ARKANSAS MEDICAID
DEPARTMENT OF HUMAN SERVICES
PRIOR AUTHORIZATION CRITERIA AND PREFERRED PRODUCTS LIST

CONTACT THE MAGELLAN HELP DESK FOR ASSISTANCE
PHONE: 800-424-7895 FAX: 800-424-7976

Drug/Drug Class:	Diabetic Supplies
First Implementation Date:	To be announced
Updated:	5/3/2024
Status Criteria:	Criteria Revision New Criteria Preferred List
NOTE:	DME providers using provider type 16 must submit claims through the Magellan portal. Any providers using provider type 07 must submit claims as an NCPDP prescription. Any reference to pharmacy claims pertains to claims submitted on the portal by DME providers **AND** claims submitted as NCPDP claims by a pharmacy.

BLOOD GLUCOSE METER (BGM) AND OTHER SUPPLIES INFORMATION:

- No prior authorization (PA) is required if the following criteria is met.
  - Beneficiary must have a prescription for a preferred BGM and/or supplies (i.e., blood glucose test strips, lancets, lancing device, urine reagent strips, or calibration solution).
  - There will be a 365-day lookback for a BGM in Medicaid pharmacy claim history. One (1) claim for a preferred BGM is allowed every 365 days. See the table below for maximum quantities.
  - Pharmacy claims may be processed for lancets and preferred blood glucose test strips without a PA at the quantities below unless there is a paid pharmacy claim for a continuous glucose monitor (CGM) in the past 365 days. If the beneficiary has a paid CGM claim in the past 365 days, blood glucose test strips and lancets will have a limit of ≤100 in the past 93 days (including the incoming claim) and would require a PA to exceed that amount.
  - Pharmacy claims may also be processed for insulin syringes, insulin pen needles, urine reagent strips, and lancing devices without a PA unless quantities exceed the limits below.
  - Requests for quantities outside of the documented limitation will require prior authorization. Submit a PA request for quantity override by fax to 800-424-7976 with the following information.
    - Current chart notes with documentation of required testing frequency.
    - Current blood glucose testing logs that demonstrate testing is required above the limitation.

NOTE: Any product not listed below will be considered non-preferred and requires documentation of the medical necessity over preferred options.

BLOOD GLUCOSE METERS (BGMs) AND LIMITATIONS		
Manufacturer	**Product Name**	**Limitation**
LIFESCAN	ONETOUCH ULTRA2 GLUCOSE SYSTEM	1 meter per 365 days
LIFESCAN	ONETOUCH VERIO FLEX SYSTEM KIT	
LIFESCAN	ONETOUCH VERIO REFLECT SYSTEM	
TRIVIDIA HEALTH	TRUE METRIX METER	
TRIVIDIA HEALTH	TRUE METRIX AIR METER	
TRIVIDIA HEALTH	RELION TRUE METRIX AIR METER	
BLOOD GLUCOSE AND KETONE TESTING SUPPLIES AND INSULIN SYRINGES WITH LIMITATIONS		
Manufacturer	**Product Name**	**Limitation without CGM**
LIFESCAN	ONE TOUCH VERIO TEST STRIPS	200 per 31 days
LIFESCAN	ONE TOUCH ULTRA TEST STRIPS	
TRIVIDIA HEALTH	TRUE METRIX TEST STRIPS	
TRIVIDIA HEALTH	RELION TRUE METRIX TEST STRIPS	
ANY MANUFACTURER	INSULIN SYRINGES (with WAC pricing)	N/A
	INSULIN PEN NEEDLES (with WAC pricing)	
ANY MANUFACTURER	LANCETS	200 per 31 days
	LANCING DEVICE	1 per 186 days
	CALIBRATION SOLUTION	1 bottle per 31 days
	URINE REAGENT STRIPS	200 per 31 days

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CONTINUOUS GLUCOSE MONITOR (CGM) INFORMATION:

