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 Cynthia Neuhofel

DATE: August 13, 2025

SUBJ: **AR Medicaid Prior Authorization Edits and Preferred Drug List updates approved at the AR Medicaid DUR Board July 16, 2025 meeting for the following:**

Preferred Drug List Full Review: Angiotensin Converting Enzyme Inhibitors (ACEI), Paxlovid, Oral Antivirals, Chronic Gastrointestinal Motility, and Rosacea Agents

Preferred Drug List Abbreviated Review: Anticoagulants, Angiotensin Receptor Modulators (ARBs and renin inhibitors), Beta Adrenergic Blockers, Benign Prostatic Hyperplasia (BPH), Calcium Channel Blockers (CCB), Estrogen Replacement Agents, Osteoporosis Agents, Dry Eye Ophthalmic Agents, Skeletal Muscle Relaxers, and Thrombopoiesis Stimulating Proteins

Manual Review PA Criteria: Treatment of Chronic Spontaneous Urticaria (CSU) with biologics, Targeted Immunomodulators, Amvuttra (vutrisiran), Ozempic (semaglutide), Kerendia (finerenone), Carisoprodol, Savella (milnacipran), Long-Acting Opioids, Fabhalta (iptacopan), Vanrafia (atrasentan), Vykat XR (diazoxide choline), Qfitlia (fitusiran), Vyvgart Hytrulo (efgartigimod-hyaluronidase), Ctexli (chenodiol) and Bucapsol (buspirone)

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I. ANNOUNCEMENTS

1) QUARTERLY NEWSLETTER

As a service to our providers, we publish a quarterly provider newsletter with some updates for the Medicaid program and 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 July 2025 quarterly newsletter can be found with the following link.
https://ar.primetherapeutics.com/documents/d/arkansas/arkansas-medicaid-quarterly-newsletter-july-2025-final

2) ELECTRONIC PA (ePA) and CoverMyMeds

Beginning 8/1/2025, the Arkansas Medicaid Prescription Drug Program will add new functionality to begin accepting electronic prior authorization (ePA) requests via CoverMyMeds, in addition to fax requests.

The CoverMyMeds tool will simplify the prior authorization process by prompting prescribers to answer required clinical questions and can offer real-time approval if clinical criteria are met. This will allow prescribers to submit prior authorization requests electronically, with the ability to upload supporting documents, and track the request in real time.

Additionally, pharmacy providers who utilize CoverMyMeds will have the opportunity to initiate medication ePA requests on behalf of the member for completion by the prescriber. CoverMyMeds will direct the case to the prescriber's queue and prompt them to complete and submit the ePA to Arkansas Medicaid.

Please refer to the Arkansas Medicaid Pharmacy Website at https://ar.primetherapeutics.com/provider-documents#tab6-rncs for additional information on ePA and CoverMyMeds.

Resources:
• https://ar.primetherapeutics.com/documents/d/arkansas/arkansas-medicaid-two-ways-to-submit-a-prior-authorization
• https://ar.primetherapeutics.com/documents/d/arkansas/arkansas-medicaid-covermymeds-faqs

3) INFORMATIONAL DRUG UPDATES

a. AVMAPKI / FAKZYNJA CO-PACK (AVMAPKI 0.8 mg capsules & FAKZYNJA 200 mg tab)

AVMAPKI FAKZYNJA CO-PACK is indicated for the treatment of adult patients with KRAS-mutated recurrent low-grade serous ovarian cancer (LGSOC) who have received prior systemic therapy.

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

AVMAPKI FAKZYNJA CO-PACK prior authorization requests will be reviewed based on the oncology policy.

b. LIVMARLI (maralixibat chloride) tablet—new formulation

Livmarli is now available in 9.5 mg/mL solution, 19 mg/mL solution and multiple tablet strengths. The criteria and quantity edits below are updated to account for the dosing specific to the dosage form from the package insert. Also, the minimum age has changed since the last review, so the specific age has been stricken, and the generic language about referring to the package insert was inserted.

APPROVAL CRITERIA:

- Beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- Beneficiary must have a confirmed diagnosis of **ONE** (1) of the following:
  - Alagille syndrome (ALGS) with a baseline presence of cholestatic pruritis
  - Progressive Familial Intrahepatic Cholestasis (PFIC) with a baseline presence of cholestatic pruritis
  - Diagnosis consistent with any new FDA indication
- Beneficiary has elevated serum bile acid concentration
- Beneficiary has documented failure of ursodeoxycholic acid (Ursodiol) **AND** a bile acid sequestrant unless there is a documented contraindication
- Beneficiary should continue ursodeoxycholic acid concomitantly
- Beneficiary should be limited to the following doses:
  - ALGS patient using 9.5 mg/mL solution—max of 28.5mg per day
  - ALGS patient using tablets—max of 30 mg per day
  - PFIC patient using 19 mg/mL solution—max of 38 mg per day
  - PFIC patient using tablets—max of 40 mg per day
- Beneficiary should not be approved or continue with any of the following:
  - Documented hepatic decompensation
  - Not concurrently ordered ursodeoxycholic acid
  - If continued pruritis or has no decrease in serum bile acid after trial with maximum dose of 380 mcg/kg per day
- Prescribers must submit the following:
  - Current chart notes
  - Current labs including serum bile acid level, LFTs, and fat-soluble vitamins (A, D, E, and INR)
  - Current weight for dose determination
- Initial approval for 3 months

RENEWAL REQUIREMENTS:

- Beneficiary must be compliant on therapy (defined as 75% utilization)
- Beneficiary must demonstrate a positive response with decrease in pruritis or decrease in serum bile acid after trial with maximum dose of 380 mcg/kg per day
- Providers should provide the following:
  - Current chart notes
  - Current labs including serum bile acid level, LFTs, and fat-soluble vitamins (A, D, E, and INR)
  - Current weight for dose determination

QUANTITY EDITS:

- 9.5 mg/mL solution—3 bottles (90 mL)/30 days
- 19 mg/mL solution—2 bottles (60 mL)/30 days
- 10 mg tablet—#62/31 days
- 15 mg tablet—#62/31 days
- 20 mg tablet—#62/31 days
- 30 mg tablet—#31/31 days

4) PREFERRED DRUG LIST
PDL UPDATE EFFECTIVE OCTOBER 1, 2025

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.

A. Classes with full review without criteria

1. Angiotensin Converting Enzyme (ACE) Inhibitors/Combination Products

Preferred Agents

- Benazepril tablet (generic for Lotensin®)
- Benazepril/Amlodipine capsule (generic for Lotrel®)
- Benazepril/HCTZ tablet (generic for Lotensin HCT®)
- **Captopril tablet (generic for Capoten®)**
- Enalapril tablet (generic for Vasotec®)
- Enalapril/HCTZ tablet (generic for Vaseretic®)
- Fosinopril tablet (generic for Monopril®)
- Fosinopril/HCTZ tablet (generic for Monopril HCT®)
- Lisinopril tablet (generic for Zestril®)
- Lisinopril/HCTZ tablet (generic for Zestoretic®)
- Quinapril tablet (generic for Accupril®)
- Quinapril/HCTZ tablet (generic for Accuretic®)
- Ramipril capsule (generic for Altace®)

Non-Preferred Agents

- Accupril® tablet (quinapril)
- Accuretic® tablet (quinapril/HCTZ)
- Altace® capsule (ramipril)
- Captopril/HCTZ tablet (generic for Capozide®)
- Enalapril solution (generic for Epaned®)
- Epaned® solution (enalapril)
- Lotensin® tablet (benazepril)
- Lotensin HCT® tablet (benazepril/HCTZ)
- Lotrel® capsule (benazepril/amlodipine)
- Moexipril tablet (generic for Univasc®)
- Perindopril tablet (generic for Aceon®)
- Qbrelis® solution (lisinopril)
- Trandolapril tablet (generic for Mavik®)
- Vasotec® tablet (enalapril)
- Vasoretic® tablet (enalapril/HCTZ)
- Zestoretic® tablet (lisinopril/HCTZ)
- Zestril® tablet (lisinopril)

2. **Antivirals, General (Paxlovid™) (New PDL class)**

Preferred Agents

- **Paxlovid™ tablets (nirmatrelvir and ritonavir)**

Non-preferred Agents

- None

3. **Oral Antiviral Agents (New PDL class)**

Preferred Agents

- Acyclovir tablet and capsule (generic for Zovirax®)
- Acyclovir suspension (generic for Zovirax®)
- Oseltamivir suspension (generic for Tamiflu®)
- Oseltamivir capsule (generic for Tamiflu®)
- Valacyclovir tablet (generic for Valtrex®)

Non-preferred Agents

- Famciclovir tablet (generic for Famvir®)
- Flumadine® tablet (rimantadine)
- Relenza® diskhaler (zanamivir)
- Rimantadine tablet (generic for Flumadine®)
- Tamiflu® suspension (oseltamivir)
- Tamiflu® tablet (oseltamivir)
- Valtrex® tablet (valacyclovir)
- Xofluza® suspension (baloxavir)
- Xofluza® tablet (baloxavir)

Age Edits:

- Acyclovir suspension available for patients < 7 years of age without prior authorization
- Oseltamivir suspension available for patients < 13 years of age without prior authorization

4. **Rosacea Agents (New PDL class)**

Preferred Agents

- Metronidazole 0.75% cream (generic for MetroCream®/Rosadan®)
- Metronidazole 0.75% gel (generic for MetroGel®/Rosadan®)
- Metronidazole 1% gel (generic for MetroGel®)

