Division of Medical Services
P.O. Box 1437, Slot S401, Little Rock, AR 72203-1437
P: 501.682.8292 F: 501.682.1197

Provider Memorandum

TO: Arkansas Medicaid Enrolled Prescribing Providers and Pharmacy Providers
FROM: Cynthia Neuhofel, Pharm.D. Division of Medical Services Pharmacy Program
DATE: November 18, 2026
SUBJ: AR Medicaid Prior Authorization Edits and Preferred Drug List updates approved at the AR Medicaid DUR Board October 21, 2026 meeting for the following:

Preferred Drug List Full Review with PA Criteria: Pulmonary Arterial Hypertension agents, Erythropoiesis Stimulating Agents, Narcolepsy Agents, Hepatitis C Agents, Targeted Immunomodulator Agents, Calcium Channel Blockers, LAMA Bronchodilators, LABA/LAMA Bronchodilators, and ICS/LABA/LAMA Bronchodilators

Manual Review PA Criteria: Dermatomyositis, LYNAVOY (linerixibat), TRYNGOLZA (olezarsen), LIPFENDRA (enlicitide), TRUTAKNA (atacicept-vymj), LEQEMBI IQLIK (lecanemab), MOUNJARO (tirzepatide), and isotretinoin

Table of Contents

I. ANNOUNCEMENTS 3
1. QUARTERLY NEWSLETTER 3
2. INFORMATIONAL DRUG UPDATES 3
a. CAVHANZA (nilotinib) tablet 3
b. JIDEYTRO (zidesamtinib) tablet 3
c. ZENBEXUS (iberdomide) capsule 3
d. RASONQUE (daraxonrasib) tablet 4
e. FUROSCIX READYFLOW 80 mg/mL single-dose prefilled autoinjector 4
f. PHYSICIAN ADMINISTERED DRUGS UPDATE 4
II. PREFERRED DRUG LIST 4
1. CLASSES WITH FULL REVIEW WITH CRITERIA 4
a. PULMONARY ARTERIAL HYPERTENSION 4
b. ERYTHROPOIESIS STIMULATING AGENTS 8
c. NARCOLEPSY AGENTS 8
d. HEPATITIS C AGENTS 11
e. TARGETED IMMUNOMODULATORS 12

f. CALCIUM CHANNEL BLOCKERS 30
g. LONG-ACTING MUSCARINIC ANTAGONISTS (LAMA) BRONCHODILATORS 32
h. INHALED COMBINATION PRODUCTS (LABA/LAMA) BRONCHODILATORS 32
i. INHALED COMBINATION PRODUCTS (ICS/LABA/LAMA) BRONCHODILATORS 32

III. NEW DRUG or UPDATED PRIOR AUTHORIZATION CRITERIA 33

1. LYNAVOY (linerixibat) 40 mg tablet 33
2. TRYNGOLZA (olezarsen) 50 mg and 80 mg injection 34
3. LIPFENDRA (enlicitide) 20 mg tablets 35
4. TRUTAKNA (atacicept-vymj) 150 mg/mL injection 37
5. LEQEMBI IQLIK (lecanemab) 250 mg/1.25 mL & 360 mg/1.8 mL inj 37
6. MOUNJARO (tirzepatide) injection (FOR MACE) 40
7. ISOTRETINOIN capsule (FOR ACNE) 41

IV. FRIENDLY REMINDERS 42

I. ANNOUNCEMENTS

1. QUARTERLY NEWSLETTER

As a service to our providers, we publish a quarterly provider newsletter with 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 October 2026 quarterly newsletter can be found with the following link.
https://ar.primetherapeutics.com/documents/d/arkansas/arkansas-medicaid-quarterly-newsletter-october-2026

2. INFORMATIONAL DRUG UPDATES

a. CAVHANZA (nilotinib) tablet

This medication has been added to the oncology policy.
https://ar.primetherapeutics.com/documents/d/arkansas/oncology_policy_04172024

1.1 Adult Patients with Newly Diagnosed Ph+ CML-CP
CAVHANZA is indicated for the treatment of adult patients with newly diagnosed Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase.

1.2 Adult Patients with Resistant or Intolerant Ph+ CML-CP and CML-AP
CAVHANZA is indicated for the treatment of adult patients with chronic phase and accelerated phase Philadelphia chromosome positive chronic myelogenous leukemia (Ph+ CML) resistant or intolerant to prior therapy that included imatinib.

Additional pediatric use information is approved for Novartis Pharmaceuticals Corporation's TASIGNA (nilotinib) capsules. However, due to Novartis Pharmaceuticals Corporation's marketing exclusivity rights, this drug product is not labeled with that pediatric information.

b. JIDEYTRO (zidesamtinib) tablet

This medication has been added to the oncology policy.
https://ar.primetherapeutics.com/documents/d/arkansas/oncology_policy_04172024

JIDEYTRO is indicated for the treatment of adult patients with locally advanced or metastatic ROS1-positive non-small cell lung cancer (NSCLC) who received a prior ROS1 kinase inhibitor.

c. ZENBEXUS (iberdomide) capsule

This medication has been added to the oncology policy.
https://ar.primetherapeutics.com/documents/d/arkansas/oncology_policy_04172024

ZENBEXUS is indicated, in combination with daratumumab and hyaluronidase-fihj and dexamethasone, for the treatment of adult patients with multiple myeloma who have received at least 1 prior line of therapy including a proteasome inhibitor and an immunomodulatory agent.

This indication is approved under accelerated approval based on minimal residual disease (MRD)-negative complete response (CR) at any time. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

d. RASONQUE (daraxonrasib) tablet

This medication has been added to the oncology policy.
https://ar.primetherapeutics.com/documents/d/arkansas/oncology_policy_04172024

RASONQUE is indicated for the treatment of adult patients with metastatic pancreatic adenocarcinoma who have received at least one prior systemic therapy or who are not candidates for multiagent systemic therapy.

e. FUROSCIX READYFLOW 80 mg/mL single-dose prefilled autoinjector

The FUROSCIX ReadyFlow will follow the same criteria as FUROSCIX On-Body Infusor.

f. PHYSICIAN ADMINISTERED DRUGS UPDATE

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

II. PREFERRED DRUG LIST

PDL UPDATE EFFECTIVE JANUARY 1, 2027
PRIOR AUTHORIZATION CRITERIA EFFECTIVE OCTOBER 21, 2026

NOTE: Medications with a change in PDL status are notated as bold font.

1. CLASSES WITH FULL REVIEW WITH CRITERIA

a. PULMONARY ARTERIAL HYPERTENSION

PREFERRED AGENTS WITH CRITERIA

- **ADEMPAS (riociguat)—brand preferred**
- ambrisentan (generic for LETAIRIS)
- **bosentan (generic for TRACLEER) tablet**
- **epoprostenol (generic for VELETRI)**
- **macitentan (generic for OPSUMIT)**
- **sildenafil suspension (generic for REVATIO)***
- sildenafil tablet and vial (generic for REVATIO)
- tadalafil (generic for ADCIRCA/ALYQ)
- **treprostinil (generic for REMODULIN)**
- **YUTREPIA (treprostinil)**

***Sildenafil suspension**

- Payable at Point of Sale (POS) for beneficiaries < 7 years of age or who have a diagnosis of NPO (Appendix A) in history

NON-PREFERRED AGENTS

- ADCIRCA (tadalafil)
- bosentan (generic for TRACLEER) tablet for suspension
- LETAIRIS (ambrisentan)
- OPSUMIT (macitentan)
- OPSYNVI (macitentan/tadalafil)
- ORENITRAM ER (treprostinil)
- REMODULIN (treprostinil)
- REVATIO (sildenafil)
- **riociguat (generic for ADEMPAS)**
- TADLIQ (tadalafil)
- TRACLEER tablet (bosentan)
- TRACLEER tablet for suspension (bosentan)
- TYVASO and TYVASO DPI (treprostinil)
- UPTRAVI (selexipag)
- VELETRI (epoprostenol)
- WINREVAIR (sotatercept-csrk) (see criteria for WINREVAIR)

PAH WHO GROUP 1 APPROVAL CRITERIA:

- Prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Treatment regimen requested
  - Baseline 6-minute walk distance (6MWD)
  - Documentation of WHO-Functional Class
    - WHO-FC I (low risk): No limitation of physical activity
    - WHO-FC 2 (low risk): Slight limitation; comfortable at rest
    - WHO-FC 3 (intermediate risk): Marked limitation, comfortable at rest, but less than ordinary activity causes symptoms
    - WHO-FC 4 (high risk): Symptoms at rest, signs of right heart failure, inability to perform any activity without symptoms
- Treatment options by risk status
  - Initial therapies and those at low risk should receive an endothelin receptor antagonist (ERA) and a phosphodiesterase type-5 inhibitor (PDE5i)
    - Sildenafil and tadalafil criteria for POS approval without a PA
      - Diagnosis of pulmonary heart disease in the last 365 days; **OR**
      - Diagnosis of persistent fetal circulation in the last 365 days; **OR**
      - Diagnosis of chronic respiratory disease arising in the perinatal period in the last 365 days
  - Intermediate risk patient despite ERA/PDE5i therapy
    - Switch from PDE5i to riociguat; **OR**
    - Add selexipag
  - Intermediate high to high-risk patient despite oral therapy
    - Add IV epoprostenol or IV/SC treprostinil; **OR**
    - Switch from PDE5i to riociguat; **OR**
    - Add selexipag

- Triple and quadruple therapy will continue to be reviewed on a case-by-case basis for medical necessity over PDE/ERA therapy alone based on treatment guidelines.
- Diagnoses other than PAH WHO Group 1 will be reviewed on a case-by-case basis.
- Therapeutic duplication (TD) edit applies to preferred drugs within the same drug class type (ERA, PDE5i, and prostacyclin) or same pathway (endothelin, NO/cGMP, and prostacyclin).
- Claims will deny at point of sale (POS) if any of the following are present:
    - Ambrisentan, bosentan, macitentan, tadalafil or sildenafil—deny claim for diagnosis of current pregnancy in Medicaid medical history
    - Ambrisentan—deny claim for diagnosis if idiopathic pulmonary fibrosis (ICD-10 code J84.112) is in Medicaid medical history in the previous year
    - Bosentan—deny claim if glyburide claim in Medicaid drug history in the previous 45 days **OR** deny incoming claim for glyburide if bosentan claim in Medicaid drug history in the previous 45 days
    - Tadalafil or sildenafil
        - Deny claim if ADEMPAS (riociguat) is found in Medicaid drug history in the previous 45 days
        - Deny if any of the following:
            - One of the following diagnoses in the last 180 days:
                - Cavernosal fibrosis; **OR**
                - Hypotension; **OR**
                - Leukemia; **OR**
                - Life-threatening arrhythmia; **OR**
                - Malignant hypertension; **OR**
                - Multiple myeloma; **OR**
                - Myocardial infarction; **OR**
                - Peyronie's disease; **OR**
                - Retinitis pigmentosa; **OR**
                - Sickle cell disease; **OR**
                - Stroke; **OR**
                - Unstable angina
            - History of any of the following in the last 45 days:
                - Alpha-adrenergic blockers; **OR**
                - Nitrates; **OR**
                - tamsulosin
            - Concurrent use of any of the following:
                - indinavir; **OR**
                - lopinavir-ritonavir; **OR**
                - ritonavir

