Notice of PDL Changes

Kentucky Medicaid

Pharmacy Provider Notice – October 2025 P&T PDL Changes

December 1, 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 **November 10, 2025.**

The Kentucky Medicaid P&T Committee met on October 14, 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 January 1, 2026, 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
Acne Agents, Oral	Amnesteem Claravis Zenatane ***isotretinoin 10 mg, 20 mg, 30 mg, 40 mg capsule***	Absorica Absorica LD isotretinoin 25 mg, 35 mg capsule
Antiemetics and Antivertigo Agents	aprepitant capsule, capsule dose pack QL Diclegis tablet CC, QL dronabinol capsule CC, QL meclizine tablet metoclopramide solution, tablet ondansetron ODT, solution, tablet prochlorperazine tablet promethazine 12.5 mg, 25 mg suppository promethazine syrup, tablet	Akynzeo capsule QL Antivert chewable tablet, tablet Anzemet tablet ***Bonjesta tablet*** Compro suppository doxylamine/pyridoxine tablet CC, QL Emend capsule, capsule dose pack, suspension QL Gimoti nasal spray AE, CC, QL granisetron tablet Marinol capsule CC, QL prochlorperazine suppository

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Drug Class	Preferred Agents	Non-Preferred Agents
	Promethegan 12.5 mg, 25 mg suppository scopolamine patch	Promethegan 50 mg suppository Reglan tablet Sancuso patch CC, QL Transderm-Scop patch trimethobenzamide capsule
Cytokine and Cell-Adhesion Molecule (CAM) Antagonists	***adalimumab-aaty*** CC, QL Enbrel CC, QL Hadlima CC, QL Humira CC, QL Otezla CC, QL ***Pyzchiva*** CC, QL Rinvoq AE, CC, QL Rinvoq LQ AE, CC, QL ***Taltz*** CC, QL Tyenne CC, QL Xeljanz CC, QL ***Yesintek*** CC, QL ***Yuflyma*** CC, QL	Abrilada CC, QL Actemra CC, QL adalimumab-aacf CC, QL adalimumab-adaz CC, QL adalimumab-adbm CC, QL adalimumab-fjkp CC, QL adalimumab-ryvk CC, QL Amjevita CC, QL Avsola vial CC Bimzelx AE, CC, QL Cibinqo CC, QL Cimzia CC, QL ***Cosentyx*** CC, QL Cyltezo CC, QL Enspryng AE, CC, QL Entyvio pen CC, QL Entyvio vial CC Hulio CC, QL Hyrimoz CC, QL Idacio CC, QL Ilaris CC, QL Ilumya AE, CC, QL Imuldosa CC, QL Inflectra vial CC Infliximab vial CC Kevzara AE, CC, QL Kineret CC, QL Olumiant AE, CC, QL Omvoh AE, CC, QL Orencia CC, QL Otulfi CC, QL Remicade vial CC Renflexis vial CC Selarsdi CC, QL Siliq AE, CC, QL Simponi CC, QL Simponi Aria AE, CC, QL Simlandi CC, QL Skyrizi AE, CC, QL Sotyktu AE, CC, QL Stelara CC, QL

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Drug Class	Preferred Agents	Non-Preferred Agents
		Steqeyma CC, QL Tremfya AE, CC, QL ustekinumab CC, QL ustekinumab-aekn CC, QL ustekinumab-ttwe CC, QL Velsipity AE, CC, QL Xeljanz XR CC, QL Yusimry CC, QL Zymfentra CC, QL
Immunomodulators, Atopic Dermatitis	Adbry autoinjector AE, CC, QL Adbry syringe AE, CC, QL Dupixent pen CC, QL Dupixent syringe CC, QL ***Ebglyss*** AE, CC, QL Eucrisa CC, QL ***Nemluvio*** AE, CC, QL pimecrolimus cream tacrolimus ointment	Elidel ***Opzelura cream*** AE, CC, QL Vtama AE, CC, QL
Stimulants and Related Agents	Adderall XR capsule CC, QL atomoxetine capsule CC, QL clonidine ER tablet CC, 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 dextroamphetamine sulfate 5 mg, 10 mg, 15 mg guanfacine ER tablet CC, QL ***Jornay PM capsule*** AE, QL Methylin solution CC, QL methylphenidate solution CC, QL methylphenidate ER tablet 10 mg, 20 mg CC, QL methylphenidate tablet CC, QL Qelbree ER capsule CC, QL Vyvanse capsule CC, QL Vyvanse chewable tablet CC, QL	Adderall capsule QL Adzenys XR-ODT tablet AE, CC, 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 sulfate tablet 2.5 mg, 7.5 mg, 20 mg, 30 mg 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 lisdexamfetamine capsule QL lisdexamfetamine chewable tablet QL methamphetamine tablet QL methylphenidate CD capsule QL methylphenidate ER capsule QL

