ARKANSAS DEPARTMENT OF HUMAN SERVICES

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MEMORANDUM

TO: Arkansas Medicaid Enrolled Prescribing Providers and Pharmacy Providers

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

DATE: February 18, 2026

SUBJ: AR Medicaid Prior Authorization Edits and Preferred Drug List updates approved at the AR Medicaid DUR Board January 21, 2026 meeting for the following:

Preferred Drug List Full Review: Hereditary Angioedema Agents and Idiopathic Pulmonary Fibrosis Agents

Preferred Drug List Abbreviated Review: Cephalosporins, HIV, Topical Antiparasitic Medications (Lice Treatment), Growth Hormones, Pancreatic Enzymes, Leukotriene Receptor Antagonists, Bronchodilators, Short-Acting Beta Agonists (SABA), Bronchodilators, Long-Acting Beta Agonists (LABA), Bronchodilators, Short Acting Muscarinic Antagonists (SAMA), Bronchodilators, Long-Acting Muscarinic Antagonists (LAMA), Bronchodilators, Combination Products (LABA/LAMA), Bronchodilators, Combination Products (ICS/LABA/LAMA), Inhaled Antibiotics

Manual Review PA Criteria: Chronic Spontaneous Urticaria, Lynkuet® (elinzanetant), Veozah® (fezolinetant), Acthar HP®, Cortrophin®, Samsca® (tolvaptan), Orlynvah™ (sulopenem etzadroxil/probenecid), Blujepa (gepotidacin), Leqembi® Iqlik (lecanemab-irmb), Galzin® (zinc acetate), Palsonify™ (paltusotine), Revcovi® (elapegademase-lvlr)

Quantity Claim Edits: Butalbital (non-codeine) products

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I. ANNOUNCEMENTS

A. QUARTERLY NEWSLETTER

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

The January 2026 quarterly newsletter can be found with the following link.
https://ar.primetherapeutics.com/documents/d/arkansas/arkansas-medicaid-quarterly-newsletter-january-2026

B. PRIOR AUTHORIZATION PROCESS FOR PHYSICIAN-ADMINISTERED DRUGS

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

What's Changing?

- Beginning January 1, providers who request PAD PAs for medical claims must submit the PAs to Prime Therapeutics, the existing Pharmacy vendor.
- Providers must submit PAD PA requests by initiating an electronic request through CoverMyMeds at **https://www.covermymeds.health/.** Requests can also be faxed to 800-424-7976.
- Providers faxing PAD PA requests should use the PAD PA form. **https://ar.primetherapeutics.com/documents/d/arkansas/arrx_general_pad_form-1**
- AFMC will no longer process PA requests.

Additional Information:

- Effective 1/1/2026, any modifications to existing PAs requires a new PA number to be assigned with any changes. Billers will need to ensure they are getting the updated PA numbers.
- Contact information for billing issues only does not change.
- The process for billing submissions does not change.

Physician-Administered Drugs (PAD) information can be found on the procedure code tables **Procedure Code Tables - Arkansas Department of Human Services** and on the Prime Therapeutics portal at **https://ar.primetherapeutics.com/documents/d/arkansas/arkansas_medicaid_pad_criteria**

C. INFORMATIONAL DRUG UPDATES

1. MEDICATIONS ADDED TO THE ONCOLOGY POLICY

https://ar.primetherapeutics.com/documents/d/arkansas/oncology_policy_04172024

a. Komzifti™ (ziftomenib) capsules
KOMZIFTI is a menin inhibitor indicated for the treatment of adult patients with relapsed or refractory acute myeloid leukemia (AML) with a susceptible nucleophosmin 1 (NPM1) mutation who have no satisfactory alternative treatment options.

b. Hyrnuo® (sevabertinib) tablet
HYRNUO is a kinase inhibitor indicated for the treatment of adult patients with locally advanced or metastatic non-squamous non-small cell lung cancer (NSCLC) whose tumors have HER2 (ERBB2) tyrosine kinase domain (TKD) activating mutations, as detected by an FDA-approved test, and who have received a prior systemic therapy.

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

c. Inluriyo™ (imlunestrant) tablet
INLURIYO is an estrogen receptor antagonist indicated for treatment of adults with ER-positive, HER2-negative, ESR1-mutated advanced or metastatic breast cancer with disease progression following at least one line of endocrine therapy

d. Ensacove™ (ensartinib) capsules
ENSACOVE is a kinase inhibitor indicated for the treatment of adult patients with anaplastic lymphoma kinase (ALK)-positive locally advanced or metastatic non-small cell lung cancer (NSCLC) who have not previously received an ALK-inhibitor.

D. PREFERRED DRUG LIST
PDL UPDATE EFFECTIVE APRIL 1, 2026

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

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

1) **Classes with full review without criteria—no updates**
2) **Classes with full review with criteria**

a) **Hereditary Angioedema (NEW PDL CLASS)**

ACUTE HAE TREATMENT
Preferred Agents with Criteria (Acute treatment)
- Berinert® (human C1-esterase inhibitor) vial
- Icatibant syringe (generic for Sajazir™ and Firazyr®)

Non-Preferred Agents (Acute treatment)
- Ekterly® (sebetralstat) tablet
- Firazyr® (icatibant) syringe
- Ruconest® (C1 esterase inhibitor recombinant) vial
- Sajazir™ (icatibant) syringe

APPROVAL CRITERIA for ACUTE TREATMENT:
- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with hereditary angioedema (HAE) Type 1 or Type 2 due to C1-esterase inhibitor (C1-INH) deficiency with diagnosis confirmed by a mutation in the C1-INH gene. HAE with normal C1-INH (HAE Type III) will be reviewed on a case-by-case basis. Type 1 and Type 2 HAE are defined as follows:
  - Type 1 HAE: Decreased quantities of C4 level, C1-INH protein level and C1-INH function level; **OR**
  - Type 2 HAE: Decreased quantities of C4 level AND decreased C1-INH function (C1-INH protein level may be normal or elevated)
- Beneficiary must have ≥ 1 severe or life-threatening laryngeal attack **OR** had 2-3 moderate attacks causing extremity, facial or abdominal swelling in the last year **OR** has been on preventative HAE medications
- Beneficiary must NOT be on an ACEi, estrogens, any other medication determined to precipitate an angioedema attack
- Must be prescribed by or in consultation with an allergist, immunologist, or hematologist
- Prescriber must submit the following:
  - Current chart notes with documentation of exacerbations over the last 12 months including ER discharge summaries with history of angioedema attack severity, location, frequency, treatment and duration of attack after treatment
  - Previous therapies tried (i.e., HAE meds, antihistamines, glucocorticoids, epinephrine)
  - Proposed treatment plan for both acute and prophylaxis treatment
  - Documentation of expected angioedema triggers and plan for avoidance
  - Provide the following labs:

        - Complement C1 esterase inhibitor level
        - Complement C4 level
        - Functional C1 inhibitor activity
    - For non-preferred medications, medical necessity over the preferred agents for the requested indication is required.

