NOTICE OF PDL CHANGES
KENTUCKY MEDICAID

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

PHARMACY PROVIDER NOTICE – OCTOBER 2026 P&T PDL CHANGES

November 10, 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 **October 23, 2026.**

The Kentucky Medicaid P&T Committee met on October 13, 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 **January 1, 2027**, 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
Antiparasitics, Topical	permethrin cream spinosad suspension	Crotan lotion Elimite cream Eurax cream Eurax lotion malathion lotion ***Natroba suspension*** Ovide lotion Pruradik lotion
Cytokine & CAM Antagonists	adalimumab-aaty (CF) autoinjector adalimumab-aaty (CF) syringe ***adalimumab-adaz (CF) pen*** ***adalimumab-adaz (CF) syringe*** ***adalimumab-adbm (CF) Crohn's (only labeler 00597)*** ***adalimumab-adbm (CF) psoriasis/uveitis pen (only labeler 00597)*** ***adalimumab-adbm (CF) syringe (only labeler 00597)*** ***adalimumab-adbm (CF) pen (only labeler 00597)*** adalimumab-fkjp (CF) pen 40 mg adalimumab-fkjp (CF) syringe 40 mg	Abrilada (CF) pen Abrilada (CF) syringe Actemra ACTpen Actemra syringe adalimumab-aacf (CF) pen adalimumab-aacf (CF) syringe adalimumab-adbm (CF) Crohn's (only labeler 82009) adalimumab-adbm (CF) psoriasis/uveitis pen (only labeler 82009) adalimumab-adbm (CF) syringe (only labeler 82009) adalimumab-adbm (CF) pen (only labeler 82009)

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Drug Class		
	Enbrel mini cartridge Enbrel SureClick pen Enbrel syringe Enbrel vial Hadlima PushTouch autoinjector Hadlima syringe Hadlima (CF) PushTouch autoinjector Hadlima (CF) syringe Otezla tablet Otezla tablet dose pack Otezla XR tablet Otezla XR tablet dose pack Pyzchiva syringe Pyzchiva vial Rinvoq tablet Rinvoq LQ solution Taltz autoinjector Taltz syringe Tyenne syringe Tyenne autoinjector Xeljanz solution Xeljanz tablet Yesintek syringe Yesintek vial Yuflyma autoinjector kit Yuflyma (CF) Crohn's/UC/HS Yuflyma syringe kit	adalimumab-fkjp (CF) syringe 20 mg adalimumab-ryvk (CF) autoinjector adalimumab-ryvk (CF) syringe Amjevita (CF) autoinjector Amjevita (CF) syringe Avsola vial Avtozma syringe Avtozma autoinjector Bimzelx autoinjector Bimzelx syringe Cibinqo tablet Cimzia pen Cimzia syringe Cosentyx syringe Cosentyx Sensoready pen Cosentyx syringe Cosentyx UnoReady pen Cosentyx injection Cyltezo (CF) Crohn's/UC/HS pen Cyltezo (CF) pen Cyltezo (CF) psoriasis/uveitis pen Cyltezo (CF) syringe Enspryng syringe Entyvio pen Entyvio vial Hulio (CF) pen Hulio (CF) syringe ***Humira Crohn's/UC/HS pen*** ***Humira pen*** ***Humira psoriasis/uveitis/ adolescent HS pen*** ***Humira syringe*** ***Humira (CF) pediatric Crohn's syringe*** ***Humira (CF) Crohn's/UC/HS pen*** ***Humira (CF) pediatric UC pen*** ***Humira (CF) pen*** ***Humira (CF) psoriasis/uveitis/ adolescent HS pen*** ***Humira (CF) syringe*** Hyrimoz (CF) pediatric Crohn's syringe Hyrimoz (CF) Crohn/UC start pen Hyrimoz (CF) pen Hyrimoz (CF) psoriasis pen Hyrimoz (CF) syringe Icotyde tablet Idacio (CF) Crohn's/UC pen Idacio (CF) pen Idacio (CF) psoriasis pen Idacio (CF) syringe Ilaris vial Ilumya syringe