Non-preferred Agents

- Azelaic acid 15% gel (generic for Finacea® gel)
- Brimonidine 0.33% gel (generic for Mirvaso®)
- Epsolay® 5% cream (benzoyl peroxide)
- Finacea® 15% foam (azelaic acid)
- Ivermectin 1% cream (generic for Soolantra®)
- MetroCream® 0.75% cream (metronidazole)
- MetroGel® 1% gel (metronidazole)
- Metronidazole 0.75% lotion (generic for MetroLotion®)
- Mirvaso® 0.33% gel (brimonidine)
- Noritate® 1% cream (metronidazole)
- Rhofade® 1% cream (oxymetazoline)
- Rosadan® 0.75% cream (metronidazole)
- Rosadan® 0.75% gel (metronidazole)
- Soolantra® 1% cream (ivermectin)

B. Classes with full review with PA criteria

1. Gastrointestinal Motility, Chronic

Preferred Agents

- Linzess® capsule (linaclotide)
- Lubiprostone capsule (generic for Amitiza®)
- Movantik® tablet (naloxegol)

Non-Preferred Agents

- Alosetron tablet (generic for Lotronex®)
- Amitiza® capsule (lubiprostone)
- Ibsrela® tablet (tenapanor)
- Lotronex® tablet (alosetron)
- Motegrity® tablet (prucalopride)
- Prucalopride tablet (generic for Motegrity®)
- Relistor® tablet (methylnaltrexone)
- Relistor® syringe/vial (methylnaltrexone)
- Symproic® tablet (naldemedine)
- Trulance™ tablet (plecanatide)
- Viberzi™ tablet (eluxadoline)

Preferred Agent Criteria
Linzess, Movantik, generic Amitiza (PA Review and point-of-sale [POS] edit)

NOTE: Criteria for irritable bowel syndrome with constipation (IBS-C), chronic idiopathic constipation (CIC), opioid-induced constipation (OIC), or functional constipation (FC)

- The beneficiary has a history of a preferred product within the past 60 days; **OR**
  - The beneficiary has a history of polyethylene glycol (e.g., MiraLAX, GlycoLAX) or lactulose within the past 14 - 60 days; **AND**
- The beneficiary will not be taking the requested medication with other chronic GI motility agents in the same class as the requested agent; **AND**
- The beneficiary has not had a mechanical gastrointestinal obstruction in the last 30 days; **AND**
- **For Amitiza,** the beneficiary is at least 18 years of age; **AND**
- **For Linzess,** the beneficiary does not have history of opioid use in the past 60 days; **AND**
  - The beneficiary is greater than or equal to 6 years of age if 72 mcg is requested; **OR**
  - The beneficiary is at least 18 years of age if 145 mcg or 290mcg is requested; **AND**
- **For Movantik,** the beneficiary has a history of an opioid or buprenorphine use in the past 60 days; **AND**
  - The beneficiary is at least 18 years of age.

Non-Preferred Agent Criteria
Viberzi & Lotronex (PA Review only, not in POS)

- The beneficiary has diagnosis of irritable bowel syndrome with diarrhea (IBS-D); **AND**
- The beneficiary has tried and failed at least three agents from any of the following classes:
  - Bulk Producing Agents (e.g., Metamucil [psyllium], Citrucel [methylcellulose])
  - Antispasmodic Agents (e.g., dicyclomine, hyoscyamine)
  - Antidiarrheal Agents (e.g., loperamide, diphenoxylate/atropine); **AND**
- If Lotronex®, the beneficiary is female; **AND**
- The beneficiary will not be using the requested agent concomitantly with other chronic GI motility agents in the same class as the requested agent; **AND**
- The beneficiary is at least 18 years of age.

All other Agents

- Must meet the criteria for specific indication (IBS-C, CIC, OIC, FC or IBS-D); **AND**
- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication; **AND**
- Meets routine PDL Criteria.

C. Classes with abbreviated review without criteria

1. Anticoagulants

Preferred Agents

- Dabigatran capsule (generic for Pradaxa®)
- Eliquis® tablet (apixaban)
- Enoxaparin injection (generic for Lovenox®)
- **Jantoven® tablet (warfarin)**
- Warfarin tablet (generic for Coumadin®)
- Xarelto® tablet (rivaroxaban) **BRAND ONLY**

Non-Preferred Agents

- Arixtra® injection (fondaparinux)
- Dabigatran capsule (generic for Pradaxa®)
- Fondaparinux injection (generic for Arixtra®)
- Fragmin® injection (dalteparin)
- Lovenox® injection
- Pradaxa pellet pack (dabigatran)
- Pradaxa® capsule (dabigatran)
- Rivaroxaban 2.5 mg tablet (generic for Xarelto®)
- Rivaroxaban suspension (generic for Xarelto®)
- Savaysa® tablet (edoxaban)
- Xarelto® suspension (rivaroxaban)

2. Angiotensin II Receptor Blockers (ARB)/ARB Combination Products

Angiotensin II Receptor Blockers (ARB)/ARB Combination Products

Preferred Agents

- Irbesartan tablet (generic for Avapro®)
- Irbesartan/HCTZ tablet (generic for Avalide®)
- Losartan tablet (generic for Cozaar®)
- Losartan/HCTZ tablet (generic for Hyzaar®)
- Olmesartan tablet (generic for Benicar®)
- Olmesartan/amlodipine tablet (generic for Azor®)
- Valsartan tablet (generic for Diovan®)
- Valsartan/HCTZ tablet (generic for Diovan HCT®)
- Valsartan/Amlodipine tablet (generic for Exforge®)
- Valsartan/Amlodipine/HCTZ tablet (generic for Exforge HCT®)

Preferred Agents with Criteria

- Entresto® tablet (valsartan/sacubitril)
- **Entresto® sprinkle (valsartan/sacubitril)**

Non-Preferred Agents

- Atacand® tablet (candesartan)
- Atacand HCT® tablet (candesartan/HCTZ)
- Avalide® tablet (irbesartan/HCTZ)
- Avapro® tablet (irbesartan)
- Azor® tablet (olmesartan/amlodipine)
- Benicar® tablet (olmesartan)
- Benicar HCT® tablet (olmesartan/HCTZ)
- Candesartan tablet (generic for Atacand®)
- Candesartan/HCTZ tablet (generic for Atacand HCT®)
- Cozaar® tablet (losartan)
- Diovan® tablet (valsartan)
- Diovan HCT® tablet (valsartan/HCTZ)
- Edarbi® tablet (azilsartan)
- Edarbyclor® tablet (azilsartan/chlorthalidone)
- Eprosartan tablet (generic for Tevetan®)
- Exforge® tablet (valsartan/amlodipine)
- Exforge HCT® tablet (valsartan/amlodipine/HCTZ)
- Hyzaar® tablet (losartan/HCTZ)
- Micardis® tablet (telmisartan) [HCFA term date 6/30/2026]
- Micardis HCT® tablet (telmisartan/HCTZ)
- Olmesartan/HCTZ tablet (generic for Benicar HCT®)
- Olmesartan/Amlodipine/HCTZ tablet (generic for Tribenzor®)
- Telmisartan tablet (generic for Micardis®)
- Telmisartan/Amlodipine tablet (generic for Twynsta®)
- Telmisartan/HCTZ tablet (generic for Micardis HCT®)
- **Tribenzor® tablet (olmesartan/amlodipine/HCTZ)**
- **Valsartan solution**
- **Valsartan/sacubitril tablet (generic for Entresto®)**

Direct Renin Inhibitors

Preferred Agents

- NONE

Non-Preferred Agents

- Aliskiren tablet (generic for Tekturna®)
- Tekturna® tablet (aliskiren)

3. **Beta Adrenergic Blocking Agents**

Preferred Agents

- Acebutolol capsule (generic for Sectral®)
- Atenolol tablet (generic for Tenormin®)
- Atenolol/chlorthalidone tablet (generic for Tenoretic®)
- Bisoprolol fumarate 5 mg and 10 mg tablet (generic for Zebeta®)
- Bisoprolol/HCTZ tablet (generic for Ziac®)
- Carvedilol tablet (generic for Coreg®)
- Labetalol HCl 100 mg, 200 mg, 300 mg tablet (generic for Normodyne®)
- Metoprolol succinate ER tablet (generic for Toprol XL®)
- Metoprolol tartrate tablet (generic for Lopressor®)
- Nebivolol HCL tablet (generic for Bystolic®)
- Propranolol HCl immediate release tablet (generic for Inderal®)
- Sotalol/Sotalol AF tablet (generic for Betapace®)

Non-Preferred Agents

- Betapace®/Betapace AF® tablet (sotalol)
- Betaxolol tablet (generic for Kerlone®)
- Bisoprolol fumarate 2.5 mg tablet (generic for Zebeta®)
- Bystolic® tablet (nebivolol)
- Carvedilol phosphate CR capsule (Coreg CR®)
- Hemangeol® solution (propranolol)
- Inderal LA® capsule (propranolol ER)
- Inderal XL® capsule (propranolol ER)
- Innopran XL® capsule (propranolol ER)
- Kapspargo® sprinkle (metoprolol)
- Labetalol HCL 400 mg tablet (generic for Normodyne®)
- Lopressor® tablet (metoprolol)
- Lopressor® solution (metoprolol)
- Metoprolol/HCTZ tablet (generic for Lopressor HCT®)
- Nadolol tablet (generic for Corgard®)
- Pindolol tablet (generic for Visken®)
- Propranolol HCl ER capsule (generic for Inderal LA®/Innopran XL®)
- Propranolol HCl solution
- Propranolol/HCTZ tablet (generic for Inderide®)
- Sotylize®* solution (See Criteria for Sotalol (Sotylize®) Solution)
- Tenoretic® tablet (atenolol/chlorthalidone)
- Tenormin® tablet (atenolol)
- Timolol Maleate tablet (generic for Blocadren®)
- Toprol XL® tablet (metoprolol XL)

4. **Benign Prostatic Hyperplasia**

Preferred Agents

- Alfuzosin ER tablet (generic for Uroxatral®)
- Doxazosin tablet (generic for Cardura®)
- Dutasteride capsule (generic for Avodart®)
- Finasteride tablet (generic for Proscar®)**
- Tamsulosin capsule (generic for Flomax®)
- Terazosin capsule (generic for Hytrin®)