RENEWAL REQUIREMENTS:

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

QUANTITY EDITS:

2 doses per claim

PREVENTATIVE HAE TREATMENT

Preferred Agents with Criteria (Preventative treatment)

- Haegarda® (human C1-esterase inhibitor) vial

Non-Preferred Agents (Preventative treatment)

- Andembry® (garadacimab) autoinjector
- Cinryze® (human c1-esterase inhibitor) vial
- Dawnzera™ (donidalorsen) autoinjector
- Orladeyo® (berotralstat) capsule and oral pellet
- Takhzyro® (lanadelumab-flyo) vial and syringe

APPROVAL CRITERIA for PREVENTATIVE TREATMENT:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with hereditary angioedema (HAE) Type 1 or Type 2 due to C1-esterase inhibitor (C1-INH) deficiency with diagnosis confirmed by a mutation in the C1-INH gene. HAE with normal C1-INH (HAE Type III) will be reviewed on a case-by-case basis. Type 1 and Type 2 HAE are defined as follows:
    - Type 1 HAE: Decreased quantities of C4 level, C1-INH protein level and C1-INH function level; **OR**
    - Type 2 HAE: Decreased quantities of C4 level AND decreased C1-INH function (C1-INH protein level may be normal or elevated)
- Beneficiary must have ≥ 1 severe or life-threatening laryngeal attack **OR** had 2-3 moderate attacks causing extremity, facial or abdominal swelling in the last year **OR** has been approved for acute medication treatment for HAE
- Beneficiary must NOT be on an ACEi, estrogens, any other medication determined to precipitate an angioedema attack
- This medication must be used for prophylaxis only
- Prescriber must submit the following:
    - Current chart notes with documentation of exacerbations over the last 12 months including ER discharge summaries with history of angioedema attack severity, location, frequency, treatment and duration of attack after treatment
    - Previous therapies tried (i.e., HAE meds, antihistamines, glucocorticoids, epinephrine)
    - Proposed treatment plan for both acute and prophylaxis treatment
    - Documentation of expected angioedema triggers and plan for avoidance
    - Provide the following labs:
        - Complement C1 esterase inhibitor level
        - Complement C4 level
        - Functional C1 inhibitor activity
    - IF beneficiary has tried and had an insufficient response or contraindication to BOTH of the following classes of medication, provide that documentation.
        - 17α-alkylated androgens (e.g., danazol, stanozolol, oxandrolone, methyltestosterone)

        - Antifibrinolytic agents (e.g., ε-aminocaproic acid, tranexamic acid)
    - For non-preferred medications, medical necessity over the preferred agents for the requested indication is required.
- Initial PA will be for 3 months with response to therapy required on renewal

RENEWAL REQUIREMENTS:

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

b) Idiopathic Pulmonary Fibrosis (NEW PDL CLASS)

Preferred Agents with Criteria

- Pirfenidone tablet (generic for Esbriet®)

Non-Preferred Agents

- Esbriet® (pirfenidone) tablet—Manufacturer obsolete 10/30/2025
- Jascayd® (nerandomilast) tablet
- Ofev® (nintedanib) capsule
- Pirfenidone capsule (generic for Esbriet®)

APPROVAL CRITERIA FOR ESBRIET (pirfenidone)

- Beneficiary meets the minimum age recommended in the manufacturer's package insert
- Beneficiary is prescribed no more than the maximum dose or treatment duration from the manufacturer's package insert or based on support from the official Compendia
- Prescribed by or in consultation with a pulmonologist
- Beneficiary must be diagnosed with idiopathic pulmonary fibrosis (IPF). Confirmation will require the following:
    - Confirmed by either a lung biopsy or high-resolution computed tomography (CT) scan of the lungs with presence of the usual interstitial pneumonia (UIP) pattern with documentation of some of the following:
        - Basal and peripheral dominance
        - Honeycombing (usually subpleural)
        - Reticular opacities or ground-glass opacities
        - Traction bronchiectasis
        - Airspace enlargement with fibrosis
    - Baseline Pulmonary Function Tests (PFTs)
        - Forced vital capacity (FVC) is ≥ 50% predicted; **AND**
        - Carbon monoxide diffusing capacity (DLCO) is ≥ 30% predicted
    - Other known causes of interstitial lung disease (e.g., environmental exposures, connective tissue disease, drug toxicity) have been ruled out
- Beneficiary should NOT be approved or continue the medication if meet one of the following:
    - Likely to receive a lung transplant or has had a lung transplant
    - Has relevant airways obstruction (i.e., pre-bronchodilator FEV1/FVC < 0.8)
    - Currently smoking
    - Severe hepatic impairment (Child Pugh C). Patients with mild to moderate hepatic impairment (Child Pugh A or B) should use ESBRIET with caution and consider dose modification or discontinuation if needed.
    - End-stage renal disease requiring dialysis. For patients with mild to severe renal impairment, monitor for adverse events and modify dose or discontinue as needed.
    - Develops Severe Cutaneous Adverse Reactions (SCAR)
- Prescriber must submit the following:
    - Current chart notes and documentation to support the diagnosis (e.g., CT scan results and/or biopsy results)
    - Strength of medication and dosage form requested (PA is entered for specific dose)
    - Current labs including liver function tests

- Baseline pulmonary function tests (PFTs)
- Baseline 6-minute walk test (6MWT)
- Documentation verifying the smoking status with **ONE** of the following:
  - exhaled carbon monoxide level (eCO) < 6 ppm; **OR**
  - carboxyhemoglobin (COHb) levels < 3%; **OR**
  - urine cotinine concentration < 200 mg/mL

RENEWAL REQUIREMENTS:

- Beneficiary must remain compliant on therapy (defined as 75% utilization)
- Beneficiary must remain a non-smoker
- Beneficiary must demonstrate a positive response with improved, stable or slowed progression based on radiographic results, pulmonary function tests, and/or clinical presentation

- Prescriber must submit the following
  - Current chart notes
  - Current labs including LFTs
  - Documentation of response to therapy with any of the following:
    - Current pulmonary function tests
    - Current 6MWT
    - Current CT scan results of lung

QUANTITY EDITS:

- 267 mg tablet or capsule #270/30 days
- 801 mg tablet #90/30 days

APPROVAL CRITERIA FOR OFEV (nintedanib):

