



The following tables provide a summary of the official recommendations made by the Pharmacy and Therapeutics (P&T) Advisory Committee at the **October 13, 2026**, meeting.

Pending is the review by the Commissioner of the Department for Medicaid Services of the Cabinet for Health and Family Services of these recommendations and final decisions.

RECOMMENDATIONS

	DESCRIPTION OF RECOMMENDATION	P&T VOTE
1	<p>New Product to Market: Hepcludex® (bulevirtide-gmod)</p> <p>Non-PDL</p> <p>Approval Duration: 1 year initial, 1 year renewal</p> <ul style="list-style-type: none"> <i>Hepcludex® (bulevirtide-gmod) is a viral entry inhibitor that is indicated for the treatment of chronic hepatitis delta virus (HDV) infection in adults without cirrhosis or with compensated cirrhosis.</i> <p>Initial Approval Criteria:</p> <ul style="list-style-type: none"> Diagnosis hepatitis D virus infection; without cirrhosis or with compensated cirrhosis; AND Prescribed by, or in consultation with, a hepatologist, gastroenterologist, infectious disease, transplant or other appropriate specialist; AND Patient does NOT have decompensated cirrhosis (Child-Pugh B or C); AND Documentation (e.g., chart note or lab report) of the following clinical data: <ul style="list-style-type: none"> Recent (within 3 months) quantitative HDV RNA level (HDV viral load); AND Elevated alanine aminotransferase (ALT) levels (>34 U/L for females and > 49 U/L for males); AND Prescriber attests that hepatitis B virus (HBV) infection is managed as clinically appropriate; AND Patient must meet the minimum age recommended by the package insert for this FDA-approved indication. <p>Renewal Criteria:</p> <ul style="list-style-type: none"> Patient has experienced disease improvement or stabilization as evidenced by one of the following: <ul style="list-style-type: none"> Reduction in HDV RNA levels or undetectable HDV RNA; OR Reduction or normalization of ALT values. <p>Quantity Limit: 1 vial per day</p>	<p>Decision 8 For 0 Against</p>
2	<p>New Product to Market: Xocova™ (ensitrelvir)</p> <p>Anti-Infective – Oral Antivirals, COVID-19: Non-Preferred</p> <p>Approval Duration: 1 month</p> <ul style="list-style-type: none"> <i>Xocova™(ensitrelvir) is an inhibitor of the SARS-CoV-2 main protease (Mpro), also referred to as 3C-like protease (3CLpro) or nonstructural protein 5 (nsp5) protease.</i> 	<p>Decision 8 For 0 Against</p>





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	<p><i>Inhibition of SARS-CoV-2 Mpro renders it incapable of processing the viral polypeptides pp1a and pp1ab, preventing viral replication.</i></p> <p>Approval Criteria:</p> <ul style="list-style-type: none"> Member does not have known or suspected active COVID-19 infection at the time treatment is initiated; AND Recent contact with and suspected exposure to COVID-19; AND Treatment will be initiated as soon as possible and within 72 hours of symptom onset; AND If the patient is a female of childbearing potential, the patient is not pregnant. <p>Age Limit: ≥ 12 years of age</p> <p>Quantity Limit: 7 tablets per 5-day course and 1 fill per 30 days</p>	
3	<p>New Product to Market: Lynavoy® (lirerixibat)</p> <p>Anti-Infective – Gastrointestinal, Bile Salts: Non-Preferred</p> <p>Approval Duration: 1 year initial, 1 year renewal</p> <ul style="list-style-type: none"> <i>Lynavoy® (lirerixibat) is an ileal bile acid transporter (IBAT) inhibitor approved for cholestatic pruritus associated with primary biliary cholangitis (PBC) in adults.</i> <p>Initial Approval Criteria:</p> <ul style="list-style-type: none"> Diagnosis of cholestatic pruritus associated with primary biliary cholangitis; AND Patient meets two of the following: <ul style="list-style-type: none"> Elevation of alkaline phosphatase (ALP levels > 200 IU/L); OR Presence of antimitochondrial antibody (AMA) or other PBC-specific autoantibodies (including sp100 or gp210, if AMA is negative); OR Histopathological evidence of primary biliary cirrhosis; AND Patient does NOT have decompensated cirrhosis or prior or active hepatic decompensation events (variceal hemorrhage, ascites, hepatic encephalopathy); AND Prescribed by, or in consultation with, a hepatologist or gastroenterologist; AND Patient has a history of trial and therapeutic failure, allergy, contraindication (including potential drug-drug interactions with other medications), or intolerance to at least 1 pruritus treatment (ursodiol or cholestyramine); AND Patient must meet the minimum age recommended by the package insert for this FDA-approved indication. <p>Renewal Criteria:</p> <ul style="list-style-type: none"> Patient does not have unexplained liver elevations or uncorrected vitamin deficiencies; AND Patient has experienced reduction in pruritus. <p>Quantity Limit: 2 tablets per day</p>	<p>Decision 8 For 0 Against</p>
4	<p>New Product to Market: Awiqli® (insulin icodec-abae)</p> <p>Diabetes – Insulin and Related Agents: Non-Preferred</p>	<p>Decision 8 For 0 Against</p>





