Notice of PDL Changes

Kentucky Medicaid

Pharmacy Provider Notice – July 2024 P&T PDL Changes

August 30, 2024

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 **July 9, 2024**.

The Kentucky Medicaid P&T Committee met on July 9, 2024. 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 October 1, 2024, 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
Angiotensin-Converting Enzyme (ACE) Inhibitors + Diuretic Combinations	benazepril/HCTZ ***enalapril/HCTZ*** ***fosinopril/HCTZ*** lisinopril/HCTZ	Accuretic captopril/HCTZ Lotensin HCT quinapril/HCTZ Vaseretic Zestoretic
Angiotensin Modulator + Calcium Channel Blocker Combinations	amlodipine/benazepril amlodipine/olmesartan amlodipine/valsartan	***amlodipine/valsartan/HCTZ*** Azor Exforge HCT Exforge Lotrel Olmesartan/Amlodipine/HCTZ telmisartan/amlodipine trandolapril/verapamil Tribenzor

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Drug Class	Preferred Agents	Non-Preferred Agents
Antiarrhythmics, Oral	amiodarone 100, 200 mg disopyramide dofetilide flecainide mexiletine propafenone Sorine sotalol sotalol AF	amiodarone 400 mg Betapace Betapace AF Multaq Norpace Norpace CR Pacerone propafenone SR/ER ***quinidine sulfate*** qunidine gluconate ER Rythmol SR Sotylize CC Tikosyn
Antidepressants, SNRIs	desvenlafaxine succinate ER tablet venlafaxine tablet venlafaxine ER capsule ***venlafaxine ER tablet***	desvenlafaxine ER base tablet Effexor XR capsule Fetzima ER capsule Fetzima ER capsule dose pack Pristiq ER tablet venlafaxine besylate ER tablet
Antidepressants, SSRIs	citalopram solution citalopram tablet escitalopram tablet fluoxetine capsule fluoxetine solution paroxetine tablet sertraline oral concentrate sertraline tablet	Celexa tablet citalopram capsule escitalopram solution fluoxetine 90 mg DR capsule QL fluoxetine tablet fluvoxamine ER capsule fluvoxamine tablet Lexapro tablet paroxetine CR tablet paroxetine ER tablet paroxetine mesylate capsule ***paroxetine suspension*** Paxil CR tablet Paxil suspension Paxil tablet Pexeva tablet Prozac capsule ***sertraline capsule*** Zoloft oral concentrate Zoloft tablet
Beta Blockers	atenolol atenolol/chlorthalidone bisoprolol bisoprolol/HCTZ	acebutolol betaxolol Bystolic carvedilol ER

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Drug Class	Preferred Agents	Non-Preferred Agents
	carvedilol ***Hemangeol*** [CC] labetalol metoprolol succinate ER metoprolol tartrate nadolol nebivolol propranolol ER propranolol solution propranolol tablet	Coreg CR Coreg Corgard Inderal LA Inderal XL Innopran XL Kapspargo Lopressor Metoprolol/HCTZ Pindolol Propranolol/HCTZ Tenoretic Tenormin Timolol Toprol XL Ziac
Calcium Channel Blockers	amlodipine Cartia XT diltiazem diltiazem CD capsule diltiazem ER 24HR capsule diltiazem XR Dilt-XR nifedipine ER Taztia XT Tiadylt ER verapamil tablet verapamil ER tablet	Calan SR Cardizem Cardizem CD Cardizem LA ***diltiazem ER 12HR capsule*** Diltiazem ER (LA) tablet felodipine ER felodipine ER isradipine Katerzia levamlodipine Matzim nicardipine nifedipine IR nimodipine nisoldipine ER Norliqva Norvasc Nymalize solution Nymalize syringe Procardia XL Sular ER Tiazac ER verapamil ER capsule verapamil ER PM capsule verapamil SR capsule Verelan PM
Narcolepsy Agents	***Nuvigil tablet*** [CC, QL] Provigil tablet [CC, QL]	armodafinil tablet [QL] modafinil tablet [QL] sodium oxybate solution [CC, QL]

