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: August 14, 2024

SUBJ: **AR Medicaid Prior Authorization Edits approved at the AR Medicaid DUR/DRC Board July 17, 2024 meeting for the following:**

Manual review criteria for: Allergen Induced Rhinitis (Ragwitek®, Grastek®, Oralair®, Odactra™); Vitiligo (Opzelura® (ruxolitinib)); Pustular Psoriasis (Spevigo® (spesolimab)); Crysvita® (burosumab-twza); Rezdiffra™ (resmetirom); Wegovy® (semaglutide) MACE indication; Tryvio™ (aprocitentan); Voydeya™ (danicopan); Lymepak™ (doxycycline hyclate); Myhibbin™ (mycophenolate mofetil); Fluoride toothpaste (Fraiche 5000 Previ, Fraiche 5000 Sensitive, Denta 5000 Plus Sensitive)

Preferred Drug List (PDL) therapeutic classes with PA criteria: Vaginal hormones and multiple sclerosis

Policy: DAW code update

Other important topics diabetic supplies update, COVID coverages ending, copay overages

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I. ANNOUNCEMENTS

1) COVID COVERAGES ENDING

The following COVID related exemptions are being end dated on 9/30/2024:

1. Claims with a COVID diagnosis will no longer bypass Audit 5105 (OUTPT/POD LAB X-RAY SERV LIMITED TO $500 PER SFY).
2. Claims with a COVID diagnosis will no longer bypass Edit 1050 (SERVICES REQUIRE PRIMARY CARE PHYSICIAN REFERRAL).
3. Member's Copay and Cost Share will no longer be bypassed for COVID treatment. As of 10/1/2024, members will have a copay/cost share for COVID treatment.
4. COVID OTC tests will no longer be covered.
5. Emergency Use Authorization (EUA) drugs for COVID not FDA approved will no longer be covered.

For more information on COVID unwinding go to: **https://humanservices.arkansas.gov/u/covid-exemptions**

2) COPAY OVERAGES

The Division of Medical Services (DMS), Pharmacy Program, routinely reviews determinations that a Medicaid member has paid copays for prescriptions over their aggregate cap, where that member is due a refund of their copay(s) paid out of pocket per Federal regulations. See 42 CFR 447.56(f) and link: **https://www.ecfr.gov/current/title-42/part-447/section-447.56#p-447.56(f).**

In the event a Medicaid member is due a copay refund, the member's pharmacy may be called, and a letter may be sent to the member's pharmacy requesting that the claim be rebilled and the member be refunded the overage. If the pharmacy does not reverse the identified claim(s) within 35 business days of the date of the letter, the claim(s) will be reversed, as the member is due a copay refund, based on the member's current eligibility at the time of the impacted claim(s).

3) DIABETIC SUPPLIES UPDATE

Effective August 1, 2024, Arkansas Medicaid began accepting Pharmacy and DME claims for diabetic supplies (including patch-type insulin pumps, CGMs, BGMs, and test strips) through the Pharmacy Program.

- AR Medicaid Pharmacy providers who are filling diabetic supply prescriptions may continue to use their current Point-of-Sale (POS) system.
- DME providers must register and bill through the new portal via web claim submissions. We encourage DME Providers to register as soon as possible. For more information on this process, see the Web Claims Submission Guide. A registration guide for the web portal is available at **https://ar.magellanrx.com/documents/d/arkansas/arkansas-medicaid-rx-uac-quick-start-guide**

Diabetic supplies may be billed with a prescription for children and adults. For adults, diabetic supplies will **not** count towards prescription limits. This program applies to traditional FFS Medicaid members, including ARKids B. This program does not apply to members with dual Medicare/Medicaid or those managed in the ARHome program by a QHP.

For DME providers, the live training dates have already been held, but a video of the training is now posted on the pharmacy website at **https://ar.magellanrx.com/provider-documents** under the Diabetic Supplies tab.

The Prime Therapeutics/Magellan Rx Help Desk is available Monday through Friday 8am-5pm to help with any questions. The Help Desk number is 800-424-7895.

4) 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/ Magellan Rx portal under the pharmacy tab. **https://ar.magellanrx.com/provider-documents**
The July 2024 quarterly newsletter can be found with the following link.
https://ar.magellanrx.com/documents/d/arkansas/arkansas-medicaid-quarterly-newsletter-july-2024-final

5) PREFERRED DRUG LIST

PDL UPDATE EFFECTIVE OCTOBER 1, 2024

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

Non-preferred agents require a prior authorization submission. Prescribers with questions on how to obtain a PA should call the Prime Therapeutics/ Magellan Rx 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/ Magellan Rx pharmacy unit at 1-800-424-7976. Any PA request for off-label use will be reviewed on a case-by-case basis.