WINREVAIR CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- 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 pulmonary arterial hypertension (PAH, World Health Organization [WHO] Group 1) Functional Class (FC) II or III or a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The medication must be prescribed by or in consultation with a cardiologist or pulmonologist
- The beneficiary has tried and failed a preferred medication from each of the following categories given as triple therapy for at least 90 days unless contraindicated:
    - Phosphodiesterase Inhibitors; **AND**
    - Endothelin Receptor Antagonists; **AND**
    - Prostacyclin Analogues
- The beneficiary should not be approved or continue the medication if meets one of the following:
    - The beneficiary is diagnosed with pulmonary hypertension WHO groups 2, 3, 4, or 5
    - Baseline platelet count is < 50,000/mm^2
    - Experiencing serious bleeding
    - Pregnant
    - Breastfeeding
    - Current smoker without a smoking cessation plan
    - Has restrictive, constrictive, or congestive cardiomyopathy
    - Left ventricular ejection fraction < 45% on an echocardiogram within the previous 6 months
    - Any symptomatic coronary disease events in the previous 6 months; **OR**
    - Considered Functional Class I
- The prescriber must submit the following:
    - Current chart notes with documentation of previous therapies
    - Current labs, including hemoglobin (Hgb) and platelets
    - Attestation that Hgb and platelet levels are monitored before each dose for the first 5 doses, or longer if values are unstable, and periodically thereafter, to determine if dose adjustments are required
    - Attestation that the beneficiary has been counseled on signs and symptoms of blood loss
    - Attestation that the beneficiary of reproductive potential has been counseled that WINREVAIR can impair fertility (male or female)
    - Attestation that a female beneficiary of reproductive potential has been counseled to use contraception due to embryo-fetal toxicity
    - Attestation that a female beneficiary has been counseled that breastfeeding is not recommended during treatment with WINREVAIR, and for 4 months after the final dose.
    - Baseline 6-minute walk distance (6MWD); **AND**
    - Baseline echocardiogram

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)

- The beneficiary must demonstrate a positive response with stabilization of PAH
- The prescriber must submit the following:
    - Current chart notes
    - Current labs, including Hgb and platelets
    - Current 6-minute walk distance; **AND**
    - Documentation that female of reproductive potential is continuing contraception and is not pregnant

QUANTITY EDITS
Each strength #4 injections per month (doses of 90 mg or 120 mg every 3 weeks)

b. ERYTHROPOIESIS STIMULATING AGENTS

Criteria for this class has not changed.

PREFERRED AGENTS WITH CRITERIA

- ARANESP syringe (darbepoetin alfa in polysorbate)
- **ARANESP vial (darbepoetin alfa in polysorbate)**
- EPOGEN (epoetin alfa)
- RETACRIT (epoetin alfa)—**Pfizer brand only**

NON-PREFERRED

- MIRCERA (methoxy peg-epoetin beta)
- PROCRIT (epoetin alfa)
- REBLOZYL (luspatercept)
- **RETACRIT (epoetin alfa)—Vifor brand only**

APPROVAL CRITERIA FOR PREFERRED AGENTS WITH CRITERIA

- The Prime system reviews lab results for the previous 30 days for a hemoglobin (Hgb) level.
- If a Hgb level is available and ≤ 10 g/dL, a claim will be processed at point-of-sale without prior authorization.
- If hemoglobin level is not available in the Prime system or the beneficiary does not meet the above lab requirement, a prior authorization request must be submitted.

c. NARCOLEPSY AGENTS

PREFERRED AGENTS WITH CRITERIA

- armodafinil (generic for NUVIGIL)
- **modafinil (generic for PROVIGIL)**
- XYREM (sodium oxybate) – brand only

NON-PREFERRED AGENTS

- NUVIGIL (armodafinil)
- **ORZEYFUL (oveporexton)**
- PROVIGIL (modafinil)

- sodium oxybate (generic for XYREM)
- SUNOSI (solriamfetol)
- WAKIX (pitolisant)
- XYWAV (calcium, magnesium, potassium, and sodium oxybates)

APPROVAL CRITERIA

- All requests for non-FDA-approved diagnoses or for new indications without developed criteria will be reviewed on a case-by-case basis.

NARCOLEPSY

- 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 excessive sleepiness associated with narcolepsy. Diagnosis of narcolepsy is based on International Classification of Sleep Disorders (ICSD-3) or Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria. Requests for any other diagnosis will be reviewed on a case-by-case basis.
- The beneficiary profile will be reviewed for medications or diagnoses that may be contributing to excessive daytime sleepiness besides narcolepsy
- The prescriber should submit the following for initial request for narcolepsy:
    - Most recent polysomnogram (PSG) results
    - Most recent multiple sleep latency test (MSLT) from morning after PSG with the following:
        - Mean sleep latency of less than 8 minutes per nap
        - Documented sleep onset rapid eye movement (SOREM) periods in more than 2 naps (one MSLT SOREM may be replaced by SOREM during PSG the night preceding MSLT)
    - Current chart notes
    - Baseline Epworth Sleepiness Scale (ESS)
- Requests for non-preferred medications for beneficiary ≥ 19 years of age require a documented trial and failure of at least one agent from each drug class that is FDA-approved for this indication (e.g., CII stimulants and preferred CIII and CIV narcolepsy agents) in the last year with documentation of the medical necessity over the preferred medications.
- Requests for non-preferred medications for beneficiary ≥ 7 years of age and < 19 years of age require a documented trial and failure of at least one agent from each drug class that is FDA-approved for this indication (e.g., CII stimulant and preferred CIII narcolepsy agent) in the last year with documentation of the medical necessity over the preferred medications

SHIFT WORK DISORDER

- 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 excessive sleepiness associated with shift work disorder (SWD)
- The beneficiary profile will be reviewed for medications or diagnoses that may be contributing to excessive daytime sleepiness besides SWD
- The prescriber must submit the following for initial request for shift work disorder (SWD):
    - Most recent polysomnogram (PSG) results with sleep study performed during the beneficiary's normal sleep time
    - Most recent multiple sleep latency test (MSLT) performed during beneficiary's normal worktime
        - Mean sleep latency of less than 8 minutes per nap
        - Documented sleep onset rapid eye movement (SOREM) periods in more than 2 naps (one MSLT SOREM may be replaced by SOREM during PSG the night preceding MSLT)
    - Current chart notes
    - Baseline Epworth Sleepiness Scale (ESS); AND
    - Current work schedule

NARCOLEPSY WITH CATAPLEXY

- 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 as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with narcolepsy with cataplexy
- The beneficiary ages ≥ 7 years and < 19 years must have a trial of a CII stimulant in the last year
- The beneficiary ≥ 19 years must have both of the following unless contraindicated:
    - Trial and failure of CII stimulant in the last year
    - Trial and failure of a preferred CIV stimulant in the last year
- The prescriber must submit the following for initial request:
    - Most recent polysomnogram (PSG) results; AND
    - Most recent multiple sleep latency test (MSLT) from morning after PSG with the following:
        - Mean sleep latency of less than 8 minutes per nap; AND
        - Documented sleep onset rapid eye movement (SOREM) periods in more than 2 naps (one MSLT SOREM may be replaced by SOREM during PSG the night preceding MSLT)
    - Current labs, including LFTs
    - Current chart notes
    - Baseline Epworth Sleepiness Scale (ESS) Score for excessive daytime sleepiness associated with narcolepsy; AND

    - Baseline description of cataplexy events for beneficiaries with cataplexy diagnosis
- Requests for non-preferred medications for beneficiary ≥ 19 years of age require a documented trial and failure of at least one agent from each of the listed drug classes (e.g., CII stimulants and preferred CIII and CIV narcolepsy agents) in the last year with documentation of the medical necessity over the preferred medications.
- Requests for non-preferred medications for beneficiary ≥ 7 years of age and < 19 years of age require a documented trial and failure of at least one agent from each of the listed drug classes (e.g., CII stimulant and preferred CIII narcolepsy agent) in the last year with documentation of the medical necessity over the preferred medications.