- Beneficiary meets the minimum age recommended in the manufacturer's package insert
- Beneficiary is prescribed no more than the maximum dose or treatment duration from the manufacturer's package insert or based on support from the official Compendia
- Prescribed by or in consultation with a pulmonologist
- Beneficiary must be diagnosed with idiopathic pulmonary fibrosis, chronic fibrosing interstitial lung disease with progressive phenotype, **OR** systemic sclerosis associated interstitial lung disease. Confirmation will require the following depending on diagnosis:
  - **Idiopathic pulmonary fibrosis (IPF)**
    - Confirmed by either a lung biopsy or high-resolution computed tomography (CT) scan of the lungs with presence of the usual interstitial pneumonia (UIP) pattern with documentation of some of the following:
      - Basal and peripheral dominance
      - Honeycombing (usually subpleural)
      - Reticular opacities or ground-glass opacities
      - Traction bronchiectasis
      - Airspace enlargement with fibrosis
    - Baseline Pulmonary Function Tests (PFTs)
      - Forced vital capacity (FVC) is ≥ 50% predicted; **AND**
      - Carbon monoxide diffusing capacity (DLCO) corrected for hemoglobin is 30-79% of predicted
    - Other known causes of interstitial lung disease (e.g., environmental exposures, connective tissue disease, drug toxicity) have been ruled out
  - **Chronic fibrosing interstitial lung diseases with progressive phenotype (also called progressive pulmonary fibrosis)** with a high-resolution CT scan indicating pulmonary fibrosis is affecting ≥ 10% of the lungs with at least **TWO** of the following criteria with at least **ONE** of the examples listed with the criteria in the last 24 months:
    - Worsening respiratory symptoms (e.g., increased dyspnea on exertion)
    - Radiological evidence of disease progression with at least **ONE** of the following examples:
      - Increased extent or severity of traction bronchiectasis and bronchiolectasis
      - New ground-glass opacity with traction bronchiectasis

- New fine reticulation
- Increased extent or increased coarseness of reticular abnormality
- New or increased honeycombing
- Increased lobar volume loss
- PFTs indicate disease progression with at least **ONE** of the following examples:
  - FVC decline ≥ 10% predicted; **OR**
  - FVC decline ≥ 5% and < 10% predicted with worsening symptoms or imaging; **OR**
  - DLCO decline (corrected for Hb) ≥ 10% predicted

- **Systemic sclerosis-associated interstitial lung disease (SSC-ILD)** requires a diagnosis of systemic sclerosis (SSC) based on rheumatology guidelines and interstitial lung disease with the following:
  - High-resolution CT scan indicates pulmonary fibrosis is affecting ≥ 10% of the lungs
  - Baseline PFTs
    - Forced vital capacity (FVC) is ≥ 40% predicted; **AND**
    - Carbon monoxide diffusing capacity (DLCO) corrected for hemoglobin is 30-89% of predicted

- Beneficiary should NOT be approved or continue the medication if one of the following is met:
  - Likely to receive a lung transplant or has had a lung transplant
  - Has relevant airways obstruction (i.e., pre-bronchodilator FEV1/FVC < 0.7)
  - Pregnant or breastfeeding
  - Currently smoking
  - Moderate or severe hepatic impairment (Child Pugh B or C). Patients with mild hepatic impairment (Child Pugh A) can be treated with a reduced dose of OFEV.
  - Has gastrointestinal perforation
  - Severe renal impairment (CrCl < 30 mL/min) or end-stage renal disease
  - Caution in beneficiaries with known risk of bleeding (benefit outweighing the risk should be provided)
- Prescriber must submit the following:
  - Current chart notes and documentation to support the diagnosis (e.g., CT scan results and/or biopsy results)
  - Dose requested (PA is entered for specific dose)
  - Current labs including liver function test
  - Baseline pulmonary function tests (PFTs)
  - Baseline 6-minute walk test (6MWT)
  - Letter of medical necessity over immunosuppressant for SSC-ILD patients (i.e., mycophenolate)
  - Documentation verifying the smoking status with **ONE** of the following:
    - exhaled carbon monoxide level (eCO) < 6 ppm; **OR**
    - carboxyhemoglobin (COHb) levels of < 3%; **OR**
    - urine cotinine concentration < 200 mg/mL
  - For non-preferred medications, medical necessity over the preferred agents for the requested indication is required.

RENEWAL REQUIREMENTS:

- Beneficiary must remain compliant on therapy (defined as 75% utilization)
- Beneficiary must remain a non-smoker
- Beneficiary must demonstrate a positive response with improved, stable or slowed progression based on radiographic results, pulmonary function tests, and/or clinical presentation
- Prescriber must submit the following:
  - Current chart notes
  - Current labs including LFTs
  - Documentation of response to therapy with any of the following:
    - Current pulmonary function tests
    - Current 6MWT
    - Current CT scan results of lungs

QUANTITY EDITS:

- 100 mg--#60/30 days
- 150 mg--#60/30 days

APPROVAL CRITERIA FOR JASCAYD (nerandomilast):

- Beneficiary meets the minimum age recommended in the manufacturer's package insert
- Beneficiary is prescribed no more than the maximum dose or treatment duration from the manufacturer's package insert or based on support from the official Compendia
- Prescribed by or in consultation with a pulmonologist
- Beneficiary must be diagnosed with idiopathic pulmonary fibrosis **OR** progressive pulmonary fibrosis. Confirmation will require the following depending on diagnosis:
    - **Idiopathic pulmonary fibrosis (IPF)**
        - Confirmed by either a lung biopsy or high-resolution computed tomography (CT) scan of the lungs with presence of the usual interstitial pneumonia (UIP) pattern with documentation of some of the following:
            - Basal and peripheral dominance
            - Honeycombing (usually subpleural)
            - Reticular opacities or ground-glass opacities
            - Traction bronchiectasis
            - Airspace enlargement with fibrosis
        - Baseline Pulmonary Function Tests (PFTs)
            - Forced vital capacity (FVC) is ≥ 50% predicted; **AND**
            - Carbon monoxide diffusing capacity (DLCO) corrected for hemoglobin is 30-79% of predicted
        - Other known causes of interstitial lung disease (e.g., environmental exposures, connective tissue disease, drug toxicity) have been ruled out
    - **Progressive pulmonary fibrosis (PPF)**
        - With a high-resolution CT scan indicating pulmonary fibrosis is affecting ≥ 10% of the lungs with at least **TWO** of the following criteria with at least **ONE** of the examples listed with the criteria in the last 24 months:
            - Worsening respiratory symptoms (e.g., increased dyspnea on exertion)
            - Radiological evidence of disease progression with at least **ONE** of the following examples:
                - Increased extent or severity of traction bronchiectasis and bronchiolectasis
                - New ground-glass opacity with traction bronchiectasis
                - New fine reticulation
                - Increased extent or increased coarseness of reticular abnormality
                - New or increased honeycombing
                - Increased lobar volume loss
                - PFTs indicate disease progression with at least **ONE** of the following examples:
                    - FVC decline ≥ 10% predicted; **OR**
                    - FVC decline ≥ 5% and < 10% predicted with worsening symptoms or imaging; **OR**
                    - DLCO decline (corrected for Hb) ≥ 10% predicted
- Beneficiary should not be approved if likely to receive a lung transplant or has had a lung transplant
- Beneficiary should not be approved with relevant airways obstruction (i.e., pre-bronchodilator FEV1/FVC < 0.8)
- Beneficiary will not be approved if currently smoking
- Beneficiary should not be approved if diagnosed with end stage renal disease ((eGFR <15 mL/min/1.73 m^2) or severe hepatic impairment (Child Pugh C)
- Prescriber must submit the following:
    - Current chart notes and documentation to support the diagnosis (e.g., CT scan results and/or biopsy results)
    - Baseline pulmonary function tests (PFTs)
    - Baseline 6-minute walk test (6MWT)
    - Documentation verifying the smoking status with **ONE** of the following:

        - exhaled carbon monoxide level (eCO) < 6 ppm; **OR**
        - carboxyhemoglobin (COHb) levels of < 3%; **OR**
        - urine cotinine concentration < 200 mg/mL
    - For non-preferred medications, medical necessity over the preferred agents for the requested indication is required.

