Pharmacy Provider Notice #283– September 2022 P&T PDL Changes

November 1st, 2022

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 as adopted by the Commissioner of DMS of the Cabinet for Health and Family Services by order dated October 3, 2022.

The Kentucky Medicaid Pharmacy and Therapeutics Advisory Committee (Committee) met on September 15, 2022. The necessary quorum was attained, and the expertise, vote, and recommendations were captured within the Committee's official recommendations. DMS, through the Commissioner, reviewed the recommendations and in consultation rendered these final decisions.

On December 1st, 2022 the following changes will be effective:

Existing Drug Classes

Drug Class	The following products will remain *preferred* products:	The following products will become *preferred* products:	The following products will become *non-preferred* products and require prior authorization (PA):	The following products will remain *non-preferred* products and require prior authorization (PA):
Ace Inhibitors	benazepril lisinopril quinapril ramipril	enalapril solution (Amneal)		*Accupril®* *Altace®* *captopril* *enalapril solution* *Epaned™ CC* *fosinopril* *Lotensin®* *moexipril* *perindopril* *Prinivil®* *Qbrelis™ CC, QL* *trandolapril* *Vasotec®* *Zestril®*
Anticonvulsants: Second Generation	Banzel® CC, QL Gabitril® QL lamotrigine chewable tablets, tablets (except dose packs) levetiracetam ER QL levetiracetam solution, tablets QL Sabril® CC, QL topiramate QL zonisamide QL	lacosamide solution, tablets QL		*Briviact® CC, QL* *Diacomit™ CC, QL* *Elepsia® XR QL* *Epidiolex™ CC* *Eprontia™* *Fintepla® QL* *Fycompa™ QL* *Keppra® solution, tablets QL* *Keppra XR® QL* *Lamictal®* *Lamictal ODT®* *Lamictal® XR™ QL* *lamotrigine dose packs* *lamotrigine ER QL* *lamotrigine ODT*

Drug Class	The following products will remain *preferred* products:	The following products will become *preferred* products:	The following products will become *non-preferred* products and require prior authorization (PA):	The following products will remain *non-preferred* products and require prior authorization (PA):
				Qudexy® XR QL *rufinamide* QL *Spritam* QL *tiagabine* QL *Topamax®* QL *topiramate ER* QL *Trokendi XR™* QL *vigabatrin* *Vimpat®* QL *Xcopri®* CC, QL *Zonisade™* QL
Antidepressants: Tricyclics	amitriptyline clomipramine doxepin concentrate imipramine hydrochloride mirtazapine nortriptyline capsule	doxepin capsules		*amoxapine* *Anafranil®* *desipramine* *doxepin tablets* *imipramine pamoate* *maprotiline* *Norpramin®* *nortriptyline solution* *Pamelor®* *protriptyline* *Remeron®* *trimipramine*
Dopamine Receptor Agonists	pramipexole ropinirole		*bromocriptine*	*Mirapex® ER* *Neupro®* *Parlodel®* *pramipexole ER* *ropinirole ER*
Antipsychotics: Injectable	Abilify Maintena™ CC, QL Aristada ER™ CC, QL Aristada Initio™ CC, QL fluphenazine decanoate CC, QL Geodon® injection CC, QL haloperidol decanoate CC, QL haloperidol lactate CC, QL Invega® Sustenna® CC, QL Invega Trinza™ CC, QL olanzapine CC, QL Risperdal® Consta® CC, QL	Invega® Hafyera CC, QL Perseris ER™ CC		*Haldol® Decanoate* QL *Haldol® Lactate* QL *ziprasidone injection* QL *Zyprexa®* QL *Zyprexa® Relprevv* QL
Beta-Blockers	atenolol bisoprolol metoprolol tartrate metoprolol succinate ER nadolol propranolol propranolol ER	nebivolol		*acebutolol* *betaxolol* *Bystolic™* *Corgard®* *Hemangeol™* *Inderal® LA* *Inderal® XL* *InnoPran XL®* *Kapspargo™* *Lopressor®* *pindolol* *Tenormin®*

Drug Class	The following products will remain *preferred* products:	The following products will become *preferred* products:	The following products will become *non-preferred* products and require prior authorization (PA):	The following products will remain *non-preferred* products and require prior authorization (PA):
				Timolol *Toprol XL®*
Calcium Channel Blockers (Non-DHP)	Cartia XT diltiazem diltiazem ER/CD Dilt-XR Taztia XT® Tiadylt ER® verapamil		*verapamil ER capsules*	*Calan® SR* *Cardizem®* *Cardizem CD®* *Cardizem LA®* *diltiazem ER (generic Cardizem LA®)* *Matzim LA™* *Tiazac ER®* *verapamil ER tablets* *verapamil ER PM* *Verelan®* *Verelan PM®*
Movement Disorders	Austedo® CC, AE, QL tetrabenazine	Ingrezza® CC, AE, QL		*Ingrezza® Initiation pack AE, QL* *Xenazine®*
Pulmonary Arterial Hypertension (PAH) Agents	Alyq® CC, QL ambrisentan CC tadalafil CC, QL Tracleer® tablets CC, QL Revatio suspension™ CC	sildenafil tablets CC	*Revatio tablets™ CC* *Ventavis® CC*	*Adcirca™ QL* *Adempas® QL* *bosentan tablets* *Letairis™* *Opsumit® QL* *Orenitram ER™* *sildenafil suspension CC* *Tracleer® 32 mg tablets for suspension CC, QL* *Tyvaso™* *Tyvaso™ DPI* *Uptravi® QL*

