ARKANSAS MEDICAID PROVIDER QUARTERLY NEWSLETTER

JULY 2026

DRUG UTILIZATION REVIEW (DUR) BOARD UPDATE

The following will be presented during the **July 15, 2026,** DUR Board meeting.

Preferred Drug List Full Review	Anaphylaxis agents
Preferred Drug List Full Review with PA Criteria	Calcitonin Gene-Related Peptide (CGRP) Antagonist, Atopic Dermatitis Immunomodulators, Asthma and misc. indications Immunomodulators, Epilepsy
Preferred Drug List Abbreviated Review	Medication Assisted Treatment, Triptans, Colony Stimulating Factors, Erythropoiesis Stimulating Agents, Urea Cycle Disorders, Vesicular Monoamine Transporter 2 Inhibitors, Ophthalmic Antibiotics, Otic Antibiotic and Antibiotic/Corticosteroid combo, Seizure Rescue
Manual Review PA Criteria	QUIOFIC (folic acid), DESMODA (desmopressin), YUVIWEL (navepegritide), KYGEVVI (doxecitine and doxribtimine), IMCIVREE (setmelanotide), CONTEPO (fosfomycin), SAPHNELO (anifrolumab), BAXFENDY (baxdrostat), HEPCLUDEX (bulevirtide), FILSPARI (sparsentan)

https://ar.primetherapeutics.com/documents/d/arkansas/ar-medicaid-dur-board-agenda-for-july-15-2026

EDUCATIONAL TIP ON CoverMyMeds®

Goal of the preferred drug list through CoverMyMeds®

For the prescriber to consider whether a preferred alternative can meet the patient's clinical needs before pursuing a non-preferred product instead of just selecting **"no acceptable alternative"** because it is in the treatment plan.

As drug costs continue to rise, providers are encouraged to consider medications on the Arkansas Medicaid Preferred Drug List (PDL) whenever clinically appropriate. Selecting a preferred agent can help reduce delays in therapy, minimize administrative burden, and support cost-effective care as many preferred products do not require prior authorization.

When therapeutic alternatives are provided during the prior authorization process in CoverMyMeds®, providers should select a preferred alternative unless there is documented clinical justification why the preferred options are not appropriate for the patient.

This is particularly important as new formulations and dosage forms of existing medications enter the market at substantially higher costs than therapeutically comparable preferred products. If there are any questions on the preferred product process on CoverMyMeds®, you can contact the Prime Therapeutics Help Desk at 1-800-424-7895.

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

DUR Board Meeting Dates

July 15, 2026
October 21, 2026

PAD Subcommittee Dates
September 9,2026

TREND WITH NEW MANUFACTURERS/PRODUCTS

Certain manufacturers ("labelers") create high-cost, medically unnecessary products that are designed to bypass common reimbursement controls and generate excessive payments despite offering little or no additional clinical value compared with existing low-cost alternatives. Because the labeler controls these list prices, reimbursement can be substantially higher than clinically equivalent alternatives.

Common Characteristics of Medically Unnecessary Products

1. Unusual Strengths - Examples include concentrations that differ slightly from commonly available products to create a unique product classification.
2. Unusual Ingredient Combinations - Combining existing ingredients into new products with minimal clinical advantage.
3. Kits - Packaging existing products into kits that alter dosing-unit calculations and reimbursement methodologies.

Arkansas Medicaid is actively monitoring products from identified labelers associated with medically unnecessary utilization patterns. Pharmacies are encouraged to be aware of these products and to make purchasing decisions based on clinical appropriateness.

Before purchasing or prescribing a common product that is now available in unusual strengths or now available in a kit, contact the patient's insurer to verify the status of that new product. Many times, insurers will place prior authorization criteria and/or formulary limitations to minimize the extra reimbursement for these products, and the original common product may not even need prior authorization.

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.

Rare diseases being discussed in the July 2026 DUR Board meeting:

1. **Central Diabetes Insipidus**

Central diabetes insipidus (CDI) or arginine vasopressin deficiency (AVP-D) is characterized by a decreased release of arginine vasopressin (AVP) due to decrease in production or secretion from the posterior pituitary. Inability to respond to or produce ADH leads to inability of the kidneys to reabsorb water, resulting in hypotonic polyuria and, if lack of hydration, hypernatremia.