RENEWAL REQUIREMENTS:

- Beneficiary must remain compliant on therapy (defined as 75% utilization)
- Beneficiary must remain a non-smoker
- Beneficiary must demonstrate a positive response with improved, stable or slowed progression based on radiographic results, pulmonary function tests, and/or clinical presentation
- Prescriber must submit the following:
    - Current chart notes
    - Current labs including LFTs
    - Documentation of response to therapy with any of the following:
        - Current pulmonary function tests
        - Current 6MWT
        - Current CT scan results of lungs

QUANTITY EDITS:
Both strengths--#62/31 days

3) Classes with abbreviated review without criteria

a) Bronchodilators, Short-Acting Beta Agonists (SABA)

Preferred Short-Acting Beta Agonists

- Albuterol sulfate 0.63mg/3ml solution
- Albuterol sulfate 1.25mg/3ml solution
- Albuterol sulfate 2.5mg/0.5ml solution
- Albuterol sulfate 2.5mg/3ml solution
- ProAir RespiClick® (albuterol sulfate inhalation powder)
- Ventolin® HFA (albuterol) - **BRAND ONLY**
- Xopenex® HFA (levalbuterol) - **BRAND ONLY**

Non-Preferred Short-Acting Beta Agonists

- Albuterol HFA (ALL generics)
- Levalbuterol HFA inhaler (generic for Xopenex HFA®)
- Levalbuterol inhalation solution (generic for Xopenex® nebulizer)

b) Bronchodilators, Long-Acting Beta Agonists (LABA)

Preferred Long-Acting Beta Agonists with Criteria

- Serevent Diskus® (salmeterol xiafoate disk with device)

Non-Preferred Long-Acting Beta Agonists

- Arformoterol inhalation solution (generic for Brovana®)
- Brovana® Inhalation Solution (arformoterol)
- Formoterol fumarate inhalation solution (generic for Perforomist®)
- Perforomist® inhalation solution (formoterol fumarate)
- Striverdi Respimat® (olodaterol)

c) Bronchodilators, Short-Acting Muscarinic Antagonists (SAMA)

Preferred Agents with Criteria

- Atrovent HFA® (ipratropium bromide)
- Combivent Respimat® (ipratropium/albuterol)
- Ipratropium bromide solution (generic for Atrovent® solution)
- Ipratropium/albuterol sulfate (generic for DuoNeb® inhalation solution)

Non-Preferred Agents
- None

d) Bronchodilators, Long-Acting Muscarinic Antagonists (LAMA)

Preferred Agents with Criteria
- Spiriva HandiHaler® (tiotropium bromide) - **BRAND ONLY**

Non-Preferred Agents
- Incruse Ellipta® (umeclidinium bromide)
- Spiriva Respimat® (tiotropium bromide)
- Tiotropium bromide (generic of Spiriva Handihaler®)
- Tudorza Pressair® (aclidinium bromide)
- Yupelri® (revefenacin)

e) Bronchodilators, Combination Products (LABA/LAMA)

Preferred Agents with Criteria
- Anoro Ellipta® (umeclidinium/vilanterol) – **BRAND ONLY**
- Bevespi Aerosphere® (formoterol/glycopyrrolate)
- Stiolto Respimat® (tiotropium/olodaterol)

Non-Preferred Agents
- Duaklir Pressair® (aclidinium/formoterol)
- Umeclidinium/vilanterol (generic for Anoro Ellipta®)

f) Bronchodilators, Combination Products (ICS/LABA/LAMA)
Preferred Agents
- None

Non-Preferred Agents
- Breztri® Inhaler (budesonide/glycopyrrolate/formoterol)
- Trelegy Ellipta® (fluticasone furoate/umeclidinium/vilanterol)

g) Cephalosporins

Preferred Agents
- Cefadroxil capsule and suspension (generic for Duricef®)
- Cefdinir capsule and suspension (generic for Omnicef®)
- Cefpodoxime tablet and suspension (generic for Vantin®)
- Cefprozil tablet and suspension (generic for Cefzil®)
- Cefuroxime tablet (generic for Ceftin®)
- Cephalexin capsule and suspension (generic for Keflex®)

Non-Preferred Agents
- Cefaclor capsule, ER tablet, and suspension (generic for Ceclor®)
- Cefadroxil tablet (generic for Duricef®)
- Cefixime tablet, capsule, and suspension (generic for Suprax®)
- Cephalexin tablet (generic for Keflex®)

h) Growth Hormones

Preferred Agents that require manual review for prior authorization
- Genotropin® (somatropin)
- Norditropin® (somatropin)

Non-Preferred Agents
- Humatrope® (somatropin)
- Ngenla® pen (somatrogon-ghla)
- Nutropin AQ® pen® (somatropin)

- Omnitrope® (somatropin)
- Skytrofa® (lonapegsomatropin-tcgd)
- Sogroya® (somapacitan-beco)
- Zomacton® (somatropin)