New Products to Market

Drugs Requiring PA	Criteria for Prior Authorization
Quviviq™	**Non-prefer in the PDL class:** *Sedative Hypnotic Agents* **Length of Authorization:** 6 months initial; 1 year renewal • Daridorexant (Quviviq™) is an orexin receptor antagonist indicated in the treatment of adult patients with insomnia characterized by difficulties with sleep onset and/or sleep maintenance. **Criteria for Approval:** **Initial Approval Criteria** • Approval of non-preferred agents requires trial and therapeutic failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance of 1 preferred agent, unless otherwise specified. **Maximum Duration:** 60 days **Age Limit:** ≥ 18 years **Quantity Limit:** 30 tablets/30 days
Igalmi™	**Non-prefer in the PDL class:** *Sedative Hypnotic Agents*

Drugs Requiring PA	Criteria for Prior Authorization
	Length of Authorization: 12 months • Dexmedetomidine (Igalmi™) is an alpha-2 adrenergic agonist indicated in adults for the acute treatment of agitation associated with schizophrenia or bipolar I or II disorder. **Criteria for Approval:** **Initial Approval Criteria** • Patient has agitation associated with a confirmed diagnosis of schizophrenia or bipolar disorder, defined as meeting DSM-5 criteria for schizophrenia, schizoaffective, or schizophreniform disorder or bipolar I or II disorder; AND • Agitation is NOT due to acute intoxication; AND • Prescriber attestation that patient will be monitored by a healthcare provider, including an assessment of vital signs and alertness to prevent falls and syncope; AND • Patient is NOT taking medications known to prolong the QT interval; AND • Prescriber attestation that patient has been advised to avoid activities requiring mental alertness for at least 8 hours following administration. **Renewal Criteria** • Patient must continue to meet the above criteria; AND • Prescriber attestation of response (patient not requiring alternative agents following treatment of mild to moderate agitation); AND • Patient has not experienced any treatment-restricting adverse effects (e.g., syncope, orthostatic hypotension, fall, QT prolongation, symptomatic bradycardia). **Age Limit:** ≥18 years **Quantity Limit:** 120 mcg film: 2 per day 180 mcg film: 2 per day ** Approval requires trial and therapeutic failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance of 2 preferred agents (may include any preferred benzodiazepine or antipsychotic).*

Ibsrela®	**Non-preferred in the PDL class:** *GI Motility Agents*
	Length of Authorization: 1 year
	• Tenapanor (Ibsrela) is a locally acting, sodium/hydrogen exchanger 3 (NHE3) inhibitor indicated for irritable bowel syndrome with constipation (IBS-C) in adults.
	Criteria for Approval:
	Initial Approval Criteria
	• Patient does NOT have known or suspected mechanical GI obstruction; AND
	• Patient does NOT have severe diarrhea; AND
	• Patient has failed on 1 of the following regimens:
	  ○ Osmotic laxatives; OR
	  ○ Antispasmodics; AND
	• Patient has had at least a 1-month trial and therapeutic failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance of 2 preferred agents.
	Age Limit: ≥ 18 years
	Quantity Limit: 60 tablets/ 30 days

Mounjaro™	**Non-preferred in the PDL class:** *Diabetes: GLP-1 Receptor Agonists*

Drugs Requiring PA	Criteria for Prior Authorization
	Length of Authorization: 1 year • Tirzepatide (Mounjaro) is a glucose-dependent insulinotropic polypeptide (GIP) receptor agonist and glucagon-like peptide-1 (GLP-1) receptor agonist indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus (T2DM). **Criteria for Approval:** **Initial Approval Criteria** • Diagnosis of Type II Diabetes Mellitus; AND • Trial and failure, intolerance or contraindication to metformin. OR • Diagnosis of chronic kidney disease (ICD-10 Group N18) AND trial and failure of, intolerance or contraindication to ≥ 1 SGLT2 inhibitor plus metformin; OR • Diagnosis of atherosclerotic cardiovascular disease (ASCVD); OR • Diagnosis of heart failure with reduced ejection fraction AND trial and failure of, intolerance or contraindication to ≥ 1 SGLT2 inhibitor. AND • Trial and therapeutic failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance of at least 3-month therapy with 1 preferred GLP-1 agent, unless otherwise specified. **Age Limit:** None **Quantity Limit:** 4 pens per 28 days
Vtama®	**Non-preferred in the PDL class:** *Topical Psoriasis Agents* **Length of Authorization:** 1 year • Tapinarof (Vtama) cream is an aryl hydrocarbon receptor agonist indicated for the topical treatment of plaque psoriasis in adults **Criteria for Approval:** • Patient must have an adequate trial and failure, contraindication or intolerance, of at least two preferred medications within the last 90 days. • Patient has NOT experienced any treatment-restricting adverse effects **Age Limit:** ≥18 years **Quantity Limit:** 1 tube per 30 days
Camzyos™	**Non-PDL class** **Length of Authorization:** 1 year • Mavacamten (Camzyos) is a reversible selective cardiac myosin inhibitor indicated for the treatment of adults with symptomatic New York Heart Association (NYHA) class 2 to class 3 obstructive hypertrophic cardiomyopathy (HCM) to improve functional capacity and symptoms. **Criteria for Approval:** **Initial Approval Criteria** • Patient has a diagnosis of obstructive hypertrophic cardiomyopathy (oHCM) consistent with current guidelines (e.g., American College of Cardiology Foundation/American Heart Association, European Society of Cardiology guidelines); AND • Patient has New York Heart Association (NYHA) Class 2 or Class 3 disease; AND • Patient has documented left ventricular ejection fraction (LVEF) ≥ 55%; AND • Patient will be monitored for LVEF, Valsalva left ventricular outflow tract (LVOT) gradient assessment, and heart failure symptoms); AND