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Drug Class	Preferred Agents	Non-Preferred Agents
		Imuldosa syringe Imuldosa vial Inflectra vial Infliximab vial Kevzara pen Kevzara syringe Kineret syringe Olumiant tablet Omvoh pen Omvoh syringe Omvoh vial Orencia Clickject autoinjector Orencia syringe Otulfi syringe Otulfi vial Remicade vial Renflexis vial Selarsdi syringe Selarsdi vial Siliq syringe Simlandi autoinjector Simlandi (CF) autoinjector kit Simlandi (CF) syringe kit Simponi Aria vial Simponi pen Simponi syringe Skyrizi on-body Skyrizi pen Skyrizi syringe Skyrizi vial Sotyktu tablet Starjemza syringe Starjemza vial Stelara syringe Stelara vial Steqeyma syringe Steqeyma vial tofacitinib citrate ER tablet tofacitinib citrate tablet tofacitinib citrate solution Tremfya autoinjector Tremfya pen Tremfya syringe Tremfya vial ustekinumab-aekn syringe ustekinumab syringe ustekinumab vial ustekinumab-ttwe syringe ustekinumab-ttwe vial Velsipity tablet Xeljanz XR tablet

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Drug Class	Preferred Agents	Non-Preferred Agents
		Yusimry (CF) pen Zymfentra pen Zymfentra syringe
Gastrointestinal Motility, Chronic	Linzess capsule lubiprostone capsule Movantik tablet ***prucalopride tablet***	alosetron tablet Amitiza capsule Ibsrela tablet Lotronex tablet Motegrity tablet Symproic tablet Viberzi tablet
Laxatives and Cathartics	Clenpiq solution constulose solution enulose solution GaviLyte-C GaviLyte-G GaviLyte-N Generlac solution Golytely solution lactulose solution PEG 3350/Electrolyte solution PEG 3350 and Electrolytes PEG 3350/Sod Sul/NaCl/KCl/ASB/C powder packet sodium sulfate/potassium sulfate/magnesium sulfate solution Suflave solution Suprep solution Sutab tablet	alvimopan capsule ***Kristalose packet*** ***lactulose packet***
Sodium-Glucose Cotransporter 2 (SGLT2) Inhibitors	dapagliflozin tablet Synjardy tablet Xigduo XR tablet	dapagliflozin/metformin ER tablet Farxiga tablet Inpefa tablet Invokamet tablet Invokamet XR tablet Invokana tablet ***Jardiance tablet*** Segluromet tablet Steglatro tablet Synjardy XR tablet
Ophthalmics, Immunomodulators	Restasis droperette	Cequa cyclosporine 0.05% Miebo Restasis Multidose Tryptyr Tyrvaya Verkazaia 0.1% Vevye ***Xiidra***

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NEW PRODUCTS TO MARKET

Drug Requiring PA	Criteria for Prior Authorization

Hepcludex® (bulevirtide-gmod)	**Non-PDL**
	
	Approval Duration: 1 year initial, 1 year renewal
	
	Initial Approval Criteria:
	• 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:
	  ○ 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.
	
	Renewal Criteria:
	• Patient has experienced disease improvement or stabilization as evidenced by one of the following:
	  ○ Reduction in HDV RNA levels or undetectable HDV RNA; **OR**
	  ○ Reduction or normalization of ALT values.
	
	Quantity Limit: 1 vial per day

Xocova™ (ensitrelvir)	**Anti-Infective – Oral Antivirals, COVID-19: Non-Preferred** **Approval Duration:** 1 month **Initial Approval Criteria:** • 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. **Age Limit**: ≥ 12 years of age **Quantity Limit**: 7 tablets per 5-day course and 1 fill per 30 days
Lynavoy® (linerixibat)	**Anti-Infective – Gastrointestinal, Bile Salts: Non-Preferred** **Approval Duration:** 1 year initial, 1 year renewal

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Drug Requiring PA	Criteria for Prior Authorization

	Initial Approval Criteria:
	• Diagnosis of cholestatic pruritus associated with primary biliary cholangitis; **AND**
	• Patient meets two of the following:
	  ○ 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.
	