A. VAGINAL HORMONES

Preferred Agents:

- **Estradiol cream (generic for Estrace®)**
- **Premarin® (estrogens, conjugated) cream**

Non-Preferred Agents:

- Estrace® cream (estradiol)
- Estradiol tablet (generic for Vagifem® and Yuvafem®)
- Estring® (estradiol) vaginal ring
- Femring® (estradiol acetate) vaginal ring
- Imvexxy® (estradiol) vaginal insert
- Vagifem® (estradiol) vaginal tablet
- Yuvafem® (estradiol) vaginal tablet

B. MULTIPLE SCLEROSIS AGENTS

Preferred agents WITHOUT criteria

- **Ampyra® (dalfampridine ER) tablet**
- Avonex® (interferon beta – 1A injection)
- Copaxone® 20 mg injection- **Brand Only**
- **Dalfampridine ER tablet (generic for Ampyra®)**
- Dimethyl fumarate capsule (generic for Tecfidera®)
- **Fingolimod capsule (generic for Gilenya®)**
- **Teriflunomide tablet (generic for Aubagio®)**

Preferred agents WITH criteria

- **Kesimpta® pen (ofatumumab)**

POS criteria for Kesimpta (Briumvi®, Lemtrada®, Ocrevus® and Tysabri® are excluded from the pharmacy program.) Beneficiary must meet one of the following:

Criteria 1:

- Medicaid prescription history contains at least 6 claims for preferred multiple sclerosis medication(s) in the previous year (6 months total with multiple drugs or all with single drug)

Criteria 2:

- Medicaid prescription history contains a claim for Kesimpta® in the last 2 months.

Non-Preferred Agents

- Aubagio® tablet (teriflunomide)
- Bafiertam® capsule (monomethyl fumarate)
- Betaseron® (interferon Beta – 1B injection)
- Copaxone® 40 mg injection (glatiramer)
- Extavia® (Interferon Beta – 1B injection)
- Glatiramer acetate injection (generic for Copaxone®)
- Glatiramer acetate injection (generic for Glatopa®)
- Glatopa® injection (glatiramer)
- Gilenya® capsule (fingolimod)
- Mavenclad® tablet (cladribine)
- Mayzent® tablet (siponimod)
- Plegridy® pen and syringe (peginterferon beta – 1A)
- Ponvory® tablet (ponesimod)
- Rebif®/Rebif Rebidose (interferon beta – 1A/albumin)
- Tascenso® ODT (fingolimod)
- Tecfidera® capsule (dimethyl fumarate)
- Vumerity® capsule (diroximel fumarate)
- Zeposia® capsule (ozanimod)

Non-preferred medications approval criteria
All Non-preferred medications:

- 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
- Beneficiary has a confirmed diagnosis of a relapsing form of multiple sclerosis (MS) including clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease
- Initial request must be submitted by or in consultation with a neurologist or other appropriate specialist
- Beneficiary with moderately active disease must have tried and failed multiple preferred products with different mechanisms of action. If tried Kesimpta®, beneficiary must have taken for at least 6 months. Failure is defined by any of the following:
  - At least one relapse during therapy with preferred medications
  - MRI indicates additional lesions compared to baseline
  - Beneficiary demonstrates an increased disability as measured by the Expanded Disability Status Scale (EDSS) compared to baseline
  - Documented adverse effects to the preferred agents
- Beneficiary with highly active or rapidly evolving aggressive disease will be reviewed on a case-by-case basis
- Beneficiary is not prescribed other Disease-Modifying Therapies (DMTs) for the treatment of MS to be used concomitantly
- Prescriber must submit **ALL** of the following:
  - Current chart notes

  - Documentation of previous therapies with response
  - Letter of medical necessity over the various preferred medications
  - Baseline MRI with documentation of lesions
  - Baseline Expanded Disability Status Scale (EDSS)
- See additional criteria noted below for specific medications

FUMARATES: Bafiertam®, Vumerity®

- Beneficiary does **NOT** have any of the following:
  - Moderate to severe renal impairment
  - Moderate to severe hepatic impairment
  - Previous failure with any fumarate product
  - Prescribed concomitant fumarate therapies
- Prescriber must submit **ALL** of the following (in addition to info requested above):
  - Current labs including a CBC including lymphocyte count and LFTs
  - Confirmed negative for pregnancy and attestation of contraception use in patient of reproductive potential
  - Medical necessity over dimethyl fumarate

INTERFERONS: Betaseron®, Extavia®, Plegridy®, Rebif®/Rebif Rebidose®

- Prescriber must submit **ALL** of the following (in addition to the info requested above):
  - Current labs including CBC with differential and LFTs
  - Attestation that patient has been counseled about depression
  - Medical necessity over Avonex®

