOT MEETING POS CRITERIA:**

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication

- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with hypertension or edema associated with congestive heart failure, hepatic cirrhosis, or renal disease or a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The prescriber must submit the following:
    - Current chart notes
    - Baseline blood pressure or description of edema
    - Medical necessity over hydrochlorothiazide tablet and capsule; AND
    - For beneficiaries 7 years of age and older, attestation of NPO status will be required every 6 months (effective 8/1/2025)

**RENEWAL REQUIREMENTS:**

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary should have an improvement with underlying diagnosis
- The prescriber must submit the following:
    - Current chart notes
    - Current blood pressure or description of edema; AND
    - Continued medical necessity of Inzirqo suspension over oral solid dosage forms

**QUANTITY EDITS:**

- 2 bottles per month (if the beneficiary requires a higher dose, a quantity override can be entered)

**5. KERENDIA (finerenone) tablet**

**APPROVAL CRITERIA:**

- The beneficiary must be ≥ 18 years of age; AND
- The beneficiary must be diagnosed with one of the following:
    - Type 2 diabetes mellitus and chronic kidney disease (CKD) with a risk of sustained estimated glomerular filtration rate (eGFR) decline, end stage kidney disease, cardiovascular death, non-fatal myocardial infarction, and hospitalization for heart failure; OR
    - Heart failure (HF) with left ventricular ejection fraction (LVEF) ≥ 40% with risk of cardiovascular death, hospitalization for heart failure, or urgent heart failure visits
- The beneficiary must have eGFR ≥ 25 mL/min/1.73m$^2$

- The beneficiary with CKD must have UACR of ≥ 30 mg/g
- The beneficiary's dose must be consistent with the package insert based on current eGFR and potassium levels
- The beneficiary with CKD should be taking an angiotensin-converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) unless contraindicated
- The beneficiary with HF should be taking standard of care heart failure medications
- The beneficiary must be a non-smoker or must be participating in a tobacco cessation program
- The beneficiary must have a normal serum potassium level (< 5 mEq/L)
- The beneficiary is not receiving concomitant strong CYP3A4 inhibitors (e.g., fluconazole) and strong or moderate CYP3A4 inducers (e.g., efavirenz, rifampicin)
- The beneficiary has not been diagnosed with adrenal insufficiency (Addison's disease)
- The beneficiary must not have severe hepatic impairment (Child Pugh C)
- The prescriber must submit the following:
    - Current chart notes
    - Documentation of previous therapies tried, and symptoms associated with HF or CKD
    - Current labs, including potassium and eGFR
    - For beneficiary with HF: current blood pressure, weight, LVEF and documentation of HF events
    - For beneficiary with CKD: current Urinary Albumin-to-Creatinine Ratio (UACR)
- Initial approval for 3 months

**RENEWAL REQUIREMENTS:**

- The beneficiary with CKD must demonstrate a decrease in UACR and sustained or improved eGFR after dose titration
- The beneficiary must be a non-smoker or remain in a tobacco cessation program
- The beneficiary must have a potassium level that remains < 5.5 mEq/L
- The prescriber must submit the following:
    - Current chart notes and updated potassium level and eGFR
    - For beneficiary with HF – current blood pressure, weight, LVEF and any change in HF symptoms
    - For beneficiary with CKD – current Urinary Albumin-to-Creatinine Ratio (UACR); AND
    - Attestation that HF beneficiary has demonstrated stabilization or improvement based on functional status (e.g., improved HF symptoms, improved LVEF, decrease in hospitalizations)

- Approval for 6 months

**QUANTITY EDITS:**

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

**6. LASIX ONYU (furosemide) 80 mg single-dose prefilled cartridge**

**APPROVAL CRITERIA:**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with chronic heart failure
- Must be prescribed by, or in consultation with, a cardiologist
- Beneficiary must have tried and failed oral furosemide (160 mg) **AND** one of the following:
    - Torsemide (40 mg)
    - Bumetanide (4 mg)
- Beneficiary must be adherent to CHF therapies (i.e., ACE/ARB, beta blockers, salt restrictions)
- Beneficiary must have documented recent weight gain and increased edema or other symptoms of extracellular volume expansion (e.g., jugular venous distention, pulmonary congestion or rales)
- Prescriber must submit ALL the following:
    - Current chart notes
    - Current and previous therapies for heart failure
    - Medical necessity over oral and IV furosemide and other diuretics
    - Current and baseline weight
    - Confirmation that beneficiary has a history of at least one prior hospitalization or emergency department visit due to heart failure
    - Current labs
    - Attestation that LASIX ONYU will be used short-term then transitioned back to oral diuretics as soon as practical.

**RENEWAL REQUIREMENTS:**

- Beneficiary continues to have episodes of edema associated with heart failure
- Beneficiary has documented positive response to the use of LASIX ONYU with a decrease in edema to prevent hospitalization
- Prescriber must submit the following:
    - Current chart notes
    - Continued treatment plan for edema
    - Current weight and description of edema

iv. BONE RESORPTION SUPPRESSION AND RELATED AGENTS

**Preferred Agents**

- alendronate sodium tablet (generic for FOSAMAX)

**Preferred Agents with Criteria**

- **BONSITY (teriparatide)**
- **ENOBY (denosumab)—biosimilar for PROLIA**
- **FORTEO (teriparatide)—BRAND NAME ONLY**
- **XTRENBO (denosumab)—biosimilar for XGEVA**

