ARKANSAS MEDICAID PROVIDER QUARTERLY NEWSLETTER

JULY 2025

DRUG UTILIZATION REVIEW (DUR) BOARD UPDATE

The following will be presented during the **July 16, 2025,** DUR Board meeting.

Preferred Drug List Full Review	ACE inhibitors/combination products, general antivirals (Paxlovid), oral antivirals, Rosacea agents, and chronic gastrointestinal motility agents
Preferred Drug List Abbreviated Review	Anticoagulants, ARBs/combo products/renin inhibitors, beta adrenergic blockers, benign prostatic hyperplasia, calcium channel blockers, estrogen replacement agents, osteoporosis, dry eye ophthalmic agents, skeletal muscle relaxants, and thrombopoiesis stimulating proteins
Disease State Review	Chronic spontaneous urticaria and certain indications for various targeted immunomodulators (i.e., plaque psoriasis, psoriatic arthritis, rheumatoid arthritis, ulcerative colitis, juvenile idiopathic arthritis, ankylosing spondylitis, IL-1 receptor antagonist deficiency, cryopyrin-associated periodic syndromes, Still's disease)
Manual Review PA Criteria	Amvuttra® (vutrisiran), Ozempic® (semaglutide), Kerendia® (finerenone), carisoprodol, Savella® (milnacipran), long-acting opioids, Fabhalta® (iptacopan), Vanrafia™ (atrasentan), Ctexli™ (chenodiol), Vyvgart Hytrulo® (efgartigimod-hyaluronidas-qvfc), Vykat XR™ (diazoxide choline), Qfitlia™ (fitusiran), Bucapsol™ (buspirone)

https://ar.primetherapeutics.com/documents/d/arkansas/dur-board-agenda-for-july-16-2025

ELECTRONIC PA (ePA) and CoverMyMeds®:

Beginning 8/1/2025, the Arkansas Medicaid Prescription Drug Program will add new functionality to begin accepting electronic prior authorization (ePA) requests via CoverMyMeds®, in addition to fax requests.

The CoverMyMeds tool will simplify the prior authorization process by prompting prescribers to answer required clinical questions and can offer real-time approval if clinical criteria are met. This will allow prescribers to submit prior authorization requests electronically, with the ability to upload supporting documents, and track the request in real time. Additionally, pharmacy providers who utilize CoverMyMeds will have the opportunity to initiate medication ePA requests on behalf of the member for completion by the prescriber. CoverMyMeds will direct the case to the prescriber's queue and prompt them to complete and submit the ePA to Arkansas Medicaid.

Please refer to the Arkansas Medicaid Pharmacy Website at https://ar.primetherapeutics.com/provider-documents#tab6-rncs for additional information on ePA and CoverMyMeds.

Resources:

- https://ar.primetherapeutics.com/documents/d/arkansas/arkansas-medicaid-two-ways-to-submit-a-prior-authorization
- https://ar.primetherapeutics.com/documents/d/arkansas/arkansas-medicaid-covermymeds-faqs

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. – 4:30 p.m.,
Central Time (CT)
excluding State holidays

ARHOME COST-SHARING INFORMATION:

Cost Sharing for Adult Medicaid Beneficiaries

The Arkansas Medicaid program covers medical costs, so beneficiaries don't have big bills after an emergency or illness. But some beneficiaries may pay a small share as well. The out-of-pocket costs are small **but important**. This is a summary of what beneficiaries may need to pay.

Components of cost sharing:

- **Copay**: A small fee beneficiaries pay when they receive a prescription or a medical service.
- **Copay limit**: Limits to the total amount beneficiaries pay each quarter (3-month period). Once a beneficiary meets the limit, he/she will not pay a copay for the rest of that quarter.
- **Copay overpayments:** If a beneficiary has met the quarterly copay limit, copays will stop for the current quarter and then restart at the beginning of the next quarter. If a beneficiary paid a copay after the limit is reached, they may be owed a refund. If this happens with a beneficiary that paid copays for drugs after the limit is met in a quarter, then the dispensing pharmacy should reverse and rebill the claims to provide copay reimbursements to the beneficiary.

