# Notice of PDL Changes

Kentucky Medicaid

## Pharmacy Provider Notice – July 2025 P&T PDL Changes

**September 4, 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 **August 11, 2025**.

The Kentucky Medicaid P&T Committee met on July 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 October 15, 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 |
|---|---|---|
| Bladder Relaxants | oxybutynin solution QL, syrup QL, 5 mg tablet QL<br>oxybutynin ER QL<br>solifenacin QL<br>***tolterodine QL***<br>***tolterodine ER QL*** | darifenacin ER QL<br>Detrol QL<br>Detrol LA QL<br>Ditropan XL QL<br>fesoterodine ER QL<br>flavoxate QL<br>Gelnique CC, QL<br>Gemtesa CC, AE, QL<br>Myrbetriq QL<br>mirabegron ER QL<br>oxybutynin 2.5 mg tablet QL<br>Oxytrol QL<br>***Toviaz ER QL***<br>trospium QL<br>trospium ER QL<br>Vesicare QL<br>Vesicare LS QL |

AE = Age Edit CC = Clinical Criteria MD = Maximum Duration QL = Quantity Limit ST = Step Therapy

# Notice of PDL Changes

Kentucky Medicaid

| Drug Class | Preferred Agents | Non-Preferred Agents |
|---|---|---|
| Narcolepsy Agents | ***armodafinil tablet*** CC, QL<br>Provigil tablet CC, QL | modafinil tablet QL<br>***Nuvigil tablet*** CC, QL<br>sodium oxybate solution CC, QL<br>Sunosi tablet CC, QL<br>Wakix tablet CC, QL<br>Xyrem solution CC, QL<br>Xywav solution CC, QL |
| Skeletal Muscle Relaxants | baclofen 5 mg, 10 mg, 20 mg tablet<br>cyclobenzaprine tablet QL<br>Methocarbamol 500 mg, 750 mg tablet<br>orphenadrine ER tablet<br>tizanidine tablet QL | Amrix ER capsule QL, MD<br>baclofen suspension QL<br>baclofen solution QL<br>baclofen 15 mg tablet<br>carisoprodol tablet QL, MD<br>carisoprodol/ASA tablet QL, MD<br>carisoprodol/ASA/codeine tablet QL, MD<br>***chlorzoxazone tablet*** QL<br>cyclobenzaprine ER capsule QL<br>Dantrium capsule QL<br>dantrolene capsule QL, CC<br>Fexmid tablet QL, MD<br>Fleqsuvy suspension QL<br>Lorzone tablet QL<br>Lyvispah granules pack QL<br>metaxalone tablet QL<br>Methocarbamol 1000 mg tablet<br>Norgesic Forte tablet<br>Norgesic tablet<br>orphenadrine/ASA/caffeine tablet<br>Orphengesic Forte tablet<br>Soma tablet QL, MD<br>Tanlor tablet<br>tizanidine capsule QL<br>Zanaflex capsule QL<br>Zanaflex tablet QL |
| Stimulants & Related Agents | Adderall XR capsule CC, QL<br>atomoxetine capsule CC, QL<br>clonidine ER tablet CC, QL<br>Concerta tablet CC, QL<br>dexmethylphenidate ER tablet CC, QL<br>dexmethylphenidate tablet CC, QL<br>dextroamphetamine sulfate tablet CC, QL<br>dextroamphetamine/amphetamine ER capsule CC, QL<br>dextroamphetamine/amphetamine tablet CC, QL<br>dextroamphetamine sulfate 5 mg, 10 mg, 15 mg | Adderall capsule QL<br>Adzenys XR-ODT tablet AE, QL<br>amphetamine sulfate tablet QL<br>Aptensio XR sprinkle capsule QL<br>Azstarys capsule QL<br>Cotempla XR-ODT tablet AE, QL<br>Daytrana patch QL<br>Desoxyn tablet QL<br>Dexedrine capsule ER QL<br>dextroamphetamine ER capsule QL<br>dextroamphetamine solution QL |

