NOTICE OF PDL CHANGES
KENTUCKY MEDICAID

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

PHARMACY PROVIDER NOTICE – APRIL 2026 P&T PDL CHANGES

May 13, 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 **May 7, 2026.**

The Kentucky Medicaid P&T Committee met on April 21, 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 July 1, 2026, the following changes will be effective:

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
Bone Resorption Suppression and Related Agents	alendronate tablet QL Bonsity AE, CC, QL ***Enoby syringe AE, CC, QL*** Forteo pen AE, CC, QL ibandronate tablet Jubbonti syringe AE, CC, QL raloxifene tablet	Actonel tablet QL alendronate solution QL Atelvia DR tablet QL Bildyos syringe AE, CC, QL Binosto tablet QL Bosaya AE, CC, QL calcitonin-salmon nasal spray, vial Conexxence syringe AE, CC, QL Evenity syringe AE, CC, QL Evista tablet Fosamax tablet QL Fosamax Plus D tablet QL Miacalcin vial Prolia syringe AE, CC, QL Reclast solution risedronate sodium tablet QL, DR tablet QL Stoboclo syringe AE, CC, QL teriparatide pen AE, CC, QL Tymlos pen AE, CC, QL zoledronic acid bag, bottle, vial

Drug Class	Preferred Agents	Non-Preferred Agents
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Janumet CC, QL Januvia CC, QL Jentadueto CC, QL Jentadueto XR CC, QL linagliptin/metformin QL ***sitagliptin/metformin ER*** CC, QL Nesina CC, QL Tradjenta CC, QL	alogliptin QL alogliptin/metformin QL alogliptin/pioglitazone QL Brynovin solution QL Glyxambi QL ***Janumet XR*** CC, QL Kazano QL Kombiglyze XR QL Onglyza QL Oseni QL Qtern QL saxagliptin QL saxagliptin/metformin ER QL sitagliptin QL sitagliptin/metformin CC, QL Steglujan AE, QL Trijardy XR QL Zituvio CC, QL Zituvimet CC, QL Zituvimet XR CC, QL
Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists	***Mounjaro*** AE, CC, QL Ozempic AE, CC, QL Trulicity CC, QL Victoza CC, QL	exenatide CC, QL liraglutide CC, QL Rybelsus AE, CC, QL Soliqua AE, CC, QL Xultophy AE, CC, QL

NEW PRODUCTS TO MARKET

Drug Requiring PA	Criteria for Prior Authorization
Palsonify™ (paltusotine)	**Non-PDL** **Approval Duration:** 12 months initial, 12 months renewal **Initial Approval Criteria:** • Documented diagnosis of acromegaly requiring medical therapy; **AND** • Prescribed by, or in consultation with, an endocrinologist or neurosurgeon, or specialist experienced in acromegaly management; **AND** • Inadequate response to pituitary surgery and/or surgery is not an option; **AND** • Documentation of inadequate response, intolerance, or contraindication to at least one injectable somatostatin analogue (SSA) following a trial of at least one month (≥ 30 days) (e.g., octreotide, lanreotide, Sandostatin, Somatuline); **AND** • Historical or current IGF-1 above the upper limit of normal for age/sex, or documentation of prior elevation with ongoing requirement for somatostatin-based medical therapy; **AND** • Provider attestation that the patient has been counseled on and is able to comply with empty-stomach administration instructions.

Drug Requiring PA	Criteria for Prior Authorization

	Renewal Criteria:
	
	• Documentation (e.g., progress note) of a positive response, such as:
	  ○ IGF-1 reduced to ≤1.0 × ULN or clinically meaningful reduction from baseline; **AND**
	  ○ Improvement or stabilization of acromegaly signs and symptoms (e.g., headache, soft tissue swelling, sweating, joint pain).
	