	Beginning 2023
Adult clients who pay to cost sharing	Adult clients above 20% of FPL who are in the following programs: **ARHOME**: Only Individuals enrolled in a QHP and those awaiting enrollment in a QHP; medically frail clients will NOT have cost sharing **Workers with Disabilities**, and **Transitional Medicaid Adult Exemptions:** Individuals in these Medicaid programs who do NOT have to pay copays include: Under 20% FPL Individuals in hospice Medically frail Pregnant women 19- and 20-year-olds American Indian/Alaskan Native
Service-specific copay amounts	Adults pay $4.70/$9.40, depending on the service. (These copay amounts to not apply to ARKids B.) **Exemptions** Services that are exempt from copays (copays are not charged) include: Emergency services Preventive services Family planning services and supplies Inpatient hospitalization Pregnancy-related services

IABP BENEFICIARY IDENTIFICATION FOR MEDICAID BILLING:

Sometimes adult beneficiaries ages 19-64 that have been identified to be eligible for ARHOME eligibility (the adult expansion eligibility) are placed in a temporary plan called Interim Alternative Benefit Plan (IABP) before a Qualified Health Plan (QHP) is assigned. The QHP plans are the BCBS and Ambetter plans, for instance. If a beneficiary is in this temporary IABP eligibility, they will not be issued an official identification/eligibility card. These beneficiaries are eligible for regular Medicaid billing with their normal Medicaid ID, and the pharmacy billing will be the regular Fee for Service (FFS) BIN/PCN for prescription billing.

Arkansas Medicaid FFS-Prime Therapeutics:

BIN: 017606
PCN: P027017606
Group: ARMEDICAID

Pharmacies are encouraged to call the Prime Therapeutics Help Desk at 800-424-7895 to confirm the beneficiary's Medicaid ID, or pharmacies may enroll to have access to the Arkansas Medicaid Pharmacy portal Home - Arkansas or https://ar.primetherapeutics.com/home to view beneficiary eligibility.

CONTINUOUS GLUCOSE MONITOR UPDATE:

Abbott is discontinuing the FreeStyle Libre 2 and FreeStyle Libre 3 sensors. The FreeStyle Libre 2 and FreeStyle Libre 3 sensors will be available until September 30, 2025.

Beneficiaries will need their healthcare provider to provide a new prescription for the FreeStyle Libre 3 Plus or FreeStyle Libre 2 Plus sensor. If the beneficiary has a FreeStyle Libre 2 reader or existing app, this can be used with FreeStyle Libre 2 Plus. If the beneficiary has a FreeStyle Libre 3 reader or existing app, this can be used with FreeStyle Libre 3 Plus.

Source: https://www.freestyle.abbott/us-en/transition.html#faq

BENZODIAZEPINE TAPERING:

The American Society of Addiction Medicine (ASAM) strategized with 9 medical and professional societies (e.g., American Psychiatric Society, American Academy of Family Physicians, and 7 others) to develop a *Joint Clinical Practice Guideline on Benzodiazepine Tapering*.

This joint guidance is extremely detailed with recommendations on many scenarios outside of the typical patient population including:

- Patients co-prescribed benzodiazepines and opioids
- Patients on benzodiazepines with underling substance use disorder
- Patients that are pregnant or lactating
- Patients with co-occurring psychiatric disorders
- Patients with severe complicated withdrawal symptoms

