CareSource PASSE
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Re: Summary of Formulary/Prior Authorization Changes Effective JULY 1, 2024.

Your health care is our priority. That is why we are writing to tell you that on JULY 1, 2024, there will be changes made to Arkansas Medicaid's Preferred Drug List (PDL) and CareSource PASSE's management of products not on Arkansas Medicaid's PDL. A PDL is a list of preferred drugs.

SUMMARY OF CHANGES TO THE ARKANSAS MEDICAID PDL EFFECTIVE JULY 1, 2024:

THE FOLLOWING MEDICATION(S) WILL BE PREFERRED ON THE PDL EFFECTIVE JULY 1, 2024.

Product Name	Dose(s)	Notes – If Applicable
AIRDUO®RESPICLICK AEROSOL POWDER	ALL	
ALVESCO®HFA AEROSOL WITH ADAPTER	ALL	
ARNUITY ELLIPTA®BLISTER, WITH INHALATION DEVICE	ALL	
BRIXADI®SYRINGE	ALL	
NARATRIPTAN TABLET (GENERIC for AMERGE®)	ALL	
QVAR REDIHALER® HFA AEROSOL	ALL	
SUBLOCADE® SOLUTION, EXTENDED RELEASE SYRINGE	ALL	
SUMATRIPTAN NASAL SPRAY (GENERIC for IMITREX®)	5MG, 20MG	
SUMATRIPTAN SYRINGE	6MG/0.5ML	
ZOLMITRIPTAN TABLET, ODT (GENERIC for ZOMIG®, ZOMIG® ZMT)	ALL	
DEXCOM®G6, G7	Corresponding sensor, receiver & transmitter	Now accepted on pharmacy benefit; Prior authorization & quantity limits apply • Took effect 5/1/2024
OMNIPOD-5® - DASH, GO, G6, G7	Corresponding pods & intro kit	
ONE TOUCH®ULTRA2, VERIO FLEX/REFLECT	Corresponding glucose system, test strips	
RELION TRUE METRIX®, TRUE METRIX®, TRUE METRIX® AIR	Corresponding meter, test strips	
VGO®INSULIN DEVICE	ALL	

Product Name	Dose(s)	Notes – If Applicable
BLOOD GLUCOSE & KETONE TESTING SUPPLIES, INSULIN SYRINGES	ALL	

THE FOLLOWING MEDICATION(S) WILL BE NON-PREFERRED ON THE PDL EFFECTIVE JULY 1, 2024

Product Name	Dose(s)	Notes – If Applicable
AMITIZA®CAPSULE	ALL	
FLUTICASONE HFA AEROSOL WITH ADAPTER (GENERIC for FLOVENT HFA®)	ALL	
PREZISTA®TABLET	600MG, 800MG	
RETACRIT®VIAL	ALL	CSL Vifor brand only is non-preferred; Pfizer brand remains preferred with criteria • Took effect 4/5/2024
SABRIL®POWDER PACKET	500MG	
TREPROSTINIL VIAL (GENERIC for REMODULIN®)	ALL	
ZOLMITRIPTAN SPRAY, NON-AEROSOL (Generic for ZOMIG®)	5MG	

THE FOLLOWING MEDICATION(S) HAVE A CHANGE IN PRIOR AUTHORIZATION/CRITERIA ON THE PDL EFFECTIVE JULY 1, 2024

Product Name	Dose(s)	Notes – If Applicable
ADALIMUMAB-AATY(CF) SYRINGE, KIT (YUFLYMA®-HUMIRA® biosimilar)	ALL	New prior authorization criteria. Took effect 4/12/2024
ADALIMUMAB-AATY(CF) AUTO-INJECTOR/ SYRINGE, KIT (YUFLYMA® - HUMIRA® biosimilar)	ALL	New quantity limit. Took effect 4/12/2024
ADALIMUMAB-ADBM(CF) PS-UV, CYLTEZO® (CF) PSORIA-UV (HUMIRA® PEN biosimilar)	40MG	New quantity limit. Took effect 5/1/2024
ADALIMUMAB-ADBM(CF) SYRINGE/PEN (CYLTEZO®-HUMIRA® biosimilar)	40 MG	New quantity limit. Took effect 5/1/2024
ADALIMUMAB-ADBM(CF) CRHN & CYLTEZO®(CF) CRH-UC-HS PEN - HUMIRA® biosimilar)	40MG	New quantity limit. Took effect 5/1/2024
BUDESONIDE AMPULES FOR NEBULIZER (GENERIC for PULMICORT RESPULES®)	ALL	New quantity limit

