Pharmacy Quarterly Newsletter

Quarter 1 2026 Volume 1, Number 9

Events

Second Quarter Provider Webinar Forum
Wednesday, April 29th 9:00am – 10:00am EST https://kyportal.medimpact.com/sites/default/files/2026-04/kym_pwf_pc_4-15-26_0.pdf

Current Drug Recalls and Market Withdrawals

Notice Date	Drug/Manufacturer	Source
2/5/26	**All Lot Recall:** Freestyle Libre 3 and Freestyle Libre 3 plus Sensor	Link
2/18/26	**All Lot Recall:** True Metrix Blood glucose monitoring system	Link

For additional information regarding the recalls, please refer to the FDA recall notifications at:

https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts

Dexcom G6 Discontinuation

Starting July, 1, 2026 Dexcom G6 will no longer be manufactured. While supplies may continue to be available through patients local pharmacy or medical distributor for a period of time after that date, we cannot guarantee availability. To ensure uninterrupted Dexcom CGM supplies and support, we recommend pharmacies and prescribers collaborate to upgrade patients to either Dexcom G7 or Dexcom G7 15 Day by July 2026.

Zolgensma & Itvisma Billing Guidance

As a reminder, all Zolgensma and Itvisma prior authorization (PA) requests must be sent to MedImpact for review and approval.

Once the Zolgensma or Itvisma PA request is approved:

MCO members: the claim will need to be billed through MCOs using the 837-p/CMS-1500 form. MCO shall coordinate the billing with the pharmacy and the provider, which must be one of two specialty pharmacies (provider type 54) cleared for this process: Accredo Health Group or Orsini Pharmaceutical Services.

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FFS members: MedImpact will include Gainwell Provider Helpdesk contact information in the approval letter for providers to reach out to regarding any billing questions. MedImpact pharmacist will include in the notification email and request that Zolgensma or Itvisma be billed using the 837-P/CMS-1500 form. FFS providers shall coordinate the billing with the pharmacy, which must be one of two specialty pharmacies (provider type 54) cleared for this process: Accredo Health Group or Orsini Pharmaceutical Services.

CGRP Prior Authorizations

On April 15th, 2026, the Commonwealth of Kentucky Department of Medicaid Services (DMS) implemented a policy allowing each member to utilize only one Calcitonin Gene-Related Peptide (CGRP) Inhibitor for acute migraine treatment and one for preventative migraine treatment at a time.

If a member currently has an approved Prior Authorization (PA) for both treatment categories and their prescriber submits a new PA request to switch to a different formulation, the existing PA will be updated to the new formulation, provided the member meets the approval criteria. Renewal requests for the same formulation will follow the standard renewal criteria.

For Nurtec ODT, which may be used for both acute and preventative therapy, if a member is prescribed a second CGRP inhibitor (either acute or preventative), a soft edit will prompt the pharmacist to confirm that Nurtec ODT and the second CGRP inhibitor are not being used for the same purpose. Use of Nurtec ODT in combination with two or more CGRP inhibitors of any type will no longer be approved. Providers may reference the table below to identify migraine therapies on the Medicaid Preferred Drug List (PDL):

Preferred Drug Category	Preferred Agents	Preferred with PA	Non-Preferred
ANTIMIGRAINE AGENTS, CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS AND OTHER AGENTS: **ACUTE TREATMENT**		Nurtec ODT Ubrelvy tablet	~~Reyvow tablet~~ (manufacturer discontinued) Zavzpret spray
ANTIMIGRAINE AGENTS, CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS AND OTHER AGENTS: **PROPHYLAXIS, INJECTABLE**		Aimovig autoinjector Ajovy autoinjector Ajovy syringe Emgality pen	Emgality 100 mg/mL syringe
ANTIMIGRAINE AGENTS, CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS AND OTHER AGENTS: **PROPHYLAXIS, ORAL**		Nurtec ODT Qulipta tablet	

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Furoscix Injection Kit Prior Authorization Criteria

Please be advised that DMS will implement clinical criteria for Furoscix Injection Kit starting May 1, 2026. The new prior authorization (PA) criteria are defined below. Pharmacy providers are encouraged to work with prescribers and their impacted patients to either obtain the necessary prior authorization or find alternative therapies when appropriate.

