



Division of Medical Services
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MEMORANDUM

TO: Arkansas Medicaid Enrolled Prescribing Providers and Pharmacy Providers
FROM: Cynthia Neuhofer, Pharm.D. Division of Medical Services Pharmacy Program
DATE: May 27, 2020
SUBJ: AR Medicaid Prior Authorization Edits Approved at the AR Medicaid DUR Board April 15, 2020 meeting for the following: Manual review criteria for: Brukinsa™, Tazverik™, Ayvakit™, Revlimid®, and Spravato®; Point-of-Sale criteria changes for: Lovaza® and Lysteda®; New Claim Edits: Leucovorin, Targeted Immunomodulators, and Gabapentin.

Preferred Drug List (PDL) therapeutic classes from the May 13, 2020 Drug Review Committee Meeting for the following: Short-acting opioids, Allergic conjunctivitis ophthalmic agents, Ophthalmic antibiotics, Ophthalmic antibiotic/steroid combinations, Anti-inflammatory ophthalmic agents, Ophthalmic glaucoma agents, Topical corticosteroids

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I. ANNOUNCEMENTS

A. UPDATE ON REVATIO SUSPENSION

Revatio® suspension is indicated for pulmonary arterial hypertension. Multiple manufacturers have brought generic Revatio® Suspension (sildenafil suspension) to the market. Because brand name of Revatio® Suspension remains more beneficial to the State, Revatio® Suspension is considered a State Supported Brand medication. Pharmacies should process claims with brand name Revatio® Suspension for proper payment.

B. REINSTATEMENT OF EARLY REFILL EDIT AND REFILL TOO SOON LOGIC

Reinstatement of EARLY REFILL (ER) EDIT and REFILL TOO SOON (RTS) LOGIC for all non-controlled drugs:

Beginning March 23, 2020, due to the COVID-19 emergency, Arkansas Medicaid POS pharmacy providers have been allowed to bypass the early refill ProDUR alert for non-controlled prescriptions. Currently, this change allows the pharmacy provider to enter an override for an early refill DUE alert. The claim will then pay at Point-of-Sale (POS) as long as all additional criteria for that drug is met. In addition, on March 23, 2020, the update to the POS system also included the removal of the “Refill Too Soon” Accumulation Logic from all non-controlled medications. The Refill Too Soon Accumulation Logic removed the requirement to allow an accumulation of up to 12 days of non-controlled medications per 186 days.

The ER DUE override allowance and the removal of the Refill Too Soon Logic will remain in effect until **July 31, 2020**.

However, beginning **August 1, 2020**, the early refill (ER) hard edit will be re-implemented. After which, the POS system will NOT allow the pharmacist to override any early refill DUE level alert without an approved prior authorization. The pharmacy provider will be required to call the Magellan Help Desk when seeking a prior authorization for an early refill. This will prevent non-controlled drugs from being filled if there is more than 25% of the day’s supply remaining.

In addition to restoring the ER hard edit, the Medicaid POS system will once again implement the Refill Too Soon (RTS) Logic for all non-controlled drugs. On August 1, 2020, all non-controlled drug claims will have an allowance of 15 days of accumulation per 186 days. This will allow an accumulation of 15 days with the accumulation beginning on the first day of re-implementation of the rule (August 1, 2020). Additionally, on **October 1, 2020**, the RTS Logic *will decrease to 12 days* in the past 186 days (with the rule going no further than August 1, 2020 to count toward the accumulated days).

EFFECTIVE July 1, 2020:

II. PREFERRED DRUGS LIST (PDL):

****Bolded medications have had a change in status.****

SHORT-ACTING OPIOIDS

Preferred Status only for strengths noted: (Quantity edits, MME edits, accumulation edits, and refill too soon edits apply)

- Acetaminophen-codeine tablet 300-15 mg, 300-30 mg, 300-60 mg
- Acetaminophen-codeine elixir or solution 120 mg-12 mg/5 ml in 118 ml and 473 ml bottle
- Codeine tablet 15 mg, 30 mg, 60 mg,
- Hydrocodone / acetaminophen tablet 5/325 mg, 7.5/325 mg, 10/325 mg
- Hydrocodone/ acetaminophen oral solution 7.5-325 mg/15 ml
- Hydrocodone/ibuprofen tablet 7.5/200 mg
- Hydromorphone tablet 2 mg, 4 mg, 8 mg
- Morphine IR tablet 15 mg, 30 mg,
- Morphine oral solution 10 mg/5 ml, 20 mg/5 ml,
- Morphine concentrated oral solution 100 mg/5 ml
- Meperidine tablet 50 mg
- Meperidine oral solution 50 mg/ 5 ml
- Oxycodone tablet 5 mg, 10 mg, 15 mg, 20 mg, 30 mg
- Oxycodone oral solution 5 mg/ 5 ml
- Oxycodone/ acetaminophen tablet 5 mg-325 mg, 7.5 mg-325mg, 10mg – 325 mg
- Oxycodone/ acetaminophen solution 5-325 mg/ 5 ml
- Tramadol tablet 50 mg
- Tramadol/ acetaminophen tablet 37.5 mg-325 mg

Non-Preferred Status for all strengths unless otherwise noted

- Acetaminophen-codeine elixir or solution 120 mg-12 mg/5 ml unit dose cups, and 300 mg-30 mg/12.5 ml unit dose cups
- **APADAZ® (benzhydrocodone/acetaminophen), 4.08mg-325mg, 6.12mg-325mg. and 8.16mg-325mg**
- Butalbital compound w/codeine
- butalbital/caffeine/APAP w/codeine 50 mg-325 mg-30 mg, and 50 mg-300 mg-30 mg
- Butorphanol 10 mg/ml nasal spray
- CAPITAL® and CODEINE (acetaminophen with codeine) oral suspension 120 mg-12 mg/ 5 ml
- Carisoprodol Compound w/Codeine
- Dihydrocodeine/APAP/caffeine 320.5 mg- 30 mg
- FIORICET® with CODEINE 50 mg-300 mg-30 mg
- FIORINAL® with codeine No. 3
- Hydrocodone / acetaminophen tablet, 5-300 mg, 7.5-300 mg, 10-300 mg, 2.5-325 mg
- Hydrocodone/APAP Oral Solution Unit Dose Cups 7.5-325 mg/15 ml, 5-163 mg/7.5 ml, 10-325 mg/ 15 ml, 2.5-108 mg/ 5 ml, 5-217 mg/ 10 ml,
- Hydrocodone-ibuprofen tablet 10 mg-200 mg, 5 mg-200 mg
- Hydromorphone 1 mg/1 ml oral solution
- Hydromorphone 3 mg rectal suppository
- **Levorphanol tablets**
- Meperidine tablet 100 mg
- NUCYNTA® (tapentadol) tablet and oral solution