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Drug Class	Preferred Agents	Non-Preferred Agents
		methylphenidate ER tablet 18 mg, 27 mg, 36 mg, 54 mg, 63 mg, 72 mg tablet QL methylphenidate ER sprinkle capsule QL methylphenidate LA capsule QL methylphenidate ER OROS QL methylphenidate chewable tablet QL methylphenidate patch QL Mydayis ER capsule AE, QL Onyda XR suspension AE, QL ProCentra solution QL QuilliChew ER tablet AE, QL Quillivant XR QL Relexxii tablet QL Ritalin LA capsule QL Ritalin tablet QL Strattera capsule QL Xelstrym patch QL Zenzedi QL
Chronic Obstructive Pulmonary Disease (COPD) Agents	albuterol-ipratropium inhalation solution QL Anoro Ellipta QL Atrovent HFA QL Breztri Aerosphere AE, QL Combivent Respimat QL ipratropium inhalation solution QL roflumilast tablet CC, QL Spiriva Handihaler QL Stiolto Respimat QL ***Trelegy Ellipta*** *AE, CC, QL*	Bevespi Aerosphere QL Daliresp tablet AE, CC, QL Duaklir Pressair Incruse Ellipta QL Ohtuvayre AE, CC, QL Spiriva Respimat QL tiotropium QL Tudorza Pressair QL umeclidinium-vilanterol QL Yupelri solution AE, CC, QL

NEW PRODUCTS TO MARKET

Drugs Requiring PA	Criteria for Prior Authorization
Zelsuvmi™	**Dermatologics – Topical Antiviral Agents: Non-Preferred** **Approval Duration:** 3 months **Approval Criteria:** • Diagnosis of molluscum contagiosum (MC); **AND** • Prescribed by, or in consultation with, a dermatologist; **AND**

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Drugs Requiring PA	Criteria for Prior Authorization

	• Patient has had a trial and failure (at least 3 months) of ≥ 1 of the following conventional therapies:
	  ○ Cantharidin,
	  ○ Silver nitrate,
	  ○ Cryotherapy,
	  ○ Curettage; **AND**
	• Patient meets one of the following:
	  ○ Patient has atopic dermatitis (AD); **OR**
	  ○ Patient is immunocompromised; **OR**
	  ○ Patient has concomitant bacterial infection; **AND**
	• Patient is not on concurrent treatment for MC; **AND**
	• Patient meets the minimum age recommended by the package insert for the provided indication.
	
	Age Limit: 1 year of age or older
	
	Quantity Limit: 1 kit (31 grams) per month

Vykat™	**Non-PDL**
	
	Approval Duration: 12 months
	
	Approval Criteria:
	• Diagnosis of hyperphagia; **AND**
	• Clinical confirmation of Prader-Willi Syndrome (PWS) documented by a genetic test identifying abnormal DNA methylation of chromosome 15q11.2Q13 region; **AND**
	• Prescribed by, or in consultation with, an endocrinologist, geneticist, or other specialist in the treatment of PWS; **AND**
	• Patient has had a baseline fasting plasma glucose (FPG) and HbA1c performed; **AND**
	• Prescriber attests to monitoring the following during treatment:
	  ○ FPG as clinically indicated; **AND**
	  ○ HbA1c as clinically indicated; **AND**
	  ○ Signs or symptoms of edema; **AND**
	• Patient meets the minimum age recommended by the package insert for the provided indication.
	