**Non-Preferred Agents**

- ACTONEL (risedronate)
- alendronate solution (generic for FOSAMAX)
- ATELVIA (risedronate DR)
- **AUKELSO (biosimilar for XGEVA)**
- BILDYOS (biosimilar for PROLIA)
- **BILPREVDA (biosimilar for XGEVA)**
- BINOSTO (alendronate)
- **BOMYNTRA (biosimilar for XGEVA)**
- BOSAYA (biosimilar for PROLIA)
- calcitonin salmon (generic for MIACALCIN)
- CONEXXENCE (biosimilar for PROLIA)
- EVENITY (romosozumab-aqqg)
- EVISTA (raloxifene)
- FOSAMAX (alendronate)
- FOSAMAX PLUS D (alendronate/cholecalciferol)
- ibandronate tablet (generic for BONIVA)
- JUBBONTI (biosimilar for PROLIA)
- MIACALCIN (calcitonin salmon)
- OSENVELT (biosimilar for PROLIA)
- **PROLIA (denosumab)**
- **raloxifene (generic for EVISTA)**
- risedronate (generic for ACTONEL)
- risedronate DR (generic for ATELVIA)
- STOBOCLO (biosimilar for PROLIA)
- teriparatide (generic for FORTEO)

- TYMLOS (abaloparatide)
- WYOST (biosimilar for PROLIA)
- **XGEVA (denosumab)**

**PHARMACY PRIOR AUTHORIZATION CRITERIA:**

**APPROVAL CRITERIA:**
**Non-Preferred Bisphosphonates**

- Requires chart notes for manual review
- Requires documentation of medical necessity over preferred options

**General criteria for the class**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for the FDA approved indication
- Beneficiary must follow the preferred drug list
- Beneficiary has a documented contraindication, intolerance, treatment failure, or ineffective response to oral bisphosphonates or intravenous (IV) bisphosphonates (e.g., alendronate, risedronate, ibandronate, or zoledronic acid).
    - Ineffective response is defined as a further decrease in T-score or new fracture after 12 months of therapy
    - If oral bisphosphonate is contraindicated or patient is intolerant, intravenous bisphosphonate should be tried
    - Therapy should consist of the bisphosphonate along with adequate calcium and vitamin D
- Beneficiary meets **ONE** of the following pertaining to osteoporosis:
    - History of fragility or low trauma fracture (other than skull, facial bone, finger, or toes) as an adult
    - Bone mineral density scan (BMD) via bone density scan (DXA) T-score ≤ -2.5 at the conventional skeletal sites including the total hip, femoral neck, lumbar spine (posterior-anterior, not lateral), or radius
    - Bone mineral density (BMD) T-score of -1.0 to -2.5 at the femoral neck or lumbar spine and a 10-year probability of hip fracture > 3% or a 10-year probability of a major osteoporosis-related fracture > 20%
    - Prostate cancer treated with androgen deprivation therapy with bone mineral density (BMD) T-score of ≤ -1.0 at the conventional skeletal sites including the total hip, femoral neck, lumbar spine (posterior-anterior, not lateral) or radius
- Prescriber must submit the following information for any request:
    - Current chart notes
    - Bone mineral density (BMD) T-scores (e.g., DXA scan)
    - Medical necessity for the use of the prescribed medication over the use of preferred bisphosphonates with calcium and vitamin D
- If approved, approval for 6 months

**Additional drug specific criteria**

- **Additional approval criteria for denosumab (Prolia® and biosimilars)**
    - Beneficiary must be diagnosed with **ONE** of the following:
        - Osteoporosis (men and women)—women should be postmenopausal
        - Osteoporosis (men and women) due to sustained systemic glucocorticoid therapy with high risk of fracture
        - Osteoporosis for prostate cancer patient receiving androgen deprivation therapy
        - Osteoporosis for breast cancer patient receiving aromatase inhibitor therapy
    - Continuation criteria applies if denosumab claim (Prolia® or biosimilars) is found in the Medicaid drug history in the previous 12 months
    - Therapeutic duplication is not allowed with Xgeva® or its biosimilars, and claim will deny at point-of-sale if a claim for Xgeva® or biosimilars is seen in history in previous 6 months
    - After completion of therapy, sequential therapy with an oral or injectable antiresorptive agent is recommended.

- **Additional approval criteria for Forteo® (teriparatide) or biosimilars, Tymlos® (abaloparatide), and Bonsity® (teriparatide)**
    - Beneficiary must be diagnosed with **ONE** of the following:
        - Postmenopausal women with osteoporosis and high risk of fracture (Forteo®, Tymlos®, and Bonsity®)
        - Primary or hypogonadal osteoporosis (men) with high risk for fracture (Forteo® and Bonsity®)
        - Osteoporosis (men or women) due to sustained systemic glucocorticoid therapy with high risk of fracture (Forteo® and Bonsity®)
        - Osteoporosis in men with high risk for fracture (Tymlos®)
    - Beneficiary cannot exceed 24 months of therapy in their lifetime
    - Medical necessity over the use of denosumab and preferred bisphosphonates
    - For Tymlos®, provide the medical necessity over Forteo®/Bonsity® if other criteria are met
    - After completion of therapy, sequential therapy with an oral or injectable antiresorptive agent is recommended.

- **Additional approval criteria for Evenity® (romosozumab-aqqg)**
    - Beneficiary must be a postmenopausal woman with osteoporosis at high risk for fracture
    - Beneficiary must not have uncontrolled hypocalcemia, and pre-existing hypocalcemia has been corrected and will be monitored. Labs must be provided.
    - Beneficiary must not have a history of myocardial infarction or stroke within the previous year
    - Beneficiary must take adequate calcium and vitamin D concomitantly

- Beneficiary cannot exceed 12 months of therapy
- Provider must submit the medical necessity over preferred products (e.g., bisphosphonates, denosumab, etc.)
- After completion of therapy, sequential therapy with an oral or injectable antiresorptive agent is recommended.

