



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

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

THE FOLLOWING MEDICATIONS WILL BE PREFERRED ON THE PDL EFFECTIVE OCTOBER 1, 2024*.

Product Name	Strength(s)	Notes If Applicable
ADDERALL® XR CAPSULE	ALL	Update – Remains Preferred; *Effective 9/1/2024
AMPHETAMINE/DEX TROAMPHETAMINE ER CAPSULE (GENERIC for ADDERALL XR®)	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

Product Name	Strength(s)	Notes If Applicable
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 MEDICATIONS WILL BE NON-PREFERRED ON THE PDL EFFECTIVE OCTOBER 1, 2024*.

Product Name	Strength(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	*Took effect 7/1/2024*Effective 9/1/2024
SUMATRIPTAN (GENERIC for IMITREX®) SYRINGE	6MG/0.5ML	Correction - Remains Non-Preferred; *Took effect 7/1/2024

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 OCTOBER 1, 2024*.

Product Name	Strength(s)	Notes If Applicable
ADALIMUMAB-RYVK (CF) (Generic for SIMLANDI®) SYRINGE	40MG	Updated criteria & quantity limit to 2 units per 21 days; *Took effect 7/19/2024
ADBRY® AUTO INJECTOR	300MG/2ML	Updated quantity limit to 4 units per 23 days; *Took effect 7/1/2024
ARNUIITY ELLIPTA® BLISTER, WITH INHALATION DEVICE	100MCG, 200MCG	Updated quantity limit to 1 inhaler (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

Product Name	Strength(s)	Notes If Applicable
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
CEQR® 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 PELLETT	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

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

Product Name	Strength(s)	Notes If Applicable
BRINEURA® KIT	ALL	Prior authorization is required for medical benefit code: J0567



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Product Name	Strength(s)	Notes If Applicable
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 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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