ARKANSAS MEDICAID PROVIDER QUARTERLY NEWSLETTER

OCTOBER 2025

DRUG UTILIZATION REVIEW (DUR) BOARD UPDATE

The following will be presented during the **October 15, 2025,** DUR Board meeting.

Preferred Drug List Full Review	tetracycline agents, topical antibiotics, butalbital agents without codeine, androgenic agents
Preferred Drug List Abbreviated Review	targeted immunomodulators, Alzheimer's agents, anti-Parkinson's agents, bowel prep agents, hepatitis C medications, HMG-CoA reductase inhibitors, immune globulins, neuropathic pain agents, penicillamine/cystine-depleting agents, phosphate removing agents, platelet aggregation inhibitors, proton pump inhibitors, sedative hypnotics
Disease State Review	Bullous Pemphigoid
Manual Review PA Criteria	Empaveli® (pegcetacoplan), Wegovy® (semaglutide), Rezdiffra® (resmetirom), Sephience™ (sepiapterin), Harliku™ (nitisinone), Ekterly® (sebetralstat), Andembry® (garadacimab), Dawnzera™ (donidalorsen), Anzupgo® (delgocitinib), Egrifta WR™ (tesamorelin), Egrifta SV® (tesamorelin), Brinsupri™ (brensocatib), Zelsuvmi™ (berdazimer)

https://ar.primetherapeutics.com/documents/d/arkansas/dur-board-agenda-for-october-15-2025

PHYSICIAN-ADMINISTERED DRUG PRIOR AUTHORIZATION PROCESS:

Tentatively, in early 2026, Arkansas Medicaid will partner with Prime Therapeutics to process prior authorization requests for physician-administered drugs. Prescribing providers must submit physician-administered drug authorization requests to Prime Therapeutics either:

- By fax: 800-424-7976 or
- Electronically: via CoverMyMeds

Medical billing will continue to be processed through the provider portal. Official notice with start date and FAQ resources will be coming soon.

MANUFACTURERS LEAVING THE MEDICAID DRUG REBATE PROGRAM:

Arkansas Medicaid, as directed by the Medicaid Drug Rebate Program (MDRP), will only pay for a drug billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A "covered labeler" is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. Information on covered labelers can be found at the following site https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/newreinstated-terminated-labeler-information

On October 1, 2025, multiple manufacturers chose to leave the Medicaid Drug Rebate Program including Salerno Pharmaceuticals, Gemini Pharmaceuticals, SMG Pharmaceuticals, AMAG Pharmaceuticals, Monarch PCM, Circassia

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

Pharmaceuticals, Bausch Health US, Oceanside Pharmaceuticals, Santarus, Salix Pharmaceuticals, Bausch & Lomb, and Pedinol Pharmacal.

Some of the medications impacted include Diuril suspension, Xifaxan tablets, Relistor tablets, Trulance tablets, and Apriso capsules. Since these medications will no longer be covered by Arkansas Medicaid, we ask that you review any patients prescribed these medications for a treatment plan with other appropriate medications. Bausch Health has a patient assistance program available for Medicaid patients for many of the impacted medications with information found at the following site https://www.bauschhealthpap.com/.

ELECTRONIC PA (ePA) and CoverMyMeds®:

Beginning 8/1/2025, the Arkansas Medicaid Prescription Drug Program added a new functionality to accept 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

RESPIRATORY SYNCTIAL VIRUS (RSV):

American Academy of Pediatrics (AAP) no longer recommends SYNAGIS for prevention of RSV disease in infants and children. All claims for RSV immunizations in children (VFC) should be medically billed using CPT codes. No outpatient pharmacy billing claims should be submitted to Arkansas Medicaid. Please review medical billing policies for more information.

BEYFORTUS (nirsevimab)

- BEYFORTUS is available through the Vaccines for Children (VFC) program, and no prior authorization is required.
- ACIP recommends 1 dose of nirsevimab for all infants aged < 8 months born during or entering their first RSV season (50mg for infants weighing < 5kg [< 11 lb] and 100 mg for infants weighing ≥ 5kg [≥ 11 lb]). Providers should bill with procedure code 90380 or 90381.
- Either maternal vaccination during pregnancy or nirsevimab administration to the infant is recommended, but both are not needed for most infants.
- ACIP recommends 1 dose of nirsevimab (200 mg, administered as two 100 mg injections given at the same time at different injection sites) for infants and children aged 8-19 months who are increased risk for severe RSV disease and entering their second RSV season. Providers should bill with procedure code 90380 or 90381.
- The recommendations for nirsevimab apply to infants and children recommended to receive palivizumab by AAP.
- If BEYFORTUS has been given, the patient cannot be given SYNAGIS.