i) HIV

Preferred Agents

- Abacavir tablet and solution (generic for Ziagen)
- Abacavir/lamivudine tablet (generic for Epzicom)
- Atazanavir capsule (generic for Reyataz)
- Biktarvy tablet (bictegravir/emtricitabine/tenofovir)
- Cimduo tablet (lamivudine/tenofovir)
- Complera tablet (emtricitabine/rilpivirine/tenofovir) **– BRAND ONLY**
- Darunavir ethanolate 600 mg, 800 mg tablets (generic for Prezista)
- Delstrigo tablet (doravirine/lamivudine/tenofovir)
- Descovy tablet (emtricitabine/tenofovir alafenam)
- Dovato tablet (dolutegravir/lamivudine)
- Edurant tablet (rilpivirine)
- Efavirenz tablet (generic for Sustiva)
- Efavirenz/emtricitabine/tenofovir disoproxil fumarate tablet (generic for Atripla)
- Emtricitabine/tenofovir disoproxil fumarate tablet (generic for Truvada)
- Emtriva solution (emtricitabine)
- Evotaz tablet (atazanavir/cobicistat)
- Fosamprenavir tablet (generic for Lexiva)
- Genvoya tablet (elvitegravir/cobicistat/emtricitabine/tenofovir)
- Isentress powder, chew, tablet, and HD tablet (raltegravir potassium)
- Juluca tablet (dolutegravir/rilpivirine)
- Lamivudine tablet and solution (generic for Epivir)
- Lamivudine/zidovudine tablet (generic for Combivir)
- Lopinavir/ritonavir tablet (generic for Kaletra)
- Nevirapine tablet, suspension, and ER tablet (generic for Viramune)
- Norvir powder (ritonavir)
- Odefsey tablet (emtricitabine/rilpivirine/tenofovir)
- Pifeltro tablet (doravirine)
- Prezcobix tablet (darunavir/cobicistat)
- Prezista suspension (darunavir ethanolate)
- Prezista 75 mg, 150 mg tablets
- Reyataz powder (atazanavir)
- Ritonavir tablet (generic for Norvir)
- Stribild tablet (elvitegravir/cobicistat/emtricitabine/tenofovir)
- Symfi Lo tablet (efavirenz/lamivudine/tenofovir) - **BRAND ONLY Manuf obs 5/29/25**
- Symfi tablet (efavirenz/lamivudine/tenofovir) **- BRAND ONLY**
- Symtuza tablet (darunavir/cobicistat/emtricitabine/tenofovir)
- Tenofovir disoproxil fumarate tablet (generic for Viread)
- Tivicay PD tablet for suspension and Tivicay tablet (dolutegravir sodium)
- Triumeq PD tablet for suspension and Triumeq tablet (abacavir/dolutegravir/lamivudine)
- Tybost tablet (cobicistat)
- Zidovudine tablet and syrup (generic for Retrovir)

Non-Preferred Agents

- Aptivus capsule (tipranavir)
- Edurant Ped tablet for suspension (rilpivirine)
- Efavirenz/lamivudine/tenofovir disoproxil fumarate tablet (generic for Symfi and Symfi Lo)
- Emtricitabine capsule (generic for Emtriva)
- Emtricitabine/rilpivirine/tenofovir tablet (generic for Complera)
- Emtriva capsule (emtricitabine)

- Epivir solution and tablet (lamivudine)
- Etravirine tablet (generic for Intelence)
- Fuzeon vial (enfuvirtide) --**Manuf obsolete date 11/3/2025**
- Intelence tablet (etravirine)
- Kaletra solution and tablet (lopinavir/ritonavir)
- Norvir tablet (ritonavir)
- Prezista 600 mg, 800 mg tablet (darunavir)
- Retrovir syrup and capsule (zidovudine)
- Reyataz capsule (atazanavir)
- Rukobia tablet (fostemsavir tromethamine)
- Truvada tablet (emtricitabine/tenofovir)
- Viracept tablet (nelfinavir)
- Viread tablet and powder (tenofovir)
- **Vocabria tablet (cabotegravir)**
- Ziagen solution (abacavir)
- Zidovudine capsule (generic for Retrovir)

Non-Preferred Agents with Criteria

- Apretude* vial (cabotegravir)
- Cabenuva* vial (cabotegravir and rilpivirine)
- Maraviroc* tablet (generic for Selzentry)
- Selzentry* solution and tablet (maraviroc)
- Sunlenca* tablet and vial (lenacapavir sodium)
- **Yeztugo* tablet and vial (lenacapavir sodium)**

Note: Trogarzo is available as a medical claim only. PA criteria may apply.

j) Inhaled Antibiotics

Preferred Agents with Criteria

- Bethkis® (Tobramycin)—**BRAND ONLY**
- Kitabis Pak® (Tobramycin)—**BRAND ONLY**
- Tobramycin (generic for Tobi®)

Non-Preferred Agents

- Arikayce® (amikacin liposome) – **Criteria for Arikayce**
- Cayston® (Aztreonam)
- Tobi® (Tobramycin)
- Tobi Podhaler® (Tobramycin)
- Tobramycin (generic for Bethkis®)
- Tobramycin pak (generic for Kitabis Pak®)

k) Leukotriene Receptor Antagonists

Preferred Agents with Criteria

- Montelukast tablet, chewable tablet, and granules (generic for Singulair®)

Non-Preferred Agents

- Accolate® tablet (zafirlukast)
- Singulair® tablet (montelukast)
- Singulair® 4 mg chewable tablet (montelukast)—**HCFA termed 6/6/2026**
- Singulair® 5 mg chewable tablet (montelukast)
- Zafirlukast tablet (generic for Accolate®)
- Zileuton ER tablet (generic for Zyflo CR®)
- Zyflo® 600 mg tablet (zileuton)—**Manufacturer obsolete 9/30/2025**

l) Pancreatic Enzymes

Preferred Agents
- Creon® capsule (pancrelipase)
- Zenpep® capsule (pancrelipase)

Non-Preferred Agents
- Pertzye® capsule (pancrelipase)
- Viokace® tablet (pancrelipase)

m) Topical Antiparasitic Medications (Lice Treatment)

Preferred Agents
- Permethrin 1% topical liquid OTC (e.g., Lice Killing liquid, Lice Treatment)
- Piperonyl butoxide 4% /Pyrethrum extract 0.33% OTC (e.g., Lice Killing Shampoo,
- Complete Lice Treatment, Lice Killing shampoo)
- Permethrin 5% cream (generic for Elimite™)
- Natroba 0.9%™ suspension (spinosad)* - **BRAND ONLY**

***BRAND Natroba may be filled once every 60 days. This medication should not, in general, require retreatment. However, if retreatment is required additional chart notes documenting reason for retreatment (re-infestation, product did not completely kill all nits, etc.) will be needed.**

Non-Preferred Agents
- Croton® 10% lotion (crotamiton)
- Elimite™ cream (permethrin)—**HCFA term 4/30/2026**
- Eurax® 10% cream/lotion (crotamiton)
- Malathion lotion 0.5% (generic for Ovide®)
- Ovide® 0.5% lotion (malathion)
- **Pruradik™ 10% lotion (crotamiton)**
- Spinosad suspension 0.9% (generic for Natroba™)
- Vanalice™ gel (piperonyl butoxide, pyrethrins)