- **Additional approval criteria for Miacalcin®/Fortical® (calcitonin)**
  - Beneficiary must be diagnosed with **ONE** of the following:
    - Paget's disease of the bone
    - Hypercalcemia
    - Postmenopausal osteoporosis
  - Reserve for women greater than 5 years postmenopause at high risk of fracture with osteoporosis who cannot tolerate raloxifene, bisphosphonates, estrogen, denosumab, abaloparatide, or teriparatide
  - Provider must submit the medical necessity over all other alternatives

- **Additional approval criteria for Evista® (raloxifene)**
  - Diagnosis of post-menopause in the previous 2 years; **AND**
    - Diagnosis of carcinoma in situ of breast in the previous 2 years; **OR**
    - Diagnosis of atypical hyperplasia of breast in the previous 2 years; **OR**
    - Diagnosis of Family History of Malignant Neoplasm of Breast in previous 2 years;

    **OR**

  - Diagnosis of post-menopause in the previous 2 years; **AND**
    - Diagnosis of osteoporosis in the previous 2 years; **AND**
      - Diagnosis of esophageal strictures in the previous 2 years; **OR**
      - Diagnosis of esophageal achalasia in the previous 2 years

**APPROVAL CRITERIA FOR XGEVA AND BIOSIMILARS (denosumab)**

- Beneficiary must be diagnosed with **ONE** of the following:
  - Multiple myeloma or bone metastases from solid tumors
  - Giant cell tumor of the bone that is unresectable or where surgical resection is likely to result in severe morbidity and patient is skeletally mature
  - Hypercalcemia of malignancy refractory to IV bisphosphonate therapy with albumin-corrected calcium of > 12.5 mg/dL (3.1 mmol/L)
    - Must have trial and failure of IV bisphosphonates; **OR**
    - Have documented contraindication or intolerance to intravenous bisphosphonates (e.g., ibandronate, pamidronate, zoledronic acid)

- Therapeutic duplication is not allowed with Prolia® or its biosimilars, and claim will deny at point-of-sale if a claim for Prolia® or biosimilars is seen in history in previous 6 months
- Beneficiary must follow the preferred drug list
- Beneficiary should delay therapy if has pre-existing hypocalcemia until corrected
- Prescriber must submit the following:
    - Current chart notes
    - Previous therapies tried with response
    - Documentation of medical necessity
    - Current labs including albumin-corrected calcium for hypercalcemia diagnosis
- Approval for 6 months

**RENEWAL REQUIREMENTS:**

- Beneficiary must be compliant on therapy (defined as 75% utilization)
- Beneficiary must have a positive response without intolerable side effects
    - For osteoporosis medications—absence of fractures or increase in bone mineral density (BMD) compared to pretreatment baseline
    - For Xgeva® or biosimilars—absence/delay in skeletal-related events, disease stabilization, or corrected serum calcium ≤ 11.5 mg/dL
- Prescriber must submit the following:
    - Current chart notes
    - Documentation of response to therapy
    - Current BMD score if available
    - Current labs if applicable

## c. CLASSES WITH ABBREVIATED REVIEW WITHOUT CRITERIA

### *i. ANTIDEPRESSANTS*

**Preferred Agents with Criteria**

- bupropion HCl regular-release (generic for WELLBUTRIN)
- bupropion HCl extended-release (generic for WELLBUTRIN XL)
- bupropion HCl sustained-release (generic for WELLBUTRIN SR)
- citalopram tablet and solution (generic for CELEXA)
- desvenlafaxine succinate ER (generic for PRISTIQ)
- duloxetine 20 mg, 30 mg, and 60 mg capsule (generic for CYMBALTA)
- escitalopram oxalate tablet and solution (generic for LEXAPRO)
- fluoxetine HCl 10mg, 20mg, 40mg capsule and solution (generic for PROZAC)
- fluoxetine HCl/olanzapine (generic for SYMBYAX)
- fluvoxamine maleate (generic for LUVOX)
- mirtazapine tablet (generic for REMERON)
- paroxetine HCl regular-release tablet (generic for PAXIL)

- sertraline HCl tablet and oral conc (generic for ZOLOFT)
- trazodone 50mg, 100mg, 150mg tablet (generic for DESYREL)
- venlafaxine HCl extended-release capsule (generic for EFFEXOR ER)
- venlafaxine HCl regular-release tablet (generic for EFFEXOR)

**Non-Preferred Agents**

- AUVELITY (dextromethorphan/bupropion)
- bupropion HCl extended-release tablet (generic for FORFIVO XL)
- CELEXA (citalopram)
- citalopram capsule (generic for CELEXA)
- desvenlafaxine ER tablet
- duloxetine HCl 40 mg DR capsule (generic for IRENKA DR)
- EFFEXOR XR (venlafaxine)
- EMSAM (selegiline)
- escitalopram oxalate capsule
- EXXUA ER (gepirone)
- FETZIMA (levomilnacipran)
- fluoxetine HCl tablet (generic for PROZAC)
- fluoxetine HCl 90mg weekly capsule (generic for PROZAC)
- fluvoxamine maleate extended-release capsule (generic for LUVOX CR)
- FORFIVO XL (bupropion)—Manufacturer obsolete 12/5/25
- LEXAPRO (escitalopram)
- MARPLAN (isocarboxazid)
- **milnacipran (generic for SAVELLA)** –see manual review criteria
- mirtazapine ODT (generic for REMERON SOLTAB)
- NARDIL (phenelzine)
- nefazodone HCl (generic for SERZONE)
- paroxetine HCl CR tablet, ER tablet, and suspension (generic for PAXIL)
- paroxetine mesylate (generic for BRISDELLE)
- PAXIL IR and CR tablet (paroxetine)
- phenelzine (generic for NARDIL)
- PRISTIQ (desvenlafaxine)
- PROZAC (fluoxetine)—Manufacturer obsolete date 6/19/25
- RALDESY (trazodone)
- REMERON (mirtazapine)
- SAVELLA (milnacipran HCl)*–see manual review criteria—**Brand Preferred**
- sertraline capsule (generic for ZOLOFT)
- SPRAVATO (esketamine)–see manual review criteria
- tranylcypromine (generic for PARNATE)
- trazodone 300mg tablet (generic for DESYREL)
- TRINTELLIX (vortioxetine HBr)