Non-Preferred Agents

- Cardura® tablet (doxazosin)
- Cardura® XL tablet (doxazosin)
- Cialis® tablet (tadalafil)‡
- Dutasteride/Tamsulosin capsule (generic for Jalyn®)
- Flomax® capsule (tamsulosin) –HCFA term date 10/31/2025
- Proscar® tablet (finasteride)
- Rapaflo® capsule (silodosin)
- Silodosin capsule (generic for Rapaflo®)
- Tadalafil tablet (generic for Cialis®)‡
- **Tezruly™ solution (terazosin)**

****Diagnosis of Benign Prostatic Hypertrophy in the past 3 years**
‡Denial for diagnosis of erectile dysfunction

5. **Calcium Channel Blockers**

Dihydropyridine and Combination Products

Preferred Agents

- Amlodipine besylate tablet (generic for Norvasc®)
- Amlodipine/benazepril capsule (generic for Lotrel®)
- Amlodipine/olmesartan tablet (generic for Azor®)
- Amlodipine/valsartan tablet (generic for Exforge®)
- Amlodipine/valsartan/hctz tablet (generic for Exforge HCT®)
- Nifedipine IR capsule (generic for Procardia®)
- Nifedipine ER tablet (generic for Adalat CC®, Procardia XL®)

Non-Preferred Agents

- Amlodipine/atorvastatin tablet (generic for Caduet®)
- Amlodipine/olmesartan/hctz tablet (generic for Tribenzor®)
- **Azor® tablet (amlodipine/olmesartan)**
- **Caduet® tablet (amlodipine/atorvastatin)**
- Exforge® tablet (amlodipine/valsartan)
- Exforge HCT® tablet (amlodipine/valsartan/hctz)
- Felodipine ER tablet (generic for Plendil®)
- Isradipine capsule (generic for Dynacirc®)
- Katerzia® suspension (amlodipine)
- Levamlodipine tablet (generic for Conjupri®)
- **Lotrel® capsule (amlodipine/benazepril)**
- Nicardipine capsule (generic for Cardene®)
- Norliqva® (amlodipine suspension)
- Nimodipine capsule (generic for Nymalize®)
- Nisoldipine ER tablet (generic for Sular®)
- Norvasc® tablet (amlodipine)
- Nymalize® solution (nimodipine)
- Procardia XL® tablet (nifedipine ER)
- **Sular ER® tablet (nisoldipine)**
- **Tribenzor® tablet (amlodipine/olmesartan/hctz)**

Non-Dihydropyridine and Combination Products

Preferred Agents

- **Cartia XT 24 hr capsule (diltiazem)**
- **Diltiazem CD 24 hr capsule (generic for Cardizem CD®)**
- **Dilt-XR 24 hr capsule (diltiazem)**
- Diltiazem XR 24 hr capsule (generic for Dilacor XR®)
- Diltiazem ER 24 hr capsule (generic for Tiazac®)
- Diltiazem tablet (generic for Cardizem®)
- **Tiadylt® ER 24 hr capsule (diltiazem)**
- Verapamil tablet (generic for Calan®)
- Verapamil ER tablet (generic for Calan SR®)

Non-Preferred Agents

- Cardizem® tablet (diltiazem)
- Cardizem CD® capsule (diltiazem)
- Cardizem LA® tablet (diltiazem)
- Diltiazem ER 12 hr capsule (generic for Cardizem SR®)
- Diltiazem LA 24 hr tablet (generic for Cardizem LA® and Matzim LA®)
- Matzim LA® tablet (diltiazem ER)
- **Tiazac® capsule (diltiazem ER)**

- Verapamil ER capsules and tablets (generic for Verelan®, Verelan PM®)
- Verelan PM® capsule (verapamil ER)—manufacturer discontinue 12/31/2024

6. Estrogen Replacement Agents

Preferred Agents

- Climara® Pro patch (estradiol/levonorgestrel)
- Estradiol oral tablet (generic for Estrace®)
- Estradiol once weekly transdermal (generic for Climara®)
- Estradiol twice weekly transdermal (generic for Alora®, Vivelle-Dot®, Minivelle®, Dotti®, Lyllana®)
- Premarin® tablet (conjugated estrogen)
- Prempro® tablet (conjugated estrogen/medroxyprogesterone)

Non-Preferred Agents

- **Abigale tablet (estradiol/norethindrone)**
- **Abigale Lo® tablet (estradiol/norethindrone)**
- Activella® tablet (estradiol/norethindrone acetate)
- Bijuva® capsule (estradiol/progesterone)
- Climara® patch (estradiol)
- Combipatch® patch (estradiol/norethindrone acetate)
- DivigeL® topical gel (estradiol)
- Dotti® patch (estradiol)
- Duavee® tablet (estrogens, conjugated/Bazedoxifene)
- Elestrin® gel (estradiol)
- Estrace® tablet (estradiol)
- Estradiol gel (generic for Estrogel®)
- Evamist® spray (estradiol)
- Fyavolv® tablet (ethinyl estradiol/norethindrone)
- Jinteli® tablet (ethinyl estradiol/norethindrone)
- Lyllana® patch (estradiol)
- Menest® tablet (estrogens, esterified)
- Menostar® patch (estradiol)
- Mimvey® tablet (estradiol/norethindrone acetate)
- Minivelle® patch (estradiol)
- Vivelle-Dot® patch (estradiol)

Non-Preferred Agents with Criteria

- Angeliq® tablet (Estradiol/drospirenone)
- Estradiol/norethindrone tablet (generic for Activella®, Amabelz®, Lopreeza®, Mimvey®
- Ethinyl estradiol/norethindrone acetate (Femhrt®, Jinteli®, Fyavolv®)
- Premphase® (estrogens, conjugated/medroxyprogesterone)

7. Osteoporosis

***Signifies a biosimilar**

Preferred Agents

- Alendronate sodium 5mg daily dose (generic for Fosamax®)
- Alendronate sodium 10mg daily dose (generic for Fosamax®)
- Alendronate sodium 35mg weekly dose (generic for Fosamax®)
- Alendronate sodium 70mg weekly dose (generic for Fosamax®)

Non-Preferred Agents with Criteria

- Prolia® injection (denosumab)—**BRAND ONLY**
- Raloxifene tablet (generic for Evista®)

Non-Preferred Agents without Criteria

- Actonel® tablet (risedronate)
- Atelvia® tablet (risedronate DR)
- **Alendronate sodium solution (generic for Fosamax®)**
- Binosto® effervescent tablet (alendronate)
- **Bonsity® injection (teriparatide)**
- Calcitonin-Salmon (generic for Miacalcin® and Fortical®)
- **Conexxence injection (denosumab-bnht)***
- Evenity® injection (romosozumab-aqqg)
- Evista® tablet (raloxifene)
- Forteo® injection (teriparatide)
- Fosamax® 70 mg tablet (alendronate)
- Fosamax® Plus D tablet (alendronate plus vitamin D)
- **Ibandronate syringe (generic for Boniva®)**
- **Ibandronate tablet (generic for Boniva®)**
- **Jubbonti® syringe (denosumab-bbdz)***
- **Miacalcin® vial (calcitonin-salmon)**
- **Risedronate tablet (generic for Actonel®)**
- **Stoboclo® syringe (denosumab-bmwo)***
- Teriparatide injection (generic for Forteo®)
- Tymlos® injection (abaloparatide)

8. **Ophthalmics, Dry Eye Agents**

Preferred Agents with Criteria

- Restasis® single dose emulsion vial (cyclosporine 0.05%) **BRAND ONLY**

Non-Preferred Agents

- Cequa® solution (cyclosporine 0.09%)
- **Cyclosporine 0.05% emulsion (generic for Restasis®)**
- **Eysuvis 0.25% drops (loteprednol etabonate)**
- Miebo® drops (perfluorohexyloctane 100%)
- Restasis® multidose emulsion vial (cyclosporine 0.05%)
- **Tryptyr® solution (acoltremon)**
- Tyrvaya® nasal spray (varenicline tartate)
- Verkazia® emulsion (cyclosporine 0.1%)
- Vevye® solution (cyclosporine 0.1%)
- Xiidra® solution (lifitegrast 5%)

9. **Skeletal Muscle Relaxants (excluding carisoprodol containing products)**

Preferred Agents

- Baclofen 5 mg, 10 mg, 20 mg tablet (generic for Lioresal®)
- Chlorzoxazone 500 mg tablet (generic for Parafon®)
- Cyclobenzaprine 5 mg and 10 mg tablet (generic for Flexeril®)
- Metaxalone 400 mg, 800mg tablet (generic for Skelaxin®)
- Methocarbamol 500 mg and 750 mg tablet (generic for Robaxin®)
- Tizanidine HCl tablet (generic for Zanaflex®)

Non-Preferred Agents

- Amrix® ER capsule (cyclobenzaprine)
- Baclofen 15 mg tablet
- Baclofen solution (generic for Ozobax®, Ozobax DS®)
- Baclofen suspension (generic for Fleqsuvy®)
- Chlorzoxazone 250 mg, 375 mg, and 750 mg tablet (generic for Lorzone®)
- Cyclobenzaprine HCl 7.5 mg tablet (generic for Fexmid®)
- Cyclobenzaprine HCl extended-release capsule (generic for Amrix®)
- Dantrium® capsule (dantrolene)
- Dantrolene capsule (generic for Dantrium®)
- Fexmid® tablet (cyclobenzaprine 7.5 mg)
- Fleqsuvy® suspension (baclofen)
- Lorzone® tablet (generic for chlorzoxazone)
- Lyvispah® granule (baclofen) [manufacturer obsolete date 06/30/2025]
- **Metaxolone 640 mg tablet**
- Methocarbamol 1000 mg tablet (generic for Tanlor®)
- Norgesic Forte® tablet (orphenadrine/aspirin/caffeine)
- **Norgesic® tablet (orphenadrine/aspirin/caffeine)**
- Orphenadrine citrate ER tablet (generic for Norflex®)
- **Orphenadrine/aspirin/caffeine tablet (generic for Norgesic®)**
- **Orphengesic™ Forte tablet (orphenadrine/aspirin/caffeine)**
- Tanlor® 1,000 mg tablet (methocarbamol)
- Tizanidine HCL capsule (generic for Zanaflex®)
- Zanaflex® capsule and tablet (tizanidine)