	Quantity Limit:
	• 150 mg tablets: 3 per day
	• 75 mg tablets: 3 per day
	• 25 mg tablets: 2 per day

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Drugs Requiring PA	Criteria for Prior Authorization

Tryptyr®	**Ophthalmic – Immunomodulators: Non-Preferred**
	
	Approval Duration: 3 months initial, 12 months renewal
	
	Initial Approval Criteria:
	• Patient has diagnosis of dry eye disease (DED); **AND**
	• Prescribed by or in consultation with an ophthalmologist or optometrist; **AND**
	• Patient has had a trial and failure of preservative-free, nonprescription lubricating eye drops (e.g., artificial tears); **AND**
	• Patient has had ≥ 1 month trial and therapeutic failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance of 2 preferred agents; **AND**
	• Prescriber has documented at least 1 of the following signs of DED:
	  ○ Corneal fluorescein staining (CFS) score of ≥ 2 points in any field on a 0-to-4-point scale; **OR**
	  ○ Schirmer tear test (STT) of 1 to 10 mm in 5 minutes; **AND**
	• Patient meets the minimum age recommended by the package insert for the provided indication.
	
	Renewal Criteria:
	• Patient continues to meet the above criteria; **AND**
	• Patient has improvement in signs of DED, as measured by at least 1 of the following:
	  ○ Decrease in corneal fluorescein staining score; **OR**
	  ○ Increase in number of mm per 5 minutes using Schirmer tear test.
	
	Age Limit: 18 years of age or older
	
	Quantity Limit: 60 vials per 30 days

Andembry®	**Non-PDL** **Approval Duration:** 6 months initial, 12 months renewal **Initial Approval Criteria:** • Diagnosis of hereditary angioedema (HAE); **AND** • Documentation of confirmed diagnosis of HAE by one of the following tests: ○ Complement testing, **OR**

Drugs Requiring PA	Criteria for Prior Authorization
	○ C1 Inhibitor protein and functional tests; **AND** • Prescribed for prophylactic use; **AND** • Prescribed by, or in consultation with, an immunologist, hematologist, or other specialist in the diagnosis and treatment of HAE; **AND** • Patient is not on concurrent treatment with alternative prophylactic agent for HAE (e.g., Takhzyro, Haegarda, Cinryze, Dawnzera, Orladeyo); **AND** • Patient meets the minimum age recommended by the package insert for this FDA-approved indication. **Renewal Criteria:** • Prescriber attestation of improvement compared to baseline in hereditary angioedema attacks (i.e., reductions in attack frequency or attack severity). **Quantity Limit:** 1.2 mL (200 mg) per month
Sephience™	**Non-PDL** **Approval Duration:** 1 month initial, 12 months renewal **Initial Approval Criteria:** • Confirmed diagnosis of phenylketonuria (PKU) with elevated blood phenylalanine (Phe) levels; **AND** • Prescribed by, or in consultation with, a metabolic disease expert or other specialist in the management of PKU; **AND** • Provider attests that that the patient is on, and will continue, a phenylalanine-restricted diet supervised by a metabolic disease specialist or knowledgeable healthcare provider; **AND** • Provider attests to the presence of a monitoring plan for dietary intake; **AND** • Provider attests that the patient will have regular blood Phe level assessments as clinically indicated; **AND** • The requested dose does not exceed the maximum FDA-approved dose for this condition based on patient weight. **Renewal Criteria:** • Patient must continue to meet initial approval criteria; **AND**

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Drugs Requiring PA	Criteria for Prior Authorization
	• Prescriber provides documentation (e.g., chart notes or summary) confirming sustained biochemical response, defined as continued ≥ 30% reduction in blood phenylalanine (Phe) levels. **Age Limit:** 1 month of age or older