AE = Age Edit CC = Clinical Criteria MD = Maximum Duration QL = Quantity Limit ST = Step Therapy

# Notice of PDL Changes

Kentucky Medicaid

| Drug Class | Preferred Agents | Non-Preferred Agents |
|---|---|---|
| | guanfacine ER tablet CC, QL<br>Methylin solution CC, QL<br>methylphenidate solution CC, QL<br>methylphenidate ER tablet 10 mg, 20 mg CC, QL (generic Metadate)<br>***methylphenidate ER tablet 18 mg, 27 mg, 36 mg, 54 mg tablet CC, QL (generic Concerta)***<br>methylphenidate tablet CC, QL<br>Qelbree ER capsule CC, QL<br>Vyvanse capsule CC, QL<br>Vyvanse chewable tablet CC, QL | dextroamphetamine sulfate tablet 2.5 mg, 7.5 mg, 20 mg, 30 mg QL<br>Dyanavel XR suspension AE, QL<br>Dyanavel XR tablet AE, QL<br>Evekeo ODT QL<br>Evekeo tablet QL<br>Focalin tablet QL<br>Focalin XR capsule QL<br>Intuniv ER tablet QL<br>Jornay PM capsule AE, QL<br>lisdexamfetamine capsule QL<br>lisdexamfetamine chewable tablet QL<br>methamphetamine tablet QL<br>methylphenidate CD capsule QL<br>methylphenidate ER capsule QL<br>methylphenidate ER tablet 63 mg, 72 mg tablet QL (generic Relexxii) QL<br>methylphenidate ER sprinkle capsule QL<br>methylphenidate LA capsule QL<br>methylphenidate ER OROS QL<br>methylphenidate chewable tablet QL<br>methylphenidate patch QL<br>Mydayis ER capsule AE, QL<br>Onyda XR suspension AE, QL<br>ProCentra solution QL<br>QuilliChew ER tablet AE, QL<br>Quillivant XR QL<br>Relexxii tablet QL<br>Ritalin LA capsule QL<br>Ritalin tablet QL<br>Strattera capsule QL<br>Xelstrym patch QL<br>Zenzedi QL |
| Glucagon Agents | Baqsimi spray CC<br>Glucagen<br>***Gvoke autoinjector, syringe***<br>Proglycem suspension<br>***Zegalogue autoinjector AE***<br>***Zegalogue syringe AE*** | diazoxide suspension<br>***glucagon emergency kit***<br>Gvoke vial |

AE = Age Edit CC = Clinical Criteria MD = Maximum Duration QL = Quantity Limit ST = Step Therapy

## NEW PRODUCTS TO MARKET

| Drugs Requiring PA | Criteria for Prior Authorization |
|---|---|
| Zunveyl® | **Central Nervous System - Alzheimer's Agents: Non-Preferred**<br><br>**Approval Duration:** 12 months<br><br>**Approval Criteria:**<br>• Non-preferred (NPD) criteria: ≥ 1 week trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance of 2 preferred agents.<br><br>**Quantity Limit:** 2 tablets per day |
| Qfitlia™ | **Non-PDL**<br><br>**Approval Duration:** 1 year initial, renewal<br><br>**Initial Approval Criteria:**<br>*Hemophilia A*<br>• Prescribed for prophylactic treatment to prevent or reduce bleeding episodes in patients with Hemophilia A; **AND**<br>• Prescriber provides documentation (e.g., lab result within the past year) of either:<br>  ○ Presence of Factor VIII inhibitors; **OR**<br>  ○ Absence of Factor VIII inhibitors; **AND**<br>• Prescribed by, or in consultation with, a hematologist; **AND**<br>• Prescriber attests patient is not on another non-factor prophylactic agent (e.g., Alhemo, Hemlibra, Hympavzi); **AND**<br>• Trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to one agent approved for either:<br>  ○ Hemophilia A WITH inhibitors (i.e., Alhemo, Hemlibra); **OR**<br>  ○ Hemophilia A WITHOUT inhibitors (i.e., Hemlibra, Hympavzi)**; AND**<br>• Patient meets the minimum age recommended by the package insert for the provided indication. |