GLATIRAMER: Copaxone® 40 mg, Glatopa® 20 mg or 40 mg

- Prescriber must submit the necessity over Copaxone® 20mg daily (convenience would not be considered medically necessary)

SPHINGOSINE 1-PHOSPHATE RECEPTOR MODULATOR: Mayzent®, Ponvory®, Tascenso ODT®, Zeposia®

- Beneficiary does **NOT** have any of the following:
  - Current systemic or clinically significant infection
  - Use of any other antineoplastic, immunosuppressive or immunomodulator drugs to treat other conditions
  - Baseline heart rate ≤55 bpm
  - Moderate to severe hepatic impairment (Child-Pugh class B or C)
  - MI, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization or Class II or IV heart failure in the last 6 months
  - Presence of Mobitz type II second-degree, third-degree AV block, sick sinus syndrome, or sino-atrial block, unless have a pacemaker
  - Previous treatment with alemtuzumab
- Prescriber must submit **ALL** of the following (in addition to info requested above):
  - Current labs including a CBC including lymphocyte count and LFTs
  - Documentation of CYP2C9 genotype to determine dose for Mayzent®
  - Documentation of cardiac evaluation with ECG if beneficiary has preexisting conditions (Contraindicated in recent MI, angina, stroke, TIA, severe HF, baseline QTc interval ≥500 msec, or cardiac arrhythmias requiring therapy).
  - Baseline eye exam report
  - Vaccinate for varicella zoster virus before initiation if VZV antibody negative
  - Confirmed negative for pregnancy and attestation of contraception use in patient of reproductive potential
  - Medical necessity over fingolimod
- Mayzent® beneficiary must **NOT** have a CYP2C9 *3/*3 genotype (homozygous)

PURINE ANTIMETABOLITE: Mavenclad®

- Beneficiary should **NOT** have a diagnosis of clinically isolated syndrome
- Beneficiary does **NOT** have any of the following:
  - Human immunodeficiency virus (HIV), hep B or C, TB or other current systemic or clinically significant infection
  - Current malignancy
  - Use of any other antineoplastic, immunosuppressive or immunomodulator drugs to treat other conditions
  - Moderate to severe renal impairment (CrCl <60mL/min)
  - Moderate to severe hepatic impairment (Child-Pugh score >6)
- Prescriber must submit **ALL** of the following (in addition to info request above):
  - Medical necessity over all other DMTs
  - Treatment plan after two years of therapy
  - Current labs including a CBC with differential including lymphocyte count and LFTs
  - Confirmed negative for pregnancy and attestation of contraception use in patient of reproductive potential
  - Reports for screening Hepatitis B and C, HIV, and tuberculosis
  - Vaccinate for varicella zoster virus before initiation if VZV antibody negative

Renewal Requirements:

- Prescriber must submit current chart notes with documentation of response to therapy
- Beneficiary must have a positive response to therapy which may include any of the following:
  - Decrease in the number of relapses
  - Improvement or no decline in Expanded Disability Status Scale (EDSS)
  - Improvement in MRI findings since initiating therapy

EFFECTIVE OCTOBER 1, 2024

6) DAW CODE UPDATE (for pharmacy claims)

It came to our attention that occasionally claims were being forced through for brand name products with a DAW code which resulted in pharmacies getting paid at a generic rate and losing money without their knowledge. To prevent accidental claim submission with an incorrect DAW code, we will be streamlining the available DAW codes as seen below.

Beginning 10/1/24, only DAW codes 0,1, & 9 will be allowed.

- **DAW Code 0 – No Product Selection Indicated**
  - Allowed for all drugs except for Brand Medically Necessary Medications (DAW Code 1 required) and State Supported Brands (DAW Code 9 required).
  - Please verify when using DAW 0 that the NDC being billed is either a Generic or a Single Source Brand. If DAW code 0 is used and the NDC is not a generic or single source brand, payment will be based on generic pricing.
- **DAW Code 1 – Substitution not allowed by prescriber**
  - Allowed with approved prior authorization
  - Initial reject message prior to PA approval will read “PA Required” and “Prescriber PA Required for Brand Name”
- **DAW Code 2 – Substitution allowed-patient requested product dispensed**
  - Code will no longer be allowed
  - Reject message will read “DAW Code Value Not Supported”
- **DAW Code 3 – Substitution allowed-pharmacist selected product dispensed**
  - Code will no longer be allowed
  - Reject message will read “DAW Code Value Not Supported”
- **DAW Code 4 – Substitution allowed-generic drug not in stock**
  - Code will no longer be allowed