- OPANA® (oxymorphone) tablets
- **OXAYDO® (oxycodone) tablets 5mg, 7.5mg**
- Oxycodone 10 mg/ 0.5 ml oral syringe
- Oxycodone capsule 5 mg
- Oxycodone concentrated oral solution 20 mg/ml
- Oxycodone/ acetaminophen 2.5 mg-325 mg,
- Oxycodone/aspirin
- Oxycodone/Ibuprofen tablet 5 mg-400 mg
- Pentazocine/naloxone tablet
- **PRIMLEV™ or PROLATE™ (oxycodone/APAP) 5 mg-300 mg, 7.5 mg-300 mg, 10 mg-300 mg**
- REPREXAIN™ (hydrocodone/ibuprofen) 2.5 mg-200 mg tablet
- **Tramadol 100mg tablet**
- ZAMICET® (hydrocodone/APAP) 10 mg-325 mg/15 ml oral solution

OPHTHALMIC DROPS FOR ALLERGIC CONJUNCTIVITIS

Preferred Agents

- Azelastine HCl 0.05% eye drops (Optivar®)
- Cromolyn sodium 4% eye drops
- Ketotifen fumarate 0.025% eye drops (Alaway® or Zaditor®)
- **Olopatadine HCl 0.01% eye drops (Patanol®)**
- **Olopatadine HCl 0.02% eye drops (Pataday®)**

Nonpreferred Agents

- Alcaftadine 0.025% eye drops (Lastacaft®)
- Bepotastine besilate 1.5% eye drops (Bepreve®)
- Cetirizine 0.24% eye drops (Zerviate™)
- Epinastine HCl 0.05% eye drops (Elestat®)
- **Loteprednol etabonate 0.2% eye drops (Alrex®)**
- Lodoxamide tromethamine 0.1% eye drops (Alomide®)
- Nedocromil sodium 2% eye drops (Alocril®)
- Olopatadine HCl 0.7% eye drops (Pazeo®)

OPHTHALMIC ANTIBIOTICS

Preferred Agents

- Bacitracin/ polymyxin B ophthalmic ointment
- Ciprofloxacin 0.3% ophthalmic solution drops
- Erythromycin 0.5% ophthalmic ointment
- Gentamicin 0.3% ophthalmic ointment
- Gentamicin 0.3% ophthalmic solution drops
- Polymyxin B /trimethoprim ophthalmic solution drops
- Tobramycin 0.3% ophthalmic solution drops
- VIGAMOX® (Brand Only) moxifloxacin 0.5% ophthalmic solution drops

Nonpreferred Agents

- AZASITE® (azithromycin) 1% ophthalmic solution drops
- Bacitracin ophthalmic ointment 500 units/gm
- BESIVANCE® (besifloxacin) 0.6% ophthalmic suspension drops

- CILOXAN® (ciprofloxacin) 0.3% ophthalmic ointment
- CILOXAN® (ciprofloxacin) 0.3% ophthalmic solution drops
- Levofloxacin 0.5% ophthalmic solution drops
- MOXEZA® (moxifloxacin) 0.5% ophthalmic solution drops
- Moxifloxacin (generic Vigamox) 0.5% ophthalmic solution drops
- NATACYN® (natamycin) 5% ophthalmic suspension drops
- Neomycin/polymyxin B/ bacitracin ophthalmic ointment
- Neomycin/polymyxin B/ gramicidin ophthalmic solution drops
- Ofloxacin 0.3% ophthalmic solution drops
- Sulfacetamide 10% ophthalmic solution drops and ointment
- TOBREX® (tobramycin) 0.3% ointment
- ZYMAXID® (gatifloxacin) 0.5% ophthalmic solution drops

OPHTHALMIC ANTIBIOTICS/STEROID COMBINATIONS

Preferred Agents

- Neomycin sulfate /polymyxin B/ dexamethasone 0.1% ophthalmic suspension drops
- Neomycin sulfate /polymyxin B/ dexamethasone ophthalmic ointment
- Sulfacetamide sodium 10% / prednisolone sodium phosphate 0.23% ophthalmic solution drops
- TOBRADEX® (tobramycin / dexamethasone) 0.3%/ 0.1% ophthalmic ointment
- Tobramycin 0.3%/dexamethasone 0.1% ophthalmic suspension drops

Nonpreferred Agents

- BLEPHAMIDE® (sulfacetamide sodium 10% / prednisolone 0.2%) ophthalmic suspension drops
- BLEPHAMIDE® S.O.P. (sulfacetamide sodium 10%/ prednisolone 0.2%) ophthalmic ointment
- Neomycin 3.5 mg/ polymyxin B sulfates 10K / hydrocortisone 1% ophthalmic suspension drops
- Neomycin sulfate/ polymyxin B sulfates/ bacitracin zinc/ hydrocortisone ophthalmic ointment
- PRED-G® (gentamicin sulfate 0.3%/prednisolone acetate 0.6%) ophthalmic ointment
- PRED-G® (gentamicin sulfate 0.3%/prednisolone acetate 1%) ophthalmic suspension drops
- TOBRADEX® ST (tobramycin / dexamethasone) 0.3%/0.05% ophthalmic suspension drops
- ZYLET® (loteprednol 0.5%/tobramycin 0.3%) ophthalmic suspension drops

OPHTHALMIC ANTI-INFLAMMATORY AGENTS

Preferred Agents

- **Bromfenac 0.09% eye drops (Bromday®)**
- Dexamethasone Sodium Phosphate 0.1% eye drops (Decadron®)
- Diclofenac 0.1% eye drops (Voltaren®)
- Fluorometholone 0.1% eye drops (FML Liquifilm®)
- Fluorometholone 0.25% eye drops (FML Forte®)
- Flurbiprofen 0.03% eye drops (Ocufen®)
- Ketorolac 0.5% eye drops (Acular®)
- Prednisolone acetate 1% eye drops (Pred Forte®)
- Prednisolone sodium 1% eye drops (AK-Pred®)

Nonpreferred Agents

- Bromfenac 0.07% eye drops (Prolensa®)
- Bromfenac 0.075% eye drops (BromSite®)
- Dexamethasone 0.1% suspension eye drops (Maxidex®)

- Difluprednate 0.05% eye drops (Durezol®)
- Fluorometholone 0.1% eye drops (Flarex®)
- **Fluorometholone 0.1% ointment (FML S.O.P.®)**
- Ketorolac 0.45% eye drops (Acuvail®)
- **Ketorolac 0.4% eye drops (Acular LS®)**
- Loteprednol etabonate 0.38% gel (Lotemax SM®)
- Loteprednol etabonate 0.5% eye drops (Lotemax®)
- Loteprednol etabonate 0.5% eye gel drops (Lotemax®)
- Loteprednol etabonate 0.5% ointment (Lotemax®)
- Loteprednol etabonate 1% suspension (Inveltys®)
- Nepafenac 0.1% eye drops (Nevanac®)
- Nepafenac 0.3% eye drops (Ilevro®)
- **Prednisolone acetate 0.12% eye drops (Pred Mild®)**

OPHTHALMIC GLAUCOMA AGENTS

Preferred Status only for strengths and package sizes noted:

- ALPHAGAN® P (brimonidine) 0.15% solution drops, 5 ml, 10 ml, 15 ml (**BRAND ONLY**)
- Carteolol 1% solution drops, 5 ml, 10 ml, 15 ml (Ocupress®)
- COMBIGAN® (brimonidine 0.2%/ timolol 0.5%) solution drops 5 ml, 10 ml, 15 ml
- Dorzolamide /timolol 22.3- 6.8 mg/ml solution drops, 10 ml (Cosopt®)
- Dorzolamide 2% solution drops, 10 ml (Trusopt®)
- Latanoprost 0.005%, 2.5 ml solution drops (Xalatan®)
- Levobunolol 0.5% solution drops, 5 ml, 10 ml, 15 ml (Betagan®)
- LUMIGAN® 0.01% (bimatoprost) solution drops 2.5ml, 5ml (**BRAND ONLY**)
- **RHOPRESSA (netarsudil) 0.02% solution/ drops, 2.5ml**
- **ROCKLATAN® (netarsudil and latanoprost) 0.02%/0.005% solution/ drops, 2.5ml**
- Timolol 0.25%, 0.5% solution drops, 5 ml, 10 ml, 15 ml (Betimol®)
- TRAVATAN Z® (travoprost) 2.5 ml, 5 ml solution drops (**BRAND ONLY**)

Non-Preferred Status, all package sizes unless otherwise noted:

- ALPHAGAN® P (brimonidine) 0.1% drops
- Apraclonidine 0.5%, 1% solution drops
- AZOPT® (brinzolamide) suspension drops 1%
- Betaxolol 0.5% solution drops
- BETOPIC S® (betaxolol) 0.25% solution drops
- Bimatoprost 0.03% solution drops
- Brimonidine 0.2%, 0.15% solution drops
- COSOPT® PF (dorzolamide 2% /timolol 0.5%) solution drops
- ISTALOL® (timolol maleate) 0.5% solution drops
- LUMIGAN® (bimatoprost) 0.01% solution drops, 7.5 ml
- Metipranolol 0.3% solution drops
- **Phospholine iodide (echothiophate) kit**
- Pilocarpine 1%, 2%, 4% solution drops
- **SIMBRINZA® (bromonidine 1%/ brinzolamide 0.2%) suspension drops, 8ml**
- Timolol gel forming solution 0.25%, 0.5% (same as TIMOPTIC-XE®)
- Timolol preservative free ocudose 0.25%, 0.5%
- Travoprost 0.004% 2.5ml, 5ml solution drops

- XELPROS™ (latanoprost) 0.005% solution/drops
- ZIOPTAN® (tafluprost) solution drops 0.0015%
- VYZULTA® (latanoprostene bunod) solution drops **0.024%**

TOPICAL CORTICOSTEROIDS

Potency Class 1 – Superpotent, Preferred Status only for package sizes noted:

- **Clobetasol 0.05% solution, 50ml**
- **Clobetasol propionate 0.05% cream, 15 gm, 30 gm, 45 gm, 60 gm**
- Clobetasol propionate 0.05% cream-emollient, 15 gm, 30 gm, 60 gm
- **Clobetasol propionate 0.05% ointment, 15 gm, 30 gm, 45 gm, 60 gm**
- **Fluocinonide 0.1% cream, 30 gm, 60 gm, 120 gm**
- Halobetasol propionate 0.05% cream, 15 gm, 50 gm

Potency Class 1 – Superpotent, Non-Preferred Status, for all package sizes unless otherwise noted:

- Betamethasone dipropionate augmented 0.05% gel
- Betamethasone dipropionate augmented 0.05% lotion
- Betamethasone dipropionate augmented 0.05% ointment
- Clobetasol propionate 0.05% emollient foam
- clobetasol propionate 0.05% foam
- Clobetasol propionate 0.05% gel
- Clobetasol propionate 0.05% shampoo
- Clobetasol propionate 0.05% spray
- **Clobetasol propionate 0.05% topical lotion, 59 ml and 118ml (brand and generic)**
- Desoximetasone 0.25% spray
- Diflorasone diacetate 0.05% ointment
- Halobetasol propionate 0.01% lotion (Bryhali®)
- Halobetasol propionate 0.05% foam (Lexette®)
- Halobetasol propionate 0.05% lotion
- **Halobetasol propionate 0.05% ointment**

Potency Class 2 – Potent, Preferred Status only for package sizes noted:

- Betamethasone dipropionate Aug. 0.05% cream, 15 gm, 50 gm
- Fluocinonide 0.05% cream, 15 gm, 30 gm, 60 gm, **120 gm**
- Fluocinonide 0.05% ointment, 15 gm, 30 gm, **60 gm**
- Triamcinolone 0.5% ointment, 15 gm

Potency Class 2– Potent, Non-Preferred Status, for all package sizes unless otherwise noted:

- Amcinonide 0.1% ointment
- Desoximetasone 0.05% gel
- Desoximetasone 0.25% cream
- Desoximetasone 0.25% ointment
- Diflorasone 0.05% cream
- Fluocinonide 0.05% gel
- Fluocinonide 0.05% solution
- Halcinonide 0.1% cream
- Halcinonide 0.1% ointment

Potency Class 3 – Upper-Mid Strength, Preferred Status only for package sizes noted:

- Betamethasone dipropionate 0.05% (not augmented) Lotion, 60 ml
- Betamethasone valerate 0.1% ointment, 15 gm, 45 gm
- **Mometasone furoate 0.1% ointment, 15 gm, 45 gm**
- **Triamcinolone 0.1% ointment, 15gm, 80gm**
- Triamcinolone 0.5% cream, 15 gm

Potency Class 3 – Upper-Mid Strength, Non-Preferred Status for all package sizes unless otherwise noted:

- Amcinonide 0.1% cream
- Amcinonide 0.1% lotion
- Betamethasone dipropionate 0.05% cream (not augmented)
- Betamethasone dipropionate 0.05% ointment (not augmented)
- Betamethasone dipropionate 0.05% spray emulsion (not augmented)
- Betamethasone valerate 0.12% foam
- Fluocinonide 0.05% emollient cream
- Fluticasone propionate 0.005% ointment
- Triamcinolone 0.1% ointment, 454gm

Potency Class 4 – Mid Strength, Preferred Status only for package sizes noted:

- Fluocinolone 0.025% ointment, 15 gm, 60 gm, 120 gm
- **Mometasone furoate 0.1% cream, 15 gm, 45 gm**
- Mometasone furoate 0.1% solution, 30 ml, **60ml**
- Triamcinolone 0.1% cream, 15 gm, 28.4 gm, 30 gm, 45 gm, 80 gm, 85.2 gm

Potency Class 4 – Mid Strength, Non-Preferred Status for all package sizes unless otherwise noted:

- Clo cortolone pivalate 0.1% cream and cream pump
- Desoximetasone 0.05% ointment
- Desoximetasone 0.05% cream
- Flurandrenolide 0.05% ointment
- Hydrocortisone valerate 0.2% ointment
- Triamcinolone 0.1% cream, 454 gm
- Triamcinolone acetonide 0.1% aerosol spray

Potency Class 5 – Lower-Mid Strength, Preferred Status only for package sizes noted:

- Betamethasone valerate 0.1% cream, 15 gm, 45 gm
- Fluocinolone 0.01% cream, 15 gm, 60 gm
- Fluocinolone 0.025% cream, 15 gm, 60 gm, 120 gm
- Fluticasone propionate 0.05% cream, 15 gm, 30 gm, 60 gm
- Triamcinolone 0.025% lotion, 60 ml
- Triamcinolone 0.025% ointment 15 gm, 80 gm
- Triamcinolone 0.1% lotion, 60 ml