Recommendations for tapering benzodiazepines

- Clinicians should assess the risks and benefits of ongoing benzodiazepine prescribing at least every 3 months for reach patient.
- Clinicians should consider discontinuation or a short taper for patients who are unlikely to be physically dependent.
- Clinicians should avoid abruptly discontinuing benzodiazepines in patients who are likely to be physically dependent.
- Clinicians should develop a shared decision-making process with patients and caregivers when possible.
- Tapering can typically be done in an outpatient setting, but inpatient care should be considered when there is an imminent risk of significant harm, there are symptoms or co-occurring health conditions that complicate tapering, or there is anticipated severe or complicated withdrawal potential.
- Clinicians should consider reducing doses by 5-10% per decrease with no more than 25% decrease every 2 weeks.
- Clinicians can consider changing to a longer-acting benzodiazepine for the taper.
- Patients should be offered counseling including cognitive behavioral therapy.
- Clinicians should avoid rapid benzodiazepine reversal agents due to risks for refractory seizures and cardiac dysrhythmia.
- Clinicians should consider more frequent assessments for those with co-occurring SUDs and should not discontinue buprenorphine or methadone due to a benzodiazepine taper.

SOURCE:

Brunner, E., Chen, CY.A., Klein, T. *et al.* Joint Clinical Practice Guideline on Benzodiazepine Tapering: Considerations When Risks Outweigh Benefits. *J GEN INTERN MED* (2025). https://doi.org/10.1007/s11606-025-09499-2

ACH REBATE ANNOUNCEMENT FOR MANUFACTURERS

This notice is to inform you of two upcoming changes to all the Arkansas Medicaid Drug Rebate plans.

1) **Effective April 1, 2025, Arkansas Medicaid will now accept Electronic Payments (ACH) with the following bank information:**
   Bank: Bank of America
   Account Number: 487004245617
   Routing Number ACH/EFT: 082000073
   Routing Number DOM.WIRES: 026009593

   All backup documentation must be sent via email to ArkansasRebate@primetherapeutics.com.

2) **As of May 14, 2025**, the remittance address will change for mailed/courier check payments. The new mailing address will be:
   For U.S. Postal Service (USPS) delivery:
   Medicaid Drug Rebates
   P.O. Box 7411554
   Chicago, IL 60674-1554
   For local and national overnight courier delivery:
   Bank of America Lockbox Services
   Medicaid Drug Rebates 7411554
   540 W. Madison St, 4th Floor
   Chicago, IL 60661

Arkansas Medicaid encourages you to set up the new ACH option. If not using the new ACH option, manufacturers will have to ensure that the correct physical address is updated and utilized to accommodate the upcoming change for Bank of America from St. Louis to Chicago. If there are any issues with not having the correct physical address for a paper check, delayed payments could be documented.

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.

References:

- https://en.wikipedia.org/wiki/Rare_disease
- https://rarediseases.org/understanding-rare-disease/

Rare diseases being discussed in the July 2025 DUR Board meeting:

1) **Prader-Willi Syndrome (PWS)**

Prader-Willi Syndrome (PWS) is a genetic disorder characterized by lethargy, feeding difficulties and hypotonia in infancy. In childhood, patients present with short stature, small genitals, and an excessive appetite. In children and adults, increased appetite typically develops between the ages of three and five years after a period of normal eating and weight gain and subsequently progresses to marked hyperphagia by approximately eight years. Hyperphagia includes a strong obsession with eating, a feeling of persistent hunger, and decreased satiety. Hyperphagia continues throughout life, leading to a strong predisposition to obesity.

Cause of death in PWS patients (many of the causes are exacerbated by hyperphagia)

- Respiratory failure (almost always associated with obesity) – 30 percent
- Cardiac – 16 percent
- Gastrointestinal (perforation, distention, or obstruction) – 10 percent
- Infection – 9 percent
- Obesity – 7 percent
- Pulmonary embolism – 7 percent
- Choking – 6 percent
- Accident – 6 percent

Treatment:

The treatment of PWS is directed toward the specific symptoms for individual patients.