	Age Limit: ≥ 18 years of age
	
	Quantity Limit: 2 tablets per day

Voyxact® (sibeprenlimab-szsi)	**Non-PDL**
	
	Approval Duration: 3 months initial, 12 months renewal
	
	Initial Approval Criteria:
	
	• Diagnosis of primary immunoglobulin A nephropathy (IgAN); **AND**
	• Diagnosis is confirmed by kidney biopsy consistent with IgAN; **AND**
	• Prescriber submits documentation that patient meets the definition of high risk of disease progression, defined as:
	  ○ Proteinuria greater than or equal to 0.5 g/day; **OR**
	  ○ Urine protein-to-creatinine ratio (UPCR) greater than or equal to 0.8 g/g; **AND**
	• Prescribed by, or in consultation with, a nephrologist or other appropriate specialist in the treatment of IgAN; **AND**
	• Patient is stable on a maximally tolerated dose of angiotensin-converting enzyme inhibitors (ACEI) or angiotensin receptor blockers (ARB) unless contraindicated.
	
	Renewal Criteria:
	
	• Patient is stable on a maximally tolerated dose of angiotensin-converting enzyme inhibitors (ACEI) or angiotensin receptor blockers (ARB) unless contraindicated; **AND**
	• Prescribed by, or in consultation with, a nephrologist or other appropriate specialist in the treatment of IgAN; **AND**
	• Prescriber submits clinical documentation that the patient has experienced a clinical benefit compared to baseline, such as reduction in proteinuria or UPCR or stabilization or improvement in estimated glomerular filtration rate (eGFR).
	
	Age Limit: ≥ 18 years of age
	
	Quantity Limit: 1 syringe per 4 weeks

Attruby™ (acoramidis)	**Non-PDL** **Approval Duration:** 12 months initial, 12 months renewal **Initial Approval Criteria:**

Drug Requiring PA	Criteria for Prior Authorization

	• Documented diagnosis of transthyretin mediated cardiomyopathy (ATTR CM), either wild type or variant (hereditary), confirmed by appropriate diagnostic evaluation (e.g., Tc 99m PYP scan, cardiac MRI, biopsy, and/or genetic testing); **AND**
	• Prescribed by, or in consultation with, a cardiologist, geneticist, or specialist experienced in the management of transthyretin amyloidosis; **AND**
	• Documentation of clinical features consistent with symptomatic cardiomyopathy (e.g., heart failure symptoms such as dyspnea, fatigue, lower extremity edema, or reduced exercise tolerance); **AND**
	• Documentation that the patient is receiving optimized guideline-directed medical therapy (GDMT) for heart failure as clinically appropriate (e.g., beta-blocker, ACEi/ARB/ARNI, MRA, SGLT2i, diuretics), and/or documented medical reason(s) why not fully optimized.
	
	Renewal Criteria:
	
	• Documentation (e.g., progress note) that at least ONE of the following has occurred since treatment initiation:
	  ○ Stabilization or improvement in functional status (e.g., New York Heart Association [NYHA] class, 6-minute walk distance); **OR**
	  ○ Reduction in cardiovascular related hospitalization frequency versus baseline; **OR**
	  ○ Stabilization or improvement in cardiac biomarkers (e.g., NT proBNP) or echocardiographic/cardiac MRI parameters; **OR**
	  ○ Clinical impression from the cardiologist that the patient has derived meaningful benefit (slowed disease progression, improved symptoms, or improved quality of life); **AND**
	• Prescribed by, or in consultation with, a cardiologist, geneticist, or specialist experienced in the management of transthyretin amyloidosis.
	
	Age Limit: ≥ 18 years of age
	
	Quantity Limit: 4 tablets per day

Redemplo® (plozasiran)	**Non-PDL**
	
	Approval Duration: 12 months initial, 12 months renewal
	
	Initial Approval Criteria:
	
	• Diagnosis of familial chylomicronemia syndrome (FCS) confirmed by genetic mutations in one of the following:
	  ○ Lipoprotein lipase (LPL) gene; **OR**
	  ○ Apolipoprotein A-V (APOA5) gene; **OR**
	  ○ Glycosylphosphatidylinositol-anchored high-density lipoprotein-binding protein 1 (GPIHBP1) gene; **OR**
	  ○ Lipase maturation factor 1 (LMF1) gene; **OR**
	  ○ Apolipoprotein C-II (APOC2) gene; **AND**
	• Prescribed by, or in consultation with, an endocrinologist, or other specialist in the treatment of familial chylomicronemia syndrome (FCS); **AND**
	• Patient has a fasting triglyceride level greater than or equal to 880 mg/dL; **AND**