Product Name	Dose(s)	Notes – If Applicable
CHLORPROMAZINE VIAL (GENERIC for THORAZINE®)	25 MG/ML	New prior authorization criteria. Took effect 4/3/2024
EMZAHH TABLET (GENERIC for ORTHO MICRONOR®)	0.35 MG	New prior authorization criteria. Took effect 4/12/2024
FRAICHE®5000 GEL	ALL	New prior authorization criteria & quantity limit. Took effect 3/12/2024
INGREZZA®CAPSULE	ALL	New quantity limit. Took effect 5/6/2024
LAGEVRIO®CAPSULE	200MG	New prior authorization criteria. Took effect 5/10/2024
LIBERVANT®BUCCAL FILM	ALL	New prior authorization criteria. Took effect 4/26/2024
LYMEPAK®TABLET	100MG	New prior authorization criteria. Took effect 4/24/2024
OMVOH 100 MG/ML SYRINGE	10MG	New prior authorization criteria; Took effect 5/9/2024
OPSYNVI®TABLET	10-40MG	New quantity limit. Took effect 3/28/2024
RIZATRIPTAN TABLET, MLT (GENERIC for MAXALT®, MAXALT®MLT)	5MG, 10MG	Preferred without criteria; Update to remove criteria
SIMLANDI®(CF) AUTO-INJECTOR	40MG/0.4ML	New prior authorization criteria. Took effect 3/22/2024
SITAGLIPTIN TABLET (GENERIC for ZITUVIO®)	ALL	New quantity limit. Took effect 4/1/2024
SUMATRIPTAN KIT REFILL (GENERIC for IMITREX®)	ALL	Preferred with criteria; Update to add criteria
SUMATRIPTAN SUCCINATE TABLET (GENERIC for IMITREX®)	ALL	Preferred without criteria; Update to remove criteria
SUMATRIPTAN VIAL (GENERIC for IMITREX®)	6MG/0.5ML	Preferred with criteria; Update to add criteria
TALZENNA®CAPSULE	0.5MG	New prior authorization criteria & quantity limit; Took effect 4/17/2024 & 5/17/2024
TALZENNA®CAPSULE	0.75MG	New prior authorization criteria & quantity limit. Took effect 5/17/2024
TALZENNA®CAPSULE	0.25MG, 0.35MG, 1MG	New prior authorization criteria. Took effect 4/17/2024
VIVITROL® SUSPENSION, EXTENDED RELEASE	380MG	Preferred without criteria; Update to remove criteria
XCOPRI®TABLET	25MG	New quantity limit. Took effect 4/22/2024
XOLAIR®AUTO-INJECTOR, SYRINGE, VIAL	ALL	New indication/prior authorization criteria

SUMMARY OF CHANGES TO PRODUCTS NOT ON THE ARKANSAS MEDICAID PDL EFFECTIVE JULY 1, 2024:

THE FOLLOWING MEDICATION(S) HAVE A CHANGE IN PRIOR AUTHORIZATION/CRITERIA EFFECTIVE JULY 1, 2024.

Product Name	Dose(s)	Notes – If Applicable
ADZYNMA® KIT	ALL	Medical benefit with medical necessity
CASGEVY® VIAL	ALL	
CRESEMBA®VIAL	ALL	
IDOSE®TR IMPLANT	ALL	
LYFGENIA® INJECTION	ALL	
PANHEMATIN®VIAL	ALL	Prior authorization is required for medical benefit code: J1640

What should you do?
First, talk to your prescriber. There are a few ways you and your prescriber can find medication information:

- You can look on our website at **CareSourcePASSE.com**. On the Members page, under Tools & Resources click on “Find My Prescriptions”.
- Or, call our Member Services Department at **1-833-230-2005 (TDD/TTY: 711).**

We are here to help you. The CareSource PASSE Member Services Department is open Monday through Friday, 8 a.m. to 5 p.m. CST.

Sincerely,

CareSource PASSE

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