ARKANSAS MEDICAID PROVIDER QUARTERLY NEWSLETTER

JANUARY 2026

DRUG UTILIZATION REVIEW (DUR) BOARD UPDATE

The following will be presented during the **January 21, 2026,** DUR Board meeting.

Preferred Drug List Full Review	Hereditary Angioedema Agents and Idiopathic Pulmonary Fibrosis Agents
Preferred Drug List Abbreviated Review	Cephalosporins, HIV, Topical Antiparasitic Medications (Lice Treatment), Growth Hormones, Pancreatic Enzymes, Leukotriene Receptor Antagonists, Bronchodilators, Short-Acting Beta Agonists (SABA), Bronchodilators, Long-Acting Beta Agonists (LABA), Bronchodilators, Short Acting Muscarinic Antagonists (SAMA), Bronchodilators, Long-Acting Muscarinic Antagonists (LAMA), Bronchodilators, Combination Products (LABA/LAMA), Bronchodilators, Combination Products (ICS/LABA/LAMA), Inhaled Antibiotics
Disease State Review	Chronic Spontaneous Urticaria
Manual Review PA Criteria	Lynkuet®, Veozah®, Acthar HP®, Cortrophin®, Samsca®, Orlynvah™, Blujepa, Leqembi® Iqlik, Galzin®, Palsonify™, Revcovi®
Quantity Claim Edits	Butalbital (non-codeine) products

https://ar.primetherapeutics.com/documents/d/arkansas/dur-board-agenda-for-january-21-2026

PHYSICIAN-ADMINISTERED DRUG PRIOR AUTHORIZATION PROCESS:

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

What's Changing?

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

Additional Information:

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

THE NUMBERS LISTED BELOW ARE FOR FEE-FOR-SERVICE (FFS) SUPPORT

Prime Therapeutics Pharmacy Support Center (Pharmacy, Member, and Prior Authorization)

Help Desk Phone
1-800-424-7895
Monday – Friday
8:00 a.m. – 5:00 p.m.,
Central Time (CT)
excluding State holidays

Clinical PA Fax
1-800-424-7976
24 Hours A Day,
7 Days a Week

Division of Medical Services Pharmacy Unit
PO Box 1437, Slot S-415
Little Rock, AR 72203
Fax: 501-683-4124 OR
800-424-5851

Phone: 501-683-4120
Monday – Friday
8:00 a.m. – 5:00 p.m.,
Central Time (CT)
excluding State holidays

ARMAPP: PROVIDER PEDIATRIC MENTAL HEALTH INFORMATION AND CONSULTS AT NO-COST:

Would you like more information on current treatments for behavioral and mental health concerns for your patients? Have you ever thought, "If I could just talk to a Psychiatrist or Psychologist?" Then the ARMAPP program at UAMS and Arkansas Children's Hospital is a great option.

The ARkansas Mental Health Access in Pediatric Primary Care (ARMAPP) is an HRSA-funded program that provides behavioral and mental health education and consultation services directly to primary care providers. Enrolled providers gain access to monthly sessions focused on common behavioral and mental health issues. In addition to these educational sessions, ARMAPP offers consultations with a mental health team, including a psychiatrist and psychologist, for specific advice on medication management and behavioral resources for patients and families. These services are offered at no cost to the provider.

For more information or to enroll in ARMAPP or request a consultation, you can access the program in several ways:

- Visit the website: www.uams.health/ARMAPP
- Call the ARMAPP program: 501-364-6586
- Send an email to: ARMAPP@archildrens.org
- Use the attached QR code

Please note that the ARMAPP program does not provide crisis management, direct patient care, or direct medication management; rather, it exists to build capacity for behavioral and mental health in primary care by working directly with providers.

PSYCHIATRIC MEDICATIONS:

The focus on vulnerable children needing psychiatric care is especially important. In particular, it is important that we ensure effective psychiatric care and treatment through effective oversights on the prescribing of psychiatric medications in children.

The Arkansas Medicaid Pharmacy Program (AMPP) has greatly streamlined its prior authorization processes over the years to accommodate pharmacy outpatient prior authorizations as fast as possible. The AMPP typically responds to prior authorization requests within one (1) business day. Last August, the AMPP began accepting prescription prior authorization requests through ePA (an electronic PA system that streamlines the submission process) via CoverMyMeds. The ePA process has made requesting prior authorization even more convenient for providers and continues to shorten the turnaround time for receiving prior authorizations.