CDI is most often acquired, and up to 36% of cases are due to head trauma or transfrontal/transsphenoidal surgery when the hypothalamus or pituitary gland is disrupted. Polyuria, polydipsia, and nocturia are the most common presenting symptoms.

History and clinical examination occasionally yield useful diagnostic clues. Previous brain injury or neurosurgical intervention may indicate CDI. When confirming diagnosis of CDI, other causes for polyuria/polydipsia should be ruled out including diabetes mellitus, renal impairment, hyperglycemia, hypercalcemia and hypokalemia.

Treatment

- The most common treatment for CDI is synthetic vasopressin (desmopressin or DDAVP).
- Replacement of free water deficit
- Other medications are used including thiazide diuretics, carbamazepine, chlorpropamide, clofibrate, and indapamide. Desmopressin remains the mainstay of treatment as these alternatives carry their own list of side effects.
- Hyponatremia is a common side effect for DDAVP treatment, occurring in one in four patients, and should be avoided by allowing a regular break from DDAVP to allow a resultant aquaresis.

2. **Achondroplasia**

Achondroplasia is the most common bone dysplasia in humans associated with severe disproportionate short stature, with a prevalence of approximately 1 in 20,000 live births. The average adult height in achondroplasia is approximately 120 to 135 cm (4–4.5 ft). It is an autosomal dominant condition caused by pathogenic variants in the fibroblast growth factor receptor 3 (FGFR3) gene. Approximately 80% of cases are not inherited. The variants lead to impaired endochondral bone formation, growth restriction, bone shortening, and other skeletal anomalies.

Diagnosis is based on clinical manifestation, radiographic findings (e.g., tubular bones, short pedicles on lateral spine, short femoral neck) and genetic testing for the FDFR3 gene variant. There are two FDA approved medications for patients with achondroplasia.

- Vosoritide (VOXZOGO) is a recombinant C-type natriuretic peptide analog that stimulates endochondral ossification.
- Navepegritide (YUVIWEL) is a prodrug containing an inactive form of CNP that is released in the circulation in its active form, promoting bone growth and endochondral ossification.

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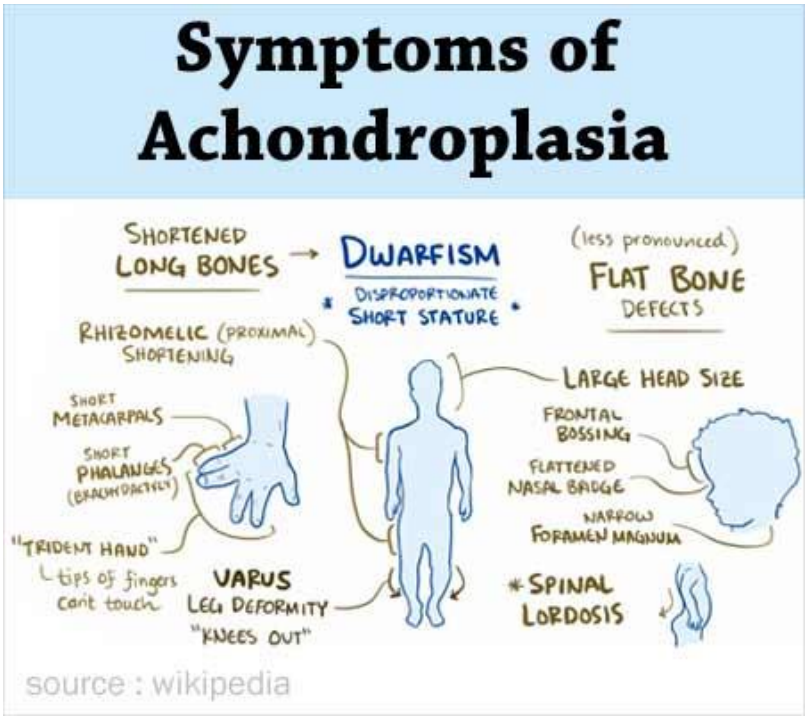


3. **Thymidine Kinase 2 Deficiency**

Thymidine kinase 2 deficiency (TK2D) is an extremely rare autosomal recessive genetic disorder that mainly affects the muscles presenting as progressive myopathy and respiratory insufficiency. Currently, there are an estimated 550 patients with confirmed TK2D in the United States with approximately 75% of them having symptom onset <12 years of age.

