Notice of PDL Changes

Kentucky Medicaid

Pharmacy Provider Notice – April 2024 P&T PDL Changes

May 24, 2024

Please be advised that the Department for Medicaid Services (DMS) is making changes to the Kentucky Medicaid Pharmacy Preferred Drug List (PDL) based on recommendations and guidance from the Kentucky Medicaid Pharmacy and Therapeutics Advisory Committee (P&T Committee) that have subsequently been adopted by the Commissioner of DMS of the Cabinet for Health and Family Services by order dated **April 18, 2024**.

The Kentucky Medicaid P&T Committee met on April 18, 2024. The expertise, vote, and recommendations were captured within the P&T Committee's official recommendations and submitted to the Commissioner for review. After the review of the Commissioner, DMS has rendered the below final decisions.

On July 1, 2024, the following changes will be effective:

EXISTING DRUG CLASSES

Agents with ***negative status changes*** will be denoted in ***bold, italics, and yellow highlight.*** These agents will now require a prior authorization for continued use. Please refer to the full PDL table below for a list of preferred alternatives for possible adjustment to therapy.

Agents with ***positive status changes*** will be denoted in ***bold, italics, and green highlight.***

Drug Class	Preferred Agents	Non-Preferred Agents
Non-Steroid Anti-Inflammatory Drugs (NSAIDs)	celecoxib QL diclofenac sodium topical gel (1%) diclofenac sodium DR/EC tablets Ibu tablet ibuprofen tablet indomethacin capsule ***indomethacin ER capsule*** ketorolac tablet meloxicam tablet ***nabumetone tablet*** naproxen sodium tablet naproxen tablet ***piroxicam capsule*** sulindac tablet	Arthrotec Celebrex QL Daypro diclofenac epolamine patch CC diclofenac potassium capsule diclofenac potassium powder pack diclofenac potassium tablet diclofenac topical solution CC diclofenac sodium SR/ER tablet diclofenac 2% solution pump CC diclofenac sodium/misoprostol diflunisal tablet Duexis tablet CC EC-Naprosyn tablet EC-Naproxen tablet Elyxyb solution AE, CC, QL etodolac capsule etodolac tablet

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Drug Class	Preferred Agents	Non-Preferred Agents
		etodolac ER tablet Feldene capsule fenoprofen capsule fenoprofen tablet Flector patch CC flurbiprofen tablet ibuprofen/famotidine tablet ***indomethacin suppository*** indomethacin suspension QL ketoprofen ER capsule ketoprofen capsule ketorolac nasal spray CC Kiprofen capsule Licart patch CC Lofena tablet meclofenamate capsule mefenamic acid capsule meloxicam capsule CC, QL nabumetone tablet Nalfon capsule Nalfon tablet Naprelan CR tablet Naprosyn naproxen DR tablet naproxen suspension naproxen sodium CR/ER tablet naproxen/esomeprazole DR tablet CC, QL oxaprozin tablet Pennsaid CC piroxicam capsule Relafen tablet Relafen DS tablet tolmetin capsule tolmetin tablet Vimovo CC, QL
Antihyperuricemics	allopurinol tablet colchicine tablet CC ***febuxostat tablet QL*** probenecid tablet probenecid/colchicine tablet	colchicine capsule CC ***Colcrys tablet CC*** Gloperba solution CC Mitigare capsule CC Uloric tablet QL Zyloprim tablet
Erythropoiesis Stimulating Proteins	Aranesp CC Epogen CC ***Mircera***	Jesduvroq CC, QL Procrit Reblozyl AE, CC

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Drug Class	Preferred Agents	Non-Preferred Agents
	Retacrit CC (Pfizer)	Retacrit CC (Vifor)
Steroids, Oral	budesonide DR capsule QL budesonide EC capsule QL ***dexamethasone elixir***, solution, tablet hydrocortisone tablet methylprednisolone dose pack, 4 mg, 32 mg tablet prednisolone solution prednisolone sodium phosphate solution 5 mg/5 mL, 15 mg/5 mL, 25 mg/5 mL prednisone dose pack, solution, tablet	Agamree AE, CC, QL Alkindi Sprinkle capsule Cortef tablet cortisone acetate tablet deflazacort tablet AE, CC, QL dexamethasone dose pack, Intensol drop Emflaza AE, CC, QL Hemady tablet Medrol dose pack, tablet methylprednisolone 8 mg, 16 mg tablet Millipred dose pack, tablet prednisolone tablet prednisolone sodium phosphate ODT, solution 10 mg/5 mL, 20 mg/5 mL prednisone Intensol oral concentrate Rayos DR tablet TaperDex dose pack Tarpeyo DR capsule
Pancreatic Enzymes	Creon capsule ***Viokace tablet*** Zenpep Capsule	Pertzye capsule
Colony Stimulating Factors	***Fylnetra*** QL Neupogen CC, QL	Fulphila CC, QL Granix QL Leukine QL Neulasta CC, QL Neulasta Onpro CC, QL Nivestym QL ***Nyvepria*** CC, QL Releuko QL Rolvedon AE, CC, QL Stimufend QL Udenyca CC, QL Zarxio QL Ziextenzo CC, QL