- Genetic counseling
- Multi-disciplined provider approach
- Growth hormones in some patients with hypogonadism
- Early intervention to assess and treat motor skills and intellectual disability
- Monitor for eye abnormalities, hip dysplasia and scoliosis
- Low-calorie diet, regular exercise and strict food supervision

References:

- https://rarediseases.org/rare-diseases/prader-willi-syndrome/
- https://www.uptodate.com/contents/prader-willi-syndrome-clinical-features-and-diagnosis?search=prader%20willi&source=search_result&selectedTitle=1~67&usage_type=default&display_rank=1
- https://www.uptodate.com/contents/prader-willi-syndrome-management?sectionName=FEEDING%20AND%20OBESITY&search=prader%20willi&topicRef=5875&anchor=H660967640&source=see_link#H660967640

2) **Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)**

Chronic inflammatory demyelinating polyneuropathy (CIDP) is an acquired, immune-mediated neuropathy affecting peripheral nerves and nerve roots, typically characterized by a relapsing-remitting or progressive course of symmetric weakness of proximal and distal muscles. Typical CIDP is the most common subtype and accounts for at least 50 to 60 percent of all cases. Typical CIDP is a fairly symmetric sensorimotor polyneuropathy characterized by proximal and distal muscle weakness that exceeds the extent of sensory loss.

Diagnosis

- Clinical presentation
- Evidence of peripheral nerve demyelination with electrodiagnostic testing with nerve conduction studies
- Cerebrospinal fluid analysis when clinical and electrophysiologic findings are not diagnostic (elevated CSF protein and normal CSF white cell count)
- Exclusion of other disorders
- General supportive criteria for diagnosis (e.g., symmetric involvement, progression over at least 2 months, and loss of deep tendon reflexes)

Treatment

- Initial therapy would include IVIG, plasma exchange or glucocorticoids
- Patients with inadequate response to initial therapy
  - No improvement—re-evaluate the diagnosis
  - No response—try a different first line medication
  - Suboptimal response—escalate dose or move to different therapy
- Patients who worsen after responding to initial therapy (and stopping medication), escalating or repeating initial therapy is recommended
- If relapse cannot be avoided with intermittent therapies, the following are suggested
  - Maintenance IVIG or SCIG
  - Maintenance glucocorticoids
  - Efgartigimod alfa (IgG antibody Fc-fragment molecule)
  - Alternative immunomodulatory agents (e.g., azathioprine, methotrexate)

References:

- https://www.uptodate.com/contents/chronic-inflammatory-demyelinating-polyneuropathy-treatment-and-prognosis?search=cidp&source=search_result&selectedTitle=2~53&usage_type=default&display_rank=2
- https://www.uptodate.com/contents/chronic-inflammatory-demyelinating-polyneuropathy-etiology-clinical-features-and-diagnosis?search=cidp&source=search_result&selectedTitle=1~53&usage_type=default&display_rank=1

3) Cerebrotendinous Xanthomatosis

Cerebrotendinous xanthomatosis (CTX) is a rare autosomal recessive lipid storage disease caused by disruption of bile acid synthesis. CTX is characterized by a wide range of symptoms, including neurological and non-neurological issues. The CYP27A1 gene, responsible for bile acid production, is mutated, reducing chenodeoxycholic acid and cholic acid. This leads to cholesterol being converted into cholestanol and bile alcohol, causing tissue accumulation and various organ-related symptoms.