ENFLONSIA (clesrovimab-cfor)

- ENFLONSIA is available through the Vaccines for Children (VFC) program, and no prior authorization is required.
- ACIP recommends 1 dose of clesrovimab-cfor for all infants aged < 8 months who are not protected by maternal vaccination born during or entering their first RSV season (105 mg for all infants regardless of weight). Providers should bill with the procedure code 90382.
- An additional 105 mg dose is recommended for infants undergoing cardiac surgery with cardiopulmonary bypass.
- If ENFLONSIA has been given, the patient cannot be given SYNAGIS.

Sobi is voluntarily discontinuing the availability of SYNAGIS for RSV prophylaxis as of December 31, 2025. Effective that date, the product will no longer be manufactured, distributed, or available for purchase.

https://publications.aap.org/redbook/resources/25379/AAP-Recommendations-for-the-Prevention-of-RSV?autologincheck=redirected

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 October 2025 DUR Board meeting:

1) Complement 3 Glomerulopathy (C3G)

Complement 3 glomerulopathy (C3G) are a group of rare forms of glomerulonephritis characterized by dysregulation of the alternative complement pathway, which results in predominant C3 deposition within the glomeruli. C3 glomerulopathy is also occasionally diagnosed in older adults. Initial clinical manifestations of C3 glomerulonephritis (C3GN) may be preceded by upper respiratory tract infection, including streptococcal infections. Some cases of what may be initially diagnosed as postinfectious glomerulonephritis are ultimately found to be consistent with C3GN.

Clinical manifestations:

- Urinary abnormalities—proteinuria and/or hematuria which may present as preserved kidney function (41 percent), nephrotic syndrome (33 percent), or, less commonly, acute kidney injury or rapidly progressive glomerulonephritis (8 percent)
- Complement abnormalities—low serum C3 levels are possible
- Kidney function impairment and hypertension—patients have varying degrees of kidney function impairment along with variable rapidity of kidney function decline and some have hypertension

Treatment from UpToDate®:

- For patients with C3GN who have moderate to severe disease (characterized by proteinuria ≥1.5 g/day and/or abnormal kidney function [but not rapidly progressive disease] considered to be due to active C3GN), we suggest initial therapy with mycophenolate mofetil (MMF) and oral glucocorticoids plus supportive measures.
- However, some clinicians would treat patients who have sub-nephrotic-range proteinuria (<3 g/day) and normal kidney function with supportive measures alone and would not administer immunosuppressive therapy unless kidney function deteriorates or proteinuria worsens substantially.
- For patients with C3GN who have rapidly progressive glomerulonephritis (i.e., rapidly deteriorating kidney function and extensive crescentic glomerulonephritis on kidney biopsy), we suggest glucocorticoids in combination with either cyclophosphamide or MMF. The goal of therapy is to try to

suppress the acute inflammatory response and halt or reverse the disease course. In such patients, we typically advocate inpatient admission for initial management.

- General supportive measures in all patients with C3GN or DDD include dietary sodium and protein restriction, blood pressure control, reduction of proteinuria with renin-angiotensin inhibition, and treatment of dyslipidemia, if present. Other aspects of therapy include diuretics to control edema and maintenance of adequate nutrition.
- For patients with C3GN and moderate to severe disease who do not respond to initial therapy with MMF plus glucocorticoids, we suggest eculizumab rather than continuation of MMF plus glucocorticoid therapy.
- Kidney transplant but disease recurrence and graft loss are common and may be refractory to treatment, mostly because standard immunosuppression does not correct the underlying abnormality.
- UpToDate® has not updated iptacopan's status. It remains listed as an investigational agent.

Resources:
https://www.uptodate.com/contents/c3-glomerulopathies-dense-deposit-disease-and-c3-glomerulonephritis?search=complement%203%20glomerulopathy&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

2) **Hereditary Angioedema:**

Hereditary angioedema (HAE) is a rare disease characterized by recurrent episodes of angioedema, without urticaria or pruritus, which most often affect the skin or mucosal tissues of the upper respiratory and gastrointestinal tracts. Although the swelling is self-limited and resolves in two to five days without treatment, laryngeal involvement may cause fatal asphyxiation. The disease is usually caused by autosomal dominant mutations in SERPING1, which encodes C1 inhibitor.