Potency Class 5 – Lower-Mid Strength, Non-Preferred Status for all package sizes unless otherwise noted:

- Betamethasone valerate 0.1% lotion
- Desonide 0.05% lotion

- Desonide 0.05% ointment
- Fluocinolone shampoo
- Flurandrenolide 0.05% cream
- Flurandrenolide 0.05% lotion
- Fluticasone propionate 0.05% lotion
- Hydrocortisone butyrate 0.1% cream
- Hydrocortisone butyrate 0.1% cream emollient
- Hydrocortisone butyrate 0.1% ointment
- **Hydrocortisone butyrate 0.1% solution**
- Hydrocortisone probutate 0.1% cream
- Hydrocortisone valerate 0.2% cream
- Prednicarbate 0.1% cream emollient
- Prednicarbate 0.1% ointment
- Triamcinolone 0.025% ointment, 454 gm, 430 gm
- Triamcinolone 0.05% ointment, 430 gm

Potency Class 6 – Mild, Preferred Status only for package sizes noted:

- **Desonide 0.05% cream, 15gm, 60gm**
- **Fluocinolone 0.01% solution, 60 ml**
- Triamcinolone 0.025% cream, 15 gm, 60 gm, 80 gm

Potency Class 6 – Mild, Non-Preferred Status for all package sizes unless otherwise noted:

- Alclometasone dipropionate 0.05% cream
- **Alclometasone dipropionate 0.05% ointment, 15 gm, 45 gm, 60 gm**
- Desonide 0.05% gel
- Fluocinolone 0.01% solution, 90 ml
- Fluocinolone scalp oil 0.01%
- Triamcinolone 0.025% cream, 454 gm

Potency Class 7 – Least Potent, Preferred Status only for package sizes noted:

- Hydrocortisone acetate 0.5% cream (covered OTC), 28.4 gm
- Hydrocortisone 0.5% cream (covered OTC), 28.4 gm, 28.35 gm
- Hydrocortisone 0.5% ointment (covered OTC), 28.35 gm
- Hydrocortisone 1% cream, 28.35 gm, 28.4 gm
- Hydrocortisone 1% ointment, 28.35gm, 28.4 gm
- Hydrocortisone 2.5% cream, 20 gm, 28 gm, 28.35 gm, 30 gm
- Hydrocortisone 2.5% ointment, 20 gm, 28.35 gm, 28.4 gm

Potency Class 7 – Least Potent, Non-Preferred Status for all package sizes unless otherwise noted:

- Hydrocortisone 1% cream, 453.6 gm
- Hydrocortisone 1% ointment, 453.6 gm
- Hydrocortisone 2.5% cream 453.6 gm
- Hydrocortisone 2.5% ointment, 453.6 gm, 454 gm
- Hydrocortisone 1% ointment in absorbbase
- Hydrocortisone 2.5% lotion
- Hydrocortisone 2.5% solution

III. PRIOR AUTHORIZATION DRUG CRITERIA (NEW OR REVISED):

Effective July 15, 2020:

1. Lovaza® (omega-3-acid ethyl esters) 1gm capsule

INDICATION:

LOVAZA® (omega-3-acid ethyl esters) is indicated as an adjunct to diet to reduce triglyceride (TG) levels in adult patients with severe (greater than or equal to 500 mg per dL) hypertriglyceridemia (HTG).

Usage Considerations: Patients should be placed on an appropriate lipid-lowering diet before receiving LOVAZA® and should continue this diet during treatment with LOVAZA®.

APPROVAL CRITERIA:

- Remove manual review status
- Make point-of-sale (POS) approval criteria
 - Diagnosis in Medicaid medical history in previous 3 years of hypertriglyceridemia; **AND**
 - Triglyceride level \geq 500mg/dL in the last 180 days; **AND**
- Recipient's Medicaid pharmacy drug history indicates at least three (3) claims of fibric acid derivatives in the last 365 days; **AND**
- Recipient's Medicaid pharmacy drug history indicates at least one (1) paid claim for one of the following in the past 14-60 days with > 7 days overlap with a fibric acid derivative:
 - Maximally tolerated statin dose
 - Ezetimibe

Manual review PA will be on a case-by-case basis if the above requirements are not found in the Medicaid system for POS approval. Prescriber must submit a letter explaining the medical necessity and submit documentation to support the diagnosis not found.

QUANTITY EDITS: #120/30 days

Effective July 15, 2020:

2. Lysteda® (tranexamic acid) 650mg tablet

INDICATION:

LYSTEDA® (tranexamic acid, USP) Tablets is an antifibrinolytic indicated for the treatment of cyclic heavy menstrual bleeding.

APPROVAL CRITERIA:

- Remove manual review status
- Make point-of-sale (POS) approval criteria
 - Diagnosis in Medicaid medical history in previous 3 years of cyclic heavy menstrual bleeding; **AND**
 - Recipient's Medicaid pharmacy drug history indicates paid claims of contraceptives or hormonal therapy with any of the following; **AND**

- 84 days' supply of oral, vaginal or patch contraceptive claims from 30-180 days in profile history (three pharmacy claims); **OR**
- 90 days' supply of injectable birth control from 90-180 days in profile history (one pharmacy claim); **OR**
- 91 days' supply for extended cycle oral contraceptive from 90-180 days in profile history (one pharmacy claim)
- Recipient's lab results in the Magellan system for the previous 30 days indicates a hemoglobin (Hgb) level of ≤ 12 g/dL.

Manual review PA will be on a case-by-case basis if the above requirements are not found in the Medicaid system for POS approval. Prescriber must submit a letter explaining the medical necessity and submit documentation to support the diagnosis not found.

DENIAL CRITERIA:

- Medicaid profile indicates a pharmacy claim for a combination hormonal contraception (estrogen and progestin combination) in the previous 30 days; **OR**
- Medicaid profile indicates a pharmacy claim for anticoagulants in the previous 30 days

QUANTITY EDITS: #30/21 days

Effective immediately:

3. Brukinsa™ (zanbrutinib) 80mg capsule

INDICATION:

BRUKINSA™ is a kinase inhibitor indicated for the treatment of adult patients (with relapsed and refractory) mantle cell lymphoma (MCL) who have received at least one prior therapy. This indication is approved under accelerated approval based upon overall response rate.