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	<p>Approval Duration: 1 year initial, 1 year renewal</p> <ul style="list-style-type: none"><i>Awiiqli® (insulin icodec-abae) is a once-weekly long-acting basal insulin for adults with type 2 diabetes mellitus.</i> <p>Initial Approval Criteria:</p> <ul style="list-style-type: none">Diagnosis of type 2 diabetes mellitus; ANDPatient is at least 18 years of age; ANDTrial and failure, allergy, contraindication (including potential drug-drug interactions with other medications), or intolerance of at least two preferred long-acting insulins. <p>Renewal Criteria:</p> <ul style="list-style-type: none">Patient is currently receiving Awiiqli and previously met initial approval criteria; ANDPatient demonstrates a positive clinical response to Awiiqli therapy; ANDContinued need for Awiiqli therapy is documented. <p>Quantity Limit: 6 mL per 28 days</p>	
5	<p>New Product to Market: Lipfendra® (enlicotide)</p> <p>Cardiovascular – Lipotropics: Non-Preferred</p> <p>Approval Duration: 6 months initial, 1 year renewal</p> <ul style="list-style-type: none"><i>Lipfendra® (enlicotide) is a proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitor indicated as an adjunct to diet and exercise to reduce low-density lipoprotein cholesterol (LDL-C) in adults with hypercholesterolemia, including heterozygous familial hypercholesterolemia (HeFH).</i> <p>Initial Approval Criteria:</p> <ul style="list-style-type: none">Diagnosis of hypercholesterolemia, including heterozygous familial hypercholesterolemia (HeFH); ANDPrescribed initially by, or in consultation with, a cardiologist, lipid specialist, endocrinologist, vascular medicine or other applicable specialist; ANDPrescriber submits documentation (e.g., chart note or lab report) of low-density lipoprotein cholesterol (LDL-C) prior to/without PCSK9 inhibitor therapy; ANDOne of the following:<ul style="list-style-type: none">Patient has not achieved LDL goal after at least 3- month trial and failure of maximally tolerated high-intensity statin therapy (e.g., rosuvastatin 40 mg daily), as defined by one of the following:<ul style="list-style-type: none">LDL-C ≥55 mg/dL for patient with a history of a major atherosclerotic cardiovascular disease (ASCVD) event, ORLDL-C ≥70 mg/dL for patient at increased risk for first ASCVD event, ORPatient does not tolerate statins (at least two statin trials of any length were unsuccessful due to adverse effects); ANDTrial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to Repatha. <p>Renewal Criteria:</p> <ul style="list-style-type: none">Prescriber submits clinical documentation (e.g., progress note or lab report) that demonstrate a reduction in LDL-C when compared to the baseline values.	<p>Decision 8 For 0 Against</p>





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	Quantity Limit: 1 tablet per day	
6	<p>New Product to Market: Trutakna™ (atacept-vymj)</p> <p>Non-PDL</p> <p>Approval Duration: 3 months initial; 1 year renewal</p> <ul style="list-style-type: none">Trutakna™ (atacept-vymj) is an immune targeted biologic used to reduce proteinuria in adults with primary IGA nephropathy who are at risk for disease progression. <p>Initial Approval Criteria:</p> <ul style="list-style-type: none">Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy; ANDPatient is not currently receiving dialysis and has not undergone kidney transplantation; ANDPrescriber submits documentation (e.g., chart note or lab report) that patient meets the definition of high risk of disease progression, as defined as:<ul style="list-style-type: none">Proteinuria ≥ 1.0 g/day; ORUrine protein-to-creatinine ratio (UPCR) ≥ 1.0 g/g; ANDDiagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy; ANDPrescribed by, or in consultation with, a nephrologist or other appropriate specialist in the treatment of IgAN; ANDPatient is stable on a maximally tolerated dose of angiotensin-converting enzyme inhibitors (ACEI) or angiotensin receptor blockers (ARB) unless contraindicated. <p>Renewal Criteria:</p> <ul style="list-style-type: none">Patient is stable on a maximally tolerated dose of angiotensin-converting enzyme inhibitors (ACEI) or angiotensin receptor blockers (ARB) unless contraindicated; ANDPrescribed by, or in consultation with, a nephrologist or other appropriate specialist in the treatment of IgAN; ANDPrescriber submits clinical documentation (e.g., chart note or lab report) that the patient has experienced disease improvement compared to baseline (such as reduction in proteinuria or UPCR) or stabilization. <p>Age Limit: ≥ 18 years of age</p> <p>Quantity Limit: 4 mL per 28 days</p>	<p>Decision 8 For 0 Against</p>
7	<p>New PDL Class: Hereditary Angioedema (HAE) Agents</p> <ul style="list-style-type: none">DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.Agents not selected as preferred will be considered non-preferred and will require PA.For any new chemical entity in the Hereditary Angioedema class, require PA until reviewed by the P&T Committee.	<p>Decision 8 For 0 Against</p>
8	<p>New PDL Class: Phenylketonuria (PKU) Agents</p> <p><i>The committee recommended to extend initial approvals from 1 month to 3 months.</i></p>	<p>Decision 8 For</p>