Infantile-onset patients (symptom onset <1 year of age) typically survive only a few years, primarily due to respiratory failure. Childhood-onset (1-12 years of age) have varying life expectancies with many only living into their teens due to respiratory failure. Late-onset (>12 years of age) typically live 20-30 years after symptom onset with respiratory failure being the most common cause of death.

Diagnosis is confirmed by the identification of biallelic pathogenic variants in TK2 by molecular genetic testing and identification of clinical presentation.

- Infantile-onset myopathy—generalized hypotonia, Gowers' sign, poor feeding, respiratory difficulties, encephalopathy, epilepsy, and hearing loss
- Juvenile onset has progressive generalized or proximal muscle weakness
- Late onset—chronic progressive external ophthalmoplegia, progressive myopathy, respiratory insufficiency, ptosis, dysphagia, and dysarthria

Treatment includes supportive care and symptom management with dietary supplements and exercise along with a new FDA approved medication (i.e., doxecitine and doxribtimine (KYGEVVI)).

4. **Acquired Hypothalamic Obesity**

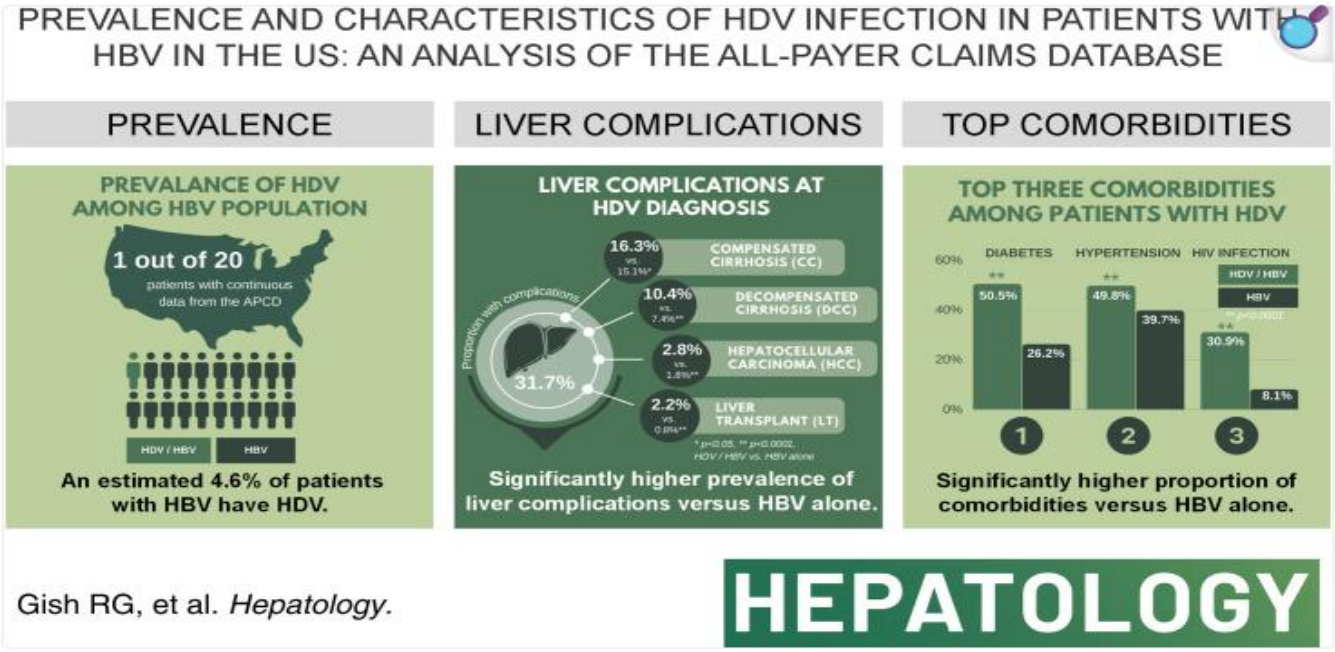
Hypothalamic obesity (HO) is defined as abnormal weight gain due to physical destruction of the hypothalamus which can be treatment-refractory. HO is characterized by rapid weight gain in the first year after hypothalamic destruction followed by refractory obesity due to an energy imbalance of decreased energy expenditure without decreased food intake. Hypothalamus destruction is typically due to surgery for craniopharyngioma or other tumors which is associated with panhypopituitarism.