- venlafaxine HCl ER tablet
- **venlafaxine besylate ER**
- VIIBRYD (vilazodone)
- vilazodone HCl (generic for VIIBRYD)
- WELLBUTRIN SR (bupropion)
- ZOLOFT (sertraline)
- ZURZUVAE (zuranolone)–see manual review criteria

*ii. PITUITARY SUPPRESSANT AGENTS*

**NOTE: All medications with a prostate cancer indication will be available as a medical bill option only. The medications available as medical bill for prostate cancer include:**

- CAMCEVI (leuprolide)
- ELIGARD (leuprolide)
- leuprolide (generic for LUPRON)
- LUPRON DEPOT 7.5 mg, 22.5 mg - 3 month, 30 mg - 4 month, 45 mg - 6 month, and Lupron® 2 week kit (leuprolide)
- TRELSTAR (triptorelin)

**Endometriosis or Uterine Leiomyoma**
**Preferred Agents**

- LUPRON DEPOT 3.75 mg and 11.25 mg - 3 month (leuprolide)

**Non-Preferred Agents**

- None

**Breast Cancer or Ovarian Cancer**
**Preferred Agents**

- LUPRON DEPOT 3.75 mg, 7.5 mg, and 11.25 mg – 3 month (leuprolide)

**Non-Preferred Agents**

- None

**Central Precocious Puberty – Manual Review**
**Preferred Agents**

- FENSOLVI (leuprolide)
- LUPRON DEPOT-PED 7.5 mg, 11.25 mg, 15 mg, 11.25 mg - 3 month kit, 30 mg - 3 month kit, and the 45 mg - 6 month kit (leuprolide)
- SYNAREL (nafarelin)

**Non-Preferred Agents**

- TRIPTODUR (triptorelin)

*iii. CII STIMULANTS*

**Preferred Agents with Criteria**

- ADDERALL XR (amphetamine/dextroamphetamine salts)
- amphetamine/dextroamphetamine salts ER (generic for ADDERALL XR)
- amphetamine/dextroamphetamine salts IR (generic for ADDERALL IR)
- atomoxetine (generic for STRATTERA)
- clonidine IR 0.1 mg, 0.2 mg, 0.3 mg tablet (generic for CATAPRES)
- clonidine ER (generic for KAPVAY ER)
- CONCERTA (methylphenidate)
- DAYTRANA (methylphenidate) **(BRAND ONLY)--** until no more stock
- dexmethylphenidate ER (generic for FOCALIN XR)
- dexmethylphenidate IR (generic for FOCALIN)
- dextroamphetamine 5 mg and 10 mg tablet (generic for ZENZEDI)
- FOCALIN (dexmethylphenidate)
- FOCALIN XR (dexmethylphenidate)
- guanfacine IR (generic for TENEX)
- guanfacine ER (generic for INTUNIV ER)
- **lisdexamfetamine (generic for VYVANSE)**
- methylphenidate IR (generic for METHYLIN, RITALIN IR)
- methylphenidate ER (generic for CONCERTA)
- VYVANSE (lisdexamfetamine)

**Non-Preferred Agents**

- ADDERALL IR (amphetamine/dextroamphetamine salts)
- ADZENYS XR-ODT (amphetamine)
- **amphetamine sulfate (generic for EVEKEO)**
- amphetamine ER ODT (generic for ADZENYS XR-ODT)
- amphetamine/dextroamphetamine ER (generic for MYDAYIS ER)
- APTENSIO XR (methylphenidate)
- ARYNTA (lisdexamfetamine)
- AZSTARYS (serdexmethylphen/dexmethylphen)
- clonidine ER (generic for NEXICLON XR)
- **clonidine IR 0.05 mg tablet**
- COTEMPLA XR-ODT (methylphenidate)
- DEXEDRINE (dextroamphetamine)
- dextroamphetamine ER (generic for DEXEDRINE spansule)
- dextroamphetamine (generic for PROCENTRA)
- dextroamphetamine 2.5 mg, **7.5 mg, 15 mg, 20 mg, and 30 mg** tablet (generic for ZENZEDI)
- DYANAVEL XR (amphetamine)
- EVEKEO (amphetamine)

- INTUNIV ER (guanfacine)
- JORNAY PM (methylphenidate)
- methamphetamine (generic for DESOXYN)
- METHYLIN (methylphenidate)
- methylphenidate chewable tablet (generic for METHYLIN chew tablet)
- methylphenidate CD/ER/LA capsule (generic for METADATE CD, RITALIN LA, APTENSIO XR)
- methylphenidate ER tablet (generic for RELEXXII ER)
- methylphenidate ER tablet (generic for METADATE ER, RITALIN SR)
- methylphenidate (generic for DAYTRANA)
- methylphenidate solution (generic for METHYLIN)
- MYDAYIS ER (amphetamine/dextroamphetamine)
- **NEXICLON XR (clonidine)**
- ONYDA XR (clonidine)
- PROCENTRA (dextroamphetamine)
- QELBREE (viloxazine)
- QUILLICHEW ER (methylphenidate)
- QUILLIVANT XR (methylphenidate)
- **RELEXXII ER (methylphenidate)**
- RITALIN IR (methylphenidate)
- STRATTERA (atomoxetine)—Manufacturer obsolete date 6/19/25
- XELSTRYM (dextroamphetamine)
- ZENZEDI (dextroamphetamine)

iv. LIPOTROPICS EXCLUDING STATINS

**Preferred Agents**

**Bile Acid Sequestrants**

- cholestyramine light (generic for QUESTRAN LIGHT, PREVALITE)
- cholestyramine (generic for QUESTRAN)
- colestipol (generic for COLESTID)