Diagnosis

- Genetic analysis for CYP27A1 variants
- Neuroimaging—brain MRI noting presence of bilateral focal cerebellar lesions and diffuse atrophy
- Biochemical testing—elevated level of serum cholestanol and serum/urine bile alcohols
- Clinical presentation—bile disorders, diarrhea, cataracts, neurologic symptoms including intellectual disability, tendon xanthomas, skeletal abnormalities and premature atherosclerosis

Treatment

- Chenodeoxycholic acid (chenodiol)
- Cholic acid
- Statins (used with chenodiol)
- Low-density lipoprotein apheresis
- Symptomatic management
  - Cataracts
  - Epilepsy
  - Parkinsonism
  - Spasticity
  - Surgery—remove xanthomas

References:

https://www.uptodate.com/contents/cerebrotendinous-xanthomatosis?search=CEREBROTENDINOUS%20XANTHOMATOSIS&source=search_result&selectedTitle=1~13&usage_type=default&display_rank=1

4) Complement 3 Glomerulopathy (C3G)

Complement 3 glomerulopathy (C3G) are a group of rare forms of glomerulonephritis characterized by dysregulation of the alternative complement pathway, which results in predominant C3 deposition within the glomeruli. C3 glomerulopathy is also occasionally diagnosed in older adults. Initial clinical manifestations of C3 glomerulonephritis (C3GN) may be preceded by upper respiratory tract infection, including streptococcal infections. Some cases of what may be initially diagnosed as postinfectious glomerulonephritis are ultimately found to be consistent with C3GN.

Clinical manifestations:

- Urinary abnormalities—proteinuria and/or hematuria which may present as preserved kidney function (41 percent), nephrotic syndrome (33 percent), or, less commonly, acute kidney injury or rapidly progressive glomerulonephritis (8 percent)
- Complement abnormalities—low serum C3 levels are possible
- Kidney function impairment and hypertension—patients have varying degrees of kidney function impairment along with variable rapidity of kidney function decline and some have hypertension

Treatment from UpToDate®:

- For patients with C3GN who have moderate to severe disease (characterized by proteinuria ≥1.5 g/day and/or abnormal kidney function [but not rapidly progressive disease] considered to be due to active C3GN), we suggest initial therapy with mycophenolate mofetil (MMF) and oral glucocorticoids plus supportive measures.
- However, some clinicians would treat patients who have sub-nephrotic-range proteinuria (<3 g/day) and normal kidney function with supportive measures alone and would not administer immunosuppressive therapy unless kidney function deteriorates or proteinuria worsens substantially.
- For patients with C3GN who have rapidly progressive glomerulonephritis (i.e., rapidly deteriorating kidney function and extensive crescentic glomerulonephritis on kidney biopsy), we suggest glucocorticoids in combination with either cyclophosphamide or MMF. The goal of therapy is to try to suppress the acute inflammatory response and halt or reverse the disease course. In such patients, we typically advocate inpatient admission for initial management.
- General supportive measures in all patients with C3GN or DDD include dietary sodium and protein restriction, blood pressure control, reduction of proteinuria with renin-angiotensin inhibition, and treatment of dyslipidemia, if present. Other aspects of therapy include diuretics to control edema and maintenance of adequate nutrition.
- For patients with C3GN and moderate to severe disease who do not respond to initial therapy with MMF plus glucocorticoids, we suggest eculizumab rather than continuation of MMF plus glucocorticoid therapy.
- Kidney transplant but disease recurrence and graft loss are common and may be refractory to treatment, mostly because standard immunosuppression does not correct the underlying abnormality.
- UpToDate® has not updated iptacopan's status. It remains listed as an investigational agent.

References:

https://www.uptodate.com/contents/c3-glomerulopathies-dense-deposit-disease-and-c3-glomerulonephritis?search=complement%203%20glomerulopathy&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

NEW FDA APPROVED MEDICATIONS IN 2025 WITH SUMMARY OF MEDICAID COVERAGE

NEW FDA APPROVED MEDS 2025	INDICATION	AR MEDICAID COVERAGE
DATROWAY	HR+ HER2- breast cancer	Excluded in pharmacy; medical review only
GRAFAPEX	Acute myeloid leukemia or myelodysplastic syndrome	Excluded in pharmacy; medical review only
JOURNAVX	Moderate to severe acute pain	Preferred as pharmacy benefit on PDL with quantity limits
AVTOZMA*	Biosimilar to Actemra	Nonpreferred in the targeted immunomodulator class
SYMBRAVO	Acute treatment of migraines	Nonpreferred in the acute migraine class