Effective Date	Agent(s) Subject to Criteria	Criteria for Approval
05/01/2026	**Furoscix Injection Kit**	**Approval Duration:** 3 months initial, 3 months renewal **Initial Approval Criteria:** • Diagnosis of Chronic Heart Failure (CHF) or Chronic Kidney Disease (CKD) including nephrotic syndrome; **AND** • Documentation of current edema/volume overload requiring parenteral diuresis; **AND** • Prescribed by, or in consultation with, a cardiologist, nephrologist, or other specialist in the treatment of CHF or CKD; **AND** • Prescriber attestation of ALL of the following: o Patient is hemodynamically stable; **AND** o Patient is a candidate for diuresis outside of the hospital; **AND** o Medication is being used for short-term, episodic decongestion; **AND** o Therapeutic plan to transition back to oral loop diuretics when clinically appropriate is in place; **AND** o Patient/caregiver has a documented home management plan (e.g., home weight measurements, symptom monitoring, follow-up labs, device alarm response,

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Effective Date	Agent(s) Subject to Criteria	Criteria for Approval

		criteria for repeat dosing, clear thresholds for escalation of care, etc.); **AND**
		• Documentation of ONE of the following:
		  ○ Recent optimization of oral diuretic strategy with insufficient response, intolerance, contraindication; **OR**
		  ○ Clinical rationale why alternative loop-diuretic formulations/settings (e.g., higher-dose oral, clinic/infusion-center IV) are not suitable for this episode; **AND**
		• Documentation of baseline renal function and electrolytes (serum creatinine/eGFR, BUN, sodium, potassium, bicarbonate) obtained prior to first dose; **AND**
		• Patient must meet the minimum age and weight recommended by the package insert for the FDA-approved indication; **AND**
		• The requested dose does not exceed the FDA-approved dose for this indication.
		
		Renewal Criteria:
		
		• Patient continues to meet the above criteria; **AND**
		• Prescriber attestation of clinically significant improvement or stabilization in clinical signs and symptoms; **AND**
		• Documentation of recent labs within the current authorization period (serum creatinine/eGFR, BUN, sodium, potassium, bicarbonate); **AND**
		• Provider attestation that a therapeutic plan to transition back to oral loop diuretics remains in place.
		
		Quantity Limit: 8 kits per 30 days

Providers are encouraged to reference the Kentucky Medicaid PDL and Prior Authorization documents found on the MedImpact Provider Portal at: https://kyportal.medimpact.com/provider-documents/drug-information.

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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Hypertonic Saline Coverage Updates

Effective April 1st, 2026, DMS implemented prior authorization (PA) criteria for the covered hypertonic saline NDCs listed below.

- Members who are new starts or have not filled hypertonic saline between November 1, 2025 and February 1, 2026 require a PA starting April 1, 2026.
- Members with at least one paid claim for hypertonic saline between November 1, 2025 and February 1, 2026 will have a grandfathered prior authorization through May 1, 2026. After May 1st, these members will need to obtain a new PA or transition to a different therapy, if appropriate.
- For diagnoses not listed below, prescribers are encouraged to obtain prior authorization for hypertonic saline and submit supporting clinical literature to demonstrate medical necessity.