Drug Requiring PA	Criteria for Prior Authorization
	• Patient will follow a low-fat diet of less than or equal to 20 grams of fat per day. **Renewal Criteria:** • Prescribed by, or in consultation with, an endocrinologist, or other specialist in the treatment of familial chylomicronemia syndrome (FCS); **AND** • Documentation of clinically significant improvement or stabilization in the patient's condition such as reduction in fasting triglyceride levels, decreased frequency or severity of pancreatitis episodes. **Age Limit:** ≥ 18 years of age **Quantity Limit:** 1 syringe per 3 months
Forzinity™ (elamipretide)	**Non-PDL** **Approval Duration:** 12 months initial, 12 months renewal **Initial Approval Criteria:** • Diagnosis of Barth Syndrome, documented by genetic test demonstrating a pathogenic variant in the tafazzin (TAZ) gene; **AND** • Patient weighs at least 30 kg; **AND** • Prescriber attestation that the patient is ambulatory and able to complete a 6-minute walk test; **AND** • Documentation of baseline muscle strength (e.g., handheld dynamometry); **AND** • Prescribed by, or in consultation with, a cardiologist, hematologist, or other specialist in the diagnosis and treatment of Barth Syndrome. **Renewal Criteria:** • Clinical documentation demonstrating improvement or stabilization of muscle strength as measured by handheld dynamometry; **AND** • Prescribed by, or in consultation with, a cardiologist, hematologist, or specialist experienced in the management of Barth Syndrome. **Age Limit:** ≥ 12 years of age **Quantity Limit:** 4 vials per 28 days
Aqvesme™ (mitapivat)	**Non-PDL** **Approval Duration**: 6 months initial, 12 months renewal **Initial Approval Criteria:** • Diagnosis of anemia with alpha or beta thalassemia; **AND** • Patient meets ONE of the following: ○ Recent (within the last 30 days) hemoglobin level of ≤10.0 g/dL; **OR**

Drug Requiring PA	Criteria for Prior Authorization
	○ Prescriber attestation that patient has required ≥ 6 red blood cell (RBC) units within the last 24 weeks; **AND** • Prescribed by, or in consultation with, hematologist or other specialist; **AND** • Patient is not on concurrent treatment with Reblozyl or Pyrukynd. **Renewal Criteria:** • Prescriber submits clinical documentation that the patient has experienced a clinical benefit compared to baseline. **Age Limit:** ≥ 18 years of age **Quantity Limit:** 2 tablets per day
Pivya (pivmecillinam)	**Non-PDL** **Approval Duration:** 1 month **Approval Criteria:** • Patient is female; **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** ○ Proteus mirabilis; **OR** ○ Staphylococcus saprophyticus; **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 Pivya is not being used as step-down therapy for infections that previously required IV antibiotics. **Age Limit:** ≥ 18 years of age **Quantity Limit:** 21 tablets per 7-day course
Zycubo® (copper histidinate)	**Non-PDL** **Approval Duration**: 6 months initial, 6 months renewal **Initial Approval Criteria:** • Diagnosis of Menkes disease; **AND**

Drug Requiring PA	Criteria for Prior Authorization

	• Patient has documented laboratory evidence of a genetic mutation in the ATP7A gene; **AND**
	• Patient has documented serum copper < 75 mcg/dL; **AND**
	• Prescriber attests to monitoring the following before initiating treatment and as clinically indicated during treatment:
	  ○ Serum copper and ceruloplasmin levels; **AND**
	  ○ Serum electrolytes; **AND**
	  ○ Kidney and liver function; **AND**
	  ○ Complete blood count (CBC); **AND**
	• Medication will not be used concomitantly with other copper-containing therapies; **AND**
	• Documentation (e.g., progress note or lab report) of response to therapy compared to baseline; **AND**
	• Prescribed by, or in consultation with, a pediatric neurologist, geneticist, or other specialist in the diagnosis and treatment of Menkes disease.
	