Providers can assist in streamlining PA requests by ensuring that the request is complete and contains all information needed to review and approve the request on the front end. A complete request must include all pages of the medication informed consent form. The AMPP has an updated form available which can be found at this link: Arkansas Medicaid Medication Informed Consent Behavioral or Psychiatric Conditions - Clients Under 18 years Form. AMPP recommends acute psychiatric facilities to submit the prior authorization requests prior to the day of discharge, if possible.

The AAMPP encourages any providers with questions or concerns to call the DHS Medicaid Pharmacy Program Help Desk any time, Monday-Friday from 8-5:00 at 50L-683-4120 for any assistance or needs for any member waiting on a prior authorization.

PRESCRIBING NON-OPIOID BUTALBITAL PRODUCTS:

INDICATION:

Fioricet® is indicated for the relief of the symptom complex of tension (or muscle contraction) headache.

DOSE:

- 1 or 2 capsules every 4 hours as needed. Total daily dosage should not exceed 6 capsules.
- Extended and repeated use of this product is not recommended because of the potential for physical dependence.

Per UpToDate®:

UpToDate® recommends against the routine use of opioids or barbiturates for treatment of tension type headache (TTH), in agreement with guidelines. The consensus is to reserve use of combination analgesic therapy with barbiturates such as butalbital or opioids for highly selected patients with episodic TTH who are unresponsive to simple analgesics or combination analgesics with caffeine when dose limits have been established and monitoring of therapy is in place. In addition, treatment may also be used for selected patients who are unable take NSAIDs or aspirin due to gastric ulcers or kidney failure or acetaminophen due to liver failure.

Opioids and barbiturates are known to increase propensity for overuse, which can cause or contribute to the transformation of episodic TTH to chronic TTH and medication overuse headache. Furthermore, these agents have the potential for the development of tolerance, dependency, and toxicity. Therefore, neither opioids nor barbiturates should be used in TTH when better options (e.g., simple analgesics and combination analgesics containing caffeine) are available. There are no comparative studies examining the efficacy of combination analgesics with codeine.

There is no high-quality evidence supporting the efficacy of barbiturates for acute migraine treatment. The use of opioids and butalbital is associated with an increased risk for the development of chronic migraine and medications-overuse headache.

The frequency of acute treatment should be limited to avoid medication overuse headache. Simple analgesics such as nonsteroidal anti-inflammatory drugs (NSAIDs) should be used 14 or fewer days a month, combination analgesics nine or fewer days a month, and butalbital-containing analgesics three or fewer days a month.

Recommendations for use:

- **Avoid for migraine:** Butalbital-containing medications should not be used for acute episodic migraines
- **Avoid for daily headaches:** Butalbital is not recommended for daily use for tension headaches (see below from UpToDate) due to the risk of physical dependence, tolerance, and rebound headaches associated with the barbiturate component.
- **Limit use:** To avoid medication overuse headache, also known as "rebound headache," the use of butalbital should be limited
- **Last resort only:** Butalbital should be reserved for patients who have failed to find relief with other treatments or have medical conditions preventing the use of standard-of-care medications.
- **Habit-forming:** All butalbital products carry a risk of physical dependence and can have pronounced sedative effects.

Resources:

1. https://www.uptodate.com/contents/tension-type-headache-in-adults-acute-treatment?search=butalbital%20guideline&source=search_result&selectedTitle=8~14&usage_type=default&display_rank=7
2. Wiley A, Watson J, et al. Acute Migraine Headache: Treatment Strategies. *Am Fam Physician.* 2025;111(4):317-327
3. Overview | Headaches in over 12s: diagnosis and management | Guidance | NICE
4. American Geriatrics Society 2023 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults. *J Am Geriatr Soc*. 2023;71:2052-2081.
5. Langer-Gould A, Anderson W, et al. The American Academy of Neurology's Top Five Choosing Wisely Recommendations. *Neurology.* 2013;81(11):1004-1011

RARE DISEASE SUMMARY

A rare disease is defined as a medical condition that affects a small percentage of the population. In the United States, it is any disease that affects fewer than 200,000 Americans. Globally, the definition varies by country, but in the United Kingdom, rare diseases are those that affect fewer than 1 in 2,000 people.