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

CRITERIA EFFECTIVE JANUARY 21, 2026

A. CHRONIC SPONTANEOUS URTICARIA

Approval Criteria for Chronic Spontaneous Urticaria (Dupixent®, Rhapsido®, and Xolair®)
- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose or treatment duration from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with chronic spontaneous urticaria (CSU) with wheals/hives with or without angioedema for > 6 consecutive weeks
- Must be prescribed by, or in consultation with, a dermatologist, allergist, or immunologist
- Beneficiary must minimize factors that can exacerbate CSU (i.e., NSAIDs, alcohol, stress, and friction from clothing)
- 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
- Beneficiary must have at least **ONE** of the following despite treatment listed below:
  - Baseline Urticaria Activity Score-7 (UAS7) must be ≥ 16
  - Baseline Itch Severity Score-7 (ISS7) must be ≥ 8
  - Baseline Urticaria Control Test (UCT) must be < 12
- Beneficiary must have tried and failed the following unless there is a contraindication to their use:
  - Non-sedating H1-antihistamine (nsAH) for a minimum of 2 weeks; **AND**
  - nsAH at 4 times the normal daily dose for a minimum of 4 weeks
- Prescriber must submit the following:
  - Current chart notes

- Baseline description of urticaria
- Baseline UAS7 and/or ISS7 and/or UCT scores
- Previous therapies that were tried with treatment duration

Renewal Requirements for Chronic Spontaneous Urticaria

- Beneficiary has been compliant with therapy (defined as: 75% utilization)
- Beneficiary taking RHAPSIDO that develops bleeding should be evaluated for continuation considering the benefit versus the risk
- Beneficiary must have a positive response with a decrease in urticaria symptoms and an improvement in **ONE** of the following (must use same test as baseline):
  - UAS7
  - ISS7
  - UCT
- Prescriber must submit the following:
  - Current chart notes
  - Documentation of current symptoms
  - Current CSU test with at least **ONE** of the following (must use the same test as baseline):
    - Urticaria Activity Score-7 (UAS7)
    - Itch Severity Score-7 (ISS7) score
    - Urticaria Control Test (UCT)

Quantity Edits for RHAPSIDO

#60/30 days

CRITERIA EFFECTIVE JANUARY 21, 2026

B. LYNKUET (elinzanetant) 60 mg capsule and VEOZAH (fezolinetant) 45 mg tablet

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with menopause and experiencing moderate to severe vasomotor symptoms **OR** a diagnosis consistent with any new FDA-approve indications. Any off-label requests will be reviewed on a case-by-case basis.
- Documentation that moderate to severe vasomotor symptoms have been disruptive to daily life must be provided (e.g., sleep disruption, night sweats, daytime hot flashes, palpitations)
- Beneficiary must be confirmed as menopausal with **ONE** of the following:
  - Spontaneous amenorrhea for ≥ 12 consecutive months; **OR**
  - Spontaneous amenorrhea for ≥ 6 months with biochemical criteria of menopause (follicle-stimulating hormone [FSH] > 40 IU/L); **OR**
  - Having had bilateral oophorectomy ≥ 6 weeks prior to the screening visit.
- Beneficiary must have tried and failed hormone replacement therapy or have a contraindication to hormone replacement therapy
- Beneficiary on VEOZAH should not have cirrhosis or severe renal impairment or end-stage renal disease (eGFR < 30 mL/min/1.73 m^2) and beneficiary on LYNKUET should not have moderate to severe hepatic impairment or end-stage renal disease (eGFR <15 mL/min/1.73 m^2)
- Beneficiary must not take VEOZAH concomitantly with CYP1A2 inhibitors (e.g., ciprofloxacin, fluvoxamine)
- Beneficiary must not take LYNKUET concomitantly with CYP3A4 inducers (e.g., carbamazepine, modafinil)
- Prescriber must submit the following:
  - Current chart notes
  - Current labs including FSH level, LFTs, and CMP
  - Duration of symptoms
  - Medical necessity over hormone replacement therapy and other options supported in literature (i.e., SSRIs, SNRIs, anti-epileptics, clonidine)
- Initial PA for 3 months

RENEWAL REQUIREMENTS:

- Beneficiary is compliant on the medication (defined as 75% utilization)
- Beneficiary has a documented improvement in symptoms
- Prescriber must submit the following:
  - Current chart notes
  - Documentation of response to treatment (e.g., sleep disruption, night sweats, daytime hot flashes, palpitations)
- Renewal PAs can be approved for 6 months

QUANTITY EDITS:

VEOZAH

- #31/31 days

LYNKUET

- #62/31 days

CRITERIA EFFECTIVE JANUARY 21, 2026

C. ACTHAR HP and CORTROPHIN (corticotropin)

APPROVAL CRITERIA FOR INFANTILE SPASMS:

- Beneficiary must be ≤ 2 years of age
- Beneficiary must have a diagnosis for infantile spasms (West Syndrome) as indicated by:
  - Epileptic spasms; **AND**
  - Developmental problems; **AND**
  - Hypsarrhythmia on electroencephalography (EEG)
- Prior authorization request should be submitted prior to beginning ACTHAR if being hospitalized and sent again upon discharge
- Beneficiary has a history of previous vigabatrin (SABRIL) and corticosteroid usage with failure
- PA requests for indications outside of infantile spasms will be considered on a case-by-case basis
- Requests for Purified Cortrophin® Gel (repository corticotropin injection) will require a patient-specific, clinically significant reason why Acthar® Gel (repository corticotropin injection) or Acthar® Gel SelfJect™ (repository corticotropin auto-injector) cannot be used
- PA will be approved at the time of discharge for the amount needed for completion of the taper. Beneficiaries cannot fill ACTHAR as a pharmacy benefit and use during hospitalization;
- Prescriber must submit the following:
  - Admission clinical notes with initial prior authorization request and discharge summary notes prior to discharge
  - ACTHAR form with initial request and resubmit the form at time of discharge with specific taper directions
  - Current body surface area (BSA)

DENIAL CRITERIA:

- Beneficiary has not trialed vigabatrin (SABRIL) and corticosteroids
- Provider has not submitted all of the required information as outlined on the ACTHAR form
- Provider intends to use ACTHAR purchased as a pharmacy benefit during an inpatient stay

CRITERIA EFFECTIVE JANUARY 21, 2026

D. SAMSCA (tolvaptan) 15 mg and 30 mg tablet

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Must be prescribed by a fellowship trained nephrologist
- Beneficiary must be diagnosed with clinically significant hypervolemic or euvolemic hyponatremia (serum sodium <125 mEq/L that is symptomatic and has resisted correction with fluid restriction) including patients with heart failure and Syndrome of Inappropriate Antidiuretic Hormone (SIADH).

- Beneficiary must be initiated or re-initiated on tolvaptan while in a hospital
- Beneficiary should not be prescribed this medication for longer than 30 days including the days used while hospitalized
- Tolvaptan should not be used in patients with autosomal dominant polycystic kidney disease (ADPKD) outside of FDA-approved REMS
- Beneficiary must not have hypovolemic hyponatremia, anuria or end stage renal disease
- Beneficiary must not have an underlying liver disease, including cirrhosis
- Beneficiary must not use concomitant strong CYP3A inhibitors (e.g., clarithromycin, ketoconazole, ritonavir)
- Prescriber must submit the following:
    - Hospital admission to support the use of the medication
    - Number of days used during hospitalization and number of days needed upon discharge (no more than 30 days total)
    - Daily dose expected after discharge (maximum of 60 mg once daily)
    - Current labs including sodium, potassium, and liver function tests

RENEWAL REQUIREMENTS:

- Renewal is not allowed as tolvaptan should be used for a maximum of 30 days per treatment.
- Further usage would require re-initiation in the hospital.