  - Reject message will read “DAW Code Value Not Supported” and “Contact Help Desk for Assistance”.
- **DAW Code 5 – Substitution allowed-brand drug dispensed as a generic**
  - Code will no longer be allowed
  - Reject message will read “DAW Code Value Not Supported”
- **DAW Code 6 – Override**
  - Code will no longer be allowed
  - Reject message will read “DAW Code Value Not Supported”
- **DAW Code 7 – Substitution NOT allowed-brand drug mandated by law**
  - Code will no longer be allowed
  - Reject message will read “DAW Code Value Not Supported”
- **DAW Code 8 – Substitution allowed-generic drug not available in marketplace**
  - Code will no longer be allowed
  - Reject message will read “PA required”
  - If generic has a shortage issue, contact the Prime Therapeutics/Magellan Help Desk for assistance
- **DAW Code 9 – Substitution allowed by prescriber but plan requests brand**
  - Allowed for use when Arkansas Medicaid requires brand name products as preferred when generics are on the market
  - Using DAW 9 for plan prefers brand (PPB) products ensures that pharmacies are reimbursed at the brand rate
  - If not a PPB product, reject message will read “Prior Authorization Required” and “State Supported Preferred Brand Only”
  - Please refer to the State Supported Brand Medications document for a complete list of the Arkansas Supported Brands.

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

CRITERIA EFFECTIVE JULY 17, 2024

1) ALLERGEN INDUCED RHINITIS (Ragwitek®, Grastek®, Oralair®, Odactra™)

APPROVAL CRITERIA:

- 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
- Beneficiary must have a diagnosis consistent with the FDA approved package insert. Any off-label requests will be reviewed on a case-by-case basis.
  - **Grastek®—**immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens
  - **Odactra™—**immunotherapy for the treatment of house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive in vitro testing for IgE antibodies to *Dermatophagoides farinae* or *Dermatophagoides pteronyssinus* house dust mites, or by positive skin testing to licensed house dust mite allergen extracts
  - **Oralair®—**immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the five grass species contained in this product
  - **Ragwitek®—**immunotherapy for the treatment of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen

- Beneficiary must have appropriate testing for the specific allergen (e.g., grass, pollens, ragweed, dust mites) for the drug requested. The testing can be either serum testing for the specific IgE antibodies or skin test and must be positive for the specific allergen.
- For Grastek®, Oralair®, and Ragwitek®, the previous allergy season for either ragweed or grass pollen will be reviewed for Medicaid drug claims that are used to treat allergy symptoms. For Odactra®, the Medicaid drug claims for the past 6 months will be reviewed. The beneficiary must have filled drugs to treat allergy symptoms in at least 2 of the following categories during the previous allergy season for Grastek®, Oralair®, and Ragwitek® or in the last 6 months for Odactra® and have at least 2 claims in consecutive months in each category:
  - Nasal inhaled steroid
  - Oral (systemic) antihistamine
  - Leukotriene modifier
  - Ophthalmic allergy drops (topical ocular mas cell stabilizers or antihistamines) for treating allergic conjunctivitis
- Beneficiary should not be approved or continue this therapy with any of the following:
  - Duplication of therapy with allergy shots or other SL allergen extract tablet
  - Has severe, unstable or uncontrolled asthma
  - For continued approval, beneficiary must remain compliant
- Once an approved PA is entered into the system, the continued approval of subsequent claims of the SL allergen extract will require that the beneficiary is adherent to therapy. PAs for incoming claims that are more than 7 days late on a previous 30-day supply will not be renewed.

QUANTITY EDITS:

- #31/ 31 days

CRITERIA EFFECTIVE JULY 17, 2024

2) VITILIGO (Opzelura® (ruxolitinib))

APPROVAL CRITERIA FOR NONSEGMENTAL VITILIGO:

- 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
- Beneficiary must be diagnosed with nonsegmental vitiligo
- Beneficiary must meet the following:
  - Body surface area (BSA) involvement must be ≤10%
  - Trial and failure of the following within the last 6 months with 12 weeks trial each
    - Medium to superpotent topical corticosteroid used continuously or intermittently
    - Topical calcineurin inhibitor (i.e., pimecrolimus or tacrolimus)
  - Treatment area includes face, neck, eyelids, or hands
- Prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried
  - Baseline description of vitiligo with location
  - BSA of vitiligo
  - Letter of medical necessity over other treatment options
- Beneficiaries that do not meet the above criteria will require prior authorization review on a case-by-case basis
- Initial approval will be 24 weeks

RENEWAL REQUIREMENTS:

- Beneficiary must remain compliant on therapy (defined as 75% utilization)
- Beneficiary must have documented at least a 50% improvement (Clinical trial measured 75% and 90%)
- Prescriber must submit the following:
  - Current chart notes
  - Current BSA
  - Current description of vitiligo

CRITERIA EFFECTIVE JULY 17, 2024

3) PUSTULAR PSORIASIS (Spevigo® (spesolimab))

APPROVAL CRITERIA FOR PUSTULAR PSORIASIS:

