Notice of PDL Changes

Kentucky Medicaid

Pharmacy Provider Notice – April 2025 P&T PDL Changes

May 15, 2025

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 **April 24, 2024**.

The Kentucky Medicaid P&T Committee met on April 15, 2025. 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, 2025, 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
Narcotics, Long-Acting	BuTrans CC, QL fentanyl patch 12, 25, 50, 75, 100 mcg CC, QL morphine sulfate ER tablet CC, QL ***OxyContin ER tablet CC, QL*** tramadol ER tablet (generic Ultram ER) CC, AE, QL	Belbuca AE, QL buprenorphine patch QL ConZip ER capsule AE, QL Diskets fentanyl patch 37.5, 62.5, 87.5 mcg QL hydrocodone ER capsule QL hydrocodone ER tablet QL hydromorphone ER tablet QL Hysingla ER tablet QL methadone dispersible tablet CC methadone Intensol oral concentrate CC methadone oral concentrate CC methadone solution methadone tablet

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Drug Class	Preferred Agents	Non-Preferred Agents
		Methadose oral concentrate Methadose tablet morphine sulfate ER capsule QL MS Contin ER tablet QL oxycodone ER tablet QL oxymorphone ER tablet QL tramadol ER capsule AE, QL tramadol ER tablet (generic Ryzolt) AE, QL
Colony Stimulating Factors	Fulphila CC, QL Fylnetra CC, QL Neupogen CC, QL ***Releuko CC, QL***	Granix QL Leukine QL Neulasta CC, QL Neulasta Onpro CC, QL Nivestym QL Nyvepria CC, QL Rolvedon AE, CC, QL Stimufend QL Udenyca CC, QL Zarxio QL Ziextenzo CC, QL
Erythropoiesis Stimulating Proteins	Aranesp CC Epogen CC Mircera CC ***Retacrit CC (all manufacturers)***	Jesduvroq CC, QL Procrit Reblozyl CC, AE Vafseo
Phosphate Binders	calcium acetate capsule, tablet Phoslyra solution ***sevelamer carbonate powder packet, tablet***	Auryxia ferric citrate tablet Fosrenol chewable tablet, powder packet lanthanum carbonate chewable tablet Renagel ***Renvela powder packet, tablet*** Velphoro Xphozah CC, AE, QL
Insulins & Related Agents: Rapid- and Short-Acting Insulins	Humulin R vial Humulin R U-500 vial and KwikPen insulin aspart cartridge, vial, and pen insulin lispro pen, vial, and Jr. KwikPen	Admelog and Admelog Solostar CC Afrezza Apidra vial and Solostar Fiasp vial, pen, pumpcart, and FlexTouch CC Humalog 200 unit/mL KwikPen ***Humalog cartridge, vial, and KwikPen*** ***Humalog Junior (Jr) KwikPen***

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Drug Class	Preferred Agents	Non-Preferred Agents
		Humalog Tempo Pen Lyumjev pen, Tempo Pen, and vial CC Novolin R vial, pen ***Novolog vial, cartridge, and FlexPen*** Symlin AE, CC
Insulins & Related Agents: Intermediate-Acting Insulins	Humalog Mix 50-50 KwikPen Humulin 70/30 vial and KwikPen Humulin N vial insulin aspart/insulin aspart protamine pen and vial insulin lispro/insulin lispro protamine KwikPen ***insulin lispro protamine mix*** Novolin N vial Novolog Mix FlexPen	***Humalog Mix vial and KwikPen*** Humulin N KwikPen Novolin 70/30 vial, pen Novolin N pen Novolog Mix vial
Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors	Farxiga CC, QL Jardiance CC, QL Synjardy CC, QL Xigduo XR CC, QL	dapagliflozin QL dapagliflozin-metformin ER QL Inpefa CC, AE, QL ***Invokamet CC, QL*** Invokamet XR QL ***Invokana CC, QL*** Segluromet AE, QL Steglatro AE, QL Synjardy XR QL
Growth Hormones	Genotropin cartridge, syringe CC Norditropin Flexpro CC Skytrofa cartridge CC	Humatrope cartridge CC Ngenla CC, AE ***Nutropin AQ NuSpin CC*** Omnitrope cartridge, vial CC Serostim vial CC Sogroya CC, QL Zomacton vial CC

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NEW PRODUCTS TO MARKET

Drugs Requiring PA	Criteria for Prior Authorization

Alyftrek™	**Non-PDL**
	
	Approval Duration: 6 months
	
	Initial Approval Criteria:
	• Patient has a documented diagnosis of cystic fibrosis with:
	  ○ A genetic profile (e.g., gene mutation) that is considered responsive to the product based on clinical and/or in vitro data contained in the FDA labeling; **AND**
	  ○ Confirmed by an FDA-approved diagnostic test; **AND**
	• Patient meets the FDA-approved minimum age; **AND**
	• Documentation (e.g., progress notes) of baseline functional status and baseline predicted FEV1.
	