Approximately 50-60% of patients who present with craniopharyngioma go on to have HO. Despite optimal endocrine management of multiple pituitary hormone deficiencies, severe obesity is a major risk factor for craniopharyngioma-related morbidity and mortality. Many of these patients develop type 2 diabetes and MAFLD. Other causes of HO include cranial radiation, vasculitis, and head trauma.

Symptoms other than rapid weight gain include hyperinsulinemia, temperature instability, sleep disturbance, and reduced resting energy expenditure. Treatment includes increase physical activity, decrease caloric intake, treat growth hormone deficiency, treat sleep disorders, bariatric surgery and medication therapy (setmelanotide—IMCIVREE).

5. **Hepatitis Delta Virus**

Hepatitis Delta Virus (HDV) infection occurs in the setting of hepatitis B virus (HBV) infection as either a coinfection or an acute superinfection in a person with underlying chronic hepatitis B (CHB). The presence of concurrent HDV infection is associated with significantly increased risks of cirrhosis, hepatocellular carcinoma (HCC), and liver-related mortality.



Monitoring

Patients with HDV should be evaluated with imaging and noninvasive testing for the presence of cirrhosis. Assessment of hepatic fibrosis and prompt identification of cirrhosis through noninvasive methods (e.g., Fibrosis-4 and vibration-controlled transient elastography) is a critical step in HDV management.

Treatment

Treatment of acute hepatitis D is mostly supportive. There are no specific antiviral treatments for acute hepatitis D. Medications used to treat chronic HBV include PegIFN, interferon-alfa 2b, interferon-alpha N3, adefovir, telbivudine, lamivudine, tenofovir disoproxil, tenofovir alafenamide, and entecavir. Medications for chronic HBV/HDV include PegIFN alfa-2a and bulevirtide. But neither product is considered curative.

Resources:

- https://en.wikipedia.org/wiki/Rare_disease
- https://rarediseases.org/understanding-rare-disease/
- DailyMed - HEPCLUDEX- bulevirtide injection, powder, lyophilized, for solution
- DailyMed - IMCIVREE- setmelanotide solution
- DailyMed - KYGEVVI- doxecitine and doxribtimine powder, for solution
- DailyMed - YUVIWEL- navepegritide kit
- DailyMed - VOXZOGO 0.4MG- vosoritide kit VOXZOGO 0.56MG- vosoritide kit VOXZOGO 1.2MG- vosoritide kit

NEW FDA APPROVED MEDICATIONS IN Q4 2025-2026 WITH SUMMARY OF MEDICAID COVERAGE

FDA APPROVED MEDS Q4 2025-2026	INDICATION	AR MEDICAID COVERAGE
LASIX ONYU	EDEMA IN CHF	MANUAL REVIEW WITH CRITERIA DETERMINED BY THE BOARD
EYDENZELT*	BIOSIMILAR TO EYLEA	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY
JASCAYD	PULMONARY FIBROSIS	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
CONTEPO	COMPLICATED UTI	MANUAL REVIEW WITH CRITERIA DETERMINED BY THE BOARD
JAVADIN	HYPERTENSION	MANUAL REVIEW WITH NECESSITY OVER SOLID ORAL CLONIDINE
LYNKUET	VASOMOTOR SYMPTOMS	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
KOMZIFTI	AML	MANUAL REVIEW USING THE ONCOLOGY CRITERIA
REDEMPLO	FAMILIAL CHYLOMICRONEMIA	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
HYRNUO	NSCLC	MANUAL REVIEW USING THE ONCOLOGY CRITERIA
OSVYRTI & BONCRESA*	BIOSIMILAR TO PROLIA	NONPREFERRED IN THE OSTEOPOROSIS CLASS PROLIA CRITERIA
JUBEREQ & OZILTUS*	BIOSIMILAR TO XGEVA	MANUAL REVIEW WITH XGEVA CRITERIA
ITVISMA	SMA	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY
VOYXACT	IGA NEPHROPATHY	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
ARMLUPEG*	BIOSIMILAR TO NEULASTA	TO BE DETERMINED