- Prescribed by or in consultation with a dermatologist
- Beneficiary meets the minimum age recommended in the manufacturer's package insert
- Maximum dose based on support in the manufacturer's package insert or Micromedex®
- 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 (GPPPGA) total score ≥ 3 (moderate); and
  - GPPPGA pustulation sub score of ≥ 2 (mild); and
  - Presence of fresh pustules (new appearance or worsening of pustules)
  - ≥5% of BSA covered with erythema and the presence of pustules
- Beneficiary must have one of the following treatment options. Please 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
- 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
  - Active tuberculosis
- 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
  - 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 billing as a medical claim, contact AFMC for PA processing.
- Renewal requires prescriber to submit updated notes with documentation of a positive response to therapy

CRITERIA EFFECTIVE JULY 17, 2024

4) CRYSVITA® (burosumab-twza) 10 mg, 20 mg, and 30 mg injection

APPROVAL CRITERIA:

- 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
- Must be prescribed by on in consultation with a nephrologist or endocrinologist
- Beneficiary must be diagnosed with either:
  - X-linked hypophosphatemia (XLH); **OR**
  - FGF23-related hypophosphatemia in tumor-induced osteomalacia (TIO); **OR**
    - Must be a phosphaturic mesenchymal tumor
    - Tumor cannot be curatively resected or localized
  - Diagnosis consistent with any new FDA-approved indications
- Diagnosis must be confirmed by identifying at least **ONE (1)** of the following:
  - Serum fibroblast growth factor-23 (FGF23) level > 30 pg/mL
  - Phosphate regulating gene with homology to endopeptidases located on the X chromosome (PHEX-gene) mutations in the patient
  - Clinical, radiographic, and laboratory findings that support the diagnosis (e.g., evidence of Rickets, evidence of skeletal demineralization, low phosphate and high alkaline phosphatase activity for age)
- Beneficiary must have a baseline fasting serum phosphorus level with current hypophosphatemia, defined as a phosphate level below the lower limit of normal for patient's age
- Adults must have an inadequate response from oral phosphate and active vitamin D analogs
- Beneficiaries with TIO must have a tumor that cannot be curatively resected or localized
- Beneficiary should not be approved or continue this therapy with any of the following:
  - Continues to take oral phosphate or active vitamin D analogs
  - Severe renal impairment (Glomerular Filtration Rate (GFR) < 30 mL/min)
- Prescriber must submit the following:
  - Current chart notes
  - Baseline labs including serum phosphorus, serum total alkaline phosphatase activity, and vitamin D
  - Baseline symptoms (e.g., pain, mobility, growth rate, rickets on radiographic evaluation (Rickets Severity Score))
  - Medical necessity for patients with closed epiphyses over oral phosphate and vitamin D supplementation
  - Attestation that patient has discontinued oral phosphate supplement and active vitamin D analogs
  - Documentation of treatment plan
    - Where will dose be given (i.e., doctor's office, home health, infusion center etc.)
    - Where will labs be drawn
    - If this PA request originates outside of specialist clinic, provide a plan for consulting with specialist
  - Information on tumor resection for TIO patient
  - 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 billing as a medical claim, contact AFMC for PA processing.

RENEWAL REQUIREMENTS:

- Beneficiary must be compliant with treatment (defined as 75% utilization)
- Beneficiary must not demonstrate unacceptable toxicity (e.g., severe hypersensitivity reactions, hyperphosphatemia or nephrocalcinosis, severe injection site reactions, etc.)

- Beneficiary must demonstrate a positive response with at least **ONE** (1) of the following:
  - Serum phosphate levels increased compared to baseline
  - Symptom improvement (e.g., pain, mobility, growth)
  - Radiographic imaging indicates improvement in Rickets/osteomalacia
- Prescriber must submit the following:
  - Current chart notes
  - Current labs including serum phosphorus, serum total alkaline phosphatase activity, and vitamin D
  - Current symptoms (e.g., pain, mobility, growth, rickets on radiographic evaluation with RSS)
- Beneficiary with closed epiphyses must have documentation of medical necessity for continuation. Reassessment for efficacy with oral phosphate and active vitamin D analogs may be warranted.