OBSTRUCTIVE SLEEP APNEA

- 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 excessive sleepiness associated with obstructive sleep apnea (OSA)
- The beneficiary profile will be reviewed for medications or diagnoses that may be contributing to excessive daytime sleepiness besides OSA
- The prescriber should submit the following for initial request for obstructive sleep apnea (OSA):
    - Most recent polysomnogram (PSG) results
    - Current chart notes
    - Documentation of plan for monitoring compliance of positive airway treatment; AND
    - CPAP or BiPAP usage report for documentation of compliance for at least 1 month
- Requests for non-preferred medications require a documented trial and failure of at least one CII stimulant and at least one preferred CIV narcolepsy agent in the last year with documentation of the medical necessity over the preferred medications.
- PA renewal requires CPAP or BiPAP compliance

d. HEPATITIS C AGENTS

PREFERRED AGENTS WITHOUT CRITERIA

- **MAVYRET tablet and pellet packet (glecaprevir/pibrentasvir)**
- **sofosbuvir/velpatasvir (generic for EPCLUSA)**

PREFERRED AGENTS WITH CRITERIA

- ribavirin capsule
- ribavirin tablet
- **VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)**

NON-PREFERRED

- EPCLUSA (sofosbuvir/velpatasvir)
- HARVONI (ledipasvir/sofosbuvir)
- ledipasvir/sofosbuvir (generic for HARVONI)
- PEGASYS (peginterferon alfa-2a)
- SOVALDI (sofosbuvir)
- **ZEPATIER (elbasvir/grazoprevir)**

APPROVAL CRITERIA FOR VOSEVI (requires PA):

- Beneficiary must be ≥ 18 years of age with confirmed Hepatitis C based on virology labs
- Beneficiary must have been refractory to the treatment with generic EPCLUSA and/or MAVYRET
- Beneficiary meets the indications and dosing requirements from the package insert

RIBAVIRIN:

- Reviewed on a case-by-case basis with guidance from the AASLD guidelines

QUANTITY EDITS:

- MAVYRET—16 weeks (336 tablets) every 12 months
- SOFOSBUVIR/VELPATASVIR—12 weeks (84 tablets) every 12 months
- VOSEVI—12 weeks (84 tablets) per PA
- HARVONI—12 weeks (84 tablets) per PA (unless qualifies for 24 weeks)
- SOVALDI—12 weeks (84 tablets) per PA (unless qualifies for 24 weeks)

e. TARGETED IMMUNOMODULATORS

PREFERRED AGENTS WITH CRITERIA
(*Designates biosimilar)

- **adalimumab-adbm (generic for CYLTEZO)***
- ENBREL (etanercept)
- **HADLIMA (adalimumab-bwwd)***
- **ILARIS (canakinumab)**
- OTEZLA (apremilast)
- PYZCHIVA syringe (ustekinumab-ttwe)**+ *** – **brand only**
- PYZCHIVA 45 mg vial (ustekinumab-ttwe)**+ *** – **brand only**
- **STARJEMZA syringe/45 mg vial (ustekinumab-hmny)+ ***
- TALTZ (ixekizumab)**+**
- **tofacitinib (generic for XELJANZ) tablet+**
- **tofacitinib (generic for XELJANZ XR) tablet+**

+ PYZCHIVA, **STARJEMZA**, TALTZ, and **tofacitinib/tofacitinib XR** must have trial and failure of at least one preferred tumor necrosis factor (TNF) blocker (i.e., preferred adalimumab product or ENBREL) unless there is a contraindication to the use of a TNF blocker.

CONTINUATION CRITERIA FOR PREFERRED AGENTS

- ENBREL: Look back in pharmacy claims history 45 days for ≥ 1 paid claims for ENBREL
- HADLIMA or adalimumab-adbm: Look back in pharmacy claims history 45 days for ≥ 1 paid claims for any adalimumab product
- OTEZLA: Look back in pharmacy claims history 45 days for ≥ 1 paid claims for OTEZLA
- PYZCHIVA: Look back in pharmacy claims history 120 days for ≥ 1 paid claims for any ustekinumab product
- STARJEMZA: Look back in pharmacy claims history 120 days for ≥ 1 paid claims for any ustekinumab product
- TALTZ: Look back in pharmacy claims history 45 days for ≥ 1 paid claims for TALTZ
- Tofacitinib or tofacitinib XR: Look back in pharmacy claims history 45 days for ≥ 1 paid claims for any tofacitinib product

NON-PREFERRED AGENTS
(*Designates biosimilar)

- ABRILADA (adalimumab-afzb)*
- ACTEMRA syringe/autoinjector (tocilizumab)
- adalimumab-aacf (generic for IDACIO)*
- adalimumab-aaty (generic for YUFLYMA)*
- adalimumab-adaz (generic for HYRIMOZ)*
- adalimumab-fkjp (generic for HULIO)*
- adalimumab-ryvk (generic for SIMLANDI)*
- AMJEVITA (adalimumab-atto)*
- ARCALYST (rilonacept)
- AVTOZMA syringe/autoinjector (tocilizumab-anoh)*
- BIMZELX (bimekizumab-bkzx)
- CIMZIA syringe (certolizumab)
- COSENTYX syringe/pen (secukinumab)
- CYLTEZO (adalimumab-adbm)*
- ENSPRYNG (satralizumab-mwge)
- ENTYVIO pen (vedolizumab)
- HULIO (adalimumab-fkjp)*
- **HUMIRA (adalimumab)**
- HYRIMOZ (adalimumab-adaz)*
- ICOTYDE (icotrokinra)
- IMULDOSA syringe (ustekinumab-srlf)*
- KEVZARA (sarilumab)
- KINERET (anakinra)
- LEQSELVI (deuruxolitinib)
- **LISRAYA (brepocitinib)**
- LITFULO (ritlecitinib)
- OLUMIANT (baricitinib)
- OMVOH syringe/pen (mirikizumab-mrkz)
- ORENCIA syringe/autoinjector (abatacept)
- OTEZLA XR (apremilast)
- OTULFI syringe/45 mg vial (ustekinumab-aauz)*

- RINVOQ (upadacitinib)
- SELARSDI syringe/45 mg vial (ustekinumab-aekn)*
- SIMLANDI (adalimumab-ryvk)*
- SIMPONI syringe/pen (golimumab)
- SKYRIZI syringe/on-body injector/pen (risankizumab-rzaa)
- SOTYKTU (deucravacitinib)
- SPEVIGO syringe (spesolimab-sbzo)
- STELARA syringe/45 mg vial (ustekinumab)
- **STEQEYMA syringe (ustekinumab-stba)***
- **STEQEYMA 45 mg vial (ustekinumab-stba)***
- **tofacitinib solution (generic for XELJANZ)**
- TREMFYA syringe/pen/autoinjector (guselkumab)
- TYENNE syringe/autoinjector (tocilizumab-aazg)*
- ustekinumab syringe/45 mg vial (generic for STELARA)
- ustekinumab-aauz (generic for OTULFI)*
- ustekinumab-aekn syringe (generic for SELARSDI)*
- ustekinumab-ttwe syringe/45 mg vial (generic for PYZCHIVA)*
- VELSIPITY (etrasimod)
- XELJANZ solution (tofacitinib)
- **XELJANZ/XELJANZ XR tablet (tofacitinib)**
- YESINTEK (ustekinumab-kfce)*
- YUFLYMA (adalimumab-aaty)*
- YUSIMRY (adalimumab-aqvh)*
- ZYMFENTRA (infliximab-dyyb)*

AGENTS COVERED UNDER MEDICAL CLAIMS ONLY

Prime Therapeutics reviews Medical Claim Prior Authorization requests. For more information, please visit https://ar.primetherapeutics.com/documents/d/arkansas/arkansas_medicaid_pad_criteria

- ACTEMRA vial (tocilizumab)
- AVSOLA vial (infliximab-axxq)*
- AVTOZMA vial (tocilizumab-anoh)*
- CIMZIA vial (certolizumab)
- COSENTYX vial (secukinumab)
- ENTYVIO vial (vedolizumab)
- ILUMYA syringe (tildrakizumab-asmm)
- IMULDOSA vial (ustekinumab-srlf)*
- INFLECTRA vial (infliximab-dyyb)*
- infliximab vial (generic for REMICADE)
- OMVOH vial (mirikizumab-mrkz)
- ORENCIA vial (abatacept)
- OTULFI vial (ustekinumab-aauz)*
- PYZCHIVA vial (ustekinumab-ttwe)*
- REMICADE vial (infliximab)
- RENFLEXIS vial (infliximab-abda)*
- SELARSDI vial (ustekinumab-aekn)*
- SIMPONI ARIA vial (golimumab)
- SKYRIZI vial (risankizumab-rzaa)

- SPEVIGO vial (spesolimab-sbzo)
- STARJEMZA vial (ustekinumab-hmny)*
- STELARA vial (ustekinumab)
- STEQEYMA vial (ustekinumab-stba)*
- TOFIDENCE vial (tocilizumab-bavi)*
- TREMFYA vial (guselkumab)
- TYENNE vial (tocilizumab-aazg)*

GENERAL APPROVAL REQUIREMENTS

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for the FDA-approved indication
- The beneficiary's dose should not exceed the maximum dose supported in the manufacturer's package insert or MicroMedex
- The beneficiary has no therapeutic duplication with any other cytokine and CAM antagonists

APPROVAL CRITERIA FOR PLAQUE PSORIASIS

Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).

(Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, **adalimumab-adbm,** adalimumab-fkjp, adalimumab-ryvk, Amjevita, Bimzelx, Cimzia, Cosentyx, Cyltezo, **Enbrel**, **Hadlima**, Hulio, Humira, Hyrimoz, Icotyde, Imuldosa, **Otezla,** Otezla XR, Otulfi, **Pyzchiva,** Selarsdi, Simlandi, Skyrizi, Sotyktu, **Starjemza**, Stelara, Steqeyma, **Taltz**, Tremfya, ustekinumab, ustekinumab-aauz, ustekinumab-aekn, ustekinumab-ttwe, Yesintek, Yuflyma, or Yusimry)

- The medication must be prescribed by or in consultation with a dermatologist, rheumatologist, or other specialist treating plaque psoriasis
- The beneficiary has a documented diagnosis of moderate to severe plaque psoriasis
- The beneficiary must trial ≥ 6 months with at least one product from each of the following (6 months of topical and 6 months of systemic):
    - Topical drug therapy with corticosteroids, calcipotriene, calcitriol, tazarotene, roflumilast, or tapinarof; **AND**
    - Systemic drug therapy with methotrexate, acitretin, or cyclosporine
- The beneficiary must have tried and failed phototherapy or have a contraindication
- The beneficiary continues to have symptoms after trial of conventional therapy with at least one of the following:
    - Involvement of ≥ 10% body surface area (BSA)
    - Psoriasis Area and Severity Index (PASI) score ≥ 12; **OR**
    - Plaque location severely impacts quality of life (i.e., head/neck, palms, soles of feet, genitalia)
- The prescriber must submit the following:
    - Current chart notes
    - Documentation of previous therapies; **AND**
    - Current psoriasis description with BSA and PASI score
- For PYZCHIVA, STARJEMZA, or TALTZ, the beneficiary has a history of at least 3 months of one preferred tumor necrosis factor (TNF) blocker (i.e.,

preferred adalimumab product or ENBREL) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least two preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR PSORIATIC ARTHRITIS AND RHEUMATOID ARTHRITIS
Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).
Psoriatic Arthritis:
(Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, **adalimumab-adbm,** adalimumab-fkjp, adalimumab-ryvk, Amjevita, Bimzelx, Cimzia, Cosentyx, Cyltezo, **Enbrel**, **Hadlima,** Hulio, Humira, Hyrimoz, Imuldosa, Orencia, **Otezla**, Otezla XR, Otulfi, **Pyzchiva**, Rinvoq, Rinvoq LQ, Selarsdi, Simlandi, Simponi, Skyrizi, Sotyktu, **Starjemza,** Stelara, Steqeyma, **Taltz, tofacitinib, tofacitinib XR**, Tremfya, ustekinumab, ustekinumab-aauz, ustekinumab-aekn, ustekinumab-ttwe, Xeljanz, Xeljanz XR, Yesintek, Yuflyma, or Yusimry)

