NOTICE OF PDL CHANGES
KENTUCKY MEDICAID

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

PHARMACY PROVIDER NOTICE – JANUARY 2026 P&T PDL CHANGES

March 27, 2026

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 **February 13, 2026.**

The Kentucky Medicaid P&T Committee met on January 20, 2026. 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 May 1, 2026, the following changes will be effective **(unless otherwise noted)**:

EXISTING DRUG CLASSES

Agents with status changes will be shown in ***bold, italicized text***.

Agents ***moving from preferred to non-preferred status are highlighted in yellow.*** These agents will now require 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 ***moving from non-preferred to preferred status are highlighted in green***.

Drug Class	Preferred Agents	Non-Preferred Agents
Bronchodilators, Beta-Agonist **Effective April 1, 2026**	albuterol sulfate HFA QL albuterol sulfate solution QL ***albuterol sulfate syrup*** ***QL*** terbutaline tablets QL	Airsupra HFA QL albuterol sulfate HFA QL (only NDC 66993-0019-68) albuterol sulfate ER tablet QL albuterol sulfate tablet QL levalbuterol concentrate solution QL levalbuterol HFA QL levalbuterol solution QL ProAir Digihaler QL ProAir Respiclick QL Ventolin HFA QL Xopenex HFA QL

Drug Class	Preferred Agents	Non-Preferred Agents
Glucocorticoids, Inhaled	***Arnuity Ellipta*** QL ***Asmanex HFA*** QL Asmanex Twisthaler QL budesonide inhalation suspension AE, CC, QL	Alvesco QL fluticasone furoate QL fluticasone propionate Diskus QL ***fluticasone propionate HFA*** QL Pulmicort Respules QL Qvar Redihaler
Intranasal Rhinitis Agents	azelastine spray Dymista nasal spray QL fluticasone propionate spray QL ipratropium bromide spray	azelastine/fluticasone nasal spray QL Beconase AQ nasal spray QL flunisolide nasal spray QL mometasone nasal spray QL ***oloptadine nasal spray*** QL Omnaris nasal spray Patanase nasal spray Qnasl Children HFA QL Qnasl HFA QL Ryaltris nasal spray Xhance nasal spray CC Zetonna HFA QL
Macrolides/Ketolides	azithromycin clarithromycin E.E.S. granules for suspension 200mg erythromycin base tablet DR 250 mg, 500 mg erythromycin ethylsuccinate suspension Ery-Tab DR tablet 250, 500 mg	clarithromycin ER E.E.S 400 Filmtab EryPed Ery-Tab DR tablet 333 mg Erythrocin ***erythromycin base capsule DR*** erythromycin base tablet erythromycin base tablet DR 333 mg erythromycin ethylsuccinate 400 mg tablet erythromycin filmtab Zithromax
Immunosuppressives, Oral	azathioprine tablet CellCept suspension cyclosporine capsule, modified capsule, modified solution cyclosporine modified Gengraf capsule, solution mycophenolate mofetil capsule, tablet mycophenolic acid tablet tacrolimus capsule	Astagraf XL capsule CellCept capsule, tablet Envarsus XR tablet everolimus tablet Imuran tablet mycophenolate mofetil suspension Myfortic DR tablet Myhibbin suspension Neoral capsule, solution Prograf capsule, gran pack Rapamune solution, tablet Rezurock tablet AE, CC, QL Sandimmune capsule, solution ***sirolimus solution, tablet***

Drug Class	Preferred Agents	Non-Preferred Agents
		Tavneos capsule AE, CC, QL Zortress tablet

NEW PRODUCTS TO MARKET

Drug Requiring PA	Criteria for Prior Authorization

Brinsupri™
 	
Effective April 1, 2026
	Non-PDL
	
	Approval Duration: 6 months initial, 12 months renewal
	
	Initial Approval Criteria:
	
	• Provider attestation of a non-cystic fibrosis bronchiectasis diagnosis, confirmed by chest computed tomography (CT) scan; **AND**
	• Prescribed by, or in consultation with, a pulmonologist or other specialist in the treatment of this disease; **AND**
	• Prescriber attestation that the patient meets ONE of the following:
	  ○ Aged 18 years and older with ≥ 2 exacerbations; **OR**
	  ○ Aged 12 to 17 years with ≥ 1 exacerbation; **AND**
	• Patient experienced exacerbations that required antibiotic treatment in the past 12 months; **AND**
	• Provider attestation that the patient may not be a current smoker. If a smoker, they should be counseled on the harmful effects of smoking on pulmonary diseases and be informed about available smoking cessation options.
	
	Renewal Criteria:
	
	• Provider attestation that the patient has demonstrated a positive response to therapy by one of the following:
	  ○ Improvement or stabilization of symptoms; **OR**
	  ○ Reduction in or stabilization of the frequency, severity, or duration of exacerbations; **OR**
	  ○ Reduction in the decline of FEV1.
	