The swelling that occurs in HAE due to C1INH deficiency (HAE-C1INH) results from excessive production of bradykinin, a potent vasodilatory mediator. The absence or dysfunction of C1 inhibitor leads to elevated levels of plasma bradykinin during angioedema episodes in patients with HAE-C1INH. In bradykinin-mediated angioedema, histamine and other mast cell mediators are not directly involved, which explains the lack of response to antihistamines and distinguishes this form of angioedema from the mast cell-mediated angioedema that is seen in allergic reactions and urticaria.

Types of HAE

- Type 1
  - Accounts for 85% of HAE-C1INH
  - Occurs due to C1INH deficiency
  - Plasma protein and functional C1INH levels are both low
- Type 2
  - Accounts for approximately 15%
  - Occurs due to dysfunctional C1INH protein which is available in normal or elevated amounts
  - Protein levels are normal or elevated while functional C1INH is low

Acute Treatment

- Patients should be supplied with medication for acute treatment of at least two attacks
- Early treatment of HAE attacks has been shown to improve efficacy with a decrease in time to start of improvement and resolution
- All of the first-line therapies are likely to be effective if given early
- First-line therapies
    - C1INH concentrate (Berinert, Cinryze)
    - C1 inhibitor concentrate (Ruconest)
    - Ecallantide (Kalbitor)
    - Icatibant (Firazyr or Sajazir)
    - Sebetralstat (Ekterly)
- Treatments without efficacy for acute use are androgens, tranexamic acid, steroids and antihistamines

Prophylaxis Treatment

- Outside of medications, treatment includes education, testing of family members, trigger avoidance (e.g., stress, minor trauma, anxiety, surgery, infections), planning for acute treatment, baseline labs, and plan for gynecologic or obstetric care
- Therapy options
    - C1INH concentrate—Regular injections of plasma-derived C1 inhibitor concentrate (pdC1INH) {Cinryze, Haegarda} are effective and well tolerated by nearly all patients. pdC1INH prophylaxis can be administered by intravenous (IV) or subcutaneous (SC) injection. Recombinant human C1 inhibitor (rhC1INH) {Ruconest} is not approved for long-term prophylaxis, although, in a clinical trial, prophylaxis with rhC1INH provided clinically relevant reductions in frequency of HAE attacks and was well tolerated
    - Lanadelumab (Takhzyro)—Lanadelumab is a fully human monoclonal antibody to kallikrein, which became available in the United States in 2018. It is injected at a dose of 300 mg SC every two weeks and was shown to be safe and effective. In patients who experience no attacks after six months of treatment with lanadelumab, the dose may be reduced to 300 mg every four weeks.
    - Berotralstat (Orladeyo)-- Berotralstat is a synthetic small molecule developed to inhibit plasma kallikrein, which can be administered orally as once-daily capsules (150 mg). It is effective and safe for prophylaxis of HAE attacks and was approved in the United States in 2020.
    - Garadacimab (Andembry)—Garadacimab is a fully human recombinant monoclonal antibody that inhibits activated factor XII (FXIIa) by binding to its catalytic site and blocking its proteolytic activity. In was approved in the United States in 2025 and is available in many other countries.
    - Attenuated androgens—Long-term androgen therapy is usually effective but can have significant adverse effects. It is least problematic in postpubertal males, particularly when used at a low dose. It may be tolerated by females too if the doses required to control symptoms are sufficiently low.
    - Antifibrinolytics—Antifibrinolytic agents include tranexamic acid and epsilon aminocaproic acid (EACA; also called aminocaproic acid). These are less predictably effective for preventing HAE episodes compared with pdC1INH concentrate, lanadelumab, or androgens, and some patients have problems tolerating them.

- The decision to administer long-term prophylaxis to a specific patient should consider the frequency and severity of attacks, access to emergency treatment, comorbid conditions, patient preference and experience, and failure to attain adequate control with appropriate on-demand therapies

Hereditary angioedema with normal C1 inhibitor (HAE Type 3)

Information on HAE with normal C1-INH is limited as it is a rare disorder. In HAE with normal C1-INH, it is not as clear that bradykinin is the main mediator of angioedema.