Rheumatoid Arthritis:
(Abrilada, Actemra, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, **adalimumab-adbm,** adalimumab-fkjp, adalimumab-ryvk, Amjevita, Avtozma, Cimzia, Cyltezo, **Enbrel, Hadlima,** Hulio, Humira, Hyrimoz, Kevzara, Kineret, Olumiant, Orencia, Rinvoq, Simlandi, Simponi, **tofacitinib, tofacitinib XR,** Tyenne, Xeljanz, Xeljanz XR, Yuflyma, or Yusimry)
- The medication must be prescribed by or in consultation with a rheumatologist or other specialist treating psoriatic arthritis or rheumatoid arthritis
- The beneficiary has a documented diagnosis of psoriatic arthritis or rheumatoid arthritis
- Trial and failure with NSAIDs
- Trial and failure with ≥ 6 months of any of the following:
    - hydroxychloroquine
    - methotrexate
    - sulfasalazine; **OR**
    - leflunomide
- The prescriber must submit the following:
    - Current chart notes
    - Documentation of previous therapies
    - Current labs as baseline (e.g., Erythrocyte Sedimentation Rate, C-Reactive Protein level)
- Psoriatic Arthritis: For PYZCHIVA, STARJEMZA, TALTZ, tofacitinib IR, or tofacitinib XR, the beneficiary has a history of at least 3 months of one preferred tumor necrosis factor (TNF) blocker (i.e., preferred adalimumab product or ENBREL) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker

- Rheumatoid Arthritis: For tofacitinib IR or tofacitinib XR, the beneficiary has a history of at least 3 months of one preferred tumor necrosis factor (TNF) blocker (i.e., preferred adalimumab product or ENBREL) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least two preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR ULCERATIVE COLITIS

Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).

(Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, **adalimumab-adbm,** adalimumab-fkjp, adalimumab-ryvk, Amjevita, Cyltezo, Entyvio, **Hadlima,** Hulio, Humira, Hyrimoz, Imuldosa, Omvoh, Otulfi, **Pyzchiva**, Rinvoq, Selarsdi, Simlandi, Simponi, Skyrizi, **Starjemza,** Stelara, Steqeyma, **tofacitinib, tofacitinib XR,** Tremfya, Velsipity, Xeljanz, Xeljanz XR**,** ustekinumab, ustekinumab-aauz, ustekinumab-aekn, ustekinumab-ttwe, Yesintek, Yuflyma, Yusimry, or Zymfentra)

- The medication must be prescribed by or in consultation with a gastroenterologist
- The beneficiary has a documented diagnosis of moderate to severe ulcerative colitis as defined by one of the following:
    - Fecal calprotectin > 150 µg/g
    - Endoscopy Mayo subscore ≥ 2 or modified Mayo score (mMS) ≥ 5
- The beneficiary has a history of at least **ONE** of the following:
    - Hospitalized for ulcerative colitis; **OR**
    - Trialed multiple days of IV glucocorticoids; **OR**
    - Trialed ≥ 2 months of oral/rectal glucocorticoids (e.g., enteric coated budesonide, prednisone, hydrocortisone)
- The prescriber must submit the following:
    - Current chart notes
    - Documentation of previous therapies; **AND**
    - Current labs, including inflammatory markers (i.e., fecal calprotectin, endoscopic Mayo subscore)
- For PYZCHIVA, STARJEMZA, tofacitinib IR, or tofacitinib XR, the beneficiary has a history of at least 3 months of one preferred tumor necrosis factor (TNF) blocker (i.e., preferred adalimumab product) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least two preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR CROHN'S DISEASE
Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).
(Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, **adalimumab-adbm,** adalimumab-fkjp, adalimumab-ryvk, Amjevita, Cimzia, Cyltezo, Entyvio, **Hadlima**, Hulio, Humira, Hyrimoz, Imuldosa, Omvoh, Otulfi, **Pyzchiva,** Rinvoq, Selarsdi, Simlandi, Skyrizi, **Starjemza,** Stelara, Steqeyma, Tremfya, ustekinumab, ustekinumab-aauz, ustekinumab-aekn, ustekinumab-ttwe, Yesintek, Yuflyma, Yusimry, or Zymfentra)

- The medication must be prescribed by or in consultation with a gastroenterologist
- The beneficiary has a documented diagnosis of moderate to severe Crohn's Disease confirmed by assessment of stool frequency, abdominal pain score, and Simple Endoscopic Score for Crohn's Disease (SES-CD). Information for diagnosis is based on endoscopy and imaging results as well as elevated CRP and fecal calprotectin.
- The beneficiary has been hospitalized with Crohn's Disease **OR** been diagnosed with a fistula or abscess **OR** had a trial and failure with ≥ 2 months of oral/rectal glucocorticoids (e.g., enteric coated budesonide, prednisone, hydrocortisone)
- The prescriber must submit the following:
    - Current chart notes
    - Documentation of previous therapies and surgeries
    - Current labs, including CBCs and inflammatory markers (i.e., fecal calprotectin, C-reactive protein)
    - Colonoscopy or imaging reports
    - Baseline stool frequency and abdominal pain score; **AND**
    - Baseline Crohn's Disease Activity Index (CDAI) (clinical trials included beneficiaries with score ≥ 220) or Simple Endoscopic Score for Crohn's disease (SES-CD) (clinical trials included beneficiaries with score ≥ 6 or ≥ 4 for isolated ileal disease)
- For PYZCHIVA or STARJEMZA, the beneficiary has a history of at least 3 months of one preferred tumor necrosis factor (TNF) blocker (i.e., preferred adalimumab product) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least two preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents

APPROVAL CRITERIA FOR STILL'S DISEASE
(Actemra, Avtozma, **Ilaris**, or Tyenne)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist
- The beneficiary must be diagnosed with active Still's Disease (either Adult-Onset Still's Disease [AOSD] or Systemic Juvenile Idiopathic Arthritis [SJIA])
- New onset therapy
    - Initial recommended therapy for patient without macrophage activation syndrome is either an IL-1 or IL-6 biologic (e.g., tocilizumab, canakinumab)

    - If macrophage activation syndrome is suspected, high dose IV corticosteroids, cyclosporine, or a biologic may be warranted (UpToDate® recommends anakinra as the biologic in these beneficiaries)
- Subsequent therapy (without response to or intolerant to initial therapy)
    - An alternate IL-1 or IL-6 biologic; **OR**
    - Janus kinase inhibitor (JAKi); **OR**
    - DMARD; **OR**
    - Glucocorticoid
- The prescriber must submit the following:
    - Current chart notes
    - Documentation of symptoms and criteria used for diagnosis
    - Previous therapies tried; **AND**
    - Current weight for dose determination
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS
Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).
(Abrilada, Actemra, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, **adalimumab-adbm,** adalimumab-fkjp, adalimumab-ryvk, Amjevita, Avtozma, Cimzia, Cyltezo, **Enbrel, Hadlima,** Hulio, Humira, Hyrimoz, Kevzara, Orencia**,** Rinvoq, Rinvoq LQ, Simlandi, **tofacitinib tablet,** tofacitinib solution, Tyenne, Xeljanz tablet, Xeljanz oral solution, Yuflyma, or Yusimry)

- The beneficiary has a documented diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis (JIA)
- Trial and failure with NSAIDs (unless contraindication or intolerance)
- Trial and failure with ≥ 3 months of disease modifying anti-rheumatic drugs (DMARDs) with any of the following (unless contraindication or intolerance):
    - methotrexate
    - leflunomide; **OR**
    - cyclosporine
- The prescriber must submit the following:
    - Current chart notes
    - Documentation of previous therapies with description of current symptoms; **AND**
    - Current labs, including CBCs and inflammatory markers
- For tofacitinib IR, the beneficiary has a history of at least 3 months of one preferred tumor necrosis factor (TNF) blocker (i.e., preferred adalimumab product or ENBREL) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least two preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR DEFICIENCY OF IL-1 RECEPTOR ANTAGONIST
(Arcalyst and Kineret)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist
- The beneficiary has a documented diagnosis of deficiency of IL-1 receptor antagonist (DIRA)
- Trial and failure with NSAIDs (unless contraindication or intolerance)
- Trial and failure with ≥ 3 months of disease modifying anti-rheumatic drugs (DMARDs) with any of the following (unless contraindication or intolerance):
    - methotrexate
    - leflunomide; **OR**
    - cyclosporine
- The prescriber must submit the following:
    - Current chart notes
    - Documentation of previous therapies with description of current symptoms; **AND**
    - Current labs, including CBCs and inflammatory markers
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR ANKYLOSING SPONDYLITIS
Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).
(Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, **adalimumab-adbm,** adalimumab-fkjp, adalimumab-ryvk, Amjevita, Bimzelx, Cimzia, Cosentyx, Cyltezo, **Enbrel**, **Hadlima,** Hulio, Humira, Hyrimoz, Rinvoq, Simlandi, Simponi, **Taltz, tofacitinib, tofacitinib XR,** Xeljanz tablet, Xeljanz XR**,** Yuflyma, or Yusimry)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist
- The beneficiary has a documented diagnosis of ankylosing spondylitis
- Trial and failure with ≥ 3 months of standard of care drug therapy (unless contraindication or intolerance) with nonsteroidal anti-inflammatory drugs at maximum doses (e.g., naproxen, celecoxib, ibuprofen)
- The prescriber must submit the following:
    - Current chart notes; **AND**
    - Documentation of previous therapies
- For TALTZ, tofacitinib IR and tofacitinib XR, the beneficiary has a history of at least 3 months of one preferred tumor necrosis factor (TNF) blocker (i.e., preferred adalimumab product or ENBREL) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least two preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR NONRADIOGRAPHIC AXIAL SPONDYLOARTHRITIS
Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).
(Bimzelx, Cimzia, Cosentyx, Rinvoq, or **Taltz**)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist
- The beneficiary has a documented diagnosis of nonradiographic axial spondyloarthritis
- Trial and failure with ≥ 3 months of standard of care drug therapy (unless contraindication or intolerance) with nonsteroidal anti-inflammatory drugs at maximum doses (e.g., naproxen, celecoxib, ibuprofen)
- The prescriber must submit the following:
    - Current chart notes; **AND**
    - Documentation of previous therapies
- Non-preferred agents require a 3-month trial and failure or a contraindication or intolerance to at least one preferred agent with this indication.
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES
(Arcalyst, **Ilaris**, or Kineret)