	Age Limit: ≥ 12 years of age
	
	Quantity Limit: 1 tablet per day

Orlynvah™	**Non-PDL** **Approval Duration:** 1 month **Approval Criteria:** • Patient is female; **AND** • Patient is 18 years of age or older, and weighs at least 40 kg; **AND** • Documented clinical diagnosis of uncomplicated urinary tract (uUTI) infection with at least 2 signs/symptoms, (e.g., dysuria, urgency, frequency, lower abdominal pain, etc.); **AND**

Drug Requiring PA	Criteria for Prior Authorization

	• Urinalysis confirming pyuria and/or positive urinary nitrites; **AND**
	• Urine culture confirming or showing high-clinical suspicion of uUTI caused by ONE of the following susceptible organisms:
	  ○ Escherichia coli; **OR**
	  ○ Klebsiella pneumoniae; **OR**
	  ○ Proteus mirabilis; **AND**
	• Documented allergy, intolerance, contraindication, or therapeutic failure to at least 2 first-line oral agents for uUTI (e.g., sulfamethoxazole/trimethoprim tablet or suspension, amoxicillin-clavulanate, cefdinir, fosfomycin, cefpodoxime, nitrofurantoin, etc.) as appropriate, based on organism susceptibilities; **AND**
	• Provider attests that Orlynvah is not being used as step-down therapy for infections that previously required IV antibiotics.
	
	Quantity Limit: 10 tablets per 5-day course

Dawnzera™	**Non-PDL**
	
	Approval Duration: 6 months initial, 12 months renewal
	
	Initial Approval Criteria:
	
	• Diagnosis of hereditary angioedema (HAE); **AND**
	• Documentation of confirmed diagnosis of HAE by one of the following tests:
	  ○ Complement testing; **OR**
	  ○ C1 Inhibitor protein and functional tests; **AND**
	• Prescribed for prophylactic use; **AND**
	• Prescribed by, or in consultation with, an immunologist, hematologist, or other specialist in the diagnosis and treatment of HAE; **AND**
	• Patient is not on concurrent treatment with alternative prophylactic agent for HAE (e.g., Takhzyro, Haegarda, Cinryze, Dawnzera, Orladeyo); **AND**
	• Patient meets the minimum age recommended by the package insert for this FDA-approved indication.
	
	Renewal Criteria:
	
	• Prescriber attestation of improvement compared to baseline in HAE attacks (i.e., reductions in attack frequency or attack severity).
	
	Quantity Limit: 0.8mL (80 mg) per 28 days

Leqembi IQLIK™	**Central Nervous System – Alzheimer's Agents: Non-Preferred** **Approval Duration:** 6 months initial, 12 months renewal **Initial Approval Criteria:** • Patient has a diagnosis of mild cognitive impairment (MCI) due to Alzheimer's Disease (AD) or mild dementia associated with AD dementia; **AND** • Prescribed by, or in consultation with, a neurologist, geriatrician, psychiatrist, or other dementia specialist; **AND** • Patient has completed 18 months of intravenous (IV) infusions of Leqembi; **AND**

Drug Requiring PA	Criteria for Prior Authorization

	• Prior to initiation of Leqembi IV, there was confirmation of beta-amyloid plaques; **AND**
	• Prior to initiation of Leqembi IV, there was documentation of baseline disease severity utilizing one of the following scores:
	  ○ Mini-Mental Status Exam (MMSE); **OR**
	  ○ Montreal Cognitive Assessment (MoCA); **OR**
	  ○ Clinical Dementia Rating (CDR)-Global; **AND**
	• Prior to initiation of Leqembi IV, there was documentation of a brain MRI; **AND**
	• Prior to initiation of Leqembi IV, there was genotype testing for ApoE ε4 status; **AND**
	• Leqembi IQLIK will not be combined with other amyloid beta-directed antibodies (e.g., aducanumab).
	
	Renewal Criteria:
	
	• Positive clinical response as evidenced by stabilization or slowing of disease progression as documented by ONE of the following:
	  ○ MMSE (e.g., decline of 3 points or less per year); **OR**
	  ○ MoCA (e.g., score of greater than or equal to 15); **OR**
	  ○ CDR-Global Score (i.e., score of 0.5 or 1).
	