APPROVAL CRITERIA:

- Recipient ≥ 18 years of age; **AND**
- Diagnosis of Mantle Cell Lymphoma (MCL) or diagnosis consistent with FDA indication; **AND**
- Recipient must have disease which has relapsed, or is refractory, following at least one line of systemic or targeted therapy; **AND**
- Prescriber must provide the following:
 - Liver function tests including AST, ALT, Bilirubin, and INR
 - Complete blood count with differential
 - Current chart notes with documentation of previous treatments
 - Baseline computed tomography (CT) scan (if available)
- Dose reduction recommended for severe hepatic impairment (Child-Pugh C) **OR** concomitant use of moderate or strong CYP3A inhibitors **OR** grade 3 or grade 4 cytopenias; **AND**
- Consider prophylaxis for herpes simplex virus, pneumocystis jiroveci pneumonia and other infections for patients with increased risk of infection (e.g. patients with low neutrophil counts or taking immunosuppressants); **AND**
- Prescriber must provide plan for monitoring patients that require concomitant antiplatelet or anticoagulant medications; **AND**
- Initial approval for 3 months; renewal timeframe will be determined by tolerance and response to therapy

DENIAL CRITERIA:

- Recipient does not meet the FDA approved indication; **OR**
- Recipient has no history of at least one prior therapy; **OR**
- Recipient requires concomitant use of CYP3A inducers; **OR**
- Recipient is pregnant or lactating women; **OR**
- Prescriber should discontinue for any grade of intracranial hemorrhage; **OR**
- Recipient has disease progression or unacceptable toxicity that cannot be resolved by decreasing the dose

CONTINUATION CRITERIA:

- Recipient has evidence of disease response or stabilization (complete or partial response); **AND**
- Provider must submit current chart notes; **AND**
- Provider must submit current labs including CBC with differential and LFTs

QUANTITY EDITS: #120/30 days

Effective immediately:

4. Tazverik™ (tazemetostat) 200mg tablet

INDICATION:

TAZVERIK™ is indicated for the treatment of adults and pediatric patients aged 16 years and older with metastatic or locally advanced epithelioid sarcoma not eligible for complete resection. This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

APPROVAL CRITERIA:

- Recipient ≥ 16 years of age; **AND**
- Recipient is diagnosed with metastatic or locally advanced epithelioid sarcoma not eligible for complete resection or diagnosis consistent with FDA indication; **AND**
- Female recipients must not be pregnant or breastfeeding and attest to using effective contraception if of reproductive potential. Male recipients with female partners of reproductive potential must attest to using effective contraception.; **AND**
- Prescriber must submit the following:
 - Liver function tests including AST, ALT, Bilirubin, and INR
 - Complete blood count with differential
 - Current chart notes with documentation of previous treatments
 - Results of any recent MRI, CT or biopsy
- Initial PA for 3 months

DENIAL CRITERIA:

- Recipient does not meet approval criteria; **OR**
- Recipient must be able to tolerate the minimum dose of 400mg twice daily; **OR**
- Recipient must not be pregnant or breastfeeding

CONTINUATION CRITERIA:

- Provide current chart notes with previously required labs; **AND**

- Recipient must be progression free with overall response according to Response Evaluation Criteria in Solid Tumors (RECIST v1.1); **AND**
- Recipient must be able to tolerate the minimum dose of 400mg twice daily

QUANTITY EDITS: #240/30 days

Effective immediately:

5. Ayvakit™ (avapritinib) 100mg, 200mg and 300mg tablet

INDICATION:

AYVAKIT™ is a kinase inhibitor indicated for the treatment of adults with unresectable or metastatic gastrointestinal stromal tumor (GIST) harboring a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations.

APPROVAL CRITERIA:

- Recipient ≥ 18 years of age; **AND**
- Recipient is diagnosed with unresectable or metastatic GIST harboring a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations or diagnosis consistent with FDA indication; **AND**
- Prescriber should provide the following
 - Current chart notes
 - Current labs including CBC with differential, comprehensive metabolic panel (CMP) and LFTs
 - Documentation of measurable lesion

DENIAL CRITERIA:

- Recipient cannot tolerate the minimum dose of 100mg daily; **OR**
- Recipient must take moderate or strong CYP3A inhibitors or inducers; **OR**
- Recipient has severe intracranial hemorrhage; **OR**
- Reduce dose or discontinue for severe central nervous system effects; **OR**
- Recipient is pregnant or breastfeeding; **OR**
- Recipient has platelet count < 90,000/mL; **OR**
- Recipient has severe renal impairment (CLCr <29mL/min) or severe hepatic impairment (Total bilirubin >3 times ULN and any AST)

CONTINUATION CRITERIA:

- Provide current chart notes with previously required labs; **AND**
- Recipient must be progression free; **AND**
- Recipient must be able to tolerate the minimum dose of 100mg daily

QUANTITY EDITS: #30/30 days for each strength

Effective July 15, 2020:

6. Revlimid® (lenalidomide) 2.5mg, 5mg, 10mg, 15mg, 20mg and 25mg capsules

INDICATION:

- REVLIMID® is a thalidomide analogue indicated for the treatment of adult patients with:
 - Multiple myeloma (MM), in combination with dexamethasone.
 - MM, as maintenance following autologous hematopoietic stem cell transplantation (auto-HSCT).
 - Transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes (MDS) associated with a deletion 5q abnormality with or without additional cytogenetic abnormalities.
 - Mantle cell lymphoma (MCL) whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib.
 - Previously treated follicular lymphoma (FL), in combination with a rituximab product.
 - Previously treated marginal zone lymphoma (MZL), in combination with a rituximab product.

Limitations of Use:

- REVLIMID™ is not indicated and is not recommended for the treatment of patients with chronic lymphocytic leukemia (CLL) outside of controlled clinical trials

APPROVAL CRITERIA:

- Recipient ≥ 18 years of age; **AND**
- Recipient is diagnosed with one of the following or diagnosis consistent with FDA indication:
 - Multiple Myeloma
 - Myelodysplastic Syndrome
 - Mantle Cell Lymphoma
 - Follicular Lymphoma
 - Marginal Zone Lymphoma
- Prescriber must submit the following:
 - Current chart notes with documentation of specific diagnosis; **AND**
 - Documentation of previous therapies tried; **AND**
 - Documentation that the prescriber and pharmacy are certified with the Revlimid® REMS program and provide a patient-physician agreement form that the patient will comply with REMS requirements; **AND**
 - Current labs including CBC with differential and comprehensive metabolic panel (CMP); **AND**
- Female patients of childbearing potential must have two (2) negative pregnancy tests before initiating Revlimid® (1st test 10-14 days prior to beginning therapy and 2nd within 24 hours prior to beginning therapy); **AND**
- Female patients of childbearing potential must use 2 methods of reliable birth control simultaneously; Male patients must always use condoms during sexual contact with females of childbearing potential; **AND**
- Dose required as prior authorization will be entered for specific dose; **AND**
- Prior authorizations should be approved monthly until documented lab stability; **AND**
- Requirements for individual diagnoses:
 - Multiple Myeloma recipient must be taking dexamethasone concomitantly
 - Maintenance dosing for MM patients post autologous hematopoietic stem cell transplant
 - Mantle Cell Lymphoma recipients—provide documentation of two (2) prior failed therapies and one should be bortezomib

- Follicular Lymphoma recipients—provide documentation taking a rituximab product concomitantly and documentation of previous therapy
- Marginal Zone Lymphoma recipients—provide documentation taking a rituximab product concomitantly and documentation of previous therapy

DENIAL CRITERIA:

- Recipient is diagnosed with Chronic Lymphocytic Leukemia; **OR**
- Recipient is pregnant or breastfeeding; **OR**
- Recipient cannot tolerate the minimum required doses for their individual indication; **OR**
- REMS program requirements have not been met by either prescriber, pharmacy or recipient

CONTINUATION CRITERIA:

- Recipient is tolerating at least the minimum required doses for their individual indication; **AND**
- Recipient has no indication of disease progression; **AND**
- Prescriber must submit current chart notes and previously required labs; **AND**
- Prescriber must submit current dose needed; **AND**
- Prior authorization approved for 3 months once documented lab stability

QUANTITY EDITS: #1 per day for any strength

Effective May 1, 2020:

7. Spravato® (esketamine) solution

INDICATION:

SPRAVATO® is indicated, in conjunction with an oral antidepressant, for the treatment of treatment-resistant depression (TRD) in adults.

