230 N. Main St. Dayton, OH 45402 | 833-230-2005 | CareSourcePASSE.com

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

Dear Health Partner,

We are dedicated to partnering with you in the most effective way to manage our members' care. CareSource PASSE complies with Arkansas Medicaid's Evidence-Based Preferred Drug List (PDL) and also routinely reviews medications not found on Arkansas Medicaid's PDL. We encourage you to actively work with your CareSource PASSE patients in advance of the effective date above to ensure a smooth transition if necessary.

SUMMARY OF CHANGES TO THE ARKANSAS MEDICAID PDL EFFECTIVE JULY 1, 2024: THE FOLLOWING MEDICATIONS WILL BE PREFERRED ON THE PDL EFFECTIVE JULY 1, 2024.

Product Name	Strength(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	

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

THE FOLLOWING MEDICATIONS WILL BE NON-PREFERRED ON THE PDL EFFECTIVE JULY 1, 2024

Product Name	Strength(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	

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We will provide a list of your CareSource PASSE patients who are taking any medication above upon your request. Please email your request to PharmacyConversionProgram@CareSource.com. In your request, include the medication name(s), provider name, NPI, and your secure fax number. We will fax you a list of patients who have been prescribed these medications.

THE FOLLOWING MEDICATIONS WILL HAVE A CHANGE IN PRIOR AUTHORIZATION/CRITERIA ON THE PDL EFFECTIVE JULY 1, 2024.

Product Name	Strength(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 PEN (HUMIRA® 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	ALL	New quantity limit
CHLORPROMAZINE VIAL (GENERIC for THORAZINE®)	25 MG/ML	New prior authorization criteria. Took effect 4/3/2024

Product Name	Strength(s)	Notes If Applicable
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 & quantity limit; 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	40 MG/0.4 ML	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,	380MG	Preferred without criteria; Update to remove criteria

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Product Name	Strength(s)	Notes If Applicable
EXTENDED RELEASE		
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 MEDICATIONS HAVE A CHANGE IN PRIOR AUTHORIZATION/CRITERIA EFFECTIVE JULY 1, 2024.

Product Name	Strength(s)	Notes If Applicable
ADZYNMA® KIT	ALL	Medical benefit with medical necessity review
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 you should know
We know patient care is of the utmost importance to you. We are notifying our members of this change to help ensure their treatment plan is maintained. We have asked our members to contact their prescriber if they have questions.

Additional Resources
For the most up-to-date information, please utilize the Formulary resources available at CareSourcePASSE.com. You can also access the complete PDL at CareSourcePASSE.com by clicking on:

- Providers
- Tools & Resources
- Drug Formulary

We recognize each patient is unique and we appreciate your partnership in making this a successful transition. We are here to help you with any questions. Call CareSource PASSE Provider Services at **1-833-230-2100** Monday through Friday, 8 a.m. to 5 p.m. CST. Thank you for being a CareSource PASSE health partner.

Sincerely,

CareSource PASSE

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