**Cholesterol Absorption Inhibitor**

- ezetimibe (generic for ZETIA)

**Fibric Acids**

- fenofibrate tablet 48 mg, 145 mg (generic for TRICOR)
- fenofibrate tablet 54 mg, 160 mg (generic for LOFIBRA)
- gemfibrozil (generic for LOPID)

**Niacin**

- niacin ER (generic for NIASPAN ER)

**Non-Preferred Agents**

**Bile Acid Sequestrants**

- colesevelam (generic for WELCHOL®)
- COLESTID (colestipol)
- PREVALITE (cholestyramine)
- QUESTRAN (cholestyramine)
- QUESTRAN LIGHT (cholestyramine)
- WELCHOL (colesevelam)

**Cholesterol Absorption Inhibitor**

- ZETIA (ezetimibe)

**Fibric Acids**

- fenofibrate capsule (generic for ANTARA, LOFIBRA, LIPOFEN, TRICOR)
- fenofibrate tablet 40mg, 120mg (generic for FENOGLIDE)
- fenofibric acid delayed-release capsule (generic for TRILIPIX)
- fenofibric acid tablet (generic for FIBRICOR)
- FIBRICOR (fenofibric acid)
- LIPOFEN (fenofibrate)
- LOPID (gemfibrozil)

**Preferred Agents with Criteria**

**** manual review criteria**

**^^ POS edits**

**ACL Inhibitor and ACL Inhibitor/Cholesterol Absorption Inhibitor**

- None

**Apolipoprotein B Synthesis Inhibitor**

- None

**Apolipoprotein C-III Synthesis Inhibitor**

- None

**Omega-3 Fatty Acids**

- omega-3 acid ethyl esters (generic for LOVAZA)**^^**

**Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitor**

- PRALUENT (alirocumab)******
- REPATHA (evolocumab)******

**PCSK9-Directed Small Interfering RNA (siRNA)**

- None

**Non-Preferred Agents with Criteria**
**** manual review criteria**

**ACL Inhibitor and ACL Inhibitor/Cholesterol Absorption Inhibitor**
- NEXLETOL (bempedoic acid)******
- NEXLIZET (bempedoic acid/ezetimibe)******

**Apolipoprotein B Synthesis Inhibitor**
- JUXTAPID (lomitapide)******

**Apolipoprotein C-III Synthesis Inhibitor**
- REDEMPLO (plozasirin)******
- TRYNGOLZA (olezarsen)******

**Omega-3 Fatty Acids**
- icosapent ethyl (generic for VASCEPA)******

**Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitor**
- None

**PCSK9-Directed Small Interfering RNA (siRNA)**
- LEQVIO (inclisiran)******

**APPROVAL CRITERIA FOR LEQVIO (inclisiran):**
- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must use this medication as an adjunct to diet and exercise to reduce low-density lipoprotein cholesterol (LDL-C) with one of the following diagnoses:
    - Hypercholesterolemia
    - Heterozygous familial hypercholesterolemia (HeFH)
    - Homozygous familial hypercholesterolemia (HoFH)
- Beneficiary must have a trial and failure of ALL of the following:
    - High dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40 mg) OR maximally tolerated statin therapy OR alternative dosing options to mitigate side effects unless a documented contraindication
    - Ezetimibe with statin therapy

    - Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., PRALUENT or REPATHA)
- Beneficiary should have an LDL-C ≥ 70mg/dL and/or non-HDL-C ≥ 100mg/dL after a compliant trial (defined as 90 out of 120 days) of statins, ezetimibe, and PCSK9 inhibitors as defined above
- If approved, beneficiary must continue statin therapy at maximally tolerated dose
- Prescriber must submit ALL of the following:
    - Current chart notes with documentation of previous treatments
    - Current labs including lipids along with labs corresponding with previous trials of statin and ezetimibe used concomitantly and with the addition of a PCSK9 inhibitor
    - Treatment plan with goal LDL-C
    - Diet plan for lowering cholesterol
    - If beneficiary smokes, provider should submit a smoking cessation plan or documentation that the beneficiary has been counseled on smoking cessation
- Initial approval for 3 months

**APPROVAL CRITERIA FOR REDEMPLO (plozasirin):**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with familial chylomicronemia syndrome (FCS) with elevated triglycerides (≥880 mg/dL) despite previous lipid-lowering therapy
- Beneficiary must be instructed to have a diet low in fat (10 to 15 g per day)
- Prescriber must be, or in consultation with, a cardiologist
- Beneficiary must have tried and failed standard lipid-lowering therapy taken compliantly (defined as 90 out of 120 days)
- Prescriber must submit the following:
    - Current chart notes with documentation of previous treatments
    - Genetic testing results to confirm the diagnosis of FCS
    - Current triglyceride level (≥880 mg/dL) while on lipid-lowering therapy
    - Patient specific symptoms (e.g., pancreatitis, xanthomas, hepatosplenomegaly)
    - Dietary plan
- If beneficiary smokes, provider should submit a smoking cessation plan or documentation that the beneficiary has been counseled on smoking cessation
- Initial approval for 6 months

**RENEWAL REQUIREMENTS:**

- After initial approval, the beneficiary should demonstrate an improvement in triglyceride levels
- Beneficiary must be compliant with therapy
- Prescriber must submit the following:
    - Current chart notes
    - Current triglyceride level