	Age Limit: ≥ 50 years of age and ≤ 90 years of age
	
	Quantity Limit: 7.2 mL per 28 days (1 syringe per week)

Wayrilz™	**Blood Modifiers – Thrombopoiesis Stimulating Proteins: Non-Preferred** **Approval Duration:** 6 months initial, 6 months renewal **Initial Approval Criteria:** • Diagnosis of persistent or chronic immune thrombocytopenia (ITP); **AND** • Prescribed by, or in consultation with, a hematologist or liver disease specialist; **AND** • Documentation (e.g., progress note, laboratory report) of platelet count within the past 30 days; **AND** • Trial and failure (i.e., not achieved a platelet count ≥ 50 x 10^9/L) of at least one other therapy for persistent or chronic ITP, such as corticosteroids, IV immune globulin, RhO(D) immune globulin, thrombopoietin receptor antagonists, etc.; **AND** • Trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to Promacta. **Renewal Criteria:** • Documentation (e.g., progress note, laboratory report) of response to therapy. **Age Limit:** ≥ 18 years of age **Quantity Limit:** 2 tablets per day

Drug Requiring PA	Criteria for Prior Authorization

Blujepa	**Non-PDL**
	
	Approval Duration: 1 month
	
	Approval Criteria:
	
	Uncomplicated Urinary Tract (uUTI) Infection:
	
	• Patient is female; **AND**
	• Patient is 12 years of age or older, and weighs at least 40 kg; **AND**
	• Documented clinical diagnosis of uncomplicated urinary tract (uUTI) infection with at least 2 signs/symptoms, (e.g., dysuria, urgency, frequency, lower abdominal pain, etc.); **AND**
	• Urinalysis confirming pyuria and/or positive urinary nitrites; **AND**
	• Urine culture confirming or showing high-clinical suspicion of uUTI caused by ONE of the following susceptible organisms:
	  ○ Escherichia coli; **OR**
	  ○ Klebsiella pneumoniae; **OR**
	  ○ Citrobacter freundii complex; **OR**
	  ○ Staphylococcus saprophyticus; **OR**
	  ○ Enterococcus faecalis; **AND**
	• Documented allergy, intolerance, contraindication, or therapeutic failure to at least 2 first-line oral agents for uUTI (e.g., sulfamethoxazole/trimethoprim tablet or suspension, amoxicillin-clavulanate, cefdinir, fosfomycin, cefpodoxime, nitrofurantoin, etc.) as appropriate, based on organism susceptibilities.
	
	Uncomplicated Urogenital Gonorrhea:
	
	• Patient is 12 years of age or older, and weighs at least 45 kg; **AND**
	• Documented clinical diagnosis of uncomplicated urogenital gonorrhea (e.g., positive Nucleic Acid Amplification Test (NAAT), culture, or Gram stain from urogenital site confirming susceptible Neisseria gonorrhoeae); **AND**
	• Patient has limited or no alternative treatment options (e.g., documented allergy, intolerance, contraindication, treatment failure, or resistance to standard therapies such as intramuscular ceftriaxone plus oral azithromycin, intramuscular ceftriaxone, intramuscular gentamicin plus oral azithromycin, etc.).
	
	Quantity Limit: 20 tablets per 5-day course

Rhapsido®	**Non-PDL** **Approval Duration:** 12 months initial, 12 months renewal **Initial Approval Criteria:** • Diagnosis of chronic spontaneous urticaria (CSU); **AND** • Trial and failure of (≥ 14-day treatment course), contraindication, or intolerance to histamine-1 antihistamine (e.g., diphenhydramine, hydroxyzine); **AND**

Drug Requiring PA	Criteria for Prior Authorization
	• Trial and failure of (≥ 1-month treatment course), contraindication, or intolerance to Xolair; **AND** • Prescribed by, or in consultation with, an allergist, immunologist, or other applicable specialist in the diagnosis and treatment of CSU; **AND** • Patient must meet the minimum age recommended by the package insert for this FDA-approved indication. **Renewal Criteria:** • Patient has experienced disease improvement and/or stabilization such as improvement in CSU symptoms, as assessed by the prescriber. **Quantity Limit:** 2 tablets per day
Jascayd®	**Non-PDL** **Approval Duration:** 12 months initial, 12 months renewal **Initial Approval Criteria:** • Patient has a diagnosis of idiopathic pulmonary fibrosis (IPF) or progressive pulmonary fibrosis (PPF) consistent with current guidelines (e.g., American Thoracic Society/European Respiratory Society/Japanese Respiratory Society); **AND** • Provider attests that other underlying causes for pulmonary fibrosis have been ruled out; **AND** • Patient has Forced Vital Capacity (FVC) ≥ 45% of predicted normal; **AND** • Prescribed by, or in consultation with, a pulmonologist or other specialist in treating IPF, PPF, or related conditions; **AND** • Patient must meet the minimum age recommended by the package insert for the provided indication. **Renewal Criteria:** • Physician attestation that patient has experienced stability or slowing of decline based on an objective measure (e.g., absolute change from baseline in FVC). **Quantity Limit:** 2 tablets per day
Exxua™	**Non-PDL** **Approval Duration:** 6 months initial, 12 months renewal **Initial Approval Criteria:** • Diagnosis of major depressive disorder (MDD); **AND** • Prescriber must attest to monitoring of EKG during dosage titration and periodically during treatment; **AND**