- The medication must be prescribed by or in consultation with a specialist in treating CAPS
- The beneficiary must have a diagnosis of cryopyrin-associated periodic syndromes (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS) or neonatal onset multisystem inflammatory disease (NOMID)
- The prescriber must submit the following:
    - Current chart notes
    - Confirmation of the diagnosis with genetic test results if available
    - Baseline symptoms; **AND**
    - Previous therapies tried
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR GIANT CELL ARTERITIS
(Actemra, Avtozma, Rinvoq, or Tyenne)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist
- The beneficiary has a confirmed diagnosis of giant cell arteritis based on clinical symptoms and one of the following:
    - Temporal artery biopsy; **OR**
    - Ultrasound of vessels
- The prescriber must submit the following:
    - Current chart notes
    - Documentation to confirm diagnosis with biopsy results and/or ultrasound report along with labs (i.e., CRP, ESR)
    - Medical necessity over high dose corticosteroids; **AND**

    - Treatment plan for potential discontinuation in the future
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE
(Actemra)

- The medication must be prescribed by or in consultation with a rheumatologist, pulmonologist, or other specialist
- The beneficiary has a confirmed diagnosis of SSc-ILD based on clinical symptoms and the following:
    - PFTs indicate a decreased lung volume and decreased DLCO
    - High resolution CT indicates ground glass or reticular opacities; **AND**
    - Lab work consistent with scleroderma
- Trial and failure of immunosuppressant therapy with mycophenolate or cyclophosphamide unless a contraindication or intolerance
- The prescriber must submit the following:
    - Current chart notes
    - Current PFTs
    - High resolution CT report
    - Current labs
    - Baseline 6-minute walk test; **AND**
    - Medical necessity over immunosuppressant therapy with or without glucocorticoids
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR RECURRENT PERICARDITIS
(Arcalyst)

- The beneficiary is diagnosed with recurrent pericarditis based on previous episodes of acute pericarditis and has developed pleuritic chest pain. Lab work should support an inflammatory phenotype (elevated CRP, WBC, or ESR).
- The beneficiary should not receive this medication if not diagnosed with an inflammatory phenotype.
- The beneficiary should have trial and failure with all of the following (unless there is a contraindication):
    - Colchicine and NSAID or aspirin – first line therapy
    - Colchicine and glucocorticoid – second line therapy
    - Colchicine, glucocorticoid, and aspirin – third line therapy
- The prescriber must submit the following:
    - Current chart notes
    - Previous treatment for acute pericarditis
    - Electrocardiogram and echocardiogram results
    - Current labs, including CBC, ESR, and CRP; **AND**
    - Treatment plan including taper

- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR UVEITIS
Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).
(Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, **adalimumab-adbm,** adalimumab-fkjp, adalimumab-ryvk, Amjevita, Cyltezo, **Hadlima,** Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, or Yusimry)

- The medication must be prescribed by or in consultation with a rheumatologist, ophthalmologist, or other specialist for treating uveitis
- The beneficiary must be diagnosed with non-infectious intermediate, posterior, or panuveitis
- Trial and failure with all of the following:
    - Topical glucocorticoid (e.g., prednisolone, triamcinolone)
    - Systemic glucocorticoid at the maximum indicated dose unless a contraindication or intolerance (e.g., prednisone); **AND**
    - Immunosuppressant (e.g., azathioprine, methotrexate, mycophenolate, cyclosporine)
- The prescriber must submit the following:
    - Current chart notes; **AND**
    - Documentation of previous therapies tried
- Non-preferred agents require a 3-month trial and failure or a contraindication or intolerance to at least one preferred agent with this indication.
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR TUMOR NECROSIS FACTOR RECEPTOR ASSOCIATED PERIODIC SYNDROME OR HYPERIMMUNOGLOBULIN D SYNDROME/MEVALONATE KINASE DEFICIENCY
(Ilaris)

- The medication must be prescribed by or in consultation with a rheumatologist or other rare disease specialist for treating TRAPS or HIDS/MKD
- The beneficiary must be diagnosed with one of the following:
    - TNF Receptor Associated Periodic Syndrome (TRAPS) after infectious or neoplastic causes of recurrent fevers are excluded; OR
    - Hyperimmunoglobulin D (Hyper-IgD) Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)
- Trial and failure of NSAIDs and oral glucocorticoids at the maximum indicated dose unless a contraindication or intolerance
- The prescriber must submit the following:
    - Current chart notes
    - Documentation of symptoms and criteria used for diagnosis
    - Previous therapies tried
    - Current weight for dose determination; **AND**
    - Medical necessity for the use of this medication over NSAIDs and oral glucocorticoids

- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR FAMILIAL MEDITERRANEAN FEVER (Ilaris)

- The medication must be prescribed by or in consultation with a rheumatologist or other rare disease specialist for treating FMF
- The beneficiary must be diagnosed with Familial Mediterranean Fever (FMF)
- Trial and failure of colchicine unless a contraindication or intolerance (treatment recommended indefinitely)
- The prescriber must submit the following:
    - Current chart notes
    - Documentation of symptoms and criteria used for diagnosis
    - Previous therapies tried; **AND**
    - Current weight for dose determination
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR ALOPECIA AREATA

(Leqselvi, Litfulo, or Olumiant)

- The medication must be prescribed by or in consultation with a dermatologist
- The beneficiary has a documented diagnosis of alopecia areata with > 50% scalp hair loss or refractory disease
- The beneficiary does not have another cause of hair loss (i.e., androgenetic alopecia, chemotherapy-induced hair loss, or causes of hair loss other than alopecia areata)
- The beneficiary request would be denied if taking any of the following concomitantly:
    - JAK inhibitor
    - Other cytokine and CAM antagonists
    - Immunosuppressant
- Trial and failure of topical and/or intralesional corticosteroids
- Trial and failure with ≥ 6 months of disease modifying anti-rheumatic drugs (DMARDs) with any of the following (unless contraindicated):
    - methotrexate
    - leflunomide; **OR**
    - cyclosporine
- The prescriber must submit the following:
    - Current chart notes
    - Documentation of previous therapies tried with duration
    - Medical necessity over intralesional corticosteroids, topical steroids, and DMARDs; **AND**
    - Letter of medical necessity
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR POLYMYALGIA RHEUMATICA
(Kevzara)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist
- The beneficiary must be diagnosed with polymyalgia rheumatica based on clinical symptoms and supporting lab findings with the following:
    - Elevated ESR and/or CRP
    - Pain and morning stiffness about the shoulders, hip girdle, and neck; **AND**
    - Limited range of motion in shoulders, cervical spine, or hips causing difficulties with activities of daily living (such as pulling on a shirt, putting on socks/shoes, or transferring from lying to seated position)
- The prescriber must submit the following:
    - Current chart notes
    - Documentation of symptoms
    - Current labs, including ESR and CRP; **AND**
    - Medical necessity over corticosteroids at maximum tolerated doses
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR HIDRADENITIS SUPPURATIVA
Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).
(Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, **adalimumab-adbm,** adalimumab-fkjp, adalimumab-ryvk, Amjevita, Bimzelx, Cosentyx, Cyltezo, **Hadlima,** Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, or Yusimry)

- Some medications/treatments recommended in Hidradenitis Suppurativa (HS) guidelines may not be a covered product/procedure by Arkansas Medicaid. Refer to the respective provider manual for additional information.
- The beneficiary with diagnosis of Hurley Stage I HS should use options from the following list (biologics are not recommended for Hurley Stage I):
    - Topical clindamycin
    - Oral tetracyclines (tetracycline, doxycycline, minocycline)
    - Antiandrogenic agents (combined oral contraceptives, spironolactone, finasteride)
    - Metformin
    - Alternatives for refractory beneficiaries – clindamycin with rifampin, acitretin, dapsone
    - Laser therapy
    - Intralesional corticosteroids
    - Topical resorcinol; **OR**
    - Surgical drainage
- The beneficiary with diagnosis of Hurley Stage II:
    - The beneficiary should follow treatment guidelines (e.g., Journal of the American Academy of Dermatology: https://www.jaad.org/action/showPdf?pii=S0190-9622%2819%2930368-8)

    - Prior to beginning biologics, the beneficiary should have tried at least two of the following:
        - Oral tetracyclines for a minimum of 3 months (unless contraindicated)
        - Combination of rifampin and clindamycin for a minimum of 3 months (unless contraindicated)
        - Oral contraceptives for a minimum of 3 months (females only)
        - Oral retinoids for a minimum of 3 months (unless contraindicated); **OR**
        - Refractory after treatment – antibiotic therapy with adjunctive treatment of an antiandrogen, metformin, or oral contraceptives (When choosing adjunctive options, consider the beneficiary's comorbidities.)
- Beneficiaries who are refractory after at least two 3-month therapies or have progressed to Stage III during treatment may be considered for therapy with biologics
- The prescriber must submit the following:
    - Chart notes
    - Documentation of previous therapies tried including surgery or laser treatment; **AND**
    - Comorbidities that can increase HS severity must be addressed (list not all inclusive)
        - Tobacco use
        - Obesity; **OR**
        - PCOS
- Non-preferred agents require a 3-month trial and failure or a contraindication or intolerance to at least one preferred agent with this indication.
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR ENTHESITIS-RELATED ARTHRITIS
(Cosentyx)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist
- The beneficiary has a documented diagnosis of enthesitis-related arthritis
- Trial and failure with NSAIDs
- Trial and failure with ≥ 3 months of disease modifying anti-rheumatic drugs (DMARDs) with any of the following (unless contraindicated):
    - methotrexate
    - leflunomide
    - cyclosporine; **OR**
    - sulfasalazine
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR GOUT FLARES
(Ilaris)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist.
- The beneficiary must be diagnosed with gout flares.
- The beneficiary must have tried and failed non-steroidal anti-inflammatory drugs (NSAIDs), corticosteroids, and colchicine (unless contraindicated or not tolerated). Repeated courses of corticosteroids are not appropriate.
- The beneficiary with frequent gout flares (defined as three or more gout flares in the previous year) must be on a urate-lowering medication (e.g., allopurinol, febuxostat, probenecid).
- The prescriber must submit all of the following:
    - Current chart notes
    - Documentation of symptoms; **AND**
    - Current labs, including serum urate concentration and documentation of urate crystals in the synovial fluid (if available)
- PA will be approved for one dose.
- Renewal requires prescribers to submit updated notes with documentation of continued gout flare. Ilaris requires at least 12 weeks between doses.