CRITERIA EFFECTIVE JULY 17, 2024

5) REZDIFFRA™ (resmetirom) 60 mg, 80 mg, and 100 mg tablet

APPROVAL CRITERIA:

- 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
- Must be prescribed by on in consultation with a gastroenterologist or hepatologist
- Beneficiary must be diagnosed with metabolic-associated steatohepatitis (MASH) [formerly known as noncirrhotic nonalcoholic steatohepatitis (NASH)] with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) **OR** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- Fibrosis staging documentation requires the following:
  - Liver biopsy results **OR**
  - Fibrosis score results from **TWO** (2) testing modalities with at least **ONE** (1) blood-based non-invasive test (NITs) **AND** at least **ONE** (1) imaging test from the lists below:
    - NITs
      - Fibrosis-4 index (FIB-4)
      - AST to platelet ratio index (APRI)
      - NAFLD fibrosis score (NFS)
      - Enhanced liver fibrosis (ELF) or simplified ELF index
      - FibroSure®
    - Imaging tests
      - Vibration-controlled transient elastography (VCTE) (e.g., FibroSCAN®)
      - Two-dimensional shear weave elastography
      - Point shear wave elastography
      - Magnetic Resonance Elastography (MRE)
- Beneficiary must use this medication in conjunction with appropriate diet and exercise
- Prescriber must rule out any other cause for fibrosis (e.g., alcohol, hepatitis C)
- Beneficiary should not be approved or continue this therapy with any of the following:
  - Fibrosis score is not consistent with F2 or F3 fibrosis
  - Concomitant use with a strong CYP2C8 inhibitor is requested (e.g., gemfibrozil)
  - Concomitant use with a moderate CYP2C8 inhibitor (e.g., clopidogrel) requires dosage modification for REZDIFFRA
  - Severe renal impairment
- Prescriber must submit the following:
  - Current chart notes
  - Fibrosis staging documentation as listed above

- Attestation that the patient has been counseled on an appropriate diet and exercise plan
- Current labs including comprehensive metabolic panel
- Documentation of alcohol intake history
- Current weight for dose verification
  - <100 kg, the recommended dosage is 80 mg orally once daily.
  - ≥100 kg, the recommended dosage is 100 mg orally once daily

RENEWAL REQUIREMENTS:

- Beneficiary must remain compliant on therapy (defined as 75% utilization)
- To continue the medication after 12 months of therapy, the beneficiary should demonstrate a positive response to the medication as defined by:
  - Resolution of MASH/NASH without worsening of fibrosis **OR**
  - No worsening of MASH/NASH **AND** improvement in fibrosis by ≥ 1 stage
- Beneficiary must continue to refrain from excessive alcohol use
- Prescriber must submit the following:
  - Current chart notes
  - Current weight
  - Current labs
  - Attestation that patient continues with diet and exercise plan
  - Current fibrosis staging documentation requires the following:
    - Liver biopsy results **OR**
    - Fibrosis score results from **TWO** (2) testing modalities with at least **ONE** (1) blood-based non-invasive test (NITs) **AND** at least **ONE** (1) imaging test from the lists below:
      - NITs
        - Fibrosis-4 index (FIB-4)
        - AST to platelet ratio index (APRI)
        - NAFLD fibrosis score (NFS)
        - Enhanced liver fibrosis (ELF) or simplified ELF index
        - FibroSure®
      - Imaging results
        - Vibration-controlled transient elastography (VCTE) (e.g., FibroSCAN®)
        - Two-dimensional shear weave elastography
        - Point shear wave elastography
        - Magnetic Resonance Elastography (MRE)

QUANTITY EDITS:

- Each strength #31/31 days

CRITERIA EFFECTIVE JULY 17, 2024

6) WEGOVY® (semaglutide) 0.25 mg, 0.5 mg, 1 mg, 1.7 mg, & 2.4 mg injection

NOTE: Arkansas Medicaid does not currently cover medications solely for the use of weight loss. PA requests for this medication must demonstrate that the patient has established cardiovascular disease and at risk for a major cardiovascular event.

APPROVAL CRITERIA:

- 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
- For initial approval, beneficiary must meet all of the following:
  - Diagnosed with established cardiovascular disease with at least **ONE** of the following:
    - History of myocardial infarction **OR** history of stent placement or bypass surgery
    - History of stroke

        - Symptomatic peripheral arterial disease
            - Intermittent claudication with an ABI (ankle brachial index) of less than or equal to 0.9; **OR**
            - Peripheral arterial revascularization procedure or amputation due to atherosclerotic disease
    - Considered either obese or overweight (defined as baseline BMI of ≥ 27 kg/m^2)
    - Considered to be at risk for major cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke)
    - Has outlined treatment plan including reduced calorie diet and increased physical activity.
- Beneficiary must not be a current smoker or has started a smoking cessation program
- Beneficiary should not be approved or continue this therapy with any of the following:
    - No documented risk for MACE
    - Not considered overweight or obese (baseline BMI <27 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
    - Current smoker without a cessation plan
- 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

RENEWAL REQUIREMENTS:

- Beneficiary must be compliant on therapy (defined as 75% utilization)
- Renewal requires the following:
    - Improvement in cardiometabolic parameters (e.g., blood pressure, heart rate, labs) and body measurements
    - Continues with lifestyle modifications
- Prescriber must provide the following:
    - Current chart notes
    - Current BMI and weight
    - Current labs including HbA1c and lipid panel
    - Current waist circumference, blood pressure, and heart rate

QUANTITY EDITS:

Max of 4 syringes per 28 days (PA required for each strength)

CRITERIA EFFECTIVE JULY 17, 2024

7) TRYVIO™ (aprocitentan) 12.5 mg tablet

APPROVAL CRITERIA:

- 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
- Beneficiary is diagnosed with hypertension that is not adequately controlled on at least 3 other antihypertensive drugs **OR** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.