QUANTITY EDITS:

- 15 mg—#30 per claim (minus days while hospitalized)
- 30 mg—#60 per claim (minus days while hospitalized)

CRITERIA EFFECTIVE JANUARY 21, 2026

E. ORLYNVAH (sulopenem etzadroxil/probenecid) and BLUJEPA (gepotidacin) tablets

APPROVAL CRITERIA FOR ORLYNVAH:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with uncomplicated urinary tract infections (uUTI) caused by the designated microorganisms *Escherichia coli, Klebsiella pneumoniae,* or *Proteus mirabilis* and have limited or no alternative oral antibacterial treatment options
- Beneficiary with **ONE** of the following will not meet approval criteria:
    - Complicated urinary tract infections (cUTI) or as step-down treatment after intravenous antibacterial treatment of cUTI
    - Complicated intra-abdominal infections (cIAI) or as step-down treatment after intravenous antibacterial treatment of cIAI
- Beneficiary must not have known blood dyscrasias or uric acid kidney stones
- Beneficiary must not be prescribed ORLYNVAH concomitantly with ketorolac tromethamine
- Beneficiary must not have severe renal impairment (CrCl <15 mL/min) or be on hemodialysis
- Beneficiary must have tried and failed therapy with typical first-line antibiotics used for uUTI (e.g., nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin) unless contraindicated
- Prescriber must submit the following:
    - Current chart notes
    - Culture/sensitivity results documenting resistance to typical first-line agents
    - Letter of medical necessity for the rationale of use over typical first-line agents (e.g., nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin)

APPROVAL CRITERIA FOR BLUJEPA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with uncomplicated urinary tract infections (uUTI) caused by the following susceptible microorganisms: *Escherichia coli, Klebsiella pneumoniae, Citrobacter freundii complex, Staphylococcus saprophyticus,* or *Enterococcus faecalis.*

- Beneficiary with a history of QTc interval prolongation or relevant pre-existing cardiac disease, taking antiarrhythmic medications or medications that prolong the QTc interval should not take this medication.
- Beneficiary should not take concomitant strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole) or inducers (e.g., rifampin, carbamazepine, phenytoin, St. John's wort)
- Beneficiary requiring digoxin, acetylcholinesterase inhibitors, or non-depolarizing neuromuscular blocking agents should be evaluated on risk versus benefit for the concomitant use.
- Beneficiary must have tried and failed therapy with typical first-line antibiotics used for uUTI (e.g., nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin) unless contraindicated
- Prescriber must submit the following:
  - Current chart notes
  - Culture/sensitivity results documenting resistance to typical first-line agents
  - Letter of medical necessity for the rationale of use over typical first-line agents (e.g., nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin)

RENEWAL REQUIREMENTS:

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

QUANTITY EDITS:

- BLUJEPA—#20 per claim
- ORLYNVAH—#10 per claim

CRITERIA EFFECTIVE JANUARY 21, 2026

F. LEQEMBI IQLIK (lecanemab-irmb) 360 mg/1.8mL auto-injection

APPROVAL CRITERIA (consistent with LEQEMBI for infusion):

- Beneficiary must be ≥ 50 years of age
- Beneficiary must be diagnosed with mild cognitive impairment or mild dementia associated with Alzheimer's disease confirmed by **ONE** of the following:
  - Clinical Dementia Rating (CDR) Global Score of 0.5-1.0 with Memory Box Score of at least 0.5
  - Mini-Mental Status Exam [MMSE] score 20-28
  - Montreal Cognitive Assessment (MoCA) score 16-25
- 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 (ARIA) with **ONE** of the following:
    - Had genotype testing prior to treatment to assess apolipoprotein E ε4 (ApoE ε4) status (e.g., homozygote, heterozygote, or noncarrier); **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
  - **Positron Emission Tomography (PET) scan** confirming the presence of amyloid beta plaque
  - **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
- Must be prescribed by, or in consultation with, a specialist in neurology, neuropsychiatry, or gerontology
- Beneficiary must not have had a stroke, transient ischemic attack (TIA), or seizures in the past 12 months
- Beneficiary will not be approved for non-Alzheimer's dementia with cognitive impairment or dementia cause by other neurodegenerative diseases (e.g., Lewy body dementia, frontotemporal lobar degeneration, vascular dementia, metabolic impairment, traumatic brain injury, etc.).

- Beneficiary will not be approved for non-Alzheimer's causes of cognitive impairment; chronic psychiatric illness, chronic cardiovascular disease, or past history of psychotropic drug dependence.
- 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).
- Beneficiary will not be approved for LEQEMBI to be used concomitantly with other amyloid beta-directed antibodies (e.g., aducanumab, donanemab-azbt)
- Beneficiary will not be approved for LEQEMBI if receiving direct-acting oral anticoagulants (e.g., apixaban, dabigatran, edoxaban, rivaroxaban, etc.), anticoagulants (e.g., Factor Xa inhibitors), anti-platelet agents (with the exception of prophylactic aspirin or clopidogrel), or anti-thrombins (e.g., heparin, warfarin).
- Beneficiary will not be approved if they have an uncontrolled bleeding disorder (e.g., platelets <50,000 or INR >1.5)
- 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, and Lumbar puncture)
  - Behavioral health diagnoses have been assessed for contributions to memory deficits
  - Current and history of alcohol and nicotine use and alcohol or chronic substance use including prescription medications, cannabis, or other illicit drugs
- Beneficiary must have previous LEQEMBI infusions for 18 months before beginning LEQEMBI IQLIK

RENEWAL REQUIREMENTS:

- Beneficiary has been compliant with therapy (defined as: 75% utilization)
- 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, CDR-SB, MoCA, etc.
- Beneficiary has not progressed to moderate or severe Alzheimer's disease
- Prescriber must submit the following:
  - Current chart notes
  - Current dementia/cognition score (e.g., MMSE, CDR-SB, MoCA)
  - Any MRI or PET scan reports since previous approval

QUANTITY EDITS:

- #4 injections/ 28 days

CRITERIA EFFECTIVE JANUARY 21, 2026

G. GALZIN (zinc acetate) 25 mg and 50 mg capsule

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with Wilson's disease with previous chelating agent treatment (e.g., penicillamine, trientine)
- Prescribed by, or in consultation with, a fellowship trained hepatologist
- Prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Patient specific symptoms associated with Wilson's disease
  - Current labs including LFTs, ceruloplasmin, and 24-hour urinary copper excretion (24-hour urinary copper excretion >40 mcg/24 hours)
- Initial PA for 6 months