**QUANTITY EDITS:**

- #1 every 3 months

## II. NEW OR REVISED PRIOR AUTHORIZATION DRUG CRITERIA

### 1. ALLERGIC FUNGAL RHINOSINUSITIS

**APPROVAL CRITERIA:**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed a dose that meets the package insert requirements for indication, age, and weight or supported in MicroMedex®
- Beneficiary must be diagnosed with allergic fungal rhinosinusitis (AFRS) with a history for sino-nasal surgery
- Prescribed by or in consultation with a specialist in pulmonology, allergy, immunology, or otolaryngology
- Beneficiary must have a trial and failure of at least 3 months of nasal corticosteroids after surgery (e.g., fluticasone, beclomethasone, budesonide)
- Prescriber must submit the following:
    - Current chart notes with description of symptoms including sinus opacification, nasal congestion, and documentation of either unilateral or bilateral polyps with quantity
    - Documentation of previous therapies tried including information on sino-nasal surgery with results
    - Current weight and requested dose
    - Drug claims data or retail pharmacy printout if the drug claims are not available in Medicaid drug claims history
    - Medical necessity over nasal corticosteroids and surgery

**RENEWAL REQUIREMENTS:**

- Beneficiary must demonstrate an improvement in sinus opacification, sinus congestion, and/or size/quantity of nasal polyps compared to baseline
- Beneficiary must be compliant on therapy
- Prescriber must submit the following:
    - Current chart notes with description of symptoms
    - Current weight and requested dose

2. CARDAMYST (etripamil) spray

**APPROVAL CRITERIA:**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with acute symptomatic episodes of paroxysmal supraventricular tachycardia (PSVT) needing conversion to sinus rhythm
- Must be prescribed by, or in consultation with, a cardiologist
- Beneficiary must continue to have PSVT episodes despite oral preventative therapies unless contraindicated (e.g., calcium channel blockers, beta blockers)
- Beneficiary will not be approved with any of the following:
    - New York Heart Association heart failure class II to IV
    - Wolff-Parkinson-White (WPW), Lown-Ganong-Levine (LGL) syndromes, or manifest pre-excitation (delta wave) on a 12-lead electrocardiogram (ECG)
    - Sick sinus syndrome without a permanent pacemaker
    - Second degree atrioventricular (AV) Mobitz 2 block or higher degree of AV block
- Prescriber must submit the following:
    - Current chart notes
    - Previous therapies tried
    - Description of symptoms associated with PSVT along with typical frequency of episodes
    - Attestation that beneficiary and/or caregiver has been counseled on timing of administration, proper administration technique, proper dosing, and when to seek additional medical care

**RENEWAL REQUIREMENTS:**

- Prescriber must submit the following:
    - Documentation of a positive response while using CARDAMYST with history of PSVTs converted to sinus rhythm
    - Current chart notes

**QUANTITY EDITS:**

1 carton per claim containing 2 nasal spray devices (2 doses) with maximum of 3 claims (6 devices) per month

3. VOYXACT (sibeprenlimab) injection

**APPROVAL CRITERIA:**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- Beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- Beneficiary is diagnosed with primary immunoglobulin A nephropathy (IgAN) at risk for disease progression with proteinuria (either urine protein/creatinine ratio based on 24-hour urine collections [uPCR-24h] ≥0.75 g/g or urine protein ≥1.0 g/day)
- Must be prescribed by, or in consultation with, a nephrologist
- The beneficiary must demonstrate continued risk for disease progression despite at least 3 months of maximally tolerated supportive care (i.e., angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blocker (ARB), immunosuppressive therapy, sodium-glucose co-transporter 2 (SGLT2) inhibitor)
- Beneficiary must have had a previous trial and failure of Tarpeyo (budesonide delayed-release capsule) unless contraindicated
- Beneficiary must remain on supportive care at maximally tolerated doses unless contraindicated
- The prescriber must submit all of the following:
    - Current chart notes
    - Previous therapies
    - Current labs, including LFTs, eGFR, urine protein or UPCR
    - Confirmation of the IgAN diagnosis with renal biopsy results and labs
    - Medical necessity over the use of typical supportive care (i.e., ACEi, ARB, SGLT2), Tarpeyo, Filspari, and Vanrafia

**RENEWAL REQUIREMENTS:**

- Beneficiary has documented improvement in proteinuria with a reduction in UPCR or urine protein compared to baseline
- Prescriber must submit the following:
    - Current chart notes
    - Current labs, including LFTs, eGFR, lipid panel, and urine protein or UPCR

**QUANTITY EDITS:**

- #1 syringe/ 28 days

4. AQVESME (mitapivat) tablet

**APPROVAL CRITERIA:**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with anemia (hemoglobin ≤10 g/dL) and either alpha- or beta-thalassemia
- Beneficiary's diagnosis must be confirmed by lab findings of overall reduction in hemoglobin and hematocrit and **ONE** of the following:
    - Genetic testing; **OR**
    - Electrophoresis or high-performance liquid chromatography (HPLC)
- Beneficiary must meet **ONE** of the following:
    - Transfusion-dependent thalassemia defined as 6 or more red blood cell (RBC) units transfused in 24 weeks with no longer than a 6-week transfusion free period during the 24 weeks
    - Non-transfusion-dependent thalassemia defined as no more than 5 RBC units transfused in 24 weeks **AND** a baseline hemoglobin ≤10 g/dL
- Must be prescribed by, or in consultation with, a specialist in treating thalassemia (e.g., hematologist)
- Prescriber, pharmacy and patient must be enrolled in the REMS program
- Beneficiary must have iron deficiency anemia ruled out
- Beneficiary should not be diagnosed with cirrhosis (Child-Pugh Class A, B, or C)
- Beneficiary requiring concomitant strong CYP3A inhibitors (e.g., ketoconazole, ritonavir), moderate CYP3A inhibitors (i.e., cyclosporine, verapamil) or strong CYP3A inducers (e.g., phenytoin, rifampin) should not be approved as co-administration is not recommended
- Prescriber must submit the following:
    - Current chart notes with transfusion history for the last 6 months
    - Current labs including complete blood count (CBC), liver function tests (LFTs), and iron to monitor for iron deficiency
    - Attestation that LFTs will be drawn every 4 weeks for the first 24 weeks of therapy and that therapy will be discontinued if the patient's labs increase significantly or the alanine aminotransferase is >5 times upper limit of normal
    - Baseline patient-specific symptoms attributed to the anemia