10. Thrombopoiesis Stimulating Proteins

Preferred Agents with Manual Review Criteria

- Promacta® tablet (eltrombopag olamine)—**Brand Only**

Non-Preferred Agents with Manual Review Criteria

- Alvaiz® (eltrombopag choline)
- Doptelet® tablet (avatrombopag maleate)
- **Eltrombopag olamine tablet and suspension (generic for Promacta®)**
- Mulpleta® tablet (lusutrombopag)
- Promacta® suspension (eltrombopag olamine)
- Tavalisse® tablet (fostamatinib disodium)

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

CRITERIA EFFECTIVE JULY 16, 2025

1. CHRONIC SPONTANEOUS URTICARIA

APPROVAL CRITERIA FOR IMMUNOMODULATORS (Dupixent 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)

- 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
- Prescribers 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:

- Beneficiary has been compliant with therapy (defined as: 75% utilization)
- 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
- Prescribers 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)

CRITERIA EFFECTIVE JULY 16, 2025

2. TARGETED IMMUNOMODULATORS

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

GENERAL APPROVAL REQUIREMENTS:

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

APPROVAL CRITERIA FOR PLAQUE PSORIASIS:

(Abrilada, Amjevita, Bimzelx, Cimzia, Cosentyx, Cyltezo, **Enbrel,** Hadlima, Hulio, **Humira,** Hyrimoz, Idacio, Ilumya, **Otezla,** Otulfi, Pyzchiva, Selarsdi, Siliq, Simlandi, Skyrizi, Sotyktu, Stelara, Steqeyma, **Taltz**, Tremfya, Yesintek , Yuflyma, or Yusimry)

- Prescribed by or in consultation with a dermatologist, rheumatologist, or other specialist treating plaque psoriasis
- Beneficiary has a documented diagnosis of moderate to severe plaque psoriasis
- Beneficiary must trial ≥ 6 months with at least **ONE** product from each of the following (6 months of topical and 6 months of systemic):
  - Topical drug therapy with corticosteroids, calcipotriene, calcitriol, tazarotene, roflumilast, or tapinarof

    - Systemic drug therapy with methotrexate, acitretin, or cyclosporine
- Beneficiary must have tried and failed phototherapy or have a contraindication
- Beneficiary continues to have symptoms after trial of conventional therapy with at least **ONE** of the following:
    - Involvement of ≥10% body surface area (BSA)
    - Psoriasis Area and Severity Index (PASI) score ≥12
    - Plaque location severely impacts quality of life (i.e., head/neck, palms, soles of feet, genitalia)
- Prescribers must submit the following:
    - Current chart notes
    - Documentation of previous therapies
    - Current psoriasis description with BSA and PASI score
- For Taltz, the beneficiary has a history of at least 3 months of **ONE** preferred tumor necrosis factor (TNF) blocker (i.e., Humira or Enbrel) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least **TWO** preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR PSORIATIC ARTHRITIS AND RHEUMATOID ARTHRITIS:

Psoriatic Arthritis:

Abrilada, Amjevita, Bimzelx, Cimzia, Cosentyx, Cyltezo, **Enbrel,** Hadlima, Hulio, **Humira,** Hyrimoz, Idacio, Orencia, **Otezla,** Otulfi, Pyzchiva, Rinvoq, Rinvoq LQ, Selarsdi, Simlandi, Simponi, Skyrizi, Stelara, Steqeyma, **Taltz,** Tremfya, **Xeljanz, Xeljanz XR,** Yesintek, Yuflyma, or Yusimry

Rheumatoid Arthritis:

Abrilada, Actemra, Amjevita, Cimzia, Cyltezo, **Enbrel,** Hadlima, Hulio, **Humira,** Hyrimoz, Idacio, Kevzara, Kineret, Olumiant, Orencia, Rinvoq, Simlandi, Simponi, Tyenne, **Xeljanz, Xeljanz XR,** Yuflyma, or Yusimry

- Prescribed by or in consultation with a rheumatologist or other specialist treating psoriatic arthritis or rheumatoid arthritis
- Beneficiary has a documented diagnosis of psoriatic arthritis or rheumatoid arthritis
- Trial and failure with NSAIDs
- Trial and failure with ≥ 6 months of any of the following:
    - Hydroxychloroquine
    - Methotrexate
    - Sulfasalazine
    - Leflunomide
- Prescribers must submit the following:
    - Current chart notes
    - Documentation of previous therapies
    - Current labs as baseline (e.g., Erythrocyte Sedimentation Rate, C-Reactive Protein level)
- For Taltz, Xeljanz IR and Xeljanz XR, the beneficiary has a history of at least 3 months of **ONE** preferred tumor necrosis factor (TNF) blocker (i.e., Humira or Enbrel) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least **TWO** preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR ULCERATIVE COLITIS:
(Abrilada, Amjevita, Cyltezo, Entyvio, Hadlima, Hulio, **Humira,** Hyrimoz, Idacio, Omvoh, Otulfi, Pyzchiva, Rinvoq, Selarsdi, Simlandi, Simponi, Skyrizi, Stelara, Steqeyma, Tremfya, Velsipity, **Xeljanz, Xeljanz XR,** Yesintek, Yuflyma, Yusimry, or Zymfentra)

- Prescribed by or in consultation with a gastroenterologist
- Beneficiary has a documented diagnosis of moderate to severe ulcerative colitis as defined by ONE of the following:
    - Fecal calprotectin > 150 µg/g
    - Endoscopy Mayo subscore ≥ 2 or modified Mayo score (mMS) ≥ 5
- Beneficiary has been hospitalized for ulcerative colitis **OR** had a trial and failure with of ≥ 2 months of standard of care drug therapy with at least **TWO** of the following for induction or maintenance of remission:
    - Immunosuppressants (e.g., azathioprine, 6-mercaptopurine, cyclosporine)
    - Oral/rectal glucocorticoids (e.g., enteric coated budesonide, prednisone, hydrocortisone)
    - Oral/rectal 5-aminosalicyclic acid agents (e.g., mesalamine, sulfasalazine)
- Prescribers must submit the following:
    - Current chart notes
    - Documentation of previous therapies
    - Current labs including inflammatory markers (i.e., fecal calprotectin, endoscopic Mayo subscore)
- For Xeljanz IR and Xeljanz XR, the beneficiary has a history of at least 3 months of **ONE** preferred tumor necrosis factor (TNF) blocker (i.e., Humira) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least **TWO** preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR CROHN'S DISEASE:
(Abrilada, Amjevita, Cimzia, Cyltezo, Entyvio, Hadlima, Hulio, **Humira**, Hyrimoz, Idacio, Omvoh, Otulfi, Pyzchiva, Rinvoq, Selarsdi, Simlandi, Skyrizi, Stelara, Steqeyma, Tremfya, Yesintek, Yuflyma, Yusimry, or Zymfentra)

- Prescribed by or in consultation with a gastroenterologist
- Beneficiary has a documented diagnosis of moderate to severe Crohn's Disease confirmed by assessment of stool frequency, abdominal pain score, and Simple Endoscopic Score for Crohn's Disease (SES-CD). Information for diagnosis is based on endoscopy and imagining results as well as elevated CRP and fecal calprotectin.
- Beneficiary has been hospitalized with Crohn's Disease **OR** been diagnosed with a fistula or abscess **OR** had a trial and failure with ≥ 2 months of standard of care drug therapy with at least **TWO** of the following for induction or maintenance of remission:
    - Immunosuppressants (e.g., azathioprine, 6-mercaptopurine, cyclosporine)
    - Oral/rectal glucocorticoids (e.g., enteric coated budesonide, prednisone, hydrocortisone)
    - Oral/rectal 5-aminosalicyclic acid agents (e.g., mesalamine, sulfasalazine)
    - Methotrexate
- Prescribers must submit the following:
    - Current chart notes
    - Documentation of previous therapies and surgeries
    - Current labs including CBCs and inflammatory markers (i.e., fecal calprotectin, C-reactive protein)
    - Colonoscopy or imaging reports
    - Baseline stool frequency and abdominal pain score

    - Baseline Crohn's Disease Activity Index (CDAI) (clinical trials included patients with score ≥ 220) or Simple Endoscopic Score for Crohn's disease (SES-CD) (clinical trials included patients with score ≥ 6 or ≥4 for isolated ileal disease)
- Non-preferred agents require a 3-month trial and failure or a contraindication or intolerance to at least **ONE** preferred agent with this indication
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR JUVENILE IDIOPATHIC ARTHRITIS:
(Abrilada, Actemra, Amjevita, Cimzia, Cyltezo, **Enbrel**, Hadlima, Hulio, **Humira**, Hyrimoz, Idacio, Kevzara, Orencia, Rinvoq, Rinvoq LQ, Simlandi, Tofidence, Tyenne, **Xeljanz tablet**, Xeljanz oral solution, Yuflyma, or Yusimry

- Prescribed by or in consultation with a rheumatologist or other specialist
- Beneficiary has a documented diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis (JIA)
- Trial and failure with NSAIDs (unless contraindication or intolerance)
- Trial and failure with ≥ 3 months of disease modifying anti-rheumatic drugs (DMARDs) with any of the following (unless contraindication or intolerance):
    - Methotrexate
    - Leflunomide
    - Cyclosporine
- Prescribers must submit the following:
    - Current chart notes
    - Documentation of previous therapies with description of current symptoms
    - Current labs including CBCs and inflammatory markers
- For Xeljanz IR, the beneficiary has a history of at least 3 months of **ONE** preferred tumor necrosis factor (TNF) blocker (i.e., Humira) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least **TWO** preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