About 80% of rare diseases have a genetic component and only about 400 have therapies, according to Rare Genomics Institute. Chronic genetic diseases are commonly classified as rare. Among numerous possibilities, rare diseases may result from bacterial or viral infections, allergies, chromosome disorders, degenerative and proliferative causes, affecting any organ.
Rare diseases may be chronic or incurable, although many short-term medication conditions are also rare diseases.

Other interesting facts about rare diseases:

- Currently, over 7,000 rare diseases have been identified.
- 25-30 million Americans are living with a rare disease, and an estimated 350 million people worldwide have a rare disease.
- Many rare diseases may result in the premature death of infants or can be fatal in early childhood.
- All pediatric cancers are rare, and there are more than 500 types of rare cancers.
- More than 90% of rare diseases are still without an FDA-approved treatment.

Resources:

- https://en.wikipedia.org/wiki/Rare_disease
- https://rarediseases.org/understanding-rare-disease/

Rare diseases being discussed in the January 2026 DUR Board meeting:

1) **Wilson's Disease**

Wilson's disease (also referred to as hepatolenticular degeneration) is a genetic disorder of copper metabolism with an autosomal recessive pattern of inheritance that leads to impaired function of the intracellular copper transporter ATP7B. Reduced biliary excretion of copper results in its accumulation in the liver and other tissues (e.g., brain, cornea). Most patients have liver involvement that may range from asymptomatic elevations in liver

biochemistries (e.g., serum aminotransferases, bilirubin) to cirrhosis or acute liver failure. Some patients develop symptoms related to neurologic involvement.

The reported rates of organ-specific manifestations at the time of presentation vary widely:

- Liver disease: 18 to 84 percent of patients
- Neurologic symptoms: 18 to 73 percent of patients
- Psychiatric symptoms: 10 to 100 percent of patients

Lab levels for diagnosis:

- Patients with Kayser-Fleischer (KF) rings
  - 24-hour urinary copper excretion >40 mcg/24 hours (0.64 micromol/24 hours) in addition to ceruloplasmin <20 mg/dL (200 mg/L), or
  - 24-hour urinary copper excretion >100 mcg/24 hours (1.6 micromol/24 hours), regardless of ceruloplasmin level
- Patients without Kayser-Fleischer (KF) rings
  - 24-hour urinary copper excretion >100 mcg/24 hours (1.6 micromol/24 hours) in addition to ceruloplasmin <10 mg/dL (<100 mg/L)
  - with ceruloplasmin ≥10 mg/dL and 24-hour urinary copper excretion ≤40 mcg/24 hours (0.64 micromol/24 hours), the diagnosis of Wilson disease is excluded.

Treatment goals

- Removing copper that has accumulated in tissue
- Preventing copper from reaccumulating in tissue
- Improving symptoms (or preventing the development of symptoms)
- Improving and maintaining liver synthetic function (e.g., resolve jaundice and ascites, correct abnormalities in coagulation and serum albumin)

Management after progression of liver disease despite treatment

- Try alternative chelating agent
- Switch to zinc acetate which has the best absorption (zinc gluconate is alternative)
- Use combination therapy with chelating agent and zinc
- Evaluation for liver transplant

Resources:

- https://www.uptodate.com/contents/wilson-disease-clinical-manifestations-diagnosis-and-natural-history?search=wilson%20disease&source=search_result&selectedTitle=1~145&usage_type=default&display_rank=1
- https://www.uptodate.com/contents/wilson-disease-management?search=wilson%20disease&source=search_result&selectedTitle=2~145&usage_type=default&display_rank=2

2) Acromegaly

Acromegaly results from persistent hypersecretion of growth hormone (GH). Excess GH stimulates excessive hepatic secretion of insulin-like growth factor-1 (IGF-1), which causes most of the clinical manifestations of acromegaly.

When to consider acromegaly (has symptoms of growth hormone excess):

- Enlarged jaw, hands and feet; course facial features
- Cardiovascular disease, HTN, sleep apnea, Type 2 DM, arthropathies, carpal tunnel or features related to pituitary adenoma size (e.g., headache, vision loss)
- Cluster of any of the following with or without facial features
    - Sleep apnea, diabetes, carpal tunnel syndrome, colon polyps, cardiac failure with hypertension
    - Jaw prognathism or new-onset severe snoring or sleep apnea in a person without obesity
    - Presence of a pituitary macroadenoma revealed by magnetic resonance imaging (MRI); 75 to 80 percent of somatotroph adenomas are macroadenomas at the time of diagnosis. Some patients may be asymptomatic despite raised GH and insulin-like growth factor-1 (IGF-1) levels.