WASKYRA*	WISKOTT-ALDRICH	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY
CARDAMYST	TACHYCARDIA	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
LEROCHOL*	HYPERCHOLESTEROLEMIA	NONPREFERRED WITH CRITERIA IN PCSK9 INHIBITOR CLASS
EXDENSUR	SEVERE ASTHMA	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY
RYBREVANT FASPRO	NSCLC	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY
MYQORZO	CARDIOMYOPATHY	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
NUFYMCO	BIOSIMILAR TO LUCENTIS	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY
AQVESME	ANEMIA W/ THALASSEMIA	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
NEREUS	MOTION SICKNESS	NONPREFERRED IN ANTIEMETIC AGENT CLASS
ZYCUBO	MENKES DISEASE	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
FILKRI	BIOSIMILAR TO NEUPOGEN	NONPREFERRED IN COLONY STIM FACTOR CLASS
YUVEZZI*	PRESBYOPIA	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
ADQUEY*	ATOPIC DERMATITIS	NONPREERRED IN THE TOPICAL ATOPIC DERMATITIS CLASS
BYSANTI	SCHIZOPHRENIA/BIPOLAR	NONPREFERRED IN THE ANTIPSYCHOTIC CLASS
LOARGYS	ARGINASE 1 DEFICIENCY	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
DESMODA	DIABETES INSIPIDUS	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
YUVIWEL	ACHONDROPLASIA	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
ICOTYDE	PLAQUE PSORIASIS	NONPREFERRED IN THE TARGETED IMMUNOMODULATORS CLASS
LYNAVOY	CHOLESTATIC PRURITUS	TENTATIVE CRITERIA SIMILAR TO OCALIVA
AVLAYAH	MUCOPOLYSACCHARIDOSIS	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY
LIFYORLI	OVARIAN CANCER	MANUAL REVIEW USING THE ONCOLOGY CRITERIA
KRESLADI*	LEUKOCYTE ADHESION DEF	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY
AWIQLI*	TYPE 2 DIABETES	NONPREFERRED IN INSULIN CLASS
PONLIMSI*	BIOSIMILAR TO PROLIA	TO BE DETERMINED
FOUNDAYO	WEIGHT LOSS	WEIGHT LOSS IS NOT COVERED BY ARKANSAS MEDICAID
IDVYNSO	HIV-1	NONPREFERRED IN HIV CLASS
VEPPANU	BREAST CANCER	MANUAL REVIEW USING THE ONCOLOGY CRITERIA
BEQALZI*	MANTLE CELL LYMPHOMA	MANUAL REVIEW USING THE ONCOLOGY CRITERIA
BAXFENDY	HYPERTENSION	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
HEPCLUDEX	HEPATITIS DELTA VIRUS	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
DECNUPAZ*	DENDRITIC CELL NEOPLASM	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY
ZAYNICH*	COMPLICATED UTI	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
XOCOVA	COVID POST-EXPOSURE	NONPREFERRED ANTIVIRAL AGENTS CLASS

UTEBZI*	COMPLICATED UTI	MANUAL REVIEW WITH CRITERIA DETERMINED BY DUR BOARD
LUMVOA*	THYROID EYE DISEASE	EXCLUDED IN PHARMACY; MEDICAL REVIEW ONLY

***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
https://www.fda.gov/drugs/novel-drug-approvals-fda/novel-drug-approvals-2026

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/