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

- Prescribed by or in consultation with a rheumatologist or other specialist
- Beneficiary has a documented diagnosis of deficiency of IL-1 receptor antagonist (DIRA)
- Trial and failure with NSAIDs (unless contraindication or intolerance)
- Trial and failure with ≥ 3 months of disease modifying anti-rheumatic drugs (DMARDs) with any of the following (unless contraindication or intolerance):
    - Methotrexate
    - Leflunomide
    - Cyclosporine
- Prescribers must submit the following:
    - Current chart notes
    - Documentation of previous therapies with description of current symptoms
    - Current labs including CBCs and inflammatory markers
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR ANKYLOSING SPONDYLITIS:
(Abrilada, Amjevita, Bimzelx, Cimzia, Cosentyx, Cyltezo, **Enbrel**, Hadlima, Hulio, **Humira**, Hyrimoz, Idacio, Rinvoq, Simlandi, Simponi, **Taltz**, **Xeljanz tablet, Xeljanz XR**, Yuflyma, or Yusimry)

- Prescribed by or in consultation with a rheumatologist or other specialist
- Beneficiary has a documented diagnosis of ankylosing spondylitis
- Trial and failure with ≥ 3 months of standard of care drug therapy (unless contraindication or intolerance) with nonsteroidal anti-inflammatory drugs at maximum doses (e.g., naproxen, celecoxib, ibuprofen)
- Prescribers must submit the following:
    - Current chart notes
    - Documentation of previous therapies
- For Taltz, Xeljanz IR and Xeljanz XR, the beneficiary has a history of at least 3 months of **ONE** preferred tumor necrosis factor (TNF) blocker (i.e., Humira or Enbrel) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least **TWO** preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR NONRADIOGRAPHIC AXIAL SPONDYLOARTHRITIS:
(Bimzelx, Cimzia, Cosentyx, Rinvoq, or **Taltz**)

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

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

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

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

- Prescribed by or in consultation with a rheumatologist or other specialist
- Beneficiary has a confirmed diagnosis of giant cell arteritis based on clinical symptoms and ONE of the following:
    - Temporal artery biopsy
    - Ultrasound of vessels
- Prescribers must submit the following:
    - Current chart notes
    - Documentation to confirm diagnosis with biopsy results and/or ultrasound report along with labs (i.e., CRP, ESR)
    - Medical necessity over high dose corticosteroids
    - Treatment plan for potential discontinuation in the future
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

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

- Prescribed by or in consultation with a rheumatologist, pulmonologist, or other specialist
- Beneficiary has a confirmed diagnosis of SSc-ILD based on clinical symptoms and the following:
    - PFTs indicate a decreased lung volume and decreased DLCO
    - High resolution CT indicates ground glass or reticular opacities
    - Lab work consistent with scleroderma
- Trial and failure of immunosuppressant therapy with mycophenolate or cyclophosphamide unless a contraindication or intolerance
- Prescribers must submit the following:
    - Current chart notes
    - Current PFTs
    - High resolution CT report
    - Current labs
    - Baseline 6-minute walk test
    - Medical necessity over immunosuppressant therapy +/- glucocorticoids
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR RECURRENT PERICARDITIS
(Arcalyst)

- Beneficiary is diagnosed with recurrent pericarditis based on previous episode of acute pericarditis and has developed pleuritic chest pain. Lab work should support an inflammatory phenotype (elevated CRP, WBC, or ESR).
- Beneficiary should not receive this medication if not diagnosed with an inflammatory phenotype.
- Beneficiary should have trial and failure with ALL of the following (unless there is a contraindication):
    - Colchicine + NSAID or aspirin—first line therapy
    - Colchicine + glucocorticoid—second line therapy
    - Colchicine + glucocorticoid + aspirin—third line therapy
- Prescribers must submit the following:
    - Current chart notes
    - Previous treatment for acute pericarditis

    - Electrocardiogram and echocardiogram results
    - Current labs including CBC, ESR, and CRP
    - Treatment plan including taper
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR UVEITIS
(Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, **Humira**, Hyrimoz, Idacio, Simlandi, or Yusimry)

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

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

- Prescribed by or in consultation with a rheumatologist or other rare disease specialist for treating TRAPS or HIDS/MKD
- Beneficiary must be diagnosed with **ONE** of the following:
    - TNF Receptor Associated Periodic Syndrome (TRAPS) after infectious or neoplastic causes of recurrent fevers are excluded
    - Hyperimmunoglobulin D (Hyper-IgD) Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)
- Trial and failure of NSAIDs and oral glucocorticoids at the maximum indicated dose unless a contraindication or intolerance
- Prescribers must submit the following:
    - Current chart notes
    - Documentation of symptoms and criteria used for diagnosis
    - Previous therapies tried
    - Current weight for dose determination
    - Medical necessity for the use of this medication over NSAIDs and oral glucocorticoids
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR FAMILIAL MEDITERRANEAN FEVER
(Ilaris)

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

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

- Prescribed by or in consultation with a rheumatologist or other specialist
- Beneficiary must be diagnosed with active Still's Disease [either Adult-Onset Still's Disease (AOSD) or Systemic Juvenile Idiopathic Arthritis (SJIA)]
- New onset AOSD
    - Trial and failure of NSAIDs **OR** oral glucocorticoids at the maximum indicated dose unless a contraindication or intolerance for mild to moderate disease
    - If macrophage activation syndrome is suspected, a biologic is warranted (UpToDate recommends anakinra in these patients)
- Established AOSD still needing therapy
    - Trial and failure with ≥ 3 months of disease modifying anti-rheumatic drugs (DMARDs) with any of the following (unless contraindication or intolerance):
        - Methotrexate
        - Leflunomide
- Prescribers must submit the following:
    - Current chart notes
    - Documentation of symptoms and criteria used for diagnosis
    - Previous therapies tried
    - Current weight for dose determination
    - Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR ALOPECIA AREATA
(Leqselvi, Litfulo, or Olumiant)

- Prescribed by or in consultation with a dermatologist
- Beneficiary has a documented diagnosis of alopecia areata with > 50% scalp hair loss or refractory disease
- Beneficiary does not have another cause of hair loss (i.e., androgenetic alopecia, chemotherapy-induced hair loss, or causes of hair loss other than alopecia areata)
- Beneficiary request would be denied if taking any of the following concomitantly:
    - JAK inhibitor
    - Other monoclonal antibodies or cytokine & CAM antagonists
    - Immunosuppressant

- Trial and failure of topical and/or intralesional corticosteroids
- Trial and failure with ≥ 6 months of disease modifying anti-rheumatic drugs (DMARDs) with any of the following (unless contraindicated):
    - Methotrexate
    - Leflunomide
    - Cyclosporine
- Prescribers must submit the following:
    - Current chart notes
    - Documentation of previous therapies tried with duration
    - Medical necessity over intralesional corticosteroids, topical steroids, and DMARDs
    - Letter of medical necessity
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR POLYMYALGIA RHEUMATICA
(Kevzara)

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

APPROVAL CRITERIA FOR HIDRADENITIS SUPPURATIVA
(Abrilada, Amjevita, Bimzelx, Cimzia, Cosentyx, Cyltezo, Hadlima, Hulio, **Humira**, Hyrimoz, Idacio, Simlandi, Yuflyma, or Yusimry)

- Some medications/treatments recommended in Hidradenitis Suppurativa (HS) guidelines may not be a covered product/procedure by Arkansas Medicaid. Refer to the respective provider manual for additional information.
- Beneficiary with diagnosis of Hurley Stage I HS should use options from the following list (biologics are not recommended for Hurley Stage I):
    1) Topical clindamycin
    2) Oral tetracyclines (tetracycline, doxycycline, minocycline)
    3) Antiandrogenic agents (combined oral contraceptives, spironolactone, finasteride)
    4) Metformin
    5) Alternatives for refractory patients—clindamycin with rifampin, acitretin, dapsone
    6) Laser therapy
    7) Intralesional corticosteroids
    8) Topical resorcinol
    9) Surgical drainage
- Beneficiary with diagnosis of Hurley Stage II:

    - Beneficiary should follow treatment guidelines (e.g., *Journal of the American Academy of Dermatology*) https://www.jaad.org/action/showPdf?pii=S0190-9622%2819%2930368-8
    - Prior to beginning biologics, the beneficiary should have tried at least 2 of the following:
        - Oral tetracyclines for a minimum of 3 months (unless contraindicated)
        - Combination of rifampin and clindamycin for a minimum of 3 months (unless contraindicated)
        - Oral contraceptives for a minimum of 3 months (females only)
        - Oral retinoids for a minimum of 3 months (unless contraindicated)
        - Refractory after treatment—antibiotic therapy with adjunctive treatment of an antiandrogen, metformin, or oral contraceptives (when choosing adjunctive options, consideration the beneficiary's comorbidities)
- Beneficiaries who are refractory after at least two 3-month therapies or have progressed to Stage III during treatment may be considered for therapy with biologics
- Prescribers must submit the following:
    - Chart notes
    - Documentation of previous therapies tried including surgery or laser treatment
    - Comorbidities that can increase HS severity must be addressed (list not all inclusive)
        - Tobacco use
        - Obesity
        - PCOS
- Non-preferred agents require a 3-month trial and failure or a contraindication or intolerance to at least **ONE** preferred agent with this indication.
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR ENTHESITIS-RELATED ARTHRITIS
(Cosentyx)

- Prescribed by or in consultation with a rheumatologist or other specialist
- Beneficiary has a documented diagnosis of enthesitis-related arthritis
- Trial and failure with NSAIDs
- Trial and failure with ≥ 3 months of disease modifying anti-rheumatic drugs (DMARDs) with any of the following (unless contraindicated):
    - Methotrexate
    - Leflunomide
    - Cyclosporine
    - Sulfasalazine
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR GOUT FLARES
(Ilaris)

- Prescribed by or in consultation with a rheumatologist or other specialist.
- Beneficiary must be diagnosed with gout flares.
- Beneficiary must have tried and failed non-steroidal anti-inflammatory drugs (NSAIDs), corticosteroids, and colchicine (unless contraindicated or not tolerated). (Repeated courses of corticosteroids are not appropriate.)
- Beneficiary with frequent gout flares (defined as 3 or more gout flares in the previous year) must be on a urate-lowering medication (e.g., allopurinol, febuxostat, probenecid).
- Prescribers must submit ALL of the following:
    - Current chart notes
    - Documentation of symptoms

    - Current labs including serum urate concentration and documentation of urate crystals in the synovial fluid (if available)
- PA will be approved for 1 dose.
- Renewal requires prescribers to submit updated notes with documentation of continued gout flare. Ilaris requires at least 12 weeks between doses.