APPROVAL CRITERIA:

- Recipient must be between ages 18 and 64 years old; **AND**
- Recipient must be diagnosed with treatment resistant depression (TRD); **AND**
- Prescriber must provide current chart notes and documentation of previous therapies failed; **AND**
- Recipient must have failed treatment with a minimum of THREE (3) separate therapeutic trials including antidepressants from at least TWO (2) different drug classes (SSRI, SNRI and bupropion) as well as at least ONE (1) trial of augmentation therapy with one of the following:
 - Atypical antipsychotic
 - Lithium
 - Antidepressant from a different class
- Recipient profile will be reviewed for compliance on previous therapies with at least EIGHT (8) weeks EACH for the nonconcurrent monotherapies at maximally tolerated doses; **AND**
- **IF** recipient has tried IV Ketamine, provide documentation of trial and response; **AND**
- Recipient profile must indicate a current fill of oral antidepressant at maximally tolerated dose; **AND**
- Prescriber must provide a baseline depression assessment using a validated depression rating scale; **AND**
- Prescriber must be a psychiatrist who is enrolled as a Spravato® REMS-certified provider; **AND**
- Recipient must be enrolled in the Spravato® REMS program; **AND**

- Medication must be administered under the direct supervision of a healthcare provider with post-administration observation for a minimum of 2 hours; **AND**
- Prescriber must make arrangements with the recipient's pharmacy for delivery of Spravato®; **AND**
- Recipient must be receiving concurrent oral antidepressant therapy; **AND**
- Prescriber must provide documentation of treatment plan for possible serious cardiac adverse event during treatment session (i.e. access to emergency care); **AND**
- Prescriber must review the recipient PDMP for evidence of abuse potential and attest that the recipient will be monitored for signs of abuse or misuse; **AND**
- Initial approval for 4 weeks only

DENIAL CRITERIA:

- Recipient does not meet the approval criteria; **OR**
- Recipient is pregnant or breastfeeding; **OR**
- Recipient has active moderate to severe substance or alcohol use disorder; **OR**
- Recipient has a contraindication:
 - Aneurysmal vascular disease
 - History of intracerebral hemorrhage
 - Hypersensitivity to esketamine, ketamine or any of the components of the medication

CONTINUATION CRITERIA:

- Recipient must be compliant on Spravato® and oral antidepressant; **AND**
- Recipient must have a positive clinical response with improvement of symptoms over baseline depression assessment score; **AND**
- Prescriber must submit current chart notes

QUANTITY EDITS:

Initial PA (weeks 1-4)—2 kits/week

Renewal PA (week 5 and after)—1 kit/week

Effective July 15, 2020:

8. Leucovorin 5mg, 10mg, 15mg and 25mg tablets AND 50mg, 100mg, 200mg, 350mg and 500mg vials

INDICATION:

- Leucovorin calcium tablets are indicated to diminish the toxicity and counteract the effects of impaired methotrexate elimination and of inadvertent overdoses of folic acid antagonists.
- Leucovorin calcium rescue is indicated after high dose methotrexate therapy in osteosarcoma.
- Leucovorin calcium is indicated in the treatment of megaloblastic anemias due to folic acid deficiency when oral therapy is not feasible.
- Leucovorin is also indicated for use in combination with 5-fluorouracil to prolong survival in the palliative treatment of patients with advanced colorectal cancer. Leucovorin should not be mixed in the same infusion as 5-fluorouracil because a precipitate may form.

It has come to our attention that Leucovorin is being prescribed for the off-label use of autism. Data is limited in support of this usage. In fact, this off-label use cannot be found in MicroMedex.

DENIAL CRITERIA:

- Recipient with a billed diagnosis of autistic disorder would cause a point-of-sale denial requiring manual review. Additional studies will be monitored for efficacy and safety. MicroMedex will be monitored for support of this current off-label use.

QUANTITY EDITS: Tablets #30/30 days; Vials—no edits since based on BSA

Effective May 1, 2020:

9. Targeted Immune Modulators Age Edits

Targeted Immune Modulators are used in the treatment of certain types of immunologic and inflammatory diseases, including rheumatoid arthritis (RA), juvenile rheumatoid arthritis (JRA), ankylosing spondylitis (AS), psoriatic arthritis (PsA), plaque psoriasis, Crohn's disease, and ulcerative colitis.

These drugs work by selectively blocking steps in the inflammatory and immune cascades. For example, abatacept and alefacept dampen the immune response by interfering with the activation of T cells, while adalimumab, etanercept, and infliximab target the inflammatory mediator TNF- α .

APPROVED AGE EDITS:

Indicated for \geq 2 years of age

- ADALIMUMAB (HUMIRA)
- ETANERCEPT (ENBREL)
- ABATACEPT (ORENCIA)
- TOCILIZUMAB (ACTEMRA)
- CANAKINUMAB (ILARIS)

Indicated for \geq 12 years of age

- USTEKINUMAB (STELARA)

Indicated for \geq 18 years of age

- ANAKINRA (KINERET)
- APREMILAST (OTEZLA)
- CERTOLIZUMAB (CIMZIA)
- GOLIMUMAB (SIMPONI)
- IXEKIZUMAB (TALTZ)
- SECUKINUMAB (COSENTYX)
- TOFACITINIB (XELJANZ)
- GUSELKUMAB (TREMIFYA)
- SARILUMAB (KEVZARA)
- BRODALUMAB (SILIQ)
- RISANKIZUMAB-RZAA (SKYRIZI)
- UPADACITINIB (RINVOQ ER)
- BARICITINIB (OLUMIANT)

As additional safety and efficacy studies identify new indications and FDA approved age changes, the allowed ages will be updated in the Magellan system.

Effective July 15, 2020:

10. Gabapentin Quantity Edits

December 19, 2019--The U.S. Food and Drug Administration (FDA) is warning that serious breathing difficulties may occur in patients using gabapentin (Neurontin, Gralise, Horizant) or pregabalin (Lyrica, Lyrica CR) who have respiratory risk factors. These include the use of opioid pain medicines and other drugs that depress the central nervous system, and conditions such as chronic obstructive pulmonary disease (COPD) that reduce lung function. The elderly are also at higher risk.

APPROVAL CRITERIA:

- For Neurontin (gabapentin), limit to 3600mg per day.
- For Gralise, limit to 1800mg per day.
- For Horizant, limit to 1200mg per day.

QUANTITY EDITS:

Gabapentin 100mg capsule--248/31 days
Gabapentin 250mg/5ml –3 bottles (1410ml) per 30 days
Gabapentin 300mg capsule –372/31 days
Gabapentin 400mg capsule –279/31 days
Gabapentin 600mg capsule –186/31 days
Gabapentin 800mg capsule –140/31 days
Gralise 300mg tablet—155/31 days
Gralise 600mg tablet—93/31 days
Horizant 300mg tablet—31/31 days
Horizant 600mg tablet—62/31 days

NOTE: Providers with patients taking doses >3600mg/ day will receive a letter about tapering down the gabapentin dose.