Drugs Requiring PA	Criteria for Prior Authorization
	• Patient will avoid concomitant use with moderate to strong CYP2C19 inhibitors, strong CYP3A4 inhibitors, and moderate to strong CYP2C19 and CYP3A4 inducers (e.g., carbamazepine, cimetidine, esomeprazole, omeprazole, phenobarbital, phenytoin, rifampin, St. John's wort); AND • Patient will avoid concomitant dual therapy with a beta-blocker and calcium channel blocker or monotherapy with disopyramide or ranolazine; AND • For females of childbearing potential, a pregnancy test is performed before starting therapy; AND • Mavacamten is prescribed by or in consultation with a cardiologist; AND • Patient must have an adequate trial and failure of ≥ 1 beta-blocker. **Renewal Criteria** • Patient must continue to meet the above criteria (not including prerequisite therapy); AND • Patient must have disease improvement and/or stabilization of disease from baseline (e.g., at least 1 NYHA class decrease, ≥ 1.5 mL/kg/min in pVO2 increase or ≥ 3 mL/kg/min in pVO2 without NYHA class worsening); AND • Patient has NOT have experienced any treatment-restricting adverse effects (e.g., heart failure, LVEF < 50%); AND • Patient will continue to be monitored for LVEF, Valsalva LVOT gradient, and heart failure symptoms. **Age Limit:** Patient is ≥ 18 years of age **Quantity Limit:** 30 capsules/ 30 days

Consent Agenda

The therapeutic classes in the table below were reviewed; no changes were made to the currently posted status for agents in these classes.

• Alzheimer's Agents • Angiotensin Modulators (Angiotensin Receptor Blockers) • Angiotensin Modulator Combinations • Antianginal & Anti-Ischemic • Antiarrhythmics, Oral • Anticoagulants • Anticonvulsants: Carbamazepine Derivatives • Anticonvulsants: First Generation • Antidepressants, Other • Antidepressants, SNRI • Antidepressants, SSRI	• Antiparkinson's Agents (Parkinson's Disease) • Antipsychotics: First-Generation (oral) • Antipsychotics: Second-Generation (oral) • Anxiolytics • Bladder Relaxant Preparations • BPH Treatments • Calcium Channel Blockers (DHP) • Lipotropics, Other • Lipotropics, Statins • Platelet Aggregation Inhibitors • Stimulants and Related Agents • Tobacco Cessation Products

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 September 15, 2022 posted on the provider web portal at: https://kentucky.magellanmedicaid.com (by clicking the Provider/Resources/Documents/Committees/P&T tabs).

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 Magellan Medicaid Administration at kyproviders@magellanhealth.com for Fee-for-Service members or the Kentucky MedImpact team at KYMCOPBM@medimpact.com for Managed Care Organization (MCO) members.

Sincerely,

ShaLeigh Hammons, CPhT

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Account Manager I
kyproviders@magellanhealth.com

Kentucky Medicaid Fee-for-Service Pharmacy Program's Contact Information		
Clinical Support Center	1-800-477-3071 Sunday – Saturday 24 hours a day	Please contact the Clinical Support Center to request a prior authorization (PA) or to check the status of a request. **NOTE: The only drugs that are now required to be submitted via fax are Brand Medically Necessary.**
Pharmacy Support Center	1-800-432-7005 Sunday – Saturday 24 hours a day	Please contact the Pharmacy Support Center when claims assistance is required. Timely filing, lock-in, and early refill (ER) overrides can be obtained through this Call Center.
Provider Services	1-877-838-5085 Monday – Friday 8:00 a.m. – 4:30 p.m.	Please contact Provider Services if you have questions about enrollment or when updating your license or bank information.
Member Services	1-800-635-2570 Monday – Friday 8:00 a.m. – 5:00 p.m.	Please contact Member Services if you are a member or if you as the provider have questions regarding the member's benefits or eligibility coverage dates.