Some causes of acromegaly

- Primary GH excess
    - GH-cell adenoma
    - Mixed cell adenoma
    - Multiple endocrine neoplasia type 1
    - Familial acromegaly
- GH excess (ectopic or iatrogenic)
    - Pancreatic islet-cell tumor
    - Lymphoma
- Growth Hormone-Releasing Hormone (GNRH) excess

Primary Medical Therapy

Transsphenoidal surgery is recommended as initial step in treatment. Patients for whom a medication can be considered as primary therapy include:

- Have an adenoma that does not appear to be fully resectable
- Are poor surgical candidates for or decline surgery
- Would benefit from preoperative medication to allow easier intubation by reducing severe laryngeal swelling and macroglossia and to improve obstructive apnea or cardiac dysfunction

Treatment of residual disease

- Repeat surgery
- Medical therapy for patients with abnormal IGF-1 and moderate symptoms of GH excess after surgery or not eligible for surgery
    - Somatostatin receptor ligands—inhibit GH secretion and shrink adenoma in some patients
        - Long-acting octreotide (Sandostatin LAR) and lanreotide (Somatuline Depot)
        - Pasireotide LAR (Signifor LAR)
        - Oral octreotide (Mycapssa)

        - Oral paltusotine (Palsonify)
    - Pegvisomant (Somavert)—GH receptor antagonist
    - Combination therapy of pegvisomant and SRL
    - Dopamine agonists (cabergoline)
- Radiation therapy—used for those not controlled by surgery or medical therapy

Resources:

- https://www.uptodate.com/contents/diagnosis-of-acromegaly?search=acromegaly&source=search_result&selectedTitle=1~78&usage_type=default&display_rank=1
- https://www.uptodate.com/contents/treatment-of-acromegaly?search=acromegaly&source=search_result&selectedTitle=2~78&usage_type=default&display_rank=2

3) Adenosine deaminase severe combined immune deficiency (ADA-SCID)

Adenosine deaminase (ADA) deficiency is an autosomal recessive genetic disorder. In approximately 80 to 90 percent of cases, it leads to a severe combined immunodeficiency (ADA-SCID) with dysfunction of T, B, and natural killer cells (T-B-NK- SCID) that presents in the first few months of life. ADA-SCID is often fatal in the first year or two of life without treatment.

Early intervention is critical since life-threatening, severe or opportunistic infections are common in the first weeks or months of life. Furthermore, the accumulation of toxic metabolites may interfere irreversibly with the development of the immune system, as well as pulmonary, gastrointestinal, neurologic, and other organ systems.

Protective measures:

- Minimize exposure to contagious illnesses
- Receive prophylactic antibiotics (e.g., *Pneumocystis jirovecii* pneumonia)
    - Trimethoprim-sulfamethoxazole
    - Pentamidine
    - Atovaquone
- No live vaccines and CMV positive blood products
- Immune globulin replacement therapy should be given
- Newly diagnosed infants should get enzyme replacement therapy (ERT) to help stabilize clinical status, restore immune function, and prevent damage to other tissues and organs prior to receiving definitive therapy

Bovine ADA formulation (pegademase) is no longer manufactured. Now a recombinant bovine ADA formulation (elapegademase) has replaced the older product. The initial clinical effects of PEG-ADA ERT are often good, especially when started in the first few months of life and in the absence of infections. Patients often see improvement in nutritional status, RBC total dAXP, B and natural killer cell numbers and antibody production, T cell numbers, hepatocellular abnormalities, pulmonary alveolar proteinosis, and bone dysplasia.

Resources:

- Kohn DB, Hershfield MS, Puck JM, et al. (2019). Consensus approach for the management of severe combined immune deficiency caused by adenosine deaminase deficiency. *The Journal of Allergy and Clinical Immunology*, *143*(3):852-863.; 143:852-863
- Grunebaum, E., Booth, C., Cuvelier, G. D. E., Loves, R., Aiuti, A., & Kohn, D. B. (2023). Updated Management Guidelines for Adenosine Deaminase Deficiency. *The Journal of Allergy and Clinical Immunology: In Practice, 11*(6), 1665–1675. https://doi.org/10.1016/j.jaip.2023.01.032
- Adenosine Deaminase Deficiency-genetic and Rare Diseases Information Center. US Department of Health and Human Services-NIH.
- https://www.uptodate.com/contents/adenosine-deaminase-deficiency-treatment-and-prognosis?search=adenosine%20deaminase%20immune%20deficiency&topicRef=3907&source=see_link#H792410350