IV. FRIENDLY REMINDERS:

1. **Effective March 1, 2019**, Arkansas Medicaid implemented **PASSE (Provider-Led Arkansas Shared Savings Entity)**, a new Medicaid program to address the needs of individuals who have intensive behavioral health and intellectual and developmental disabilities service needs. The PASSE organizations administer all medical needs and all pharmacy prescription drug needs for all PASSE members. **Any questions about prescription drugs or drug claims for PASSE members must be directed to the specific PASSE organization taking care of that member.** For more information about PASSE, please refer to the website: <https://humanservices.arkansas.gov/about-dhs/dms/passe>. For questions about each PASSE organization, please refer to this website for contact information: <https://humanservices.arkansas.gov/about-dhs/dms/passe/contact-us>
2. **MAT (Medication Assisted Treatment) with Buprenorphine/naloxone and psychosocial treatment or counseling:** Per the TIP 40: *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction: Treatment Improvement Protocol (TIP) Series 40*: **"Pharmacotherapy alone is rarely sufficient treatment for drug addiction. For most patients, drug abuse counseling—individual or group—and participation in self-help programs are necessary components of comprehensive addiction care.** As part of training in the treatment of opioid addiction, physicians should at a minimum obtain some knowledge about the basic principles of brief intervention in case of relapse. Physicians considering providing opioid addiction care should ensure that they are capable of providing psychosocial services, either in their own practices or through referrals to reputable behavioral health practitioners in their communities. In fact, DATA 2000 stipulates that when physicians submit notification to SAMHSA to obtain the required waiver to practice opioid addiction treatment outside the OTP setting, they must attest to their capacity to refer such patients for appropriate counseling and other nonpharmacological therapies."

<http://lib.adai.washington.edu/clearinghouse/downloads/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction-54.pdf>

Per ASAM National Practice Guideline, in Part 5: Buprenorphine, Summary of Recommendations, # (5) "Psychosocial treatment should be implemented in conjunction with the use of buprenorphine in the treatment of opioid use disorder." <https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf>

3. INCARCERATED PERSONS:

The Medicaid Pharmacy Program is prohibited by federal regulations, 42 C.F.R. §435.1009 and §435.1010, from paying for drug claims for Medicaid beneficiaries who, **on the date the prescription is filled, is incarcerated in a correctional or holding facility, including juvenile correctional facilities**, and are detained pending disposition of charges, or are held under court order as material witnesses. **If medications are requested for incarcerated Medicaid beneficiaries, including beneficiaries in a juvenile correctional facility, the medications cannot be billed to Medicaid Pharmacy Program and are SUBJECT TO RECOUPMENT if billed to Medicaid.** Pharmacists should contact the correctional facility regarding the facility's reimbursement procedures for the requested medications.

4. Suboxone Film (buprenorphine/naloxone) once daily dosing: as stated in the Suboxone Film package insert, the FDA approved dose for treating opioid addiction is prescribing the total daily dose as one *single daily dose*. "After treatment induction and stabilization, the maintenance dose of SUBOXONE sublingual film is generally in the range of 4 mg/1 mg buprenorphine/naloxone to 24 mg/6 mg buprenorphine/naloxone per day depending on the individual patient and clinical response. **The recommended target dosage of SUBOXONE sublingual film during maintenance is 16 mg/4 mg buprenorphine/naloxone/day as a single daily dose.** Dosages higher than 24 mg/6 mg daily have not been demonstrated to provide a clinical advantage."

5. REGARDING MANUAL REVIEW PA REQUESTS: Prior authorization (PA) requests for drugs that require a clinical manual review prior approval, require a prior authorization request for a drug as an exception to established point of sale prior approval criteria algorithm, or require a request for non-preferred drugs on the PDL, are all reviewed on a case-by-case basis through a manual review process. All manual review requests for prior authorization require, at a minimum, the prescriber to provide a letter explaining the medical necessity for the requested drug along with all written documentation to substantiate the medical necessity, e.g., chart notes, pharmacy printouts for cash, printout of private insurance paid drugs, lab results, etc. **Please note that starting the requested drug, including long-acting injectable antipsychotic agents, through either inpatient use, the use of office "samples", or by any other means, prior to a Prior Authorization request being reviewed and approved by the Medicaid Pharmacy Program does not necessitate Medicaid Pharmacy Program approval of the requested drug.**

6. CHANGE IN MANUAL REVIEW PA FOR THE AGE OF CHILDREN PRESCRIBED ANTIPSYCHOTIC AGENTS, EFFECTIVE JANUARY 1, 2017: Medicaid currently requires a manual review PA of any antipsychotic agent prescribed for children less than 10 years of age (i.e., age 9 years and under) for all new starts on an antipsychotic agent, including a change in the chemical entity for children currently on an antipsychotic agent. All documentation, chart notes, signed informed consent, and required lab work must be submitted and the manual review will be performed by the Medicaid Pharmacy Program psychiatrist.

7. REGARDING EMERGENCY OVERRIDE: In an emergency, for those drugs for which a five-day supply can be dispensed, an Arkansas Medicaid enrolled pharmacy provider may dispense up to a five-day supply of a drug that requires prior authorization e.g., a drug that requires a clinical PA or requires a PA for a non-preferred drug. **This provision applies only in an emergency when the MMA Prescription Drug Help Desk and the State Medicaid Pharmacy Program offices are closed, and the pharmacist is not able to contact the prescribing provider to change the prescription.** The Emergency Supply Policy does not apply to drugs that are not covered by the State. Frequency of the emergency override is limited to once per year per drug class for non-LTC beneficiaries and once per 60 days per drug class for LTC beneficiaries.

To submit a claim using this emergency provision, the pharmacy provider must submit "03" in the Level of Service (418-DI) field. For any Schedule-II controlled substance filled using the Medicaid Emergency Override process, please refer to the Arkansas State Board of Pharmacy regulations regarding partial fill of a Schedule-II controlled substance. See information posted on the Medicaid Pharmacy Program website, <https://arkansas.magellanrx.com/provider/documents/>.

8. HARD EDIT ON EARLY REFILL FOR CONTROLLED AND NON-CONTROLLED DRUGS: The hard edit disallowing early refills (ER) for non-controlled drugs sooner than 75% of days' supply expended was implemented on February 16, 2016. Pharmacies will no longer be able to override the ProDUR early refill edit to refill non-controlled drugs sooner than 75% of the days' supply has elapsed. Refills for non-controlled drugs sooner than 75% of the days' supply elapsed will require a manual review PA and the pharmacy or prescriber must provide documentation to Medicaid that the dose was

increased during the month which caused the prescription to run out sooner than expected/calculated. The increased dose must be within the allowed Medicaid dose edits or an approved PA must be in the system for the beneficiary for the higher dose or an early refill PA will not be approved.