	Renewal Criteria:
	• Patient has had disease response, as indicated by one or more of the following:
	  ○ Decreased pulmonary exacerbations, as compared to pre-treatment baseline; **OR**
	  ○ Improvement or stabilization of lung function, compared to baseline; **OR**
	  ○ Decrease in decline of lung function; **OR**
	  ○ Improvement in quality of life, weight gain, or growth.
	
	Age Limit: 6 years of age or older
	
	Quantity Limit:
	• 50-20-4 mg tablets: 3 per day
	• 125-50-10 mg tablets: 2 per day

Sofdra™	**Non-PDL** **Approval Duration: 6 months**

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Drugs Requiring PA	Criteria for Prior Authorization
	Initial Approval Criteria: • Patient has a diagnosis of primary axillary hyperhidrosis; **AND** • Prescriber attests hyperhidrosis is significantly interfering with activities of daily living; **AND** • Patient meets the FDA-approved minimum age. **Renewal Criteria:** • Prescriber attestation of clinically significant improvement in clinical signs and symptoms. **Age Limit:** 9 years of age or older **Quantity Limit:** 1 bottle per 30 days
Ryzumvi™	**Non-PDL** **Approval Duration:** Single fill only **Approval Criteria:** • Patient has a diagnosis of pharmacologically-induced mydriasis produced by adrenergic agonists (e.g., phenylephrine) OR parasympatholytic (e.g., tropicamide) agents; **AND** • Prescriber attests product will be used within 24 hours of the procedure; **AND** • Prescribed by, or in consultation with, an ophthalmologist or other specialist in the treatment of pharmacologically-induced mydriasis **Age Limit:** 3 years of age or older **Quantity Limit:** 1 single-patient-use vial per fill
Crenessity™	**Non-PDL** **Approval Duration: 6 months initial, 1 year renewal** **Initial Approval Criteria:** • Patient has a diagnosis of classic congenital adrenal hyperplasia (CAH) defined by ≥ 1 of the following:

Drugs Requiring PA	Criteria for Prior Authorization
	○ Elevated 17-hydroxyprogesterone (17-OHP) level; **OR** ○ Confirmed CYP21A2 genotype; **OR** ○ Positive newborn screening with confirmatory second-tier testing (e.g., liquid chromatography – tandem mass spectrometry); **OR** ○ Cosyntropin stimulation test; **AND** • Prescribed initially by, or in consultation with an endocrinologist; **AND** • Crenessity (crinecerfont) will be used as an adjunct therapy with chronic glucocorticoid therapy for CAH (e.g., hydrocortisone, prednisone, prednisolone, methylprednisolone, dexamethasone) at a minimum glucocorticoid dose required for cortisol replacement; **AND** • If prescribed concomitantly with a moderate or strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, phenobarbital, bosentan, efavirenz, etravirine, and primidone), dosages will be modified as recommended by the package insert; **AND** • Patient meets the minimum age recommended by the package insert for the provided indication. **Renewal Criteria:** • Patient must continue to meet initial approval criteria; **AND** • Patient must have disease improvement, as indicated by ≥ 1 of the following: ○ Reduction in glucocorticoid daily use; **OR** ○ Reduction in serum androstenedione (A4) levels. **Age Limit:** 4 years of age or older **Quantity Limit:** • 25 mg, 50 mg, and 100mg oral capsules: 2 per day • 50 mg/mL oral solution: 4 mL per day