APPROVAL CRITERIA FOR BEHÇET'S DISEASE
Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).
(Otezla, Otezla XR**)**

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist in the treatment of Behçet's Disease
- The beneficiary has a documented diagnosis of Behçet's Disease with oral ulcers
- Trial and failure with ≥ 3 months of the following:
    - Topical corticosteroids (e.g., triamcinolone acetonide cream 0.1% in orabase); **AND**
    - ≥ one of the following conventional oral therapies:
        - colchicine
        - azathioprine; **OR**
        - sulfasalazine
- The prescriber must submit the following:
    - Current chart notes
    - Documentation of previous therapies tried with duration; **AND**
    - Medical necessity over topical corticosteroids and conventional oral therapies
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR NEUROMYELITIS OPTICA SPECTRUM DISORDER
(Enspryng)

- Prescribed by a specialist experienced with NMOSD
- The beneficiary is diagnosed with neuromyelitis optica spectrum disorder (NMOSD) and is anti-aquaporin-4 (AQP4) antibody positive and confirmed with the following:
    - Test indicating beneficiary is seropositive for AQP4-IgG antibodies
    - The beneficiary has at least one core clinical characteristic (i.e., optic neuritis, acute myelitis, area postrema syndrome, acute brainstem syndrome, symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions, or symptomatic cerebral syndrome with NMOSD-typical brain lesions)
    - Exclusion of alternative diagnosis (i.e., Lupus, multiple sclerosis, sarcoidosis, cancer, chronic infection like HIV)
- The beneficiary must have a history of at least one documented relapse (including first attack) in the last 12 months
- The beneficiary must have an Expanded Disability Status Scale (EDSS) score ≤ 6.5
- The beneficiary is not prescribed medication for the treatment of multiple sclerosis (i.e., interferon, dimethyl fumarate, fingolimod, glatiramer)
- The beneficiary is not prescribed other treatment options for NMOSD concomitantly (i.e., eculizumab or inebilizumab)
- Prescribed to prevent future attacks (not meant to treat an acute attack)
- The prescriber must submit all of the following:
    - Current chart notes
    - Documentation of previous therapies tried
    - Confirmation of NMOSD diagnosis
    - Baseline Expanded Disability Status Scale score
    - Medical necessity over the use of immunotherapy (e.g., rituximab, azathioprine, mycophenolate, or methotrexate); **AND**
    - Results for Hepatitis B virus and tuberculosis screens (should be negative for approval)

RENEWAL REQUIREMENTS

- Renewal requires prescriber to submit updated notes with documentation of a positive response to therapy which is defined by any of the following:
    - Decrease in acute relapses
    - Improvement in EDSS
    - Reduced hospitalizations; **AND**
    - Reduction/discontinuation in plasma exchange treatments or corticosteroids

QUANTITY
#1/28 days (first month will require a quantity override to allow three injections)

APPROVAL CRITERIA FOR GENERALIZED PUSTULAR PSORIASIS
(Spevigo)

- The medication must be prescribed by or in consultation with a dermatologist
- The beneficiary must have a diagnosis of generalized pustular psoriasis (GPP) with a history of at least two GPP flares of moderate-to-severe intensity in the past 5 years. Those two flares must meet the following criteria from the Effisayil-1 trial to be considered moderate-to-severe. Documentation of those flares must be provided.
    - Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score ≥ 3 (moderate)
    - GPPGA pustulation subscore of ≥ 2 (mild)
    - Presence of fresh pustules (new appearance or worsening of pustules); **AND**
    - ≥ 5% of BSA covered with erythema and the presence of pustules
- The beneficiary must have one of the following treatment options. Document the correct treatment plan for the beneficiary.
    - Treatment and maintenance following an acute GPP flare
        - 900 mg IV infusion loading dose over 90 minutes; may repeat once after one week (requires medical prior authorization request review)
        - Followed by 300 mg SQ every 4 weeks
        - Any subsequent flares would require a medical prior authorization request review
    - Treatment and maintenance when not experiencing a GPP flare
        - 600 mg SQ loading dose
        - Followed by 300 mg SQ every 4 weeks
- The beneficiary should not be approved or continue this therapy with any of the following:
    - Has no history of at least two GPP flares of moderate-to-severe intensity as defined above; **OR**
    - Active tuberculosis
- The prescriber must submit the following:
    - Current chart notes
    - Documentation of previous biologics or disease-modifying antirheumatic drugs (DMARDs) that have been tried with response
    - Documentation of other autoimmune diagnoses for the beneficiary and treatment plan
    - Documentation that the beneficiary has been evaluated for tuberculosis; **AND**
    - Clarification if this will be billed as a medical claim through "buy and bill" or billed as a pharmacy claim through a specialty pharmacy.

Note: If this medication is intended to be billed as a medical claim, follow the physician administered drugs procedure. Contact Prime Therapeutics with any questions.

- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR DERMATOMYOSITIS
(Lisraya)

- The medication must be prescribed by or in consultation with a dermatologist, rheumatologist, or other specialist treating dermatomyositis
- The beneficiary has a documented diagnosis of dermatomyositis
    - Documentation of idiopathic inflammatory myopathy (IIM) with muscle weakness and/or inflammation; **AND**
    - Dermatomyositis subgroup of IIM supported by patient specific symptoms
- The beneficiary must have been treated with corticosteroids along with a trial ≥ 3 months of at least **TWO** of the following:
    - Methotrexate; **OR**
    - Hydroxychloroquine; **OR**
    - Mycophenolate mofetil; **OR**
    - Azathioprine; **OR**
    - Leflunomide; **OR**
    - Sulfasalazine
- The beneficiary may also be prescribed topical corticosteroids and/or topical calcineurin inhibitors
- The prescriber must submit the following:
    - Current chart notes
    - Previous treatment for dermatomyositis
    - Medical necessity over other guideline recommended options (e.g., IVIG, rituximab)
    - Patient specific symptoms to confirm diagnosis
        - Cutaneous findings (e.g., Gottron's papules, Gottron's sign, heliotrope eruption)
        - Lab evidence of myositis (serum creatine kinase and aldolase levels)
        - Muscle weakness
        - Skin biopsy if ambiguous cutaneous findings
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

QUANTITY LIMITS (LISRAYA):
#30/30 days

f. CALCIUM CHANNEL BLOCKERS

DIHYDROPYRIDINE AND COMBINATION PRODUCTS
PREFERRED AGENTS

- amlodipine (generic for NORVASC)
- amlodipine/benazepril (generic for LOTREL)
- amlodipine/olmesartan (generic for AZOR)
- amlodipine/valsartan (generic for EXFORGE)
- amlodipine/valsartan/HCTZ (generic for EXFORGE HCT)
- nifedipine IR (generic for PROCARDIA)
- nifedipine ER (generic for ADALAT CC/PROCARDIA XL)

PREFERRED AGENTS with CRITERIA

- **NORLIQVA (amlodipine)**

Payable at Point of Sale (POS) for beneficiaries < 7 years of age or who have a diagnosis of NPO (Appendix A) in history

NON-PREFERRED AGENTS

- amlodipine/atorvastatin (generic for CADUET)
- amlodipine/olmesartan/HCTZ (generic for TRIBENZOR)
- amlodipine/telmisartan (generic for TWYNSTA)
- AZOR (amlodipine/olmesartan)
- CADUET (amlodipine/atorvastatin)
- EXFORGE (amlodipine/valsartan)
- EXFORGE HCT (amlodipine/valsartan/HCTZ)
- felodipine ER (generic for PLENDIL)
- isradipine (generic for DYNACIRC)
- KATERZIA (amlodipine)
- nicardipine (generic for CARDENE)
- nimodipine (generic for NYMALIZE) –**see criteria below**
- nisoldipine ER (generic for SULAR)
- NORVASC (amlodipine)
- NYMALIZE (nimodipine)
- PROCARDIA XL (nifedipine ER)
- SDAMLO (amlodipine)
- SULAR ER (nisoldipine)
- TRIBENZOR (amlodipine/olmesartan/HCTZ)

NON-DIHYDROPYRIDINE AND COMBINATION PRODUCTS

PREFERRED AGENTS

- CARTIA XT 24 HR (diltiazem)
- diltiazem CD 24 HR (generic for CARDIZEM CD)
- DILT-XR 24 HR (diltiazem)
- diltiazem ER 24 HR (generic for TIAZAC)
- diltiazem XR 24 HR (generic for DILACOR XR)
- diltiazem tablet (generic for CARDIZEM)
- TIADYLT ER 24 HR (diltiazem)
- verapamil tablet (generic for CALAN)
- verapamil ER tablet (generic for CALAN SR)

NON-PREFERRED AGENTS

- CARDAMYST (etripamil) (see criteria for CARDAMYST)
- diltiazem ER 12 HR (generic for CARDIZEM SR)
- diltiazem LA 24 HR (generic for Cardizem LA/MATZIM LA)
- MATZIM LA (diltiazem ER)
- verapamil ER capsule (generic for VERELAN/VERELAN PM)
- verapamil ER/trandolapril (generic for TARKA)

CRITERIA FOR NIMODIPINE SOLUTION (NYMALIZE)

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with subarachnoid hemorrhage (SAH), and this medication must be ordered to help with improvement of neurological outcome by reducing the incidence and severity of ischemic deficits
- The prescriber must submit the following:
  - Current chart notes
  - Baseline blood pressure; **AND**
  - Letter of medical necessity over preferred dihydropyridine agents and nimodipine oral capsules

g. LONG-ACTING MUSCARINIC ANTAGONISTS (LAMA) BRONCHODILATORS

Criteria for this class has not changed.