RENEWAL REQUIREMENTS:

- Beneficiary must remain compliant on therapy (defined as 75% utilization)
- Beneficiary must demonstrate an improvement in symptoms, improvement in LFTs and/or improvement in 24-hour urinary copper excretion
- Prescriber must submit the following:
  - Current chart notes
  - Current patient specific symptoms
  - Current labs including LFTs, ceruloplasmin, and 24-hour urinary copper excretion

QUANTITY EDITS:

- #93/31 days for both strengths

CRITERIA EFFECTIVE JANUARY 21, 2026

H. PALSONIFY (paltusotine) 20 mg and 30 mg tablet

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must have a diagnosis of acromegaly with **ONE** of the following:
  - Had an inadequate response to surgical resection as indicated by growth hormone and serum insulin-like growth factor 1 (IGF-1) are above the reference ranges
  - Not a candidate for surgical resection
- Prescribed by, or in consultation with, a specialist knowledgeable in acromegaly (e.g., endocrinologist, oncologist)
- Beneficiary with concomitant moderate or strong CYP3A4 inducers or proton pump inhibitors may require a dose modification for PALSONIFY
- Prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried with response
  - Rationale for prescribing if patient has not had surgery
  - Current labs including baseline IGF-1 level, growth hormone
  - Medical necessity over oral octreotide and injectable octreotide/lanreotide

RENEWAL REQUIREMENTS:

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

QUANTITY EDITS:

- #60/30 days

CRITERIA EFFECTIVE JANUARY 21, 2026

I. REVCOVI (elapegademase-lvlr) 2.4 mg/1.5 mL vial

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
  - Patients transitioning from ADAGEN to REVCOVI- The starting dose of REVCOVI i is 0.2 mg/kg weekly, intramuscularly.
  - ADAGEN-naïve patients- The starting dose of REVCOVI is 0.4 mg/kg weekly based on ideal body weight or actual weight whichever is greater, divided into two doses (0.2 mg/kg twice a week), intramuscularly.
- Beneficiary must be diagnosed with adenosine deaminase severe combined immune deficiency (ADA-SCID) with diagnosis confirmed by **ONE** of the following:
  - Deficiency or absence of adenosine deaminase (ADA) in plasma, lysed erythrocytes, fibroblasts (cultured from amniotic fluid), or chorionic villus sample
  - Increase in either deoxyadenosine triphosphate (dATP) levels or in total deoxyadenosine nucleotides (dAXP) in erythrocytes.
  - Decrease in ATP concentration in erythrocytes.
  - Molecular genetic confirmation of mutations in both alleles of the ADA1 gene.
  - Positive screening by T-cell receptor excision circles (TRECs).
- Prescribed by, or in consultation with, a specialist knowledgeable in the treatment of immune deficiency disorders (e.g., immunologist, hematologist, oncologist)
- REVCOVI will be used only until definitive therapy with hematopoietic stem cell transplantation (HSCT), or if the patient is not a suitable candidate or has previously failed HSCT.
- Beneficiary does not have severe thrombocytopenia (<50,000/microL)
- Prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Current labs including trough plasma adenosine deaminase (ADA) activity, red blood cell deoxyadenosine triphosphate (dATP), trough deoxyadenosine nucleotides (dAXP) levels, total lymphocyte counts, and/or documentation of mutation in the ADA gene
  - Current weight
  - Requested dose
- Initial approval for 6 months

RENEWAL REQUIREMENTS:

- Beneficiary must remain compliant on therapy (defined as 75% utilization)
- Beneficiary must have documented disease stability or improvement as indicated by **ONE** or more of the following:
  - Normalization or increase in plasma ADA activity (target trough level ≥ 15 mmol/hr/L).
  - Red blood cell dATP level decreased (target ≤ 0.005 to 0.015 mmol/L).
  - Improvement in immune function with diminished frequency or complications of infection as evidenced in improvement in the ability to produce antibodies.
  - Improvement in red blood cell dAXP levels (target trough level ≤ 0.02 mmol/L).
- Beneficiary must not have unacceptable toxicity (i.e., severe thrombocytopenia)
- Prescriber must submit the following:
  - Current chart notes
  - Response to therapy
  - Current labs
  - Current weight
  - Requested dose

III. NEW CLAIM EDITS

EFFECTIVE APRIL 1, 2026

A. BUTALBITAL (NON-CODEINE) QUANTITY LIMITS

Butalbital combination medications, often with acetaminophen or aspirin in addition to caffeine, are used for the short-term treatment of tension headaches. These agents are generally not recommended as first-choice treatment because of the potential for dependence and serious side effects. While sometimes prescribed "off-label" for migraines, butalbital combination products are not FDA-approved for this indication. The American Academy of Neurology (AAN) recommends use only as a last resort for migraine treatment, as its risks generally outweigh the benefits for most patients. There are many other safer alternatives available for treating migraines that have stronger evidence of effectiveness.

Frequent use of butalbital is also a major risk factor for developing medication-overuse headache (MOH), where headaches transform into a chronic daily or near-daily condition. The American Migraine Prevalence and Prevention study found that using butalbital combinations just 5 or more days a month was linked to MOH.

Butalbital is a barbiturate and can be habit-forming. Therapy should be carefully monitored and limited to short-term use at a maximum of 3 days monthly and 6 tablets daily. Extended use can lead to dependence, medication-overuse headaches, and withdrawal symptoms requiring gradual 2-4 week tapering when discontinuing.

Arkansas data indicates butalbital usage far exceeding the recommended amounts and many for off-label use. Due to evidence of prescribing these products outside of treatment guidelines, the DUR Board voted to slowly decrease the number of pills allowed per month. Currently, Arkansas Medicaid allows #124/31 days. Effective 4/1/2026, the maximum allowed per 31 days will decrease to 100 total. This topic will be re-reviewed by the DUR Board during the July meeting for further discussions on decreasing further.

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, is incarcerated in a correctional or holding facility, including juvenile correctional facilities, and are detained pending disposition of charges or are held under court order as material witnesses. If medications are requested for incarcerated Medicaid beneficiaries, including beneficiaries in a juvenile correctional facility, **the medications cannot be billed to Medicaid Pharmacy Program and are subject to recoupment if billed to Medicaid**. Pharmacists should contact the correctional facility regarding the facility's reimbursement procedures for the requested medications.

4. REGARDING MANUAL REVIEW PA REQUESTS:

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

5. REGARDING EMERGENCY OVERRIDE:

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

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

6. HARD EDIT ON EARLY REFILL:

Non-controlled drugs:

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

Controlled drugs:

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

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

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

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

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

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

< 18 YEARS OF AGE:

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

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

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

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

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

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

13. **HEPATITIS C TREATMENT INFORMATION:**
Educational information on treating Hepatitis C along with treatment consultations may be obtained through the Clinician Consultation Center.

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

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

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

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

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

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