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

Your health care is our priority. That is why we are writing to tell you that on OCTOBER 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 OCTOBER 1, 2024.

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

Product Name	Dose(s)	Notes – If Applicable
ADDERALL® XR CAPSULE	ALL	Update – Remains Preferred; *Effective 9/1/2024
AMPHETAMINE/ DEXTROAMPHETAMINE ER CAPSULE (GENERIC for ADDERALL	ALL	Preferred; Prior authorization is required; *Took effect 7/1/2024
AMPYRA®& GENERIC DALFAMPRIDINE EXTENDED RELEASE	ALL	Preferred without prior authorization
ASMANEX® HFA	ALL	Preferred without prior authorization; *Took effect 7/1/2024
CONCERTA®TABLET	ALL	Update – Remains Preferred; *Effective 9/1/2024
ESTRADIOL (GENERIC for ESTRACE®) CREAM	ALL	Preferred without prior authorization
FINGOLIMOD (GENERIC for GILENYA®) CAPSULE	ALL	Preferred without prior authorization
KESIMPTA®PEN		Preferred; Prior authorization is required
METHYLPHENIDATE ER TABLET (GENERIC for CONCERTA®)	ALL	Preferred; Prior authorization is required; *Took effect 7/1/2024
SEVELAMER CARBONATE TABLET (GENERIC for RENVELA®)	ALL	Preferred without prior authorization; *Took effect 7/1/2024
TERIFLUNOMIDE (GENERIC for AUBAGIO®) TABLET	ALL	Preferred without prior authorization

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

Product Name	Dose(s)	Notes – If Applicable
EPINEPHRINE AUTO INJECTOR	0.15MG, 0.3MG	NDCs added as non-preferred: 115169549,00093598627, 00115169449 & 00093598527; *Took effect 7/1/2024
FLOVENT® DISKUS & HFA	ALL	Non-Preferred; *Took effect 7/1/2024
RENVELA®TABLET	ALL	Non-Preferred; *Effective 9/1/2024
SUMATRIPTAN (GENERIC for IMITREX®) SYRINGE	6MG/0.5ML	Correction - Remains Non-Preferred; *Took effect 7/1/2024

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

Product Name	Dose(s)	Notes – If Applicable
ADALIMUMAB-RYVK (CF) (Generic for SIMLANDI®) SYRINGE	40MG	Updated criteria & quantity limit to 2 units per 21 days; *Took effect 719/2024
ADBRY®AUTO INJECTOR	300MG/2ML	Updated quantity limit to 4 units per 23 days; *Took effect 7/1/2024
ARNUITY ELLIPTA®BLISTER, WITH INHALATION DEVICE	100MCG, 200MCG	Updated quantity limit to 1inhaler (30 units) per 23 days; *Took effect 7/1/2024
AUSTEDO ® XR TABLET & DOSE PACK	18MG, (12-18-24-30MG)	Updated quantity limit to 1 tablet per day; *Took effect 7/2/2024
CARBAMAZEPINE (Generic for TEGRETOL®) ORAL SUSPENSION	100 MG/5ML	Updated age limit; *Took effect 8/1/2024
CLINDAMYCIN-D5W INTRAVENOUS SOLUTION	ALL	Updated quantity limit for 900MG/50 ML-D5W & 600MG/50ML-D5W to 7,750ml in 23 days and 13,950ml per 23 days for 300 MG/50 ML-D5W; *Took effect 5/31/2024
CEQUR®SIMPLICITY PATCH	ALL	Updated quantity limit to 10 patches per 23 days; *Took effect 8/1/2024