9. **REFILL TOO SOON ACCUMULATION LOGIC for NON-CONTROLLED DRUGS:** Beginning February 16, 2016, when a pharmacy refills a prescription claim early, the Medicaid system began adding together the accumulated “early days” filled. Each prescription is tracked by the Generic Sequence Number (GSN), which means the drug claim is the same generic name, same strength, and same dosage form, rather than tracking by prescription number or NDC. Once the beneficiary has accumulated an “extra” 15 days’ supply for that GSN, any incoming claim that is early will reject at point of sale. For example, if the prescription drug claim was for a 30-day supply and was filled 7 days early on February 16, 2016, and filled 7 days early again on March 10, 2016, the beneficiary can only refill the prescription 1 day early on the next refill date, which would be April 8, 2016 (1 day early). The accumulation edit is set so that the beneficiary cannot accumulate *more than an extra* 15 days’ supply early during a 180-day period. In this example, the drug claim cannot be filled early again until *after* August 14, 2016, which is 180 days from the February 16, 2016 date.

Effective August 8, 2018, the RTS logic with Early Refill Accumulation Limited edit was revised for the **non-controlled drugs** which now **allow an accumulation of 12 days’ supply during the previous 180-day period.**

Effective February 14, 2018, the RTS logic with Early Refill Accumulation Limit edit is **revised for the controlled drugs.** The revised edit for **controlled drugs** will only allow an extra 7-days’ supply accumulation through early fills in previous 180-day period rather than an accumulation of an extra 15-days’ supply. The RTS logic with Early Refill Accumulation Limit edit for non-controlled drugs will remain as is. Early refills for both controlled drugs and non-controlled drugs will continue to be monitored and may be adjusted in the future to reduce misuse.

10. **REVERSE AND CREDIT MEDICAID PRESCRIPTIONS NOT PROVIDED TO BENEFICIARY:** Pharmacies are required to reverse and credit back to Medicaid original prescriptions and refills if the medication was not provided to the beneficiary. Pharmacies should reverse and credit Medicaid within 14 days of the date of service for any prescription that was not provided to the beneficiary. See the Provider Manual Update Transmittal or the Pharmacy Provider Manual Section 213.200.
11. **ANTIPSYCHOTIC AGENT CRITERIA FOR CHILDREN < 18 YEARS OF AGE** have an ongoing requirement for labs for metabolic monitoring every 6 months. When any provider sends a patient, who is less than 18 years of age for the required metabolic labs for the antipsychotic agents, the provider must include the PCP’s name and Medicaid ID number on the lab order request form. It does not have to be the PCP ordering the labs. Please refer to the Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual, Section II, 245.000 B.

For those providers who have not had their own version of the Informed Consent form approved for use with Medicaid PA requests and who use the Medicaid Informed Consent form for antipsychotic agents, the form has been updated (v072914) and is posted on the Medicaid website. As the form is updated and posted on the Medicaid website, providers are required to use the most current form. Effective, Dec. 10, 2013, the old versions will no longer be accepted.

12. **THE AR MEDICAID PHARMACY PROGRAM REIMBURSES ENROLLED PHARMACY PROVIDERS FOR COVERED OUTPATIENT DRUGS FOR MEDICAID BENEFICIARIES WITH PRESCRIPTION DRUG BENEFITS:** Only medications prescribed to that beneficiary can be billed using the beneficiary’s Medicaid ID. If medications are needed to treat remaining family members, each prescription must be billed accordingly to each family member’s Medicaid ID number. Sanctions may be imposed against a provider for engaging in conduct that defrauds or abuses the Medicaid program. This could include billing a child’s medication to a parent’s Medicaid ID number and vice-versa.
13. **ANY REIMBURSEMENT RATES STATED IN THIS MEMORANDUM (OR ANY PREVIOUS MEMORANDUMS) ARE FOR REFERENCE PURPOSES ONLY AND SUBJECT TO CHANGE:** AR Medicaid Pharmacy Program reimbursement methodology changed based on the requirements in the Affordable Care Act (ACA) and requirements of §447.502 of the final regulation and based on the CMS imposed final implementation date of April 1, 2017. The pricing methodology is lesser of methodology that applies to all brand or generic drugs for usual and customary charge, or NADAC, or ACA FUL, or SAAC. If the NADAC is not available, the allowed ingredient cost shall be WAC + 0%, SAAC, or ACA FUL. The Professional Dispensing Fee has been increased to \$9 for Brand Drugs and \$10.50 for Preferred Brand Drugs and all Generics. Reimbursement rates stated in this memo are in no way a contractual obligation by Arkansas Medicaid. NADAC pricing is subject to change and any pricing stated is only current as of the date this memo was drafted. Current Generic Upper Limits (GUL) or Maximum Allowable Cost (MAC) that have been issued at the State and/or Federal level, along with State issued Capped Upper Limits (CAP), can be found on the Arkansas Medicaid website: <https://arkansas.magellanrx.com/provider/documents/> A coversheet for the NADAC Help Desk Request for Medicaid Reimbursement Review form can be found on the Arkansas Medicaid website: https://arkansas.magellanrx.com/client/docs/rxinfo/ARRx_NADAC_Request_Medicaid_Reimbursement_Review_Form.pdf

14. **ELECTRONIC PROVIDER MEMO:** To reduce paper waste beginning April 2019, Arkansas Medicaid will no longer mail Pharmacy Program Provider Memos. An electronic message will be sent to all Medicaid enrolled prescribing providers and pharmacy providers as an alert message when the complete Provider Memo is posted on the Arkansas Medicaid Pharmacy Program website.

NOTE: To ensure you receive the notification email, please verify that your email is correct in the Arkansas Medicaid provider portal. Department of Human Services correspondence would also be included in this effort to reduce paper waste. To ensure that all correspondence is received, we ask that each provider verify that the provider portal has the correct email address used for your business communications.

The Arkansas Medicaid Pharmacy Program Provider Memos can be found at <https://medicaid.mmis.arkansas.gov/Provider/Provider.aspx>. To access the memos, select the OTHER LINKS drop-down menu in the upper-left corner of the screen, click MAGELLAN MEDICAID ADMINISTRATION, select the Administrator box, select the RESOURCES drop-down menu in the upper-right corner, click Documents, select the PHARMACY tab in the top row of tabs, and then click MEMORANDUMS. The Memo can also be found at: <https://arkansas.magellanrx.com/provider/documents/>. To access the memos, select the Pharmacy tab and then click Memorandums.

An added benefit of viewing the Medicaid Pharmacy Program Provider Memo online is the Search feature, which will allow a more accessible and efficient user experience. To use this feature, use the shortcut by pressing the Ctrl + F keys, enabling a keyword search. Starting with the January 2018 memo, the online versions of the Provider Memos will also contain active hyperlinks in the Table of Contents. To activate these hyperlinks, open the Provider Memo, hover the mouse over the Table of Contents, press the Ctrl key until the mouse cursor ("hand") appears, then place the cursor on the item desired and click the mouse. The hyperlink in the Table of Content will then redirect to the corresponding chapter of the Provider Memo.

This advance notice is to provide you the opportunity to contact, counsel, and change patients' prescriptions.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

If you have questions regarding this transmittal, or you need this material in an alternative format such as large print, please contact the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895. For copies of past Remittance Advices (RA) or Arkansas Medicaid Provider Manuals (including update transmittals), please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and out-of-state at 1-501-376-2211.