**RENEWAL REQUIREMENTS:**

- Beneficiary must be compliant on therapy (defined as 75% utilization)
- Beneficiary must have an improvement or stabilization in hemolytic anemia based on lab work and patient-specific symptoms
- Beneficiary has not developed hepatocellular injury or other severe adverse reaction
- Prescriber must submit the following:
    - Current chart notes

- Current labs including complete blood count (CBC), liver function tests (LFTs), and iron to monitor for iron overload
- Change in patient-specific symptoms since starting the medication

**QUANTITY EDITS:**

- #62/31 days

5. MYQORZO (aficamten) tablet

**APPROVAL CRITERIA:**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with symptomatic obstructive hypertrophic cardiomyopathy (oHCM) with both of the following:
  - Left ventricular ejection fraction (LVEF) ≥55%; **AND**
  - Resting left ventricular outflow tract (LVOT) should be ≥30 and post-Valsalva peak gradient (LVOT-G) should be ≥50 mmHg at screening
- Must be prescribed by, or in consultation with, a cardiologist
- Beneficiary must have tried and had an inadequate response to a beta blocker **AND** calcium channel blocker unless patient is intolerant or has a contraindication to their use
- Beneficiary will not be approved if prescribed concomitantly with rifampin, and the use of aficamten concomitantly with strong inhibitors of CYP2C9 or moderate/strong inducers of CYP3A may require aficamten dose modification
- Beneficiary will not be approved if **NOT** NYHA class II or III
- Beneficiary will not be approved if have known infiltrative or storage disorder causing cardiac hypertrophy such as Noonan syndrome, Fabry disease or amyloidosis
- Beneficiary, prescriber, and pharmacy must be enrolled in the MYQORZO REMS program
- Prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried with response
  - Baseline echocardiogram (subsequent echocardiograms two to eight weeks after initiation of therapy and every six months when on maintenance dose)

**RENEWAL REQUIREMENTS:**

- Beneficiary must remain compliant on therapy (defined as 75% utilization)
- Beneficiary must demonstrate a clinical benefit with no worsening in heart failure symptoms and LVEF must remain ≥50%
- Prescriber must submit the following:
  - Current chart notes

- Echocardiogram reports since previous prior authorization approval
- Dose requested based on current LVEF and Valsalva LVOT-G (see the package insert)

**QUANTITY EDITS:**

- Each strength #31/ 31 days

6. FORZINITY (elamipretide hydrochloride) injection

**APPROVAL CRITERIA:**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must weigh at least 30 kg and be diagnosed with Barth syndrome genetically confirmed by the presence of a *TAFAZZIN* gene pathogenic variant, and the beneficiary exhibits skeletal muscle weakness or functional impairment
- Must be prescribed by a fellowship trained specialist (e.g., cardiologist, neurologist, hematologist, geneticist)
- Beneficiary must be receiving physical therapy
- Beneficiary must not be on dialysis, and beneficiary with severe renal impairment (eGFR <30 mL/min) must be prescribed 20 mg daily
- Prescriber must submit the following:
  - Current chart notes
  - Documentation of patient-specific symptoms especially muscle strength
  - Confirmation of diagnosis with genetic testing results
  - Attestation that the patient and/or caregiver has been trained on administration
  - Renal function labs
- Initial approval for 6 months

**RENEWAL REQUIREMENTS:**

- Beneficiary must be compliant on therapy (defined as 75% utilization)
- Beneficiary must demonstrate muscle strength improvement or disease stabilization
- Prescriber must submit the following:
  - Current chart notes
  - Updated documentation of symptoms compared to baseline especially muscle strength

**QUANTITY EDITS:**

- 4 vials/28 days

7. ZYCUBO (copper histidinate) injection

**APPROVAL CRITERIA:**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be a child diagnosed with Menkes disease confirmed by **ONE** of the following:
    - Expected disease with genetic confirmation of the mutation in the ATP7A gene in the mother or patient
    - Expected disease with low serum copper levels, urine homovanillic acid/vanillylmandelic acid ratio of >4, and/or x-rays with bone abnormalities or hair sample consistent with Menkes
- Prescribed by, or in consultation with, a specialist in treating Menkes disease
- Prescriber must submit the following:
    - Current chart notes
    - Previous therapies tried
    - Confirmation of diagnosis as listed above
    - Baseline labs including serum copper and ceruloplasmin levels, serum electrolytes, kidney and liver function, and complete blood count (CBC)
- Initial prior authorization for 3 months, if tolerating can approve 6 months with next approval.

**RENEWAL REQUIREMENTS:**

- Beneficiary must be compliant on therapy (defined as 75%)
- Beneficiary must demonstrate an improved serum copper level and not have lab abnormalities that would require discontinuation
- Prescriber must submit the following:
    - Current chart notes
    - Current labs including serum copper and ceruloplasmin levels, serum electrolytes, kidney and liver function, and complete blood count (CBC) which should be monitored every 6 weeks for the first 6 months, then every 3 months for 18 months, and then every 6 months thereafter

**QUANTITY EDITS:**

- 2 vials per day

8. PIVYA (pivmecillinam) tablet

**APPROVAL CRITERIA:**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with uncomplicated urinary tract infections (uUTI) caused by the susceptible isolates of *Escherichia coli (E. coli), Proteus mirabilis, or Staphylococcus saprophyticus*
- Beneficiary with **ONE** of the following will not meet approval criteria:
    - Carnitine deficiency due to inherited disorders of mitochondrial fatty acid oxidation and carnitine metabolism (e.g., methylmalonic aciduria or propionic acidemia)
    - Acute porphyria
- Beneficiary must not be prescribed concomitant valproic acid or valproate
- Beneficiary must have tried and failed therapy with typical first-line antibiotics used for uUTI (e.g., nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin) unless contraindicated
- Prescriber must submit the following:
    - Current chart notes
    - Culture/sensitivity results documenting resistance to typical first-line agents
    - Letter of medical necessity for the rationale of use over typical first-line agents (e.g., nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin)

**RENEWAL REQUIREMENTS:**

- Any PA renewals will be reviewed on a case-by-case basis.