CONTINUOUS GLUCOSE MONITOR (CGM) PRODUCTS {DEXCOM®G6 & G7, GUARDIAN®4, GUARDIAN ®, FREESTYLE®LIBRE)	CORRESPONDING SENSOR, TRANSMITTER, RECEIVER, READER, INTRO KIT	Updated quantity limits as follows: Dexcom G6 & G7 Sensors (3 per 23 days), Freestyle Libre 2 & Freestyle Libre 3 Sensors (2 per 23 days); Omnipod (15 per 23 days), V-Go device (30 per 23 days); Guardian 4 Glucose Sensor & Guardian Sensor 3 (4 per 23 days), Dexcom G6 Transmitter (1 per 83 days); Dexcom G6 & G7 Receivers, Freestyle Libre 2 & Libre 3 Readers; Omnipod Kit Gen 5, Omnipod 5 G6-G7 Intro Kit Gen 5, Omnipod Dash Intro Kit Gen 4 (1 per 365 days); *Took effect 8/1/2024
DEFERASIROX (GENERIC FOR JADENU®) TABLET	ALL	Updated criteria; *Took effect 7/1/2024
ENTRESTO®SPRINKLE PELLET	ALL	Updated criteria & quantity limit to 120 pellets per 23 days; *Took effect 4/12/2024
EOHILIA® SUSPENSION IN PACKET	ALL	Updated quantity limit to 600mL per 23 days; *Took effect 7/1/2024
IMITREX®CARTRIDGE, PEN INJECTOR & TABLET	ALL	Currently non-preferred; New addition to Preferred Drug List (PDL); *Took effect 7/1/2024
LIVDELZI®CAPSULE	SELADELPAR	Updated criteria & quantity limit to 31 capsules per 23 days; *Took effect 8/23/2024
LIVMARLI®ORAL SOLUTION	19MG/ML	Updated strength & age limit; *Took effect 7/25/2024
MAXALT®TABLET & MLT TABLET	10MG	Currently non-preferred; New addition to Preferred Drug List (PDL); *Took effect 7/1/2024
METFORMIN HCL ER (GENERIC for GLUCOPHAGE® XR) TABLET	500MG	Updated quantity limit to 124 tablets per 23 days; *Took effect 5/28/2024
NALOXONE SYRINGE	0.4 MG/ML	Updated quantity limit to 8mL per dispense; *Took effect 6/26/2024
PRADAXA® & GENERIC DABIGATRAN CAPSULE	110 MG	Updated quantity limit to 62 tablets per 23 days; *Took effect 8/12/2024
RETEVMO®TABLET	ALL	Updated age limit & quantity limit to 62 tablets per 23 days; *Took effect 7/31/2024
SCEMBLIX®TABLET	100MG	Updated quantity limit to 124 tablets per 23 days; *Took effect 4/18/2024

SITAGLIPTIN-METFORMIN (GENERIC for JANUMET®XR) TABLET	ALL	Updated quantity limit to 2 tablets per day & 62 tablets per 23 days; *Took effect 6/14/2024
TALTZ®SYRINGE	20 MG/0.25ML, 40 MG/0.5ML	Updated strengths & quantity limit for 20 mg/0.25 ml syringe (0.25ml in 23 days) & 40mg/0.5 ml syringe (0.5ml in 23 day); *Took effect 8/5/2024
TYENNE®PEN INJECTOR & SYRINGE	ALL	Updated criteria & quantity limit to 3.6ml per 23 days; *Took effect 6/18/2024
VAFSEO®TABLET	150MG, 300MG	Updated criteria & quantity limit to 2 tablets per day & 62 tablets per 23 days for Vafseo 300mg & 3 tablets per day & 93 tablets per 23 days for Vafseo 150mg; *Took effect 7/22/2024 & 7/18/2024 respectively
VANCOMYCIN HCL VIAL	1.75GM, 2GM	Updated quantity limit; *Took effect 7/23/2024
VIGAFYDE®ORAL SOLUTION	100 MG/ML	Updated age limit; *Took effect 8/6/2024
VIJOICE®GRANULE PACKET	50 MG	Updated quantity limit; *Took effect 4/24/2024
VORANIGO®TABLET	40MG	Updated criteria, age limit & quantity limit; *Took effect 8/7/2024
WEGOVY®PEN INJECTOR	ALL	Updated criteria & quantity limit; *Took effect 7/17/2024
ZORYVE®CREAM	0.3%	Updated age limit; *Took effect 8/7/2024

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

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

Product Name	Dose(s)	Notes – If Applicable
BRINEURA® KIT	ALL	Prior authorization is required for medical benefit code: J0567
KANUMA® VIAL	ALL	Prior authorization is required for medical benefit code: J2840
LAMZEDE® VIAL	ALL	Prior authorization is required for medical benefit code: J0217
RYPLAZIM® VIAL	ALL	Prior authorization is required for medical benefit code: J2998
SOLIRIS® VIAL	ALL	Prior authorization is required for medical benefit code: J1300

ULTOMIRIS®VIAL	ALL	Prior authorization is required for medical benefit code: J1303
UPLIZNA® VIAL	ALL	Prior authorization is required for medical benefit code: J1823
VYEPTI® VIAL	ALL	Prior authorization is required for medical benefit code: J3032
XENPOZYME® VIAL	ALL	Prior authorization is required for medical benefit code: J0218

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 **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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