PREFERRED AGENT WITH CRITERIA

- SPIRIVA HANDIHALER (tiotropium bromide) – **brand only**

NON-PREFERRED AGENTS

- INCRUSE ELLIPTA (umeclidinium bromide) **– brand preferred over generic when approved**
- SPIRIVA RESPIMAT (tiotropium bromide)
- tiotropium bromide (generic of SPIRIVA)
- TUDORZA PRESSAIR (aclidinium bromide)
- umeclidinium bromide (generic for INCRUSE ELLIPTA)
- YUPELRI (revefenacin)

h. INHALED COMBINATION PRODUCTS (LABA/LAMA) BRONCHODILATORS

Criteria for this class has not changed.

PREFERRED AGENTS WITH CRITERIA

- ANORO ELLIPTA (umeclidinium/vilanterol) – **brand only**
- STIOLTO RESPIMAT (tiotropium/olodaterol)

NON-PREFERRED AGENTS

- **BEVESPI AEROSPHERE (formoterol/glycopyrrolate)**
- DUAKLIR PRESSAIR (aclidinium/formoterol)
- umeclidinium/vilanterol (generic for ANORO ELLIPTA)

i. INHALED COMBINATION PRODUCTS (ICS/LABA/LAMA) BRONCHODILATORS

PREFERRED AGENTS WITH CRITERIA

- **BREZTRI (budesonide/glycopyrrolate/formoterol)**

NON-PREFERRED AGENTS

- TRELEGY ELLIPTA (fluticasone furoate/umeclidinium/vilanterol)

APPROVAL CRITERIA FOR PREFERRED AGENTS WITH CRITERIA

Criterion 1:

- COPD diagnosis in the past two years; **AND**
- ≥ 18 years of age; **AND**
- No therapeutic duplications with other inhalers with the same mechanism of action; **OR**

Criterion 2:

- Diagnosis of asthma in the past two years; **AND**
- ≥ 12 years of age; **AND**
- No therapeutic duplication with other inhalers with the same mechanism of action; **OR**

Criterion 3:

- Paid drug claim in drug history for BREZTRI in the last six months

III. NEW DRUG or UPDATED PRIOR AUTHORIZATION CRITERIA

1. LYNAVOY (linerixibat) 40 mg tablet

APPROVAL CRITERIA:

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- 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 primary biliary cholangitis (PBC) confirmed by two of the following:
    - An alkaline phosphatase (ALP) level of at least 1.67 times ULN
    - Presence of antimitochondrial antibodies (AMA) at a titer of 1:40 or higher
    - Histologic evidence of PBC (nonsuppurative destructive cholangitis and destruction of interlobular bile ducts)
- The medication must be prescribed by or in consultation with a hepatologist or gastroenterologist
- The beneficiary must have had an inadequate response to ursodeoxycholic acid (UDCA) without improvement in LFTs and documented PBC related symptoms after a 1-year trial or the beneficiary must demonstrate intolerance to UDCA (e.g., Ursodiol)
- The beneficiary should not be diagnosed with decompensated cirrhosis or prior or active hepatic decompensation events (e.g., ascites, variceal bleeding, hepatic encephalopathy)
- The beneficiary should not be diagnosed with severe renal impairment (estimated glomerular filtration rate [eGFR] <30 mL/min/1.73 m^2)
- The prescriber must submit the following:
    - Current chart notes with beneficiary's specific symptoms
    - Documentation of previous therapies tried with response
    - Labs including liver function tests with baseline alkaline phosphatase, fat-soluble vitamin levels and INR
    - Current treatment plan; **AND**
    - Medical necessity over UDCA taken as monotherapy

RENEWAL REQUIREMENTS:

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response to Lynavoy with an improvement in symptoms and corresponding labs while experiencing no intolerable side effects
- The prescriber must submit the following:
    - Current chart notes
    - Documentation of response to therapy with summary of current symptoms; **AND**
    - Current labs, including liver function tests with alkaline phosphatase, fat-soluble vitamin levels and INR

QUANTITY LIMITS:

#60/30 days

2. TRYNGOLZA (olezarsen) 50 mg and 80 mg injection

APPROVAL 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 have high triglycerides and be diagnosed with **ONE** of the following:
    - Familial chylomicronemia syndrome (FCS) with fasting triglycerides level ≥ 880 mg/dL and confirmed by **ONE** of the following:
        - Genetic testing identifying biallelic pathogenic variants in the LPL, GPIHBP1, APOA5, APOC2, or LMF1 genes (results of genetic testing must be submitted); **OR**
        - Familial chylomicronemia score ≥ 10; **OR**
        - North American familial chylomicronemia syndrome score ≥ 45; **OR**
        - History of clinical signs and symptoms associated with FCS (i.e., pancreatitis and/or abdominal pain, eruptive xanthomas, lipemia retinalis, lipemic plasma) and a diagnosis of multifactorial chylomicronemia syndrome (MCS) has been ruled out;
    - Severe hypertriglyceridemia (sHTG: TG ≥ 500 mg/dL) and at risk of acute pancreatitis
- The medication must be prescribed by or in consultation with a cardiologist, endocrinologist, or specialist experienced in treating severe hypertriglyceridemia
- Beneficiary must have continued elevated triglyceride levels despite standard of care therapy
- The beneficiary should not be approved or continue the medication if meets **ONE** of the following:
    - Not on a low-fat diet of ≤ 20 gm of fat per day; **OR**
    - Currently a smoker

- The prescriber must submit the following:
    - Current chart notes with genetic testing to confirm diagnosis of FCS if applicable
    - Previous medications tried for lowering triglycerides
    - Current fasting labs including lipid panel
    - For FCS--documentation of symptoms associated with FCS (e.g., fatigue, pancreatitis/abdominal pain, eruptive xanthomas, lipemia retinalis, hepatosplenomegaly)
    - For sHTG—documentation supporting that patient is at risk for acute pancreatitis (other than elevated TG) or has symptoms suggesting pancreatitis; **AND**
    - Attestation that beneficiary is on a low-fat diet with ≤ 20 gm of fat per day
- Initial PA will be for 3 months, renewal PAs may be up to 6 months

RENEWAL REQUIREMENTS FOR TRYNGOLZA

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response with decrease in fasting triglycerides and decrease in symptoms documented at baseline
- The prescriber must submit the following:
    - Current chart notes
    - Current fasting labs including lipid panel
    - Current documentation of symptoms; **AND**
    - Attestation that the beneficiary remains on low-fat diet with ≤ 20 gm of fat per day

QUANTITY LIMITS:

- #1 per 30 days

3. LIPFENDRA (enlicitide) 20 mg tablets

PCSK9 INHIBITOR APPROVAL 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 as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must have one of the following diagnoses (any off-label requests will be reviewed on a case-by-case basis):
    - Patients at increased risk of major adverse cardiovascular (CV) events (CV death, myocardial infarction, stroke, unstable angina requiring hospitalization, coronary revascularization, or any ischemia-driven arterial revascularization) – REPATHA
    - Patients at increased risk of major adverse cardiovascular (CV) events (CV death, myocardial infarction, stroke, or unstable angina requiring hospitalization) – PRALUENT
    - Patients with hypercholesterolemia – PRALUENT and REPATHA and LIPFENDRA
    - Patients with heterozygous familial hypercholesterolemia (HeFH) – PRALUENT and REPATHA and LIPFENDRA

    - Patients with homozygous familial hypercholesterolemia (HoFH) – PRALUENT and REPATHA
- The 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; **AND**
    - Ezetimibe with statin therapy
- The beneficiary must have complied with previous lipid therapy required unless contraindicated (defined as 90 out of 120 days). The beneficiary's Medicaid claims history will be consulted, and a pharmacy printout may be requested to ensure compliance
- The beneficiary should have an LDL-C ≥ 70 mg/dL and/or non-HDL-C ≥ 100 mg/dL after a compliant trial of moderate-high intensity statins and ezetimibe unless the beneficiary has a contraindication
- Must be prescribed by, or in consultation with, a cardiologist, endocrinologist or lipid specialist
- The prescriber must submit all of the following:
    - Current chart notes with documentation of previous treatments
    - Current labs, including lipids as well as labs corresponding with previous trials of statins and ezetimibe taken concomitantly
    - Treatment plan with goal LDL-C
    - Diet plan for lowering cholesterol; **AND**
    - If the beneficiary smokes, the prescriber should submit a smoking cessation plan or documentation that the beneficiary has been counseled on smoking cessation
- Non-preferred medications require a trial and failure of at least **ONE** preferred agent for at least 3 months or a contraindication to the use of the preferred agent(s)
- Initial approval for 3 months

RENEWAL REQUIREMENTS:

- After initial approval, the beneficiary should demonstrate an improvement in the LDL-C levels
- The beneficiary must be compliant with therapy
- Renewals may be approved for 6 months with required response to therapy provided on each PA review
- The prescriber must submit all of the following:
    - Current chart notes; **AND**
    - Current lipid panel

QUANTITY LIMITS (LIPFENDRA):

- #30 per 30 days

4. TRUTAKNA (atacicept-vymj) 150 mg/mL injection

APPROVAL 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 as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary is diagnosed with primary immunoglobulin A nephropathy (IgAN) at risk for disease progression with proteinuria (defined as either a urine protein-to-creatinine ratio [UPCR] based on a 24-hour urine sample ≥1 g/g or total urine protein excretion ≥0.5 g per 24 hours)
- The beneficiary must have an estimated glomerular filtration rate (eGFR) ≥30 mL/min/1.73 m^2
- Must be prescribed by, or in consultation with, a nephrologist
- The beneficiary must demonstrate continued risk for disease progression (total urine protein excretion ≥0.5 g per 24 hours) despite at least 3 months of maximally tolerated doses and compliant use of supportive care (i.e., angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blocker (ARB) plus a sodium-glucose co-transporter 2 (SGLT2) inhibitor)
- The beneficiary must have had a previous trial and failure of TARPEYO (budesonide delayed-release capsule) unless contraindicated
- The 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:

- The beneficiary must be compliant on therapy
- The beneficiary has documented improvement in proteinuria with a reduction in UPCR or urine protein compared to baseline
- The prescriber must submit the following:
    - Current chart notes
    - Current labs, including LFTs, eGFR, lipid panel, and urine protein or UPC

QUANTITY LIMITS:

- 4 autoinjectors per 28 days

5. LEQEMBI IQLIK (lecanemab) 250 mg/1.25 mL & 360 mg/1.8 mL inj

APPROVAL CRITERIA:

- The beneficiary must be ≥ 50 years of age
- The beneficiary must be diagnosed with mild cognitive impairment or mild dementia associated with Alzheimer's disease confirmed by at least **ONE** objective measure/tool, including:
    - Clinical Dementia Rating (CDR) Global Score of 0.5–1.0 with Memory Box Score of at least 0.5; **OR**