NEW FDA APPROVED MEDICATIONS IN Q4 2025-2026 WITH SUMMARY OF MEDICAID COVERAGE

NEW FDA APPROVED MEDS Q4 2025-2026	INDICATION	AR MEDICAID COVERAGE
LASIX ONYU*	EDEMA IN CHF	MANUAL REVIEW WITH SAME CRITERIA AS FUROSCIX
EYDENZELT*	BIOSIMILAR TO EYLEA	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY
JASCAYD	PULMONARY FIBROSIS	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
CONTEPO*	COMPLICATED UTI	TO BE DETERMINED
JAVADIN	HYPERTENSION	MANUAL REVIEW WITH NECESSITY OVER SOLID ORAL CLONIDINE
LYNKUET	VASOMOTOR SYMPTOMS	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
KOMZIFTI	AML	MANUAL REVIEW USING THE ONCOLOGY CRITERIA
REDEMPLO	FAMILIAL CHYLOMICRONEMIA	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
HYRNUO	NSCLC	MANUAL REVIEW USING THE ONCOLOGY CRITERIA
OSVYRTI* & BONCRESA*	BIOSIMILAR TO PROLIA	NONPREFERRED IN THE OSTEOPOROSIS CLASS WITH PROLIA CRITERIA
JUBEREQ* & OZILTUS*	BIOSIMILAR TO XGEVA	MANUAL REVIEW WITH XGEVA CRITERIA
ITVISMA	SMA	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY
VOYXACT	IGA NEPHROPATHY	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
ARMLUPEG*	BIOSIMILAR TO NEULASTA	TO BE DETERMINED
WASKYRA*	WISKOTT-ALDRICH	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY
CARDAMYST*	TACHYCARDIA	TO BE DETERMINED
LEROCHOL*	HYPERCHOLESTEROLEMIA	NONPREFERRED IN PCSK9 INHIBITOR CLASS
EXDENSUR	SEVERE ASTHMA	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY

RYBREVANT FASPRO	NSCLC	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY
MYQORZO*	CARDIOMYOPATHY	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
NUFYMCO*	BIOSIMILAR TO LUCENTIS	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY
AQVESME	ANEMIA W/ THALASSEMIA	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
NEREUS*	MOTION SICKNESS	TO BE DETERMINED

*Not available on the market at the time of this newsletter release or not yet rebate eligible.
https://www.drugs.com/newdrugs-archive/2025.html

USEFUL LINKS/PHONE NUMBERS

DHS webpage
(contains official notices and other information for providers and clients)
https://humanservices.arkansas.gov/divisions-shared-services/medical- services/helpful-information-for-providers/

DHS provider manuals
https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/

Arkansas Foundation for Medical Care (AFMC)
If you are having billing issues for vaccines and other medical professional claims, contact AFMC or your outreach specialist.
https://www.afmc.org/
https://medicaid.afmc.org/services/arkansas-medicaid-management-information-system

AFMC PHONE: 479-649-8501
AFMC FAX: 479-649-0799

DME billing assistance
Kara Orvin phone: 501-630-6064
Kara.L.Orvin@dhs.arkansas.gov

Third Party Liability (TPL) phone: 501-537-1070

Provider Assistance Center (PAC)
For questions about individual or pharmacy enrollment, please contact the provider assistance center.
Provider Assistance Center (PAC) in Arkansas: 800-457-4454
Provider Assistance Center (PAC) from out of state: 501-376-2211

Opioid guidance

- https://ar.primetherapeutics.com/provider-documents
- https://www.cdc.gov/drugoverdose/
- https://www.samhsa.gov/medication-assisted-treatment
- The Dangers Of Mixing Benzodiazepines With Opiates - Opioid Treatment
- https://www.rehabs.com/blog/the-polypharmacy-overdose-a-killer-trend/
- https://narcansas.com/
- https://afmc-analytics.maps.arcgis.com/apps/MapSeries/index.html?appid=2977d338de974451af5ce8ff24d2a30c
- https://www.cdc.gov/overdose-prevention/

DUR BOARD MEETING DATES

January 21, 2026
April 15, 2026
July 15, 2026
October 21, 2026