



Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000

Governor Asa Hutchinson
Renee Mallory, RN, BSN, Interim Secretary of Health
Jennifer Dillaha, MD, Director

Date _____, 2025

RE: Binder Approval

Dear _____,

The Arkansas Kidney Disease Program has reviewed and approved your request for co-payment assistance for the prescription drug _____ with an effective date of _____, 2025.

The Program requires the lowest effective dosage of the drug to be prescribed and dispensed. It will only provide co-payment for this drug, not to exceed 360 pills each month.

As a reminder, you are required to utilize any available drug benefit, including patient assistance programs, before requesting Arkansas Kidney Disease Program assistance in paying for any drug as the Program is a payer of last resort. Resources such as Medicaid, Medicare, Veterans or private health insurance must be used first to cover the cost of any other medication listed on the Program-approved Formulary before requesting Program assistance. The Arkansas Kidney Disease Program may assist with insurance co-payments consistent with limits in effect at the time of purchase.

Remember: this approval for co-payment assistance is not for additional prescription coverage beyond that already allowed by the Arkansas Kidney Disease Program. It is counted among the three (3) medications allowed each month.

A copy of this letter must be provided to your pharmacist to verify your approval and to avoid service disruption.

If you have further questions, please contact the Arkansas Kidney Disease Program at:

- ✓ **email:** adh.akdc@arkansas.gov.
- ✓ **phone:** 501-686-2807.

Thank you for allowing us to serve you.

Charles Bedell, MPH MD
Branch Chief

CC: _____

Make sure the client gets a copy of this letter to take to the pharmacy.

rev. 08/2025