- Beneficiary must continue standard of care antihypertensive medications in combination with TRYVIO
- Prescriber and dispensing pharmacy must be enrolled in the TRYVIO REMS program
- Beneficiary should not be approved or continue this therapy with any of the following:
  - Pregnancy
  - Baseline ALT/AST 3X ULN or moderate to severe hepatic impairment
  - NYHA STAGE III-IV heart failure, unstable cardiac function, or NTproBNP ≥500 pg/mL
  - Noncompliant on standard of care pharmacologic treatment at maximally tolerated doses with 3 antihypertensive medications at the same time. Therapies vary by patient, but they typically include ACE inhibitor/ARB, calcium channel blocker, and thiazide diuretic. Optional medications may include beta blockers, alpha blockers, spironolactone, hydralazine, or minoxidil.
- Prescriber must submit the following:
  - Current chart notes
  - Current and previous pharmacologic therapies with pharmacy printouts if new to Medicaid
  - Current blood pressure and blood pressure history if available along with blood pressure cuff size
  - Current labs including CBC (for hemoglobin), LFTs, pregnancy test if female of reproductive potential
  - Current weight to monitor for fluctuations due to potential edema

RENEWAL REQUIREMENTS:

- Beneficiary must remain compliant on therapy as ordered by the prescriber (defined as 75% utilization)
- Beneficiary should demonstrate improvement in blood pressure compared to baseline
- Prescriber should submit the following:
  - Current chart notes
  - Current blood pressure
  - Current labs including CBC and LFTs
  - Current weight

QUANTITY EDITS:

- #31 tablets/31 days

CRITERIA EFFECTIVE JULY 17, 2024

8) VOYDEYA™ (danicopan) 50 mg and 100 mg tablet

APPROVAL CRITERIA:

- 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
- Beneficiary must be diagnosed with paroxysmal nocturnal hemoglobinuria (PNH) and require treatment for extravascular hemolysis (EVH) and concomitant therapy with ravulizumab or eculizumab **OR** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- Beneficiary must be vaccinated against encapsulated bacteria, including *Streptococcus pneumoniae* and *Neisseria meningitidis* types A, C, W, Y, and B, at least 2 weeks prior to initiation of VOYDEYA, and beneficiary must be provided antibiotics if vaccines were administered less than 2 weeks before starting therapy
- Prescriber and pharmacy must be enrolled in the REMS program
- The medication is prescribed by or in consultation with a hematologist

- Beneficiary must have clinically significant EVH defined as anemia with hemoglobin ≤ 9.5 g/dL and absolute reticulocyte count ≥120 X 10^9/L with or without transfusion support
- Beneficiary must have been on a stable dose of either ravulizumab or eculizumab for at least the previous 6 months.
- Beneficiary should not be approved or continue this therapy with any of the following:
  - Severe hepatic impairment (Child-Pugh C)
  - Not on a stable dose of a C5 inhibitor
  - Treatment plan does not include continuation of a C5 inhibitor
  - Active infections caused by an encapsulated bacteria (such as *Streptococcus pneumoniae*, *Neisseria meningitidis*, and *Haemophilus influenzae* type b)
  - If no vaccinations against encapsulated bacteria (such as *Streptococcus pneumoniae* and *Neisseria meningitidis*) at least 2 weeks prior to initiation of Fabhalta® and no antibiotic drug prophylaxis
  - Pregnant or breastfeeding
- Prescriber must submit the following:
  - Current chart notes
  - Documented symptoms as a baseline
  - Documentation of previous therapies
  - Current labs including complete blood count (CBC), comprehensive metabolic panel (CMP)
  - Recent history of blood transfusions
  - Pregnancy test results (if applicable)
  - Dose requested

RENEWAL REQUIREMENTS:

- Beneficiary is compliant on therapy (defined as 75% utilization)
- Beneficiary remains on C5 inhibitor
- Beneficiary has an improvement in hemoglobin and/or reticulocyte count compared to baseline
- Beneficiary has an improvement in overall clinical presentation (e.g., fatigue, dyspnea, reduction in transfusions)
- Prescriber must submit the following:
  - Current chart notes
  - Current labs including CBC and CMP

QUANTITY EDITS:

- 150 mg dose (100 mg + 50 mg taken three times daily)--#180 per 30 days
- 200 mg dose (two 100 mg taken three times daily)--#180 per 30 days