APPROVAL CRITERIA FOR BEHCET'S DISEASE

(Otezla)

- Prescribed by or in consultation with a rheumatologist or other specialist in the treatment of Behçet's Disease
- Beneficiary has a documented diagnosis of Behçet's Disease with oral ulcers
- Trial and failure with ≥ 3 months of the following:
    - Topical corticosteroids (e.g., triamcinolone acetonide cream 0.1% in orabase); AND
    - ≥ 1 of the following conventional oral therapies
        - Colchicine
        - Azathioprine
        - Sulfasalazine
- Prescribers must submit the following:
    - Current chart notes
    - Documentation of previous therapies tried with duration
    - Medical necessity over topical corticosteroids and conventional oral therapies
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR NEUROMYELITIS OPTICA SPECTRUM DISORDER

(Enspryng)

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

Renewal Requirements

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

Quantity Edits

- #1/28 days (first month will require a quantity override to allow 3 injections)

APPROVAL CRITERIA FOR GENERALIZED PUSTULAR PSORIASIS

(Spevigo)

- Prescribed by or in consultation with a dermatologist
- 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
    - GPPGA pustulation subscore 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
- Prescribers 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.
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

NOTE: If billing as a medical claim, contact AFMC for PA processing.

CRITERIA EFFECTIVE July 16, 2025

3. **AMVUTTRA (vutrisiran) 25 mg/0.5 mL 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
- Beneficiary must have the diagnosis of cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) confirmed with **TWO** of the following:
  - Echocardiogram; **OR**
  - Tissue biopsy confirming the presence of transthyretin amyloid deposits; **OR**
  - Cardiovascular magnetic resonance imaging
    - If consistent with cardiac amyloidosis, the following should be done to document the presence or absence of monoclonal protein confirmed by **ONE** of the following:
      - Serum kappa/lambda free light chain ratio analysis
      - Serum protein immunofixation
      - Urine protein immunofixation
    - If monoclonal protein is not found, bone tracer cardiac scintigraphy (pyrophosphate scan) should be performed. The presence of grade 2 or 3 is highly specific for ATTR cardiac disease and tissue biopsy is not needed, but genetic testing is needed to confirm TTR variant.
- Must be prescribed by, or in consultation with, a cardiologist
- Beneficiary must have New York Heart Association Class (NYHA) I, II, or III heart failure with symptoms of cardiomyopathy and heart failure (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema)
- Beneficiary must have left ventricular wall (interventricular septum or left ventricular posterior wall) thickness ≥ 12 mm
- Beneficiary should not be approved or continue the medication if meets one of the following:
  - Impaired renal function (eGFR < 15 mL/min/1.73m^2)
  - Baseline NT-proBNP <300 pg/mL or ≥8500 pg/mL
- Prescribers must submit the following:
  - Current chart notes
  - Symptoms specific to this patient to support diagnosis
  - Baseline 6-minute walk distance (6MWD)
  - Current labs including baseline eGFR and NT-proBNP level (≥ 300 pg/mL)
  - Baseline echocardiogram with NYHA classification and documentation of tests results to confirm diagnosis
  - Baseline Kansas City Cardiomyopathy Questionnaire-Overall Summary (KCCQ-OS) score
  - Medical necessity over ATTRUBY and VYNDAQEL/VYNDAMAX

RENEWAL REQUIREMENTS:

- Beneficiary must remain compliant on therapy (defined as 75% utilization)
- Beneficiary must demonstrate a positive response to treatment
- Prescribers must submit the following:
  - Current chart notes
  - Documentation of patient specific symptoms compared to baseline
  - Updated 6-minute walk distance (6MWD)
  - Current Kansas City Cardiomyopathy Questionnaire-Overall Summary (KCCQ-OS) score

QUANTITY EDITS:

- #1 injection per 90 days

CRITERIA EFFECTIVE JULY 16, 2025

4. **OZEMPIC (semaglutide) injection for Type 2 diabetes mellitus with chronic kidney disease**

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 type 2 diabetes mellitus and chronic kidney disease
- Beneficiary must have urine albumin-creatinine ratio (UACR) of ≥30 mg/g and eGFR <60 mL/min/1.73m^2
- Beneficiary should be taking an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) at maximally tolerated doses or have a contraindication to their use.
- Beneficiary must have a history of a sodium-glucose cotransporter 2 (SGLT-2) inhibitor use prior to beginning this medication or a has a contraindication to their use
- Prescribers must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Current labs including urine albumin-creatinine ratio (UACR), eGFR, and HbA1c
  - Current weight

RENEWAL REQUIREMENTS:

- Beneficiary must remain compliant on therapy (defined as 75% utilization)
- Prescribers must submit the following:
  - Current chart notes
  - Current labs including urine albumin-creatinine ratio (UACR), eGFR, and HbA1c
  - Current weight
  - Response to therapy

QUANTITY EDITS:

1 pen per month

CRITERIA EFFECTIVE JULY 16, 2025

5. **KERENDIA (finerenone) 10 mg, 20 mg, and 40 mg tablet**

APRPOVAL CRITERIA:

- Beneficiary must be ≥ 18 years of age
- Beneficiary must be diagnosed with **ONE** of the following:
  - Type 2 diabetes mellitus and chronic kidney disease (CKD) with a risk of sustained estimated glomerular filtration rate (eGFR) decline, end stage kidney disease, cardiovascular death, non-fatal myocardial infarction, and hospitalization for heart failure
  - Heart failure (HF) with left ventricular ejection fraction (LVEF) ≥40% with risk of cardiovascular death, hospitalization for heart failure, or urgent heart failure visits
- Beneficiary must have eGFR ≥25 mL/min/1.73m^2
- Beneficiary with CKD must have UACR of ≥30 mg/g
- Beneficiary's dose must be consistent with the package insert based on current eGFR and potassium levels
- Beneficiary with CKD should be taking an angiotensin-converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) unless contraindicated
- Beneficiary with HF should be taking standard of care heart failure medications
- Beneficiary must be a non-smoker or must be participating in a tobacco cessation program
- Beneficiary must have a normal serum potassium level (< 5 mEq/L)
- Beneficiary is not receiving concomitant strong CYP3A4 inhibitors (e.g., fluconazole) and strong or moderate CYP3A4 inducers (e.g., efavirenz, rifampicin)
- Beneficiary has not been diagnosed with adrenal insufficiency (Addison's disease)

- Beneficiary must not have severe hepatic impairment (Child Pugh C)
- Prescribers must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried, and symptoms associated with HF or CKD
  - Current labs including potassium and eGFR
  - For beneficiary with HF—current blood pressure, weight, LVEF and documentation of HF events
  - For beneficiary with CKD—current Urinary Albumin-to-Creatinine Ratio (UACR)
- Initial approval for 3 months

RENEWAL REQUIREMENTS:

- Beneficiary with CKD must demonstrate a decrease in UACR and sustained or improved eGFR after dose titration
- Beneficiary must be a non-smoker or remain in a tobacco cessation program
- Beneficiary must have a potassium level that remains < 5.5 mEq/L
- Prescribers must submit the following:
  - Current chart notes and updated potassium level and eGFR
  - For beneficiary with HF—current blood pressure, weight, LVEF and any change in HF symptoms
  - For beneficiary with CKD—current Urinary Albumin-to-Creatinine Ratio (UACR)
  - Attestation that HF patient has demonstrated stabilization or improvement based on functional status (e.g., improved HF symptoms, improved LVEF, decrease in hospitalizations, etc.)
- Approval for 6 months

CRITERIA EFFECTIVE JULY 16, 2025

6. CARISOPRODOL 250 mg and 350 mg tablet

NOTE: The following criterion pertains to any future carisoprodol containing products that become FDA approved.

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 an acute, painful musculoskeletal condition requiring a muscle relaxer
- Beneficiary must have tried and failed all preferred skeletal muscle relaxers on PDL
- Prescribers must submit the following:
  - Current chart notes
  - Beneficiary's diagnosis that requires a muscle relaxer
  - Letter of medical necessity outlining the rationale for carisoprodol over all other preferred muscle relaxers on the PDL
- If this medication is approved, the beneficiary will only be allowed up to a 3-week supply.

QUANTITY EDITS:

#63/21 days

CRITERIA EFFECTIVE JULY 16, 2025

7. SAVELLA (milnacipran) 12.5 mg, 25 mg, 50 mg and 100 mg tablets

APPROVAL CRITERIA:

- The request is for Savella (milnacipran); **AND**

  - The beneficiary has a diagnosis of fibromyalgia (ICD-10 M79.7) within the previous 2 years of history, submitted on the incoming pharmacy claim, or documented on the request; **AND**
  - The beneficiary has a history of a 90-day trial of at least 3 of the following within the past 2 years, substantiated by claims history or documented on the request:
    - SNRI
    - Gabapentin or pregabalin
    - Tricyclic antidepressant
    - Muscle relaxer; **AND**
- If previous trials cannot be substantiated via claims, the prescriber provides attestation that the beneficiary adhered to previous therapies, and the trial period was sufficient to allow for a positive treatment outcome or that the drug was discontinued due to an adverse event; **AND**
- The prescriber attests that the trial/failure(s) of the preferred medications are documented in the beneficiary's medical record (evidence of such is subject to audit).