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Drug Class	Preferred Agents	Non-Preferred Agents
		Sunosi tablet CC, QL Wakix tablet CC, QL Xyrem solution CC, QL Xywav solution CC, QL
Pulmonary Arterial Hypertension (PAH) Agents, Oral and Inhaled	Alyq CC, QL ambrisentan CC ***sildenafil suspension CC*** sildenafil tablet CC tadalafil CC, QL Tracleer tablet CC	Adcirca QL Adempas QL bosentan tablet Letairis Liqrev Opsumit QL Orenitram ER ***Revatio suspension CC*** Revatio tablet CC Tadliq Tracleer 32 mg tablets for suspension CC, QL Tyvaso CC Tyvaso DPI CC Uptravi QL Ventavis
Sedative Hypnotics	eszopiclone tablet MD, QL ***ramelteon tablet CC, MD, QL*** temazepam 15 mg, 30 mg capsule MD, QL zolpidem tartrate MD, QL ***zolpidem ER tablet MD, QL***	Ambien CR tablet MD, QL Ambien tablet MD, QL Belsomra tablet MD, QL Dayvigo tablet MD, QL Doral tablet MD, QL doxepin tablet QL Edluar SL tablet CC, MD, QL estazolam tablet MD, QL flurazepam capsule MD, QL Halcion tablet MD, QL Hetlioz capsule CC, QL Hetlioz LQ suspension CC, QL Igalmi film AE, CC, QL Lunesta tablet MD, QL quazepam tablet MD, QL Quviviq tablet AE, CC, MD, QL Restoril capsule MD, QL Rozerem tablet CC, MD, QL tasimelteon capsule CC, QL temazepam 7.5 mg, 22.5 mg capsule MD, QL triazolam tablet MD, QL zaleplon capsule MD, QL zolpidem capsule MD, QL

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Drug Class	Preferred Agents	Non-Preferred Agents
		zolpidem SL tablet MD, QL
Stimulants and Related Agents	Adderall XR capsule CC, QL atomoxetine capsule CC, QL ***clonidine ER tablet*** QL Concerta tablet CC, QL dexmethylphenidate ER tablet CC, QL dexmethylphenidate tablet CC, QL dextroamphetamine sulfate tablet CC, QL ***dextroamphetamine/amphetamine ER capsule*** CC, QL dextroamphetamine/amphetamine tablet CC, QL guanfacine ER tablet CC, QL Methylin solution CC, QL methylphenidate solution CC, QL ***methylphenidate ER 10 mg, 20 mg tablet*** QL methylphenidate tablet CC, QL Vyvanse capsule CC, QL Vyvanse chewable tablet CC, QL	Adderall capsule QL Adzenys XR-ODT tablet AE, QL amphetamine sulfate tablet QL Aptensio XR sprinkle capsule QL Azstarys capsule QL Cotempla XR-ODT tablet AE, QL Daytrana patch QL Desoxyn tablet QL Dexedrine capsule ER, QL dextroamphetamine ER capsule QL dextroamphetamine solution QL dextroamphetamine tablet QL Dyanavel XR suspension AE, QL Dyanavel XR tablet AE, QL Evekeo ODT QL Evekeo tablet QL Focalin tablet QL Focalin XR capsule QL Intuniv ER tablet QL Jornay PM capsule AE, QL lisdexamfetamine capsule QL lisdexamfetamine chewable tablet QL methamphetamine tablet QL methylphenidate CD capsule QL methylphenidate ER capsule QL methylphenidate ER sprinkle capsule QL methylphenidate ER 18 mg, 27 mg, 36 mg, 54 mg, 63 mg, 72 mg tablet QL methylphenidate LA capsule QL methylphenidate ER OROS QL methylphenidate capsule QL methylphenidate chewable tablet QL methylphenidate patch QL Mydayis ER capsule AE, QL ProCentra solution QL Qelbree ER capsule QL QuilliChew ER tablet AE, QL Relexxii tablet QL Ritalin LA capsule QL Ritalin tablet QL Strattera capsule QL Xelstrym patch QL Zenzedi QL

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NEW PRODUCTS TO MARKET

Drugs Requiring PA	Criteria for Prior Authorization

Opsynvi®	**Pulmonary Arterial Hypertension (PAH) Agents, Oral And Inhaled: Non-Preferred (NPD)**
	
	Approval Duration: 1 year
	
	Initial Approval Criteria:
	
	• Diagnosis of pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1; **AND**
	• Patient is WHO functional class (FC) 2 or 3; **AND**
	• Prescribed by, or in consultation with, a cardiologist, pulmonologist, or other specialist in the treatment of pulmonary arterial hypertension (PAH); **AND**
	• Patient has had at least a 30-day trial and failure, allergy, or contraindication (including potential drug-drug interactions with other medications) or intolerance of the following agents:
	  ○ ambrisentan; **AND**
	  ○ sildenafil or tadalafil; **AND**
	• Patient meets the minimum age recommended by the package insert for use in PAH; **AND**
	• Patient will not be using with other phosphodiesterase-5 inhibitors, e.g., sildenafil, tadalafil.
	