Drug Requiring PA	Criteria for Prior Authorization
	• Prescribed by, or in consultation with, a psychiatrist, neurologist, or another qualified healthcare provider experienced in treating depression or related conditions; **AND** • Patient has had at least a 2-week trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications), or intolerance to 2 SSRIs (e.g., citalopram, escitalopram, fluoxetine), or 2 SNRIs (duloxetine, venlafaxine, desvenlafaxine); **AND** • Patient must meet the minimum age recommended by the package insert for the provided indication. **Renewal Criteria:** • Patient has experienced disease improvement and/or stabilization such as improvement in depressive symptoms, as assessed by the prescriber. **Quantity Limit:** 1 tablet per day
Lynkuet®	**Non-PDL** **Approval Duration:** 3 months initial, 12 months renewal **Initial Approval Criteria:** • Patient has a diagnosis of menopause with moderate to severe vasomotor symptoms; **AND** • Patient does not have moderate to severe hepatic impairment; **AND** • Patient does not have end-stage renal disease (with or without hemodialysis); **AND** • If female of childbearing potential, NOT pregnant or planning to become pregnant; **AND** • Patient will avoid concomitant therapy with strong CYP3A4 inhibitors and grapefruit juice (e.g., ketoconazole, itraconazole, clarithromycin, ritonavir, darunavir, etc.); **AND** • Patient will avoid concomitant therapy with moderate to strong CYP3A4 inducers (e.g., carbamazepine, phenytoin, phenobarbital, rifampin and related agents, St. John's wort, etc.); **AND** • Prescriber attests that baseline liver function tests have been conducted and that total and direct bilirubin, alanine aminotransferase (ALT), aspartate aminotransferase (AST), and serum alkaline phosphatase (ALP) levels are not elevated ≥ 2 times the upper limit of normal (ULN); **AND** • Prescriber attests that liver function testing follow-up will be conducted as outlined in prescribing information; **AND** • Patient has trialed and failed, or is not a candidate for, hormone therapy. **Renewal Criteria:** • Patient continues to meet the above criteria; **AND** • Patient must have symptom improvement; **AND**

Drug Requiring PA	Criteria for Prior Authorization

	• Patient has not experienced ANY of the following treatment-limiting adverse effects:
	  ○ ALT or AST > 5 times the ULN; **OR**
	  ○ ALT or AST > 3 times the ULN and total bilirubin > 2 times the ULN; **OR**
	  ○ Signs or symptoms that may suggest liver injury (e.g., new onset fatigue, decreased appetite, nausea, vomiting, pruritus, jaundice, pale feces, dark urine, abdominal pain, etc.).
	
	Age Limit: ≥ 18 years of age
	
	Quantity Limit: 2 capsules 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	
• **Antiretrovirals, HIV/AIDS** • **Antibiotics, Gastrointestinal** • **Antibiotics, Inhaled** • **Antibiotics, Vaginal** • **Antifungals, Oral** • **Antihistamines, Minimally Sedating** • **Cephalosporins and Related Antibiotics** • **Epinephrine, Self-Injectable** • **Hepatitis B Agents** • **Hepatitis C Agents** • **Leukotriene Modifiers**	• **Oral Antivirals, COVID-19** • **Oral Antivirals, Herpes** • **Oral Antivirals, Influenza** • **Oxazolidinones** • **Penicillins** • **Quinolones** • **Chronic Obstructive Pulmonary Disease (COPD) Agents** • **Sulfonamides, Folate Antagonist** • **Tetracyclines**

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 October 14, 2025, 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.

KY MCO Contact Information

Program Questions	KYMCOPBM@MedImpact.com
Pharmacy Help Desk	(800) 210-7628 [24 hours per day/ 7 days per week]
Prior Authorizations	Phone (844) 336-2676 [8:00AM - 7:00PM EST/ 7 days per week]; Fax (858) 357-2612
Pharmacy Portal	https://kyportal.medimpact.com/
BIN: 023880 / PCN: KYPROD1 / GROUP: KYM01	

KY FFS Contact Information

Program Questions	KYMFFS@MedImpact.com
Pharmacy Help Desk	(877) 403-6034 [24 hours per day/ 7 days per week]
Prior Authorizations	Phone (877) 403-6034 [8:00AM - 7:00PM EST/ 7 days per week] Fax (858) 357-2612
Pharmacy Portal	https://kyportal.medimpact.com/
BIN: 026309 / PCN: KYPROD1 / GROUP: KYF01	