	Renewal Criteria:
	• Patient does not have unexplained liver elevations or uncorrected vitamin deficiencies; **AND**
	• Patient has experienced reduction in pruritus.
	
	Quantity Limit: 2 tablets per day

Awiqli® (insulin icodec-abae)	**Diabetes – Insulin and Related Agents: Non-Preferred** **Approval Duration:** 1 year initial, 1 year renewal **Initial Approval Criteria:** • Diagnosis of type 2 diabetes mellitus; **AND** • Patient is at least 18 years of age; **AND** • Trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications), or intolerance of at least two preferred long-acting insulins. **Renewal Criteria:** • Patient is currently receiving Awiqli and previously met initial approval criteria; **AND** • Patient demonstrates a positive clinical response to Awiqli therapy; **AND** • Continued need for Awiqli therapy is documented. **Quantity Limit**: 6 mL per 28 days
Lipfendra® (enlicitide)	**Cardiovascular – Lipotropics: Non-Preferred** **Approval Duration:** 6 months initial, 1 year renewal **Initial Approval Criteria:** • Diagnosis of hypercholesterolemia, including heterozygous familial hypercholesterolemia (HeFH); **AND** • Prescribed initially by, or in consultation with, a cardiologist, lipid specialist, endocrinologist, vascular medicine or other applicable specialist; **AND**

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Drug Requiring PA	Criteria for Prior Authorization

	• Prescriber submits documentation(e.g., chart note or lab report) of low-density lipoprotein cholesterol (LDL-C) prior to/without PCSK9 inhibitor therapy; **AND**
	• One of the following:
	  ○ 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:
	  ▪ LDL-C ≥55 mg/dL for patient with a history of a major atherosclerotic cardiovascular disease (ASCVD) event, **OR**
	  ▪ LDL-C ≥70 mg/dL for patient at increased risk for first ASCVD event, **OR**
	  ○ Patient does not tolerate statins (at least two statin trials of any length were unsuccessful due to adverse effects); **AND**
	• Trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to Repatha.
	
	Renewal Criteria:
	• Prescriber submits clinical documentation (e.g., progress note or lab report) that demonstrate a reduction in LDL-C when compared to the baseline values.
	
	Quantity Limit: 1 tablet per day

Trutakna™ (atacicept-vymj)	**Non-PDL**
	
	Approval Duration: 3 months initial, 1 year renewal
	
	Initial Approval Criteria:
	• Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy; **AND**
	• Patient is not currently receiving dialysis and has not undergone kidney transplantation: **AND**
	• Prescriber submits documentation (e.g., chart note or lab report) that patient meets the definition of high risk of disease progression, as defined as:
	  ○ Proteinuria ≥ 1.0 g/day; **OR**
	  ○ Urine protein-to-creatinine ratio (UPCR) ≥ 1.0 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 (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.
	
	Age Limit: ≥ 18 years of age
	Quantity Limit: 4 mL per 28 days

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NEW PDL CLASSES

PDL Class	Class Selection & Guidelines
Hereditary Angioedema (HAE) Agents	• 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 (HAE) class, require PA until reviewed by the P&T Committee.
Phenylketonuria (PKU) Agents	• DMS to select preferred agent(s) based on economic evaluation; however, at least 1 unique chemical entity should be preferred. • Agents not selected as preferred will be considered non-preferred and will require PA. • For any new chemical entity in the Phenylketonuria (PKU) class, require PA until reviewed by the P&T Committee.

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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
• **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**

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 23, 2026, posted on the provider portal at: Kentucky Medicaid P&T Committee provider documents.

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

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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	

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