CRITERIA EFFECTIVE JULY 16, 2025

8. **LONG-ACTING OPIOIDS**

Hydrocodone ER, Hydromorphone ER, Oxymorphone ER, Belbuca, and Tramadol ER (generics for Conzip and Ryzolt) will be added to posted criteria. These are currently incorporated in the AutoPA rule for POS edits.

Note: Requests for non-preferred, multi-source brand medications will still need to meet Brand Medically Necessary criteria in addition to the criteria below.

- The beneficiary is established on a long-acting opioid (LAO), defined as use in the last 60 days; **AND**
  - Routine PDL Criteria; **OR**
- The beneficiary is established on chronic, daily use of a short-acting opioid (SAO); **AND**
  - The SAO will be discontinued or decreased upon starting the LAO; AND
  - The total daily MME will be reduced upon starting the LAO to account for incomplete opioid cross-tolerance; **AND**
  - Medical necessity of using a long-acting opiate for chronic, non-cancer pain; **AND**
  - Routine PDL Criteria are met; **OR**
- If the beneficiary is not established on a long-acting or short-acting opioid meeting the criteria above, then one of the following:
  - The beneficiary has diagnosis of malignant cancer in the last 365 days; **OR**
  - **For all except methadone,** the beneficiary currently resides in long-term care; **OR**
  - **For fentanyl patches only**, the beneficiary meets NPO criteria; **AND**
- The beneficiary does not have a history of Suboxone or Subutex in the past 90 days (*State Review Required if not met*); **AND**
- For all other diagnoses other than cancer, none of the following apply:
  - 90 cumulative MME across all opioids filled in the previous 30 days, including the incoming claim
  - Two or more claims for Narcan/naloxone in the past 90 days (*State Review Required if not me*t)
  - A diagnosis for poisoning or overdose for opioids, narcotics, barbiturates, benzodiazepines, or unspecified drug or substance in the last 365 days (*State Review Required if not met).*
- Length of authorization is 6 months.

Methadone oral solution

- The beneficiary is less than or equal to 90 days of age; **AND**
- The beneficiary has a diagnosis of neonatal abstinence syndrome; **AND**
- The quantity of methadone oral solution dispensed is not more than 10mL; **AND**

- The accumulated methadone oral solution quantity between the incoming claim and any other claims within the previous 30 days do not equal more than 10mL total; **OR**
- The prescriber provides medical necessity, quantity requested, dose, and taper plan schedule.
- Length of authorization is 1 month for methadone oral solution.

Note: Routine PDL Criteria do not apply.

Therapeutic Duplication

No therapeutic duplication in drug history between long-acting narcotics

CRITERIA EFFECTIVE JULY 16, 2025

9. FABHALTA (iptacopan hcl) 200 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 or treatment duration from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with **ONE** of the following:
  - Paroxysmal nocturnal hemoglobinuria (PNH)
  - Proteinuria with Immunoglobulin A Nephropathy (IgAN) at risk of rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥1.5 g/g
  - Proteinuria with Complement 3 Glomerulopathy (C3G)
- 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 FABHALTA, 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 FABHALTA REMS program
- This medication must be prescribed by or in consultation with the following:
  - For PNH patients—hematologist or oncologist
  - For IgAN patients—nephrologist
  - For C3G patients—nephrologist
- Beneficiary does not have severe hepatic impairment (Child-Pugh class C)
- Beneficiary does not have an active serious infection caused by encapsulated bacteria, including *Streptococcus pneumonia*, *Neisseria meningitidis*, or *Haemophilus influenzae type b*
- Beneficiary of reproductive potential should not be pregnant or breastfeeding
- Beneficiary with PNH
  - Beneficiary currently taking eculizumab (SOLIRIS) or ravulizumab (ULTOMIRIS) must follow the required dose initiation per the package insert
  - Beneficiary must be clinically symptomatic (e.g., fatigue, dyspnea, pain, thrombosis, etc.) and have abnormal labs (e.g., low hemoglobin (Hgb), high lactate dehydrogenase (LDH), etc.)
  - Beneficiary has baseline Hgb level < 10 g/dL with or without previous C5 inhibitors
  - Beneficiary must not be receiving Fabhalta in combination with other complement inhibitors used to treat PNH (i.e., Empaveli, Piasky, Soliris, Ultomiris, Voydeya)
  - Prescribers must submit the following
    - Current chart notes
    - Documented symptoms as a baseline
    - Previous therapies
    - Current labs including complete blood count (CBD), comprehensive metabolic panel, and lactate dehydrogenase
    - Recent history of blood transfusions
- Beneficiary with IgAN

    - Beneficiary must demonstrate continued risk for disease progression with proteinuria ≥ 0.5 g/day, despite at least 3 months of maximally tolerated supportive care (i.e., angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blocker (ARB), immunosuppressive therapy, sodium-glucose co-transporter 2 (SGLT2) inhibitor)
    - Beneficiary must remain on supportive care at maximally tolerated doses unless contraindicated
    - Beneficiary must have had a previous trial and failure of Tarpeyo (budesonide delayed-release capsule) unless contraindicated for this patient
    - Prescribers must submit the following:
        - Current chart notes
        - Previous therapies
        - Current labs including LFTs, eGFR, lipid panel, and urine protein or UPCR
        - Confirmation of IgAN diagnosis with renal biopsy results and labs
        - Medical necessity over the use of typical supportive care (i.e., ACEi, ARB, SGLT2), Tarpeyo, Filspari, and Vanrafia.
- Beneficiary with C3G
    - Beneficiary must have tried and failed mycophenolate and/or cyclophosphamide and oral glucocorticoids unless there is a contraindication for this specific patient
    - Beneficiary should have tried and failed an angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blocker (ARB) at maximally tolerated doses unless contraindicated
    - Prescribers must submit the following:
        - Current chart notes
        - Previous therapies (e.g., RAS inhibitors, corticosteroids, mycophenolate)
        - Documented symptoms
        - Current labs including LFTs, eGFR, lipid panel, and urine protein or UPCR
        - Confirmation of C3G diagnosis with renal biopsy results and labs (protein-to-creatinine ratio (UPCR) ≥ 1 g/g and eGFR ≥ 30 mL/min/1.73 m^2)
        - Medical necessity over immunosuppressants and glucocorticoids

RENEWAL REQUIREMENTS:

- Beneficiary is compliant on therapy (defined as 75% utilization)
- Beneficiary with PNH
    - Beneficiary has an improvement in hemoglobin and/or LDH levels compared to baseline
    - Beneficiary has an improvement in overall clinical presentation (e.g., fatigue, dyspnea, reduction in transfusions)
    - Prescribers must submit the following:
        - Current chart notes
        - Current labs including CBC, CMP, and LDH
- Beneficiary with IgAN
    - Beneficiary has documented improvement in proteinuria with a reduction in UPCR or urine protein compared to baseline
    - Prescribers must submit the following:
        - Current chart notes
        - Current labs including LFTs, eGFR, lipid panel, and urine protein or UPCR
        - Attestation that patient has tested negative for pregnancy if of reproductive potential
- Beneficiary with C3G
    - Beneficiary has documented improvement of proteinuria with a reduction in UPCR or urine protein
    - Prescribers must submit the following:
        - Current chart notes
        - Current labs including LFTs, eGFR, lipid panel, and urine protein or UPCR
        - Attestation that patient has tested negative for pregnancy if of reproductive potential

QUANTITY EDITS:

- 200 mg - #31/31 days
- 400 mg - #31/31 days

CRITERIA EFFECTIVE JULY 16, 2025

10. **VANRAFIA (atrasentan hcl) 0.75 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 is diagnosed with primary immunoglobulin A nephropathy (IgAN) confirmed by biopsy and at risk for rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g
- Medication must be prescribed by, or in consultation with, a nephrologist
- Beneficiary must demonstrate continued risk for disease progression with proteinuria ≥ 0.5 g/day, despite at least 3 months of maximally tolerated supportive care (i.e., angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blocker (ARB), immunosuppressive therapy, sodium-glucose co-transporter 2 (SGLT2) inhibitor)
- Beneficiary must remain on supportive care at maximally tolerated doses unless contraindicated
- Beneficiary of reproductive potential should have a negative pregnancy test prior to beginning this medication and use effective contraception throughout the use of this medication
- Beneficiary does not have severe hepatic impairment
- Prescribers must submit the following:
    - Current chart notes
    - Previous therapies
    - Current labs including LFTs, eGFR (≥ 30 mL/min/1.73m^2), lipid panel, and urine protein or UPCR
    - Confirmation of the IgAN diagnosis with renal biopsy results and labs
    - Attestation that patient has tested negative for pregnancy if of reproductive potential

RENEWAL REQUIREMENTS:

- Beneficiary has been compliant with therapy (defined as: 75% utilization)
- Beneficiary has documented improvement in proteinuria with a reduction in urine protein-to-creatinine ratio (UPCR) or urine protein from baseline
- Prescribers must submit the following:
    - Current chart notes
    - Current labs including LFTs, eGFR, lipid panel, and urine protein or UPCR
    - Attestation that the patient of reproductive potential has tested negative for pregnancy and beneficiary remains on contraception

QUANTITY EDITS:

#31/ 31 days

CRITERIA EFFECTIVE JULY 16, 2025

11. **VYKAT XR (diazoxide choline) 25 mg, 75 mg, and 150 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 hyperphagia associated with Prader-Willi syndrome (PWS)
- Beneficiary must not be pregnant or breastfeeding
- Beneficiary should not exceed a dose of 5.8 mg/kg/day or 525 mg per day
- Beneficiary must exhibit hyperphagia with food seeking behavior with patient specific behaviors to include some of the following:
    - Frequency of foraging through trash for food