AE = Age Edit CC = Clinical Criteria MD = Maximum Duration QL = Quantity Limit ST = Step Therapy

| Drugs Requiring PA | Criteria for Prior Authorization |
|---|---|
| | **Renewal Criteria:**<br>• Prescriber attests patient has experienced clinical benefit compared to baseline (e.g., reduced bleeding frequency/severity); **AND**<br>• Prescriber provides documentation (e.g., lab result within the past year) of Hemophilia A with or without Factor VIII inhibitors.<br><br>**Initial Approval Criteria:**<br>*Hemophilia B*<br>• Prescribed for prophylactic treatment to prevent or reduce bleeding episodes in patients with Hemophilia B; **AND**<br>• Prescriber provides documentation (e.g., lab result within the past year) of either:<br>  ○ Presence of Factor IX inhibitors; **OR**<br>  ○ Absence of Factor IX inhibitors; **AND**<br>• Prescribed by, or in consultation with, a hematologist; **AND**<br>• Prescriber attests patient is not on another non-factor prophylactic agent (e.g., Alhemo, Hemlibra, Hympavzi); **AND**<br>• Trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to one agent approved for either:<br>  ○ Hemophilia B WITH inhibitors (i.e., Alhemo); **OR**<br>  ○ Hemophilia B WITHOUT inhibitors (i.e., Hympavzi)**; AND**<br>• Patient meets the minimum age recommended by the package insert for the provided indication.<br><br>**Renewal Criteria:**<br>• Prescriber attests patient has experienced clinical benefit compared to baseline (e.g., reduced bleeding frequency/severity); **AND**<br>• Prescriber provides documentation (e.g., lab result within the past year) of Hemophilia B with or without Factor IX inhibitors.<br><br>**Age Limit:** 12 years of age or older<br><br>**Quantity Limit:**<br>• 0.2 mL per month (vial)<br>• 0.5 mL per month (pen) |

AE = Age Edit CC = Clinical Criteria MD = Maximum Duration QL = Quantity Limit ST = Step Therapy

| Drugs Requiring PA | Criteria for Prior Authorization |
|---|---|
| Ryzneuta® | **Blood Modifiers - Colony Stimulating Factors: Non-Preferred**<br><br>**Approval Duration:** 6 months<br><br>**Initial Approval Criteria:**<br>• The medication is being used for prophylaxis of neutropenia related to chemotherapy, to decrease the incidence of febrile neutropenia; **AND**<br>• Patient has a non-myeloid malignancy and is receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia; **AND**<br>• Patient has had at least a 7-day trial and therapeutic failure, allergy, contraindication, or intolerance of 2 preferred agents.<br><br>**Age Limit:** 18 years of age or older<br><br>**Quantity Limit:** 1 syringe every 14 days |
| Vanrafia® | **Non-PDL**<br><br>**Approval Duration:** 6 months<br><br>**Initial Approval Criteria:**<br>• Patient has a confirmed diagnosis of primary IgA nephropathy (IgAN); **AND**<br>• Patient has proteinuria ≥ 1 g/day or urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g; **AND**<br>• Patient is currently on a stable, maximally tolerated dose of a RAAS inhibitor (ACE inhibitor or ARB), unless contraindicated or not tolerated; **AND**<br>• Prescribed by, or in consultation with a nephrologist; **AND**<br>• Provider attestation of a negative pregnancy test prior to initiation in females of reproductive potential; **AND**<br>• Provider attestation of patient counseling on teratogenic risks and contraception.<br><br>**Renewal Criteria:**<br>• Patient continues to meet all initial criteria; **AND** |

| Drugs Requiring PA | Criteria for Prior Authorization |
|---|---|
| | • Prescriber submits clinical documentation that the patient has experienced a clinical benefit compared to baseline.<br><br>**Age Limit:** 18 years of age or older<br><br>**Quantity Limit:** 30 tablets per 30 days |