**QUANTITY EDITS:**

- 3 tablets per day for a maximum of 7 days

9. LOARGYS (pegzilarginase-nbln) injection

**APPROVAL CRITERIA:**

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication

- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with hyperargininemia due to Arginase 1 Deficiency (ARG1-D) while on a dietary protein restriction with diagnosis confirmed by **ALL** of the following:
    - Elevated plasma arginine levels (>115 µmol/L); **AND**
    - Pathogenic variants in ARG1; **AND**
    - Decreased erythrocyte ARG1 activity
- Must be prescribed by, or in consultation with, a metabolic disease specialist or neurologist experienced in treating urea cycle disorders
- Beneficiary must start therapy with IV infusion in a healthcare setting (minimum of 8 weeks) and maintenance subcutaneous injections in a healthcare setting before moving to in-home subcutaneous injections once the provider deems at home administration is safe
- Beneficiary should not exceed the dosage of 0.2 mg/kg once weekly
- Prescriber must submit the following:
    - Current chart notes
    - Previous therapies tried (e.g., sodium phenylbutyrate or glycerol phenylbutyrate)
    - Baseline plasma arginine level and ammonia level prior to starting infusions and current plasma arginine level
    - Dietary plan for protein restriction
    - Current body weight and dose requested
    - Attestation that the patient/caregiver has been trained on proper administration procedure
- Approvals for 6 months on in-home subcutaneous doses

**RENEWAL REQUIREMENTS:**

- Beneficiary must be compliant on therapy (defined as 75% utilization)
- Beneficiary must have a decrease in plasma arginine levels compared to baseline
- Prescriber must submit the following:
    - Current chart notes
    - Current labs including plasma arginine level
    - Current body weight and dose requested

**QUANTITY EDITS:**

None since weight based

## III. FRIENDLY REMINDERS

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

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

2. **For vaccine billing and updates, visit the Welcome to Arkansas webpage.**
   - **https://humanservices.arkansas.gov/**
   - **https://humanservices.arkansas.gov/covid-19/dhs-response-to-covid-19/updates-for-providers/**

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

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

4. **REGARDING MANUAL REVIEW PA REQUESTS:**

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

5. **REGARDING EMERGENCY OVERRIDE:**
In an emergency, for those drugs for which a five-day supply can be dispensed, an Arkansas Medicaid enrolled pharmacy provider may dispense up to a five-day supply of a drug that requires prior authorization (e.g., a drug that requires a clinical PA or requires a PA for a non-preferred drug). **This provision applies only in an emergency when the Prime Therapeutics Help Desk and the State Medicaid Pharmacy Program offices are closed, and the pharmacist is not able to contact the prescribing provider to change the prescription.** The Emergency Supply Policy does not apply to drugs that are not covered by the State. Frequency of the emergency override is limited to once per year per drug class for non-LTC beneficiaries and once per 60 days per drug class for LTC beneficiaries.

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

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

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

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

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

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

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

9. **ANTIPSYCHOTIC AGENT CRITERIA FOR CHILDREN:**
**< 18 YEARS OF AGE:**
Each new start of any antipsychotic agent for children < 18 years of age require a completed/signed informed consent form, current metabolic labs, and documentation of medical necessity with chart notes. Beneficiaries have an ongoing requirement for labs for metabolic monitoring every 6 months. When sending for the required metabolic labs, the provider must include the PCP's name and Medicaid ID number on the lab order request form. It does not have to be the PCP ordering the labs. Please refer to the Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual, Section II, 245.000 B.
For those providers who have not had their own version of the Informed Consent form approved for use with Medicaid PA requests and who use the Medicaid Informed Consent form for antipsychotic agents, the form may be found at the following link.
**https://ar.primetherapeutics.com/provider-documents**
**< 10 YEARS OF AGE:**
Medicaid currently requires a manual review PA of any antipsychotic agent prescribed for children less than 10 years of age (i.e., age 9 years and under) for all new starts on an antipsychotic agent, including a change in the chemical entity for children currently on an antipsychotic agent. All documentation, chart notes, signed informed consent, and required lab work must be submitted, and the manual review will be performed by the Medicaid Pharmacy Program psychiatrist.

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

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

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

13. **HEPATITIS C TREATMENT INFORMATION:**
Educational information on treating Hepatitis C along with treatment consultations may be obtained through the Clinician Consultation Center.
    1) Link for the Clinician Consultation Center— **http://www.hepcap.org/hepatitis-c-consultation-warmline/**
    2) Hepatitis C Warmline for phone consultation—(844) HEP-INFO or (844) 437-4636

    The clinical consultation staff may give advice on any of the following topics:
    - HCV staging & monitoring
    - Regimen selection & dosing
    - Drug interactions
    - HIV/HCV management strategies
    - Prior HCV treatment failure, including management of complex clinical problems such as cirrhosis and renal disease
    - HCV transmission & prevention

- HCV screening & diagnostic testing
- HCV in special populations (pregnancy, co-occurring substance use and/or alcohol use disorders, psychiatric disorders, post-transplant, ESRD/dialysis, pediatrics)
  The Clinician Consultation Center is not affiliated with Arkansas Medicaid, but the information may be useful for providers in our state and provided only as an educational tool.

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

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