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Drugs Requiring PA	Criteria for Prior Authorization
Journavx™	**Non-PDL** **Approval Duration: 3 months (Limit to 1 fill per approval)** **Initial Approval Criteria:** • Patient has a diagnosis of moderate to severe acute pain; **AND** • Journavx (suzetrigine) will be used for up to 14 days; **AND** • Prescriber attests that the member's pain is unable to be managed with an NSAID, acetaminophen, or other non-opioid analgesic; **AND** • Journavx (suzetrigine) is not being prescribed to treat chronic pain; **AND** • Journavx (suzetrigine) is not being prescribed to treat pain associated with migraine; **AND** • Patient does not have severe hepatic impairment (Child-Pugh Class C); **AND** • Patient has been counseled to avoid food or drink containing grapefruit during treatment with Journavx (suzetrigine); **AND** • Patient is not concurrently taking a strong CYP3A inhibitor; **AND** • Patient is not concurrently taking a moderate or strong CYP3A inducer; **AND** • Patients using hormonal contraceptives containing progestins other than levonorgestrel and norethindrone have been counseled regarding alternative or additional contraception, if appropriate, per product labeling; **AND** • Patient meets the minimum age recommended by the package insert for the provided indication. **Age Limit:** 18 years of age or older **Quantity Limit:** 30 tablets per 14 days
Tryngolza™	**Non-PDL** **Approval Duration: 1 year** **Initial Approval Criteria:**

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Drugs Requiring PA	Criteria for Prior Authorization
	• Diagnosis of familial chylomicronemia syndrome (FCS) confirmed by genetic mutations in one of the following: o LPL gene o APOA5 gene o GPIHBP1 gene o LMF1 gene o APOC2 gene; **AND** • Patient has a fasting triglyceride level greater than or equal to 880 mg/dL; **AND** • Patient will follow a low-fat diet of less than or equal to 20 grams of fat per day; **AND** • Prescribed by, or in consultation with, an endocrinologist, or other specialist in the treatment of familial chylomicronemia syndrome (FCS); **AND** • Patient meets the minimum age recommended by the package insert for the provided indication. **Renewal Criteria:** • Prescriber attestation of clinically significant improvement or stabilization in the patient's condition. **Age Limit:** 18 years of age or older **Quantity Limit:** 1 autoinjector per month
Hympavzi™	**Non-PDL** **Approval Duration:** 1 year initial, renewal **Initial Approval Criteria:** • Prescribed for the prophylactic treatment in patients with one of the following: o Hemophilia A without inhibitors to Factor 8 (FVIII); **OR** o Hemophilia B without inhibitors to Factor 9 (FIX). • Documentation (e.g., an inhibitor lab result within the past year) demonstrating the absence of one of the following: o Factor VIII inhibitors for hemophilia A; **OR** o Factor IX inhibitors for hemophilia B; **AND** • Patient meets the minimum age recommended by the package insert for the provided indication.

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Drugs Requiring PA	Criteria for Prior Authorization

	Renewal Criteria:
	• Prescriber attests patient has experienced clinical benefit compared to baseline.
	• Documentation (e.g., an inhibitor lab result within the past year) demonstrating the absence of one of the following:
	  ○ Factor VIII inhibitors for hemophilia A; **OR**
	  ○ Factor IX inhibitors for hemophilia B.
	
	Age Limit: 12 years of age or older
	
	Quantity Limit: 300 mg (2mL) per week

Alhemo®	**Non-PDL**
	
	Approval Duration: 1 year initial, renewal
	
	Initial Approval Criteria:
	• Prescribed for the prophylactic treatment in patients with one of the following:
	  ○ Hemophilia A with inhibitors to FVIII; **OR**
	  ○ Hemophilia B with inhibitors to FIX.
	• Documentation (e.g., an inhibitor lab result within the past year) demonstrating one of the following:
	  ○ Factor VIII inhibitor for hemophilia A; **OR**
	  ○ Factor IX inhibitor for hemophilia B; **AND**
	• Patient meets the minimum age recommended by the package insert for the provided indication.
	
	Renewal Criteria:
	• Prescriber attests patient has experienced clinical benefit compared to baseline.
	• Documentation (e.g., an inhibitor lab result within the past year) demonstrating one of the following:
	  ○ Factor VIII inhibitor for hemophilia A; **OR**
	  ○ Factor IX inhibitor for hemophilia B
	
	Age Limit: 12 years of age or older

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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. However, the **Glucagon Agent** therapeutic class was removed from the consent agenda pursuant to committee recommended changes. This class will be reviewed again at the July P&T meeting.

Drug Classes With No Changes	
• Narcotic Agonist/Antagonists • Narcotics, Fentanyl Buccal Products • Narcotics, Short-Acting • Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) • Opiate Dependence Treatments • Antihyperuricemics • Sickle Cell Anemia Treatments • Thrombopoiesis Stimulating Proteins • Alpha-Glucosidase Inhibitor • Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	• Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists • Meglitinides • Metformins • Sulfonylureas • Thiazolidinediones (TZDs) • Androgenic Agents • Bone Resorption Suppression & Related Agents • 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 April 15, 2025, 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	

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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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