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	<ul style="list-style-type: none">DMS to select preferred agent(s) based on economic evaluation; however, at least 1 unique chemical entities should be preferred.Agents not selected as preferred will be considered non-preferred and will require PA.For any new chemical entity in the Hereditary Angioedema class, require PA until reviewed by the P&T Committee.	0 Against
9	Antiparasitics, Topical <ul style="list-style-type: none">DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.Agents not selected as preferred will be considered non-preferred and will require PA.For any new chemical entity in the Antiparasitics, Topical class, require PA until reviewed by the P&T Committee.	Decision 8 For 0 Against
10	Cytokine & CAM Antagonists <ul style="list-style-type: none">DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.Agents not selected as preferred will be considered non-preferred and will require PA.For any new chemical entity in the Cytokine & CAM Antagonists Topical class, require PA until reviewed by the P&T Committee.	Decision 8 For 0 Against
11	Gastrointestinal Motility, Chronic <ul style="list-style-type: none">DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.Agents not selected as preferred will be considered non-preferred and will require PA.For any new chemical entity in the Gastrointestinal Motility, Chronic class, require PA until reviewed by the P&T Committee.	Decision 8 For 0 Against
12	Laxatives and Cathartics <ul style="list-style-type: none">DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.Agents not selected as preferred will be considered non-preferred and will require PA.For any new chemical entity in the Laxatives and Cathartics class, require PA until reviewed by the P&T Committee.	Decision 8 For 0 Against
13	Sodium-Glucose Cotransporter 2 (SGLT2) Inhibitors <ul style="list-style-type: none">DMS to select preferred agent(s) based on economic evaluation; however, at least 1 unique chemical entities should be preferred.Agents not selected as preferred will be considered non-preferred and will require PA.For any new chemical entity in the SGLT2 Inhibitors class, require PA until reviewed by the P&T Committee.	Decision 8 For 0 Against
14	Ophthalmics, Immunomodulators <ul style="list-style-type: none">DMS to select preferred agent(s) based on economic evaluation; however, at least 1 unique chemical entities should be preferred.Agents not selected as preferred will be considered non-preferred and will require PA.For any new chemical entity in the Ophthalmics, Immunomodulators class, require PA until reviewed by the P&T Committee.	Decision 8 For 0 Against





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CONSENT AGENDA

For the following therapeutic classes, the P&T Committee had no recommended changes to the currently posted Preferred Drug List (PDL) status. The committee accepted the consent agenda, but made the recommendation to reevaluate the Immunomodulator, Asthma class at the January meeting.

	THERAPEUTIC CLASSES	P&T VOTE
15	<ul style="list-style-type: none">• Acne Agents, Oral• Acen Agents, Topical• Anti-Ulcer Protectants• Antibiotics, Topical• Anticholinergics and Antispasmodics• Antidiarrheals• Antiemetics and Antivertigo Agents• Antifungals, Topical• Antipsoriatics, Oral• Antivirals, Topical• Bile Salts• H. Pylori Treatment• Immunomodulators, Asthma• Immunomodulators, Atopic Dermatitis• Immunosuppressives, Oral• Multiple Sclerosis Agents• Ophthalmics, Antibiotics• Ophthalmics, Antibiotic-Steroid Combinations• Ophthalmics, Antivirals• Ophthalmics, Beta Blockers• Ophthalmics, Carbonic Anhydrase Inhibitors• Ophthalmics, Combinations for Glaucoma• Ophthalmics, Glaucoma Agents (Other)• Ophthalmics, Mast Cell Stabilizers• Ophthalmics, Mydriatic• Ophthalmics, NSAIDs• Ophthalmics, Prostaglandin Agonists• Ophthalmics, Sympathomimetics• Otics, Anesthetics and Anti-Inflammatory• Otics, Antibiotics• Proton Pump Inhibitors• Rosacea Agents, Topical• Steroids, Topical• Ulcerative Colitis Agents	Decision 8 For 0 Against