	Renewal Criteria:
	
	• Prescriber attestation of clinically significant improvement or stabilization in clinical signs and symptoms.
	
	Quantity Limit: 1 tablet per day

Winrevair™	**Non-PDL** **Approval Duration: 1 year** **Initial Approval Criteria:** • Diagnosis of pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1; **AND**

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Drugs Requiring PA	Criteria for Prior Authorization

	• Prescribed by, or in consultation with, a cardiologist, pulmonologist, or other specialist in the treatment of PAH; **AND**
	• Patient has had at least a 30-day trial and failure, allergy, or contraindication (including potential drug-drug interactions with other medications) or intolerance of the following agents:
	  ○ Adempas; **AND**
	  ○ ambrisentan; **AND**
	  ○ sildenafil or tadalafil; **AND**
	• Patient meets the minimum age recommended by the package insert for use in PAH; **AND**
	• Prescriber attests that the patient's hemoglobin and platelet will be monitored.
	
	Renewal Criteria:
	
	• Prescriber attestation of clinically significant improvement or stabilization in clinical signs and symptoms.

Voydeya™	**Non-PDL** **Approval Duration: 3 months initial, 6 months renewal** **Initial Approval Criteria:** • Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) with extravascular hemolysis (EVH); **AND** • Prescribed by, or in consultation with, a hematologist or other specialist in the treatment of PNH with EVH; **AND** • Patient meets the minimum age recommended by the package insert for use in PNH with EVH; **AND** • Patient will be using as add-on therapy to ravulizumab (Ultomiris) or eculizumab (Soliris). **Renewal Criteria:** • Prescriber attestation of clinically significant improvement or stabilization in clinical signs and symptoms, such as increase in hemoglobin levels. **Quantity Limit:** 50 mg tablet: 9 tablets per day 100 mg tablet: 6 tablets per day

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Drugs Requiring PA	Criteria for Prior Authorization
Rivfloza™	**Non-PDL** **Approval Duration: 6 months initial, 1 year renewal** **Initial Approval Criteria:** • Patient has a diagnosis of primary hyperoxaluria type 1 (PH1); **AND** • Prescribed by, or in consultation with, a nephrologist, urologist, or other applicable specialist in the diagnosis and treatment of primary hyperoxaluria type 1 (PH1); **AND** • Patient does not have severe renal impairment (eGFR < 30 mL/min/1.73 m^2); **AND** • Patient does not have moderate or severe hepatic impairment; **AND** • Patient will not use nedosiran concomitantly with lumasiran (Oxlumo). **Renewal Criteria:** • Documentation (e.g., progress notes, labs) of reduction or stabilization in serum oxalate levels; **AND** • Patient does not have severe renal impairment (eGFR < 30 mL/min/1.73 m^2); **AND** • Patient does not have moderate or severe hepatic impairment; **AND** • Patient will not use nedosiran concomitantly with lumasiran (Oxlumo). **Age Limit:** ≥ 9 years of age **Quantity Limit:** 1 syringe per month
Zymfentra™	**Cytokine and CAM Antagonists: Non-Preferred (NPD)** **Approval Duration: 6 months initial, 1 year renewal** **Initial Approval Criteria:** • Diagnosis of moderate to severe Crohn's disease (CD) or ulcerative colitis (UC); **AND** • Patient has undergone induction therapy with intravenous infliximab; **AND**

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Drugs Requiring PA	Criteria for Prior Authorization

	• Prescribed by, or in consultation with, a gastroenterologist or other specialist in the treatment of CD or UC; **AND**
	• Patient has had a trial and failure of ≥ 1 of the following conventional therapies:
	  ○ Oral/rectal 5-aminosalicylic acid agents (e.g., Apriso, balsalazide, Lialda, mesalamine, sulfasalazine)
	  ○ Oral/rectal steroids (e.g., budesonide, hydrocortisone, prednisone)
	  ○ Immunosuppressant (e.g., azathioprine, mercaptopurine); **OR**
	• Patient is deemed high-risk for intestinal complications or post-operative recurrence; **AND**
	• NOT used in combination with any other biologic agent; **AND**
	• Patient has had a 3-month trial and failure of, or contraindication or intolerance to, ≥ 1 preferred cytokine or CAM antagonist indicated for the treatment of CD or UC; **AND**
	• Patient meets the minimum age recommended by the package insert for use in CD or UC.
	
	Renewal Criteria:
	
	• Documentation (e.g., progress notes) of response to therapy compared to baseline.
	