Covered Hypertonic Saline	NDC	Criteria for Approval
NEBUSAL 3% VIAL	50190014263	**Approval Duration**: 12 months Patient has a confirmed diagnosis of ONE of the following: • Cystic fibrosis (ICD-10 group E84) • Bronchiectasis (ICD-10 group J47) • Congenital bronchiectasis (Q33.4) • Acute bronchiolitis (ICD-10 group J21)
SODIUM CHLORIDE 3% VIAL	00378699789	
PULMOSAL 7% VIAL	50190074060	
SODIUM CHLORIDE 7% VIAL	50190014123	
SODIUM CHLORIDE 7% VIAL	83490030760	

Insulin Degludec Discontinuation

Novo Nordisk has announced the discontinuation of Insulin degludec (the generic for Tresiba) vials and pens. Pharmacies and prescribers should collaborate to transition patients to therapeutically appropriate and covered alternative medications. Providers may reference the table below to identify possible alternative therapies on the Medicaid Preferred Drug List (PDL):

Preferred Agents	Non-Preferred Agents
insulin glargine Solostar U100 (generic for Lantus Solostar)	Basaglar KwikPen and Tempo Pen CC
insulin glargine vial	insulin glargine Solostar and Max Solostar (generic for Toujeo)
Lantus and Lantus Solostar	insulin glargine-yfgn pen and vial CC
Levemir FlexPen, FlexTouch, and vial	Rezvoglar Kwikpen
	Semglee (yfgn) pen and vial CC
	Toujeo Solostar and Max Solostar
	Tresiba FlexTouch and vial

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Pulmicort Rebate Status Change

H2-Pharma has announced the discontinuation of Pulmicort Flexhaler® (budesonide) National Drug Codes (NDCs) associated with labeler codes 00186 and 6129, which currently participate in the Medicaid Drug Rebate Program (MDRP). New NDCs for Pulmicort Flexhaler, associated with the manufacturer Rubicon Holdings (labeler code 85612), do not participate in the MDRP and therefore will not be covered by the Kentucky Department for Medicaid Services (DMS). Currently, there will be no change in coverage for Pulmicort Respules.

Labeler codes 00186 and 6129 will continue to be covered while supplies last; however, pharmacies and prescribers should collaborate to transition patients to therapeutically appropriate and covered alternative medications as soon as possible. Providers may reference the table below to identify possible alternative therapies on the Medicaid Preferred Drug List (PDL):

Preferred Agents	Non-Preferred Agents
Asmanex Twisthaler QL	Alvesco QL
budesonide inhalation suspension AE, CC, QL	ArmonAir Digihaler QL
Flovent HFA QL	Arnuity Ellipta QL
fluticasone propionate HFA QL	Asmanex HFA QL
	Flovent Diskus QL
	fluticasone furoate
	Pulmicort Respules QL
	Qvar Redihaler

Updates to Stelara Prior Authorizations

Please be advised that DMS implemented updates related to prior authorizations (PAs) for Stelara® (ustekinumab) and its unbranded biologic, ustekinumab. This change supports the transition to preferred biosimilar ustekinumab products, Pyzchiva® and Yesintek® and helps promote cost savings across the Kentucky Medicaid pharmacy network while maintaining comparable clinical outcomes for members.

Key Updates:

• Effective April 1, 2026, prior authorizations approved prior to January 16, 2026, for Stelara® and its unbranded biologic, ustekinumab will be termed.
• New prior authorizations for the preferred biosimilar ustekinumab products, Pyzchiva® and Yesintek® have been entered for impacted members and are approved through December 31, 2026.
• Stelara® prior authorizations approved on or after January 16, 2026, will remain active and are not impacted. These approvals were reviewed under the updated guideline applicable to non-preferred ustekinumab products.

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Pharmacy Billing and Substitution Guidance:
• Under KRS 217.822, Kentucky pharmacists may substitute an FDA-designated interchangeable biologic for a prescribed biologic product when permitted by law.
• Interchangeable biosimilar ustekinumab products may be dispensed in place of Stelara® without a new prescription.
• Pharmacies must notify the prescriber within five (5) days of dispensing the biosimilar product.
• Claims for Stelara® submitted after April 1, 2026, may be denied if an active prior authorization is not on file.

Wegovy Prior Authorization

As of January 10th, 2026, DMS implemented a restriction limiting members to one Wegovy formulation. If a member has an active prior authorization (PA) for one Wegovy formulation, and their prescriber requests for a different formulation in a new PA request, the previously approved PA will be updated to the new formulation if the member meets the approval criteria. Renewal requests for the same formulation will follow the standard renewal criteria.

