



DATE: May 8, 2026
TO: Commonwealth of Kentucky Medicaid Prescriber Network
FROM: MedImpact Healthcare Systems
Subject: Upcoming Drug Coverage Updates

Status: Effective July 1, 2026, the Commonwealth of Kentucky Department for Medicaid Services (DMS) will implement prior authorization (PA) criteria for the agents listed in the table below.

Pharmacy providers are encouraged to work with prescribers and their impacted patients to obtain the necessary prior authorization information or find alternative therapies when appropriate. A copy of the criteria is available upon request by contacting MedImpact.

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.

Effective Date	Agent(s) Subject to Criteria	Coverage Updates
07/01/2026	Actimmune (interferon gamma-1b) Dojolvi (triheptanoin) Gattex (teduglutide) Ofev (nintedanib) Voxzogo (vosoritide)	Addition of clinical criteria

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	