	Renewal Criteria:
	
	• Documentation (e.g., progress note or lab report) of response to therapy compared to baseline; **AND**
	• Prescribed by, or in consultation with, a pediatric neurologist, geneticist, or other specialist in the diagnosis and treatment of Menkes disease.
	
	Age Limit: ≤ 18 years of age
	
	Quantity Limit: 2 vials per day

Cardamyst™ (etripamil)	**Non-PDL** **Approval Duration:** 12 months initial, 12 months renewal **Approval Criteria:** • Diagnosis of paroxysmal supraventricular tachycardia (PSVT) confirmed by electrocardiogram (ECG); **AND** • Prescriber attestation that the patient has a history of sustained, symptomatic episodes of PSVT (e.g., typically lasting 20 minutes or longer); **AND** • Concurrent oral medications will be used for controlling the ventricular rate (e.g. calcium channel blockers, digoxin, amiodarone, beta-blockers) or regulating sinus rhythm (e.g. ibutilide, flecainide, amiodarone, propafenone) as clinically appropriate; **AND** • Medication will be used for the conversion of acute symptomatic episodes of PSVT; **AND** • Prescribed by, or in consultation with, a cardiologist, or other specialist in the diagnosis and treatment of PSVT. **Age limit:** ≥ 18 years of age **Quantity Limit:** 4 nasal spray devices per month

Drug Requiring PA	Criteria for Prior Authorization

Myqorzo™ (aficamten)	**Non-PDL**
	
	Approval Duration: 6 months initial, 12 months renewal
	
	Initial Approval Criteria:
	
	• Diagnosis of obstructive hypertrophic cardiomyopathy (oHCM); **AND**
	• Documentation of left ventricular hypertrophy based on ONE of the following:
	  ○ Maximal left ventricular wall thickness greater than or equal to 15 mm; **OR**
	  ○ Familial hypertrophic cardiomyopathy with a maximal left ventricular wall thickness greater than or equal to 13 mm; **AND**
	• Patient has New York Heart Association (NYHA) Class II or Class III symptoms of heart failure; **AND**
	• Documentation of left ventricular ejection fraction (LVEF) greater than or equal to 55%; **AND**
	• Patient has a peak left ventricular outflow tract gradient greater than or equal to 30 mmHg at rest or greater than or equal to 50 mmHg after provocation (Valsalva maneuver or post exercise); **AND**
	• Prescribed by, or in consultation with, a cardiologist, or other specialist in the treatment of oHCM; **AND**
	• Patient must have an adequate trial and failure of one of the following:
	  ○ beta blocker, **OR**
	  ○ non-dihydropyridine calcium channel blocker.
	
	Renewal Criteria:
	
	• Documentation of left ventricular ejection fraction (LVEF) ≥ 50% for renewal; **AND**
	• Prescriber submits clinical documentation that the patient has experienced a disease improvement and/or stabilization from baseline (e.g., at least 1 NYHA class decrease, greater than or equal to 1.5 mL/kg/min in pVO2 increase or greater than or equal to 3 mL/kg/min in pVO2 without NYHA class worsening); **AND**
	• Prescribed by, or in consultation with, a cardiologist, or other specialist in the treatment of oHCM.
	
	Age Limit: ≥ 18 years of age
	
	Quantity Limit: 1 tablet 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	
• **Narcotic Agonist/Antagonists** • **Narcotics, Fentanyl Buccal Products** • **Narcotics, Long-Acting** • **Narcotics, Short-Acting** • **Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)** • **Opiate Dependence Treatments** • **Antihyperuricemics** • **Erythropoiesis Stimulating Proteins** • **Phosphate Binders** • **Sickle Cell Anemia Treatments** • **Thrombopoiesis Stimulating Proteins** • **Alpha-Glucosidase Inhibitors** • **Insulins and Related Agents**	• **Meglitinides** • **Metformins** • **Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors** • **Sulfonylureas** • **Thiazolidinediones (TZDs)** • **Androgenic Agents** • **Glucagon Agents** • **Growth Hormone** • **Pancreatic Enzymes** • **Progestins for Cachexia** • **Steroids, Oral** • **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 May 13, 2026, 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	