PA criteria for Wegovy can be found at the following location: https://kyportal.medimpact.com/provider-documents/drug-information

Zegalogue Discontinuation

Novo Nordisk has announced the discontinuation of Zegalogue auto injector, and prefilled syringeassociated with National Drug Codes (NDCs): NDC 00169-1912-01, NDC 00169-1912-02, NDC 00169-1913- 01 and NDC 00169-1913-02. Pharmacies and prescribers should collaborate to transition patients to therapeutically appropriate and covered alternative medications. Providers may reference the table below to identify possible alternative therapies on the Medicaid Preferred Drug List (PDL):

Preferred Agents	Non-Preferred Agents
Baqsimi spray CC	diazoxide suspension
Gvoke autoinjector, syringe	glucagon emergency kit
Proglycem suspension	Gvoke vial

Providers are encouraged to reference the Kentucky Medicaid PDL and Prior Authorization documents found on the MedImpact Provider Portal at: https://kyportal.medimpact.com/provider-documents/drug information.

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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Questions / Additional Information

Please direct any questions to KYMFFS@medimpact.com for FFS members and to KYMCOPBM@medimpact.com for MCO members.

Contact Information

Contact	Contact Information	Availability
Member Services (CHFS)	800-635-2570	8AM to 5PM EST, Monday to Friday
Clinical Support Center (Prior Authorizations)	MCO Phone: 844-336-2676 FFS Phone: 877-403-6034	8AM to 7PM EST, 7 days a week
	MCO and FFS Fax: 858-357-2612	24 hours a day, 7 days a week
Pharmacy/Provider Help Desk	MCO Phone: 800-210-7628 FFS Phone: 877-403-6034	24 hours a day, 7 days a week
MAC Pricing	MAC List: Available on MedImpact Provider Portal under "Resources" page https://kyportal.medimpact.com/provider-documents/maximum-allowable-cost-mac	24 hours a day, 7 days a week
	To appeal MAC pricing: Fax: 877-357-0005 E-mail: StateMACProgram@medimpact.com	
Voice Response Eligibility Verification	800-807-1301	24 hours a day, 7 days a week
Provider Management/Enrollment	Phone: 877-838-5085 Fax: 502-226-1898	8AM to 4:30PM EST, Monday to Friday
MedImpact KY MCO and FFS PBM Account Teams	MCO: KYMCOPBM@MedImpact.com FFS: KYMFFS@MedImpact.com	8AM to 5PM EST, Monday to Friday Other times: on-call

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Contact	Contact Information	Availability
Provider Paper Claims Billing Address	Mail: ATTN: CLAIMS DEPT MedImpact Healthcare Systems, Inc. PO Box 509098 San Diego, CA 92150-9098 Email: claims@medimpact.com Fax: 858-549-1569	
Coordination of Benefits (Member Services)	FFS: 800-635-2570	8AM to 7PM EST, Monday to Friday
	AETNA: 855-300-5528	7AM to 7PM EST, Monday to Friday
	HUMANA: 800-444-9137	
	PASSPORT MOLINA: 800-578-0603	
	UNITED: 866-293-1796	
	WELLCARE: 877-389-9457	
Lock-in (Member Services)	AETNA: 855-300-5528	8AM to 5PM EST, Monday to Friday
	HUMANA: 833-410-2496	8AM to 5:30PM EST, Monday to Friday
	PASSPORT MOLINA: 800-578-0603	
	UNITED: 866-293-1796	
	WELLCARE: 877-389-9457	
Websites	DMS: https://www.chfs.ky.gov/agencies/dms/dpo/ppb/Pages/default.aspx MedImpact KY FFS & MCO Provider Portal: http://pharmacy.medimpact.com MedImpact KY FFS & MCO website: http://kyportal.medimpact.com	24 hours a day, 7 days a week

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