ONAPGO	Parkinson's Disease	Manual review with criteria determined by the DUR Board
EMBLAVEO	Complicated intra-abdominal infection	Available as pharmacy claim with quantity limits
GOMEKLI	Neurofibromatosis type 1 with plexiform neurofibromas	Manual review with criteria determined by the DUR Board
ROMVIMZA	Tenosynovial giant cell tumor	Manual review using the oncology criteria
OSPOMYV*	Biosimilar for Prolia®	Nonpreferred in the osteoporosis class with Prolia® criteria
XBRYK*	Biosimilar to Xgeva®	Manual review with Xgeva® criteria
MERILOG	Biosimilar to Novolog®	Nonpreferred in the insulin class
CTEXLI	Cerebrotendinous xanthomatosis	Manual review with criteria determined by the DUR Board
STOBOCLO	Biosimilar to Prolia®	Nonpreferred in the osteoporosis class with Prolia® criteria
OSENVELT	Biosimilar to Xgeva®	Manual review with Xgeva® criteria
OMLYCLO*	Biosimilar to Xolair®	Nonpreferred in the immunomodulators for asthma class
ARBLI*	Hypertension and diabetic nephropathy	Nonpreferred in the HTN class
BLUJEPA*	Uncomplicated urinary tract infections	To be determined
VYKAT XR	Hyperphagia in Prader-Willi Syndrome	Manual review with criteria determined by the DUR Board
CONEXXENCE*	Biosimilar to Prolia®	Nonpreferred in the osteoporosis class with Prolia® criteria
BOMYNTRA*	Biosimilar to Xgeva®	Manual review with Xgeva® criteria
QFITLIA	Hemophilia A or B with or without inhibitors	Manual review with criteria determined by the DUR Board
VANRAFIA	Immunoglobulin (IgA) nephropathy	Manual review with criteria determined by the DUR Board
IMAAVY	Generalized myasthenia gravis	Excluded in pharmacy; medical review only
AVMAPKI FAKZYNJA CO-PACK	Ovarian cancer	Manual review using the oncology criteria
EMRELIS	NSCLC	Excluded in pharmacy; medical review only
TRYPTYR	Dry eyes	Nonpreferred in the dry eye PDL class
ENFLONSIA	RSV prophylaxis	ACIP recommended for VFC program
IBTROZI*	NSCLC	Manual review using the oncology criteria
ANDEMBRY	Prevention of hereditary angioedema	Manual review with criteria determined by the DUR Board
LYNOZYFIC*	Multiple myeloma	Excluded in pharmacy; medical review only
MEZOFY*	Schizophrenia	Nonpreferred in the antipsychotic PDL class
BREKIYA*	Acute migraines	Nonpreferred in acute migraine PDL class
YUTREPIA	PAH & PH-ILD	Nonpreferred in the PAH PDL class
STARJEMZA*	Biosimilar to Stelara®	Nonpreferred in the TIMs PDL class
KHINDIVI	Adrenocortical insufficiency	Manual review with criteria determined by the DUR Board

WIDAPLIK*	Hypertension	Nonpreferred in the appropriate HTN classes
ARYNTA*	ADHD & binge eating	Nonpreferred in the ADD/ADHD PDL class
YEZTUGO	PrEP	Nonpreferred in HIV PDL class
HARLIKU*	Alkaptonuria	Manual review with criteria determined by the DUR Board

***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

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/
- https://afmc-analytics.maps.arcgis.com/apps/MapSeries/index.html?appid=2977d338de974451af5ce8ff24d2a30c
- https://www.cdc.gov/overdose-prevention/

DUR BOARD MEETING DATES

July 16, 2025
October 15, 2025
January 21, 2026
April 15, 2026
July 15, 2026