CRITERIA EFFECTIVE JULY 17, 2024

9) LYMEPAK™ (doxycycline hyclate) 100 mg tablet

APPROVAL CRITERIA:

- 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
- Beneficiary is diagnosed with early Lyme disease (as evidenced by erythema migrans) due to *Borrelia burgdorferi* **OR** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- Prescriber must be an infectious disease specialist
- Beneficiary should not be approved with any of the following:
  - Doesn't meet the minimum age and weight per the package insert
  - Medical necessity over generic doxycycline was not established

- Prescriber must submit the following:
  - Current chart notes with rationale for the Lyme disease diagnosis
  - Culture report confirming diagnosis of Lyme disease
  - Medical necessity over generic doxycycline tablets or capsules

QUANTITY EDITS:

- #42 per 21 days

CRITERIA EFFECTIVE JULY 17, 2024

10) MYHIBBIN™ (mycophenolate mofetil) 200 mg/mL suspension

APPROVAL CRITERIA:

- 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
- Beneficiary has had an allogeneic kidney transplant, heart transplant or liver transplant **OR** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- Beneficiary should not be approved with any of the following:
  - Doesn't meet the minimum age and dose per the package insert
  - Medical necessity over generic mycophenolate was not established
  - ≥7 years of age and no reason why patient could not use a solid oral dosage form
- Prescriber must submit the following:
  - Current chart notes with medical reason for immunosuppressant
  - Current labs to monitor kidney function and watch for neutropenia
  - Medical necessity of Myhibbin™ over generic Cellcept® suspension and solid oral formulations

RENEWAL REQUIREMENTS:

- Beneficiary must remain compliant (defined as 75% utilization)
- Prescriber must submit the following:
  - Current chart notes
  - Continued need for suspension dosage form over solid oral form
  - Current labs to monitor kidney function and watch for neutropenia

QUANTITY EDITS:

- 3 bottles per 35 days

CRITERIA EFFECTIVE JULY 17, 2024

11) FLUORIDE TOOTHPASTE (Fraiche 5000 PREVI & Sensitive and Denta 5000 Plus Sensitive)

APPROVAL CRITERIA:

- 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
- Beneficiary must have documented tooth sensitivity with necessity of a fluoride toothpaste
- Prescriber must submit the following:
  - Current visit notes
  - Documentation of the medical necessity over generic Denta 5000 Plus Sensitive which is available without prior authorization

QUANTITY EDITS:

- 1 tube per 31 days

III. FRIENDLY REMINDERS

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

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

2. **MAT (Medication Assisted Treatment) with buprenorphine/naloxone and psychosocial treatment or counseling:** Per the TIP 40: *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*: *Treatment Improvement Protocol (TIP) Series 40*: "Pharmacotherapy alone is rarely sufficient treatment for drug addiction. For most patients, drug abuse counseling—individual or group—and participation in self-help programs are necessary components of comprehensive addiction care. As part of training in the treatment of opioid addiction, physicians should at a minimum obtain some knowledge about the basic principles of brief intervention in case of relapse. Physicians considering providing opioid addiction care should ensure that they are capable of providing psychosocial services, either in their own practices or through referrals to reputable behavioral health practitioners in their communities."
   http://lib.adai.washington.edu/clearinghouse/downloads/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction-54.pdf

3. **For vaccine billing and updates, visit the Welcome to Arkansas webpage.**
   https://humanservices.arkansas.gov/
   https://humanservices.arkansas.gov/covid-19/dhs-response-to-covid-19/updates-for-providers/
   For adult vaccines (ages 18 and above), the following HCPCS and CPT codes are to be used in conjunction with the vaccine being administered:
   G0008 – Influenza immunization
   90471 – First vaccine administered
   90472 – Subsequent vaccines administered
   The injection administration code, **T1502,** will continue to be payable for 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**

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

5. **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.**

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

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

7. **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.

8. **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.

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

9. **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.

10. **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 any provider sends a patient, who is less than 18 years of age for the required metabolic labs for the antipsychotic agents, the provider must include the PCP's name and Medicaid ID number on the lab order request form. It does not have to be the PCP ordering the labs. Please refer to the Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual, Section II, 245.000 B.

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

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

12. **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.magellanrx.com/provider-documents** A coversheet for the NADAC Help Desk Request for Medicaid Reimbursement Review form can be found on the Arkansas Medicaid website: **https://ar.magellanrx.com/forms-documents**

13. **OPIOID INFORMATION ON THE PRIME THERAPEUTICS / MAGELLAN WEBSITE:** To provide educational materials to prescribers and pharmacists on opioid dosing, opioid use disorder, medication assisted treatment and polypharmacy, an opioid information tab has been added to the Prime Therapeutics / Magellan Rx website. **https://ar.magellanrx.com/provider-documents**

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

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