NEW PRODUCTS TO MARKET

Drugs Requiring PA	Criteria for Prior Authorization
Voquezna®	**Non-Preferred in the PDL Class:** *Proton Pump Inhibitors*

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Drugs Requiring PA	Criteria for Prior Authorization
	Approval Duration: ***8 weeks initial, 6 months renewal*** **Initial Approval Criteria:** • Diagnosis of diagnostically confirmed erosive esophagitis; **AND** • Prescribed by, or in consultation with, a gastroenterologist or other specialist in the diagnosis and treatment of erosive esophagitis; **AND** • Patient has had a ≥ 2-week trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to 2 preferred agents in this PDL class. **Renewal Criteria:** • Diagnosis of diagnostically confirmed erosive esophagitis; **AND** • Prescribed by, or in consultation with, a gastroenterologist or other specialist in the diagnosis and treatment of erosive esophagitis; **AND** • Patient has experienced symptom improvement or control during initial treatment course. **Age Limit:** ≥ 18 years of age **Quantity Limit:** 1 tablet per day
Voquezna Dual Pak® (vonoprazan/amoxicillin) Voquezna Triple Pak® (vonoprazan/amoxicillin/clarithromycin)	**Non-Preferred in the PDL Class:** *H. Pylori Treatment* **Approval Duration:** ***30 days*** **Approval Criteria:** • Diagnosis of diagnostically confirmed *H. pylori* infection; **AND** • Prescribed by, or in consultation with, a gastroenterologist or other specialist in the diagnosis and treatment of *H. pylori*; **AND** • Patient has had a ≥ 2-week trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to Pylera. **Age Limit:** ≥ 18 years of age **Quantity Limit:**

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Drugs Requiring PA	Criteria for Prior Authorization
	Voquezna Dual Pak: 1 carton of 28 tablets and 84 capsules per 14-day supply Voquezna Triple Pak: 1 carton of 56 tablets and 56 capsules per 14-day supply.

Fabhalta®	**Non-PDL**
	
	Approval Duration: ***4 months initial, 1 year renewal***
	
	Initial Approval Criteria:
	• Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by flow cytometry results demonstrating both of the following:
	  ○ The absence or deficiency of glycosylphosphatidylinositol (GPI)-anchored proteins (e.g., CD55, CD59) on at least two cell lineages; **AND**
	  ○ PNH granulocyte clone size ≥ 10%; **AND**
	• Prescribed by, or in consultation with, a hematologist or other appropriate specialist in the treatment of paroxysmal nocturnal hemoglobinuria (PNH); **AND**
	• Patient will not be using a C5 complement inhibitor (e.g., Soliris, Ultomiris) or a C3 complement inhibitor (e.g., Empaveli) while taking Fabhalta.
	
	Renewal Criteria:
	• Physician attestation of clinical benefit, such as reduction in number of blood transfusions needed, improvement or stabilization of hemoglobin levels, reduction in hemolysis.
	
	Age Limit: ≥ 18 years of age
	Quantity Limit: 2 capsules per day

Jesduvroq®	**Non-Preferred in the PDL Class:** *Erythropoiesis Stimulating Proteins* **Approval Duration:** ***6 months*** **Initial Approval Criteria** • Diagnosis of chronic kidney disease (N18.9); **AND** • Pretreatment hemoglobin level ≤ 11g/dl; **AND** • Patient has been receiving dialysis for at least 4 months; **AND**

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Drugs Requiring PA	Criteria for Prior Authorization
	• Patient is not receiving treatment with any other erythropoiesis stimulating agents. **Renewal Criteria:** • Documentation (e.g., progress note, laboratory report) demonstrating a positive response to therapy. **Quantity Limit:** 1mg one daily 2mg one daily 4mg one daily 6mg two daily 8mg three daily
Wainua™	**Non-PDL** **Approval Duration:** ***1 year*** **Initial Approval Criteria:** • Patient has a definitive diagnosis of hereditary transthyretin-mediated (hATTR) amyloidosis/FAP (familial amyloidotic polyneuropathy) as documented by: ○ Amyloid deposition on tissue biopsy; **OR** ○ Identification of a pathogenic TTR variant using molecular genetic testing; **AND** • Patient has polyneuropathy attributed to hATTR/FAP; **AND** • Patient has NOT received an orthotopic liver transplant (OLT); **AND** • Patient will not be using Wainua in combination with other TTR-reducing agents (e.g., inotersen [Tegsedi], patisiran [Onpattro], tafamidis [Vyndamax, Vyndaqel], vutrisiran [Amvuttra]). **Renewal Criteria:** • Prescriber attestation of clinically significant improvement or stabilization in clinical signs and symptoms, such as improvement in ambulation, neurologic symptoms, or activities of daily living. **Age Limit:** ≥ 18 years of age **Quantity Limit:** 1 auto-injector per 28 days