Anzupgo®	**Immunomodulators – Atopic Dermatitis: Non-Preferred**
	
	Initial Approval Criteria
	• Diagnosis of moderate to severe chronic hand eczema (CHE); **AND**
	• Documentation of Investigator's Global Assessment for Chronic Hand Eczema (IGACHE) with a score ≥ 3; **AND**
	• Prescribed by, or in consultation with, a dermatologist, allergist/immunologist, or other specialist in the treatment of chronic hand eczema; **AND**
	• Trial and failure, contraindication, or intolerance to ≥ 1 agent in 2 or more of the following categories (total prior agent use of ≥ 90 days):
	  ○ Topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone); **AND**
	  ○ Topical calcineurin inhibitor (i.e., tacrolimus or pimecrolimus); **OR**
	  ○ Immunosuppressive systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil); **AND**
	• Trial and failure, contraindication, or intolerance to preferred JAK inhibitor (e.g., Opzelura); **AND**
	• No concurrent use of other biologics or JAK inhibitors or immunosuppressants; **AND**
	• Patient must meet 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 and/or stabilization based on an objective measure.
	
	Quantity Limit: 30 grams per month

Ekterly®	**Non-PDL** **Approval Duration:** 6 months initial, renewal **Initial Approval Criteria**

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Drugs Requiring PA	Criteria for Prior Authorization

	• Diagnosis of hereditary angioedema (HAE); **AND**
	• Documentation of confirmed diagnosis of HAE by one of the following tests:
	  ○ Complement testing, **OR**
	  ○ C1 Inhibitor protein and functional tests; **AND**
	• Prescribed by, or in consultation with, an immunologist, hematologist, or other specialist in the diagnosis and treatment of HAE; **AND**
	• Patient is not on concurrent acute treatment for HAE (e.g., Ruconest, Berinert, Kalbitor, Firazyr); **AND**
	• Patient meets the minimum age recommended by the package insert for this FDA-approved indication.
	
	Renewal Criteria
	• Prescriber attestation of improvement compared to baseline in hereditary angioedema attacks (i.e., reductions in attack frequency or attack severity).
	
	Quantity Limit: 4 tablets per day

NEW THERAPEUTIC CLASS

Drug Class	Preferred Agents	Non-Preferred Agents
Antivirals, Oral: COVID-19	Paxlovid	

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. **The committee voted to postpone review of the Glucagon-Like Peptide-1 (GLP-1) Receptor Antagonists until the next P&T meeting in January and elected to remove Laxatives and Cathartics from the consent agenda.

Drug Classes With No Changes	
• **Acne Agents, Topical** • **Antibiotics, Topical** • **Antifungals, Topical** • **Antiparasitics, Topical** • **Antipsoriatics, Oral** • **Antipsoriatics, Topical**	• **Ophthalmics, Antibiotics** • **Ophthalmics, Antibiotic-Steroid Combinations** • **Ophthalmics, Antihistamines** • **Ophthalmics, Anti-Inflammatory Steroids**

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Drug Classes With No Changes	
• Antivirals, Topical • Rosacea Agents, Topical • Steroids, Topical • Anticholinergics/Antispasmodics • Antidiarrheals • Anti-Ulcer Protectants • Bile Salts • GI Motility, Chronic • H. Pylori Treatment • Histamine II Receptor Blockers • Proton Pump Inhibitors • Ulcerative Colitis Agents • Immunomodulators, Asthma • Immunosuppressives, Oral • Multiple Sclerosis Agents • Muscular Dystrophy Agents • Spinal Muscular Atrophy	• Ophthalmics, Antivirals • Ophthalmics, Beta Blockers • Ophthalmics, Carbonic Anhydrase Inhibitors • Ophthalmics, Combinations for Glaucoma • Ophthalmics, Glaucoma Agents (Other) • Ophthalmics, Immunomodulators • Ophthalmics, Mast Cell Stabilizers • Ophthalmics, Mydriatic • Ophthalmics, NSAIDs • Ophthalmics, Prostaglandin Agonists • Ophthalmics, Sympathomimetics • Otics, Anesthetics and Anti-Inflammatories • Otic Antibiotics

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 14, 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	

KY FFS Contact Information

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Pharmacy Portal	https://kyportal.medimpact.com/
BIN: 026309 / PCN: KYPROD1 / GROUP: KYF01	

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