## NEW THERAPEUTIC CLASS

| Drug Class | Preferred Agents | Non-Preferred Agents |
|---|---|---|
| Antimigraine Agents, CGRP Inhibitors & Other Agents: Acute Treatment | Nurtec ODT CC, AE, QL<br>Ubrelvy tablet CC, AE, QL | Reyvow tablet CC, AE, QL<br>Zavzpret CC, AE, QL |
| Antimigraine Agents, CGRP Inhibitors & Other Agents: Prophylaxis - Injectable | Aimovig autoinjector CC, AE, QL<br>Ajovy autoinjector CC, AE, QL<br>Ajovy syringe CC, AE, QL<br>Emgality pen CC, AE, QL | Emgality 100 mg/mL syringe CC, AE, QL |
| Antimigraine Agents, CGRP Inhibitors & Other Agents: Prophylaxis - Oral | Nurtec ODT CC, AE, QL<br>Qulipta tablet CC, AE, QL | |

## 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<br>• ACEI + Diuretic Combinations<br>• Angiotensin Modulator + Calcium Channel Blocker (CCB) Combinations<br>• Angiotensin Receptor Blockers (ARBs)<br>• Antianginal & Anti-Ischemic<br>• Antiarrhythmics, Oral<br>• Anticoagulants<br>• ARB + Diuretic Combinations<br>• Beta-Blockers<br>• Calcium Channel Blockers (CCBs)<br>• Direct Renin Inhibitors | • Antidepressants, SSRIs<br>• Antidepressants, Tricyclics<br>• Antimigraine Agents – CGRP Inhibitors & Other Agents: Acute Treatment<br>• Antimigraine Agents – CGRP Inhibitors & Other Agents: Prophylaxis – Injectable<br>• Antimigraine Agents – CGRP Inhibitors & Other Agents: Prophylaxis - Oral<br>• Antimigraine Agents -Triptans<br>• Antiparkinson's Agents<br>• Antipsychotics, First Generation |

AE = Age Edit CC = Clinical Criteria MD = Maximum Duration QL = Quantity Limit ST = Step Therapy

# Notice of PDL Changes

Kentucky Medicaid

| Drug Classes With No Changes | |
|---|---|
| • Lipotropics, Other<br>• Lipotropics, Statins<br>• PAH Agents – Oral and Inhaled<br>• Platelet Aggregation Inhibitors<br>• Alzheimer's Agents<br>• Anticonvulsants<br>• Antidepressants, Monoamine Oxidase Inhibitors<br>• Antidepressants, Other<br>• Antidepressants, SNRIs | • Antipsychotics, Second Generation: Oral and Injectable<br>• Anxiolytics<br>• Dopamine Receptor Agonists<br>• Movement Disorders<br>• Neuropathic Pain<br>• Sedative Hypnotics<br>• Tobacco Cessation Products<br>• 5-Alpha Reductase Inhibitors<br>• Alpha Blockers For Benign Prostatic Hyperplasia (BPH) |

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 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]<br>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] |

AE = Age Edit CC = Clinical Criteria MD = Maximum Duration QL = Quantity Limit ST = Step Therapy

| | |
|---|---|
| Prior Authorizations | Phone (877) 403-6034 [8:00AM - 7:00PM EST/ 7 days per week]<br>Fax (858) 357-2612 |
| Pharmacy Portal | https://kyportal.medimpact.com/ |
| BIN: 026309 / PCN: KYPROD1 / GROUP: KYF01 | |

AE = Age Edit CC = Clinical Criteria MD = Maximum Duration QL = Quantity Limit ST = Step Therapy