- No prior authorization is required if the beneficiary has one of the following diagnoses/conditions billed:
  - Billed diagnosis of diabetes (ICD-10 E10 or E11) in the last 365 days and meets one (1) of the following:
    - Medicaid pharmacy paid claim for insulin in the last 124 days; **OR**
    - Evidence of level 3 hypoglycemia (ICD-10 E16.1) billed in last 365 days; **OR**
    - Lab history in the last 365 days for blood glucose level of ≤54 mg/dL (level 2 hypoglycemia); **OR**
    - Medicaid pharmacy paid claim for a glucagon agent in the last 365 days.
  - Billed diagnosis of glycogen storage disease type 1a (ICD-10 E74.01) in the last 365 days.
  - Medicaid pharmacy paid claim for a patch-type insulin pump in the last 365 days.
  - Medicaid pharmacy paid claim for a CGM transmitter or sensor in the last 60 days.
- Requests for quantities outside of the documented limitation will require prior authorization. Submit a PA request for quantity override by fax to 800-424-7976.

NOTE: Any product not listed below will be considered non-preferred and requires documentation of the medical necessity over preferred options. For patients already maintained on a non-preferred product, please fax information to 800-424-7976 to request continuation.

CONTINUOUS GLUCOSE MONITOR (CGM) PRODUCTS AND LIMITATIONS		
Manufacturer	**Product Name**	**Limitation**
DEXCOM	DEXCOM G6 RECEIVER	1 per 365 days
DEXCOM	DEXCOM G6 SENSOR	3 per 30 days
DEXCOM	DEXCOM G6 TRANSMITTER	1 every 90 days
DEXCOM	DEXCOM G7 RECEIVER	1 per 365 days
DEXCOM	DEXCOM G7 SENSOR	3 per 30 days
ABBOTT DIABETES CARE	FREESTYLE LIBRE 2 SENSOR	2 per 28 days
ABBOTT DIABETES CARE	FREESTYLE LIBRE 2 READER	1 per 365 days
ABBOTT DIABETES CARE	FREESTYLE LIBRE 3 SENSOR	2 per 28 days
ABBOTT DIABETES CARE	FREESTYLE LIBRE 3 READER	1 per 365 days

INSULIN DELIVERY PRODUCTS APPROVAL CRITERIA:

- Requires a prior authorization request to be faxed to 800-424-7976.
- Beneficiary must have one (1) of the following diagnoses/conditions
  - Type 1 diabetes (ICD-10 E10) requiring at least 3-4 insulin injections per day without blood glucose control; **OR**
  - Type 2 diabetes (ICD-10 E11) requiring at least 3-4 insulin injections per day without blood glucose control
- Beneficiary must demonstrate motivation to control diabetes and willing to test frequently.
- Provider must submit attestation that the beneficiary has been counseled on proper usage.
- Provider must be a diabetes specialist or endocrinologist.
- Provider must submit current chart notes and a letter of medical necessity over options available without a PA.
- Traditional insulin pumps requiring tubing and cannula type supplies will remain a medical benefit.

NOTE: Any product not listed below will be considered non-preferred and requires documentation of the medical necessity over preferred options. For patients already maintained on a non-preferred product, please fax information to 800-424-7976 to request continuation.

INSULIN PUMP PRODUCTS AND LIMITATIONS		
Manufacturer	**Product Name**	**Limitations**
INSULET	OMNIPOD-5 G6 PODS	15 pods (3 boxes) per 30 days
INSULET	OMNIPOD-5 G6 KIT	1 per 365 days
INSULET	OMNIPOD DASH PODS	15 pods (3 boxes) per 30 days
INSULET	OMNIPOD DASH KIT	1 per 365 days
INSULET	OMNIPOD GO ALL STRENGTHS	15 pods (3 boxes) per 30 days
INSULET	OMNIPOD-5 G7 KIT	1 per 365 days
INSULET	OMNIPOD-5 G7 PODS	15 pods (3 boxes) per 30 days
MANNKIND	V-GO ALL STRENGTHS	30 (1 box) per 30 days

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DATE:	SUMMARY OF CHANGES:	UPDATED BY:
5/1/2024	CREATED CRITERIA AND PREFERRED LIST	DHS & MMA
5/3/2024	UPDATED URINE TEST STRIPS	DHS & MMA