	Quantity Limit: 2 syringes per month

Filsuvez®	**Non-PDL** **Approval Duration: 90 days initial, 1 year renewal** **Initial Approval Criteria:** • Patient has a diagnosis of dystrophic or junctional epidermolysis bullosa; **AND** • Prescribed by, or in consultation with, a dermatologist or other specialist in the treatment of epidermolysis bullosa; **AND** • Patient has partial thickness wounds (does not extend beyond the dermis layer) which are clean with adequate granulation tissue, excellent vascularization, and do not appear infected; **AND**

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Drugs Requiring PA	Criteria for Prior Authorization
	• Patient's wound has persisted for at least 3 weeks; **AND** • Patient wound size is at least 10 cm; **AND** • Patient is receiving standard-of-care wound therapy; **AND** • Patient has not received or is being considered for other gene therapy, stem cell transplant, or investigational cellular therapy; **AND** • Patient has not received immunosuppressive therapy or cytotoxic chemotherapy within the past 60 days; **AND** • Patient meets the minimum age recommended by the package insert for use in dystrophic or junctional epidermolysis bullosa. **Renewal Criteria:** • Clinical documentation showing improvement and no treatment-limiting adverse effects; **AND** • Patient must have disease response as defined by improvement (healing) of treated wound(s), reduction in skin infections, etc.; **AND** • Patient requires continued treatment for new and/or existing open wounds. **Age Limit:** ≥ 6 months of age
Eohilia™	**Non-PDL** **Approval Duration: 12 weeks** **Initial Approval Criteria:** • Diagnosis of eosinophilic esophagitis; **AND** • Prescribed by, or in consultation with, an allergist, immunologist, gastroenterologist, or other specialist in the treatment of eosinophilic esophagitis. **Renewal Criteria:** • Patient previously had a positive response to Eohilia; **AND** • Patient has a histologic relapse after the prior remission. **Age Limit:** 11 years or older

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Drugs Requiring PA	Criteria for Prior Authorization
	Quantity Limit: 20 mL per day for 12 weeks

Alvaiz™	**Thrombopoiesis Stimulating Proteins: Non-Preferred (NPD)**
	
	Approval Duration: 6 months
	
	Initial Approval Criteria:
	
	• Prescribed by, or in consultation with, a hematologist or liver disease specialist; **AND**
	• Patient has one of the following indications:
	  ○ Diagnosis of persistent or chronic immune thrombocytopenia (ITP) with an insufficient response to corticosteroids, immunoglobulins, or splenectomy; **OR**
	  ○ Used for the treatment of thrombocytopenia in patients with chronic hepatitis C (to allow the initiation and maintenance of interferon-based therapy); **OR**
	  ○ Diagnosis of severe aplastic anemia with an insufficient response to immunosuppressive therapy; **AND**
	• Patient meets the minimum age recommended by the package insert for respective indications.
	
	Renewal Criteria:
	
	• Documentation (e.g., progress note, laboratory report) of response to therapy.
	
	Age Limit: 6 years or older
	Quantity Limit: 9 mg: 1 per day
	18 mg: 1 per day
	36 mg: 3 per day
	54 mg: 2 per day

Rezdiffra™	**Non-PDL** **Approval Duration: 1 year** **Initial Approval Criteria:**

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Drugs Requiring PA	Criteria for Prior Authorization
	• Diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis); **AND** • Prescribed by, or in consultation with, a gastroenterologist or hepatologist; **AND** • Prescriber attests that member does not have excessive alcohol consumption. **Renewal Criteria:** • Documentation (e.g., progress note, laboratory report) of response to therapy and no treatment-limiting adverse effects. **Quantity Limit:** 1 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	
• **Angiotensin-Converting Enzyme (ACE) Inhibitors** • **Angiotensin Receptor Blockers (ARBs)** • **Antianginal & Anti-Ischemic** • **Anticoagulants** • **ARB + Diuretic Combinations** • **Direct Renin Inhibitors** • **Lipotropics, Other** • **Lipotropics, Statins** • **Platelet Aggregation Inhibitors** • **Alzheimer's Agents** • **Anticonvulsants** • **Antidepressants, Monoamine Oxidase Inhibitors (MAOIs)**	• **Antidepressants, Other** • **Antidepressants, Tricyclics** • **Antiparkinson's Agents** • **Dopamine Receptor Agonists** • **Antipsychotics** • **Anxiolytics** • **Movement Disorders** • **Tobacco Cessation Products** • **5-Alpha Reductase Inhibitors** • **Alpha Blockers for Benign Prostatic Hyperplasia (BPH)** • **Bladder Relaxants**

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 July 9, 2024, posted on the provider portal at: https://kyportal.medimpact.com/provider-documents/pt-committee

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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	

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