- Mini-Mental State Examination (MMSE) score 20–28; **OR**
- Montreal Cognitive Assessment (MoCA) score 16–25

***Note**: The above cognitive tests are the most commonly used but do not represent an exhaustive list. Use of alternative cognitive assessment tests not listed will be reviewed on a case-by-case basis.*

- The beneficiary must have the following:
  - Baseline brain Magnetic Resonance Imaging (MRI) within one year prior to initiating treatment to evaluate for pre-existing Amyloid Related Imaging Abnormalities -edema (ARIA-E) and -hemosiderin deposition (ARIA-H) with **ONE** of the following (if present, medical necessity must be provided):
    - Had genotype testing prior to treatment to assess apolipoprotein E ε4 (ApoE ε4) status (e.g., homozygote, heterozygote, or noncarrier) as homozygote has a higher incidence of ARIA; **OR**
    - Genotype testing has not been performed, and the physician has informed the patient that it cannot be determined if they are ApoE ε4 homozygotes and, therefore, if they are higher risk for developing ARIA
  - The beneficiary must have at least **ONE** of the following to confirm the diagnosis:
    - Positron Emission Tomography (PET) scan confirming the presence of amyloid beta plaque; **OR**
    - Lumbar puncture results confirming at least **ONE** of the following in cerebrospinal fluid (CSF) assessment:
      - Presence of elevated phosphorylated tau (P-tau) protein or elevated tau (T-tau) protein, and reduced beta amyloid-42 (Aβ 42); **OR**
      - Low Aβ 42/40 ratio; **OR**
      - Elevated P-tau/Aβ 42 ratio; **OR**
      - Elevated T-tau/Aβ 42 ratio
- The medication must be prescribed by, or in consultation with, a specialist in neurology, neuropsychiatry, or gerontology
- The beneficiary must not have had a stroke, transient ischemic attack (TIA), or seizures in the past 12 months
- The beneficiary will not be approved for non-Alzheimer's dementia with cognitive impairment or dementia caused by other neurodegenerative diseases (e.g., Lewy body dementia, frontotemporal lobar degeneration, vascular dementia, metabolic impairment, traumatic brain injury)
- The beneficiary will not be approved for non-Alzheimer's causes of cognitive impairment (e.g., chronic psychiatric illness, chronic cardiovascular disease, or past history of psychotropic drug dependence)
- The beneficiary will not be approved with the following MRI findings:
  - more than 4 microhemorrhages
  - any macrohemorrhage > 10 mm
  - superficial siderosis
  - vasogenic edema
  - multiple lacunar infarcts or major strokes
  - severe small vessel disease; **OR**

    - subcortical hyperintensities consistent with severe white matter disease (e.g., Fazekas score of 3).
- The beneficiary will not be approved for LEQEMBI to be used concomitantly with other amyloid beta-directed antibodies (e.g., aducanumab, donanemab-azbt)
- The beneficiary will not be approved for LEQEMBI if receiving direct-acting oral anticoagulants (e.g., apixaban, dabigatran, edoxaban, rivaroxaban), anticoagulants (e.g., Factor Xa inhibitors), anti-platelet agents (except for prophylactic aspirin or clopidogrel), or anti-thrombins (e.g., heparin, warfarin).
- The beneficiary will not be approved if they have an uncontrolled bleeding disorder (e.g., platelets < 50,000 or INR > 1.5)
- The beneficiary will not be approved if diagnosed with moderate to severe Alzheimer's disease (e.g., MMSE <20)
- The prescriber must submit the following:
    - Current chart notes
    - Previous therapies tried
    - Required documentation to support diagnosis as listed above (i.e., dementia/cognition score, brain MRI, PET scan, and lumbar puncture). Documentation must confirm diagnosis to be approved.
    - Behavioral health diagnoses have been assessed for contributions to memory deficits; **AND**
    - Physician attestation to whether the beneficiary is actively abusing alcohol or nicotine and documentation is provided of the beneficiary's smoking history or alcohol or chronic substance use including prescription medications, cannabis, or other illicit drugs
- The beneficiary must take starting dose (10 mg/kg every 2 weeks IV **OR** 500 mg once weekly SQ) for 18 months before moving to maintenance dose. Follow the dosing recommended in the package insert for transition between routes of administration

RENEWAL REQUIREMENTS:

- The beneficiary has been compliant with therapy (defined as 75% utilization)
- The beneficiary has a positive response to therapy compared to pretreatment baseline as evidenced by improvement, stability, or slowing in cognitive or functional impairment in one or more of the following:
    - MMSE; **OR**
    - CDR-SB; **OR**
    - MoCA
- Treatment should be discontinued if follow-up PET scan indicates clearance of amyloid beta plaque
- The beneficiary has not progressed to moderate or severe Alzheimer's disease
- The beneficiary has not developed ARIA-E or ARIA-H based on MRI report
- The prescriber must submit the following:
    - Current chart notes
    - Current dementia/cognition score (e.g., MMSE, CDR-SB, MoCA); **AND**
    - Any MRI or PET scan reports since previous approval

6. MOUNJARO (tirzepatide) injection (FOR MACE)

MACE APPROVAL CRITERIA:

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- 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
- For initial approval, beneficiary must meet all of the following:
    - Diagnosed with type 2 diabetes mellitus; **AND**
    - Established cardiovascular (CV) disease (e.g., MI, stent placement, stroke, symptomatic peripheral arterial disease) or has multiple CV risk factors (e.g., CABG, Angina, CHD, CAD, MI, heart failure, CVD, TIA, PAD, aortic atherosclerosis, thoracic or abdominal aortic aneurysm); **AND**
    - At risk of major adverse cardiovascular (CV) events (CV death, non-fatal myocardial infarction (MI), or non-fatal stroke); **AND**
    - Considered either obese or overweight (defined as baseline BMI of ≥ 25 kg/m^2); **AND**
    - Has outlined treatment plan including reduced calorie diet and increased physical activity.
- The beneficiary must not be a current smoker or has started a smoking cessation program
- The beneficiary should not be approved or continue this therapy with any of the following:
    - No documented risk for MACE
    - Baseline BMI < 25 kg/m^2
    - Personal or family history of medullary thyroid carcinoma (MTC)
    - Diagnosed with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)
    - Requested for weight loss only; **OR**
    - Current smoker without a cessation plan
- The prescriber must submit the following:
    - Current chart notes
    - Current labs, including HbA1c and lipid panel
    - Current and previous therapy for cardiovascular disease
    - Baseline BMI and weight
    - Baseline waist circumference, blood pressure, and heart rate
    - Current treatment plan, including medication therapy, reduced calorie diet, and physical activity plan along with attestation that beneficiary has been counseled on lifestyle modifications needed to assist with weight loss and improvement in cardiovascular disease; **AND**
    - Medical necessity over preferred GLP-1 medications with the same indication

RENEWAL REQUIREMENTS:

- The beneficiary must be compliant with therapy (defined as 75% utilization)
- Renewal requires the following:
    - Improvement in cardiometabolic parameters (e.g., blood pressure, heart rate, labs) and body measurements; **AND**
    - Improvement or stabilization of glycemic control; **AND**
    - Continues with lifestyle modifications

- The prescriber must provide the following:
    - Current chart notes
    - Current BMI and weight
    - Current labs, including HbA1c and lipid panel; **AND**
    - Current waist circumference, blood pressure, and heart rate

7. ISOTRETINOIN capsule (FOR ACNE)

APPROVAL CRITERIA:

- The beneficiary must be ≥ 12 years of age
- The prescriber must be a dermatologist
- The beneficiary must have a diagnosis of severe recalcitrant nodular acne with many inflammatory nodules measuring a diameter of 5 mm or greater
- The beneficiary has been unresponsive to conventional therapy, including ideally three consecutive months using at least **TWO** of the following (history of each beneficiary will be reviewed on a case-by-case basis):
    - Oral antibiotics (e.g., doxycycline, minocycline)
    - Oral contraceptives (females only)
    - Oral spironolactone (females only)
    - Topical retinoids, topical antibiotics, and/or benzoyl peroxide; **OR**
    - Combination of oral antibiotics with benzoyl peroxide
- The prescriber, pharmacy, wholesaler, and beneficiary must all be registered with the iPLEDGE Program and remain compliant with program requirements. Pharmacy claims will not be processed without all registrations being active
- Requests for ABSORICA 25 mg and 35 mg or ABSORICA LD require medical necessity over other options
- The beneficiary will not be approved for more than 2 courses of therapy
- The beneficiary cannot be pregnant
- The beneficiary cannot have uncontrolled hypertriglyceridemia
- The prescriber must submit the following:
    - Current chart notes with documentation of severity of acne along with previous therapies including any OTC topical options
    - Current labs, including CBC, lipid profile, LFTs, and glucose
    - Current weight; **AND**
    - Requested dose (PA is dose specific) based on **ONE** of the methods below:
        - Daily treatment 0.5 mg/kg to 2 mg/kg/day for 15-20 weeks; **OR**
        - Cumulative dose per treatment 120 mg/kg to 150 mg/kg over 4-6 months
- Initial PA will be approved for a maximum of 165 days. One renewal is possible only after at least 8 weeks following completion of the first course with a new PA request; **AND**
- Requests for diagnoses other than acne will be reviewed by DHS clinical review team on a case-by-case basis.

RENEWAL REQUIREMENTS

- Beneficiary must be medication-free for at least 8 weeks between the first and second course of therapy

- The prescriber, pharmacy, wholesaler, and beneficiary must all be registered with the iPLEDGE Program and remain compliant with program requirements. Pharmacy claims will not be processed without all registrations being active
- Prescriber must submit the following:
    - Current chart notes documenting that the beneficiary has persistent or recurring severe nodular acne despite the initial therapy
    - Current labs, including CBC, lipid profile, LFTs, and glucose
    - Current weight; **AND**
    - Requested dose (PA is dose specific) based on **ONE** of the methods below:
        - Daily treatment 0.5 mg/kg to 2 mg/kg for 15-20 weeks; **OR**
        - Cumulative dose per treatment 120 mg/kg to 150 mg/kg over 4-6 months

QUANTITY EDITS

- #60 per 30 days for max of 165 days per authorization (Quantities outside of this amount to meet cumulative dose will be approved on a case-by-case basis.)

IV. 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, are 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.