    - Frequency of sneaking or stealing food
    - Frequency of continued asking for food despite being told “no”
    - Becomes upset or distressed when denied food
    - Seems to constantly think about food
- Prescribers must submit the following:
    - Current chart notes
    - Genetic testing results confirming diagnosis of PWS
    - Patient specific clinical manifestations with examples of food seeking behavior
    - Current weight and BMI as baseline and dose verification
    - Current labs including fasting blood glucose (FBG) and HbA1c as a baseline (FBG should be monitored at least once every week for the first 2 weeks, then at least once every 4 weeks, and as clinically indicated.)
    - Specific plan to ensure that the patient is in a food-secure environment with strict limitation of food intake
- Initial PA for 4 months

RENEWAL REQUIREMENTS:

- Beneficiary must remain compliant on therapy (defined as 75% utilization)
- Beneficiary must demonstrate a positive response to treatment with a decrease in caregiver identified hyperphagia events compared to baseline
- Prescribers must submit the following:
    - Current chart notes
    - Current food seeking behavior update
    - Current weight and BMI
    - Current fasting blood glucose and HbA1c
    - Documentation of signs of fluid overload

QUANTITY EDITS:

- 25mg #120/30 days
- 75 mg #90/30 days
- 150 mg #90/30 days

CRITERIA EFFECTIVE JULY 16, 2025

12. QFITLIA (fitusiran sodium) 50 mg/0.5 mL pen and 20 mg/0.2 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 or treatment duration from the manufacturer’s package insert or based on support from the official Compendia
- Beneficiary requires routine prophylaxis to prevent or reduce the frequency of bleeding episodes and is diagnosed with hemophilia A or B with or without factor VIII or factor IX inhibitors
- Beneficiaries must meet **ONE** of the following for confirming disease severity:
    - Severe disease with < 1% of factor VIII or factor IX in blood; **OR**
    - Moderate disease with 1-5% of factor VIII or factor IX in blood with **ONE** of the following (prescriber must submit letter of medical necessity and chart notes to support):
        - History of spontaneous bleeding episodes into the central nervous system or other serious life-threatening bleed; **OR**
        - At least two (2) joint bleeds causing hemophilia-related joint damage; **OR**
        - Poor venous access; **OR**
        - High Factor VIII or Factor IX dose
- Beneficiary with inhibitors must meet **ONE** of the following:
    - High factor VIII or IX inhibitor titer (≥5 Bethesda units per mL (BU)); **OR**

  - Factor VIII or IX inhibitor titer <5 BU/mL with inadequate response to high dose factor;
- Beneficiary must have an antithrombin (AT) activity ≥ 60% prior to beginning QFITLIA
- Request must be submitted by, or in consultation with, a hemophilia specialist or hemophilia treatment center
- Beneficiary should not be prescribed prophylaxis Factor doses (e.g., FVIII, FIX, or bypassing agents)
- Beneficiary should not be prescribed QFITLIA for breakthrough bleeding
- For a beneficiary with history of symptomatic gallbladder disease, the prescriber should consider an alternative treatment and consider interruption or discontinuation if gallbladder disease occurs after beginning treatment
- Beneficiary should not have hepatic impairment (Child-Pugh A, B, or C)
- Prescribers must submit the following:
  - Chart notes for the last 24 weeks with summary of bleeding events
  - Previous therapies tried with timeline and response (prophylaxis and acute treatment)
  - Baseline factor activity, current antithrombin activity, and annualized bleeding rate
  - Current labs including CBC and LFTs
  - Documentation of **ONE** of the following for beneficiaries with inhibitors:
    - Inadequate response to Immune Tolerance Induction (ITI); **OR**
    - Rationale why the beneficiary is not a candidate for ITI;
  - Negative pregnancy test results if applicable
  - Attestation that female beneficiary of reproductive potential has been counseled on the importance of effective contraception
  - Attestation that beneficiary has been counseled on proper technique on episodic treatment with factor VIII or factor IX products as needed for breakthrough bleeding episodes
  - Medical necessity over prophylaxis factor products and HEMLIBRA for hemophilia A
- Initial PA will be for 3 months; renewal PAs may be approved for up to 6 months.

RENEWAL REQUIREMENTS:

- Beneficiary is compliant on therapy (defined as 75% utilization)
- Beneficiary must demonstrate a decrease in annualized bleeding rate and antithrombin (AT) activity compared to baseline
- Beneficiary with antithrombin activity outside of the desired range of 15-35% will require dose modification
  - AT activity <15% will require a dose decrease
  - AT activity >35% after 6 months will require a dose increase
- Beneficiary should discontinue the medication if the AT level remains <15% despite a 10 mg dose every 2 months
- Prescribers must submit the following:
  - Current chart notes
  - Current labs including CBC and antithrombin activity
  - Current requested dose
  - Summary of bleeds since last PA

QUANTITY EDITS:

- 20 mg vial—1 every 2 months
- 50mg pen—1 every 2 months
- *Dose modification to monthly dosing will require an additional override

CRITERIA EFFECTIVE JULY 16, 2025

13. **VYVGART HYTRULO (efgartigimod-hyaluronidase-qvfc) 1000 mg/5 mL syringe**

NOTE: Vials are medical benefit only.

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 **ONE** of the following:
    - Generalized myasthenia gravis (gMG) and is anti-acetylcholine receptor (AChR) antibody positive; **OR**
    - Chronic inflammatory demyelinating polyneuropathy (CIDP)
- Must be prescribed by, or in consultation with, a neurologist or a specialist in treating gMG or CIDP
- Beneficiary must not be prescribed concomitant treatment with a complement inhibitor (e.g., Soliris, Ultomiris, Zilbrysq) or another neonatal Fc receptor blocker (e.g., Rystiggo)
- Beneficiary with gMG
    - Must have a positive serologic test for anti-acetylcholine receptor (AChR) antibodies
    - Must have a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification II to IV
    - Must have MG-Activities of Daily Living (MGADL) total score ≥5
    - Must have tried and failed while on stable doses either an acetylcholinesterase (AChE) inhibitor (e.g., pyridostigmine) or immunosuppressive therapy (e.g., glucocorticoids, azathioprine, or mycophenolate) or the beneficiary has a documented contraindication or intolerance to those agents
    - Should not receive the first dose in a new cycle sooner than 50 days from beginning of previous cycle
- Beneficiary with CIDP
    - Must have other possible disease states (such as Guillain–Barré syndrome) ruled out
    - Must have previously been treated with intravenous immunoglobin (IVIG) and glucocorticoids unless there is a contraindication to their use
- Prescribers must submit the following:
    - Current chart notes
    - Previous therapies tried
    - Attestation that patient is up to date on required vaccines prior to beginning therapy
    - Documentation of patient's clinical presentation with specific symptoms
    - For gMG patients, test results documenting presence of AChR antibodies, baseline MGFA classification, and baseline MGADL total score
    - For CIDP patients, baseline disability score (e.g., Inflammatory Neuropathy Cause and Treatment (INCAT) disability score, Rasch-built overall disability scale (RODS), Modified Rankin Score (mRS), Grip strength with Martin Vigorimeter, or Medical Research Council (MRC) scale, etc.)

RENEWAL REQUIREMENTS:

- Beneficiary has been compliant with therapy (defined as: 75% utilization)
- Beneficiary has documented improvement of patient's specific symptoms
- Prescribers must submit the following:
    - Current chart notes
    - Documentation of patient's current clinical presentation after starting the requested medication
    - For gMG patients, provide current baseline MGFA classification, current MGADL total score, and documentation of continued need for treatment of gMG
    - For CIDP patients, current disability test scores with the same test used for baseline (e.g., Inflammatory Neuropathy Cause and Treatment (INCAT) disability score, Rasch-built overall disability scale (RODS), Modified Rankin Score (mRS), Grip strength with Martin Vigorimeter, or Medical Research Council (MRC) scale, etc.)

QUANTITY EDITS:

- 4 injections per 28 days

CRITERIA EFFECTIVE JULY 16, 2025

14. **CTEXLI (chenodiol) 250 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 cerebrotendinous xanthomatosis (CTX) confirmed by genetic testing and elevated serum cholestanol and bile alcohols (23S-pentol)
- Prescribers must submit the following:
  - Current chart notes
  - Clinical presentation specific to this patient
  - Genetic testing results confirming a CYP27A1 variant is present
  - Baseline labs including LFTs, serum cholestanol and serum/urine bile alcohols levels

RENEWAL REQUIREMENTS:

- Beneficiary has been compliant with therapy (defined as: 75% utilization)
- Beneficiary has documented improvement of patient's specific symptoms and serum cholestanol and serum/urine bile alcohols levels (23S-pentol)
- Prescribers must submit the following:
  - Current chart notes
  - Clinical presentation specific to this patient after starting CTEXLI
  - Current labs including LFTs, serum cholestanol and serum/urine bile alcohols levels

QUANTITY EDITS:

- #93/ 31 days

CRITERIA EFFECTIVE JULY 16, 2025

15. **BUCAPSOL (buspirone) 7.5 mg, 10 mg, and 15 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 or treatment duration from the manufacturer's package insert or based on support from the official Compendia
- Beneficiary must be diagnosed with anxiety disorders
- Beneficiary must have tried and failed first-line maintenance medication for the treatment of anxiety (e.g., SSRI, SNRI) unless there is a contraindication
- Beneficiary must have a history of buspirone generic tablet use
- Prescriber must submit the following:
  - Current chart notes
  - Long-term treatment plan (buspirone is not typically used long-term)
  - Medical necessity over buspirone generic tablets

QUANTITY EDITS:

- 7.5 mg #62/ 31 days
- 10 mg #124/ 31 days
- 15 mg #124/ 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://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.