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Drugs Requiring PA	Criteria for Prior Authorization

Agamree®	**Non-Preferred in the PDL Class:** *Steroids, Oral*
	
	Approval Duration: *1 year*
	
	Initial Approval Criteria
	
	• Diagnosis of Duchenne Muscular Dystrophy (DMD); **AND**
	• Patient is currently receiving, or planning to receive, physical therapy; **AND**
	• Patient has tried prednisone or prednisolone for at least 6 months; **OR**
	• Patient has experienced 1 of the following adverse reactions directly attributable to previous therapy with prednisone or prednisolone:
	  ○ Significant behavioral changes negatively impacting function at school, home, day care, etc.; **OR**
	  ○ Significant weight gain (e.g., crossing 2 percentiles and/or reaching 98th percentile for age and sex).
	
	Renewal Criteria:
	
	• Patient continues to receive physical therapy; **AND**
	• Patient has received benefit from therapy (i.e. stability, improvement or slowing of decline) in one or more of the following areas of assessment:
	  ○ Motor function (North Star Ambulatory Assessment (NSAA)
	  ○ Cardiology
	  ○ Endocrinology
	  ○ Orthopedics (e.g., scoliosis)
	  ○ Pulmonary function.
	
	Age Limit: ≥ 2 years of age
	Quantity Limit: 7.5 mL per day

Zilbrysq®	**Non-PDL class** **Approval Duration: *Initial 3 months; Renewal 1 year*** **Initial Approval Criteria:**

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Drugs Requiring PA	Criteria for Prior Authorization

	• Diagnosis of generalized myasthenia gravis (MGFA Clinical Classification Class II to IV) with positive serologic test for anti-acetylcholine receptor (AChR) antibodies; **AND**
	• Member has a baseline MG-Activities of Daily Living (MG-ADL) total score ≥ 6; **AND**
	• Patient has tried and failed at least two immunosuppressive therapies (one corticosteroid and one non-steroid immunosuppressive therapy, e.g., azathioprine, cyclosporine, mycophenolate); **AND**
	• Patient does not have unresolved Neisseria meningitidis infection.
	
	Renewal Criteria:
	
	• For initial renewal: Patient has disease improvement as evidenced by:
	  ○ At least 2-point reduction in MG-ADL total score from baseline; **OR**
	  ○ Improvement in signs or symptoms that impact daily function; **OR**
	• For subsequent renewal: After an initial beneficial response:
	  ○ Patient is stable on therapy; **OR**
	  ○ Patient requires continuous treatment due to new or worsening disease activity.
	
	Age Limit: ≥ 18 years
	Quantity Limit: 1 syringe per day

CONSENT AGENDA ITEMS

The therapeutic classes listed in the table below were reviewed; no changes were made to the currently posted status for agents in these classes.

Drug Classes With No Changes	
• **Narcotics, Long Acting** • **Narcotics, Short Acting** • **Narcotic Agonist/Antagonists** • **Narcotics, Fentanyl Buccal Products** • **Antimigraine Agents, Triptans**	• **Glucagon-Like Peptide (GLP-1) Receptor Agonists** • **Insulin & Related Agents** • **Meglitinides** • **Metformins**

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Drug Classes With No Changes	
• Antimigraine Agents, CGRP Inhibitors • Neuropathic Pain • Opiate Dependence Treatments • Skeletal Muscle Relaxants • Phosphate Binders • Sickle Cell Anemia Treatments • Thrombopoiesis Stimulating Proteins • Alpha-Glucosidase Inhibitors • Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	• Sodium-Glucose Cotransporter-2 (SGLT2) Inhibitors • Sulfonylureas • Thiazolidinediones (TZDs) • Androgenic Agents • Bone Resorption Suppression & Related Agents • Glucagon Agents • Growth Hormones • Progestins for Cachexia • Uterine Disorder Treatments

To review the complete summary of the final PDL selections and new products to market updates and changes, please refer to the “Commissioner’s Final Decisions” from April 18, 2024, posted on the provider portal at: https://kyportal.medimpact.com/provider-documents/pt-committee

Thank you for helping Kentucky Medicaid members maintain access to cost effective medications by selecting drugs on the preferred drug list whenever possible. For any additional information or questions that you may have, please contact the Kentucky MedImpact team at KYMFFS@medimpact.com for Fee-for-Service members or at KYMCOPBM@medimpact.com for Managed Care Organization (MCO) members.

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