Differences between HAE-C1-INH and HAE with normal C1-INH

- Later age of onset usually into adulthood for patients with normal C1-INH
- Patients with normal C1-INH have more prominent involvement of tongue, uvula and face
- Patients with normal C1-INH have less frequent abdominal attacks
- Females are affected more often and more severely
- Patients with normal C1-INH usually have decreased frequency of symptoms
- Patients with normal C1-INH rarely have hemorrhages and easy bruising like HAE-C1-INH
- Inheritance is not as common with more asymptomatic carriers

Resources:

- https://www.haea.org/assets/img/2020MAB_guidelines.pdf
- https://www.ncbi.nlm.nih.gov/books/NBK482266/

3) **Phenylketonuria**

Phenylketonuria (PKU) is a rare autosomal recessive disorder that causes an amino acid called phenylalanine to build up in the body due to a change in the phenylalanine hydroxylase (PAH) gene. This gene would normally create an enzyme to break down phenylalanine converting to tyrosine. Without the enzyme, patients build up phenylalanine when they eat proteins and aspartame.

PKU is an inborn error that is usually diagnosed with routine newborn screening. Infants with PKU typically appear normal at birth. PKU can be diagnosed with elevated level of phenylalanine (concentrations above 1,200 micromol/L (20 mg/dL)) or molecular genetic testing showing two variants of the PAH gene.

Treatment

The goal of treatment for PKU is to keep plasma phenylalanine levels within 120-360 micromol/L (2-6 mg/dL).

- Dietary intake restriction of phenylalanine
- Kuvan/Javygtor (sapropterin hcl)
- Palynziq (pegvaliase-pqpz)
- Sephience (sepiapterin)

Resources:

- https://rarediseases.org/rare-diseases/phenylketonuria/
- https://www.uptodate.com/contents/phenylketonuria-overview?search=phenylketonuria&source=search_result&selectedTitle=1~38&usage_type=default&display_rank=1

4) Bullous Pemphigoid

Bullous pemphigoid (BP) is an autoimmune blistering disease characterized by subepithelial blister formation and the deposition of immunoglobulins and complement within the epidermal and/or mucosal basement membrane zone (BMZ). BP primarily affects the elderly and is a chronic disorder with exacerbations and remissions over the course of months to years. This autoimmune process causes intense pruritic, erythematous skin that has fluid filled blisters symmetrically across the body.

Clinical presentation

- Prodromal phase may last weeks to months with pruritic, eczematous, papular or urticaria-like lesions which many never develop blisters.
- When blisters develop, they are typically 1-3 cm and can be numerous and widespread on erythematous, urticarial, or noninflammatory base.
- When blisters rupture, there are moist erosions with crusty appearance that resolve without scarring.
- Common sites for distribution include trunk, extremities, and axillary or inguinal folds. Mucosal lesions are possible, and some patients have outbreaks that are localized.
- Other presentations include non-bullous presentations, lichen planus pemphigoids, and other rare variants.
- Patients with BP can have comorbidities such as neurological disorders (e.g., dementia, stroke, MS).

Treatment Options from UpToDate®

- Initial treatment consists of the following
  - High-potency topical corticosteroid (e.g., clobetasol propionate)
  - Oral corticosteroid (e.g., prednisone or prednisolone)
  - Doxycycline
- Chronic treatment with corticosteroid-sparing agents
  - Doxycycline
  - Dapsone
  - Methotrexate
  - Mycophenolate
  - Azathioprine
- Refractory disease
  - IVIG
  - Rituximab
  - Omalizumab
  - Dupilumab

Resources:

- https://onlinelibrary.wiley.com/doi/10.1111/jdv.18220
- https://journals.sagepub.com/doi/10.1177/12034754251351854?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed

NEW FDA APPROVED MEDICATIONS IN 2025 WITH SUMMARY OF MEDICAID COVERAGE

NEW FDA APPROVED MEDS 2025	INDICATION	AR MEDICAID COVERAGE
DATROWAY	HR+ HER2- breast cancer	Excluded in pharmacy; medical review only
GRAFAPEX	Acute myeloid leukemia or myelodysplastic syndrome	Excluded in pharmacy; medical review only
JOURNAVX	Moderate to severe acute pain	Preferred as pharmacy benefit on PDL with quantity limits
AVTOZMA	Biosimilar to Actemra	Nonpreferred in the targeted immunomodulator class
SYMBRAVO	Acute treatment of migraines	Nonpreferred in the acute migraine class
ONAPGO	Parkinson's Disease	Manual review with criteria determined by the DUR Board
EMBLAVEO	Complicated intra-abdominal infection	Available as pharmacy claim with quantity limits
GOMEKLI	Neurofibromatosis type 1 with plexiform neurofibromas	Manual review with criteria determined by the DUR Board
ROMVIMZA	Tenosynovial giant cell tumor	Manual review using the oncology criteria
OSPOMYV*	Biosimilar for Prolia®	Nonpreferred in the osteoporosis class with Prolia® criteria
XBRYK*	Biosimilar to Xgeva®	Manual review with Xgeva® criteria
MERILOG	Biosimilar to Novolog®	Nonpreferred in the insulin class
CTEXLI	Cerebrotendinous xanthomatosis	Manual review with criteria determined by the DUR Board
STOBOCLO	Biosimilar to Prolia®	Nonpreferred in the osteoporosis class with Prolia® criteria
OSENVELT	Biosimilar to Xgeva®	Manual review with Xgeva® criteria
OMLYCLO*	Biosimilar to Xolair®	Nonpreferred in the immunomodulators for asthma class
ARBLI	Hypertension and diabetic nephropathy	Nonpreferred in the HTN class
BLUJEPA	Uncomplicated urinary tract infections	Manual review with criteria determined by the DUR Board
VYKAT XR	Hyperphagia in Prader-Willi Syndrome	Manual review with criteria determined by the DUR Board
CONEXXENCE	Biosimilar to Prolia®	Nonpreferred in the osteoporosis class with Prolia® criteria
BOMYNTRA	Biosimilar to Xgeva®	Manual review with Xgeva® criteria
QFITLIA	Hemophilia A or B with or without inhibitors	Manual review with criteria determined by the DUR Board
VANRAFIA	Immunoglobulin (IgA) nephropathy	Manual review with criteria determined by the DUR Board
IMAAVY	Generalized myasthenia gravis	Excluded in pharmacy; medical review only
AVMAPKI FAKZYNJA CO-PACK	Ovarian cancer	Manual review using the oncology criteria
EMRELIS	NSCLC	Excluded in pharmacy; medical review only
TRYPTYR	Dry eyes	Nonpreferred in the dry eye PDL class
ENFLONSIA	RSV prophylaxis	ACIP recommended for VFC program

IBTROZI	NSCLC	Manual review using the oncology criteria
ANDEMBRY	Prevention of hereditary angioedema	Manual review with criteria determined by the DUR Board
LYNOZYFIC	Multiple myeloma	Excluded in pharmacy; medical review only
MEZOFY*	Schizophrenia	Nonpreferred in the antipsychotic PDL class
BREKIYA	Acute migraines	Nonpreferred in acute migraine PDL class
YUTREPIA	PAH & PH-ILD	Nonpreferred in the PAH PDL class
STARJEMZA*	Biosimilar to Stelara®	Nonpreferred in the TIMs PDL class
KHINDIVI	Adrenocortical insufficiency	Manual review with criteria determined by the DUR Board
WIDAPLIK*	Hypertension	Nonpreferred in the appropriate HTN classes
ARYNTA*	ADHD & binge eating	Nonpreferred in the ADD/ADHD PDL class
YEZTUGO	PrEP	Nonpreferred in HIV PDL class
HARLIKU	Alkaptonuria	Manual review with criteria determined by the DUR Board
ZEGFROVY*	NSCLC	Manual review using the oncology criteria
EKTERLY	Acute HAE	Manual review with criteria determined by the DUR Board
KIRSTY	Biosimilar to Novolog	Nonpreferred in insulin PDL class
ANZUPGO	Chronic hand eczema	Manual review with criteria determined by the DUR Board
SEPHIENCE	PKU	Manual review with criteria determined by the DUR Board
VIZZ	Presbyopia	To be determined
VOSTALLY*	Hypertension	Nonpreferred in HTN class
MODEYSO	Diffuse midline glioma	Manual review using the oncology criteria
HERNEXEOS	NSCLC	Manual review using the oncology criteria
BRINSUPRI	Bronchiectasis	Manual review with criteria determined by the DUR Board
TONYMA*	Fibromyalgia	To be determined
DAWNZERA	Prevention of HAE	Manual review with criteria determined by the DUR Board
WAYRILZ	ITP	Nonpreferred in the thrombopoiesis stimulating proteins class
ENBUMYST*	Edema	Manual review with criteria determined by the DUR Board
INLURIYO*	Breast cancer	Manual review using the oncology criteria
PALSONIFY*	Acromegaly	Manual review with criteria determined by the DUR Board
KEYTRUDA QLEX	Multiple cancer	Excluded in pharmacy; medical review only
BONDLIDO*	Post-herpetic neuralgia	To be determined
RHAPSIDO*	CSU	Manual review with criteria determined by the DUR Board

*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

October 15, 2025
January 21, 2026
April 15, 2026
July 15, 2026