Pharmacy Provider Notice #276– May 2022 P&T PDL Changes

July 1, 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 the Department for Medicaid Services of the Cabinet for Health and Family Services by order dated June 2, 2022.

The Kentucky Medicaid Pharmacy and Therapeutics Advisory Committee (Committee) met on May 19, 2022. The necessary quorum was attained, and the expertise, vote, and recommendations were captured within the Committee's official recommendations. DMS, through its Commissioner, reviewed the recommendations and in consultation rendered its final decisions.

On <u>August 4, 2022</u> 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):
Narcotics: Short-Acting	codeine/APAP CC, AE, MD, QL hydrocodone/APAP CC, MD, QL hydrocodone/ibuprofen CC, MD, QL hydromorphone tablets CC, MD, QL morphine concentrate, solution, tablets CC, MD, QL oxycodone solution, tablets CC, MD, QL oxycodone/APAP CC, MD, QL tramadol 50 mg CC, MD, AE, QL tramadol/APAP MD, AE, QL	.	*oxycodone oral syringe MD, QL*	*Apadaz™ MD, QL* *Ascomp® with codeine CC, AE, QL* *benzhydrocodone/APAP MD, QL* *butalbital/APAP/caffeine/codeine CC, AE, QL* *butalbital compound/codeine CC, AE, QL* *carisoprodol/ASA/codeine MD, AE, QL* *codeine MD, AE, QL* *dihydrocodeine bitartrate/APAP/caffeine MD, QL* *Dilaudid® MD, QL* *hydromorphone liquid, suppositories MD, QL* *levorphanol MD, QL* *Lortab® MD, QL* *meperidine solution, tablets MD, QL* *morphine suppository MD, QL* *Nucynta™ MD, QL* *Oxaydo® MD, QL* *oxycodone capsules, concentrate MD, QL* *oxycodone/APAP (generic for Primlev and Prolate) MD, QL* *oxycodone/ASA MD, QL* *oxymorphone MD, QL* *Percocet® MD, QL*

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):
				Qdolo™ MD, AE, QL *Roxicodone®* MD, QL *Seglentis* MD, AE, QL *tramadol 100 mg* MD, AE, QL *tramadol solution* MD, AE, QL *Ultracet®* MD, AE, QL *Ultram®* MD, AE, QL *Vicodin HP* MD, QL
Narcotics: Long-Acting	Butrans™ CC, QL fentanyl transdermal 12, 25, 50, 75, 100 mcg CC, QL morphine sulfate ER (generic MS Contin®) CC, QL tramadol ER (generic Ultram® ER) CC, AE, QL		*tramadol ER tablets (generic for Ryzolt®)* AE, QL	*Belbuca™* AE, QL *buprenorphine film* AE, QL *buprenorphine patch* QL *ConZip™* AE, QL *Duragesic®* QL *fentanyl transdermal 37.5, 62.5, 87.5 mcg ,* QL *hydrocodone ER* QL *hydromorphone ER* QL *Hysingla™ ER* QL *methadone* CC, QL *morphine sulfate SA (generic Kadian®, Avinza™)* QL *MS Contin®* QL *Nucynta® ER* CC,QL *oxycodone ER* QL *OxyContin®* QL *oxymorphone ER* QL *tramadol ER (generic ConZip™)* AE, QL *Xtampza™ ER* AE, QL *Zohydro ER™* QL
Antihyperuricemics	allopurinol colchicine tablets CC probenecid probenecid/colchicine	Colcrys® CC		*colchicine capsules* CC *febuxostat* QL *Gloperba®* CC *Mitigare®* CC *Uloric®* CC, QL *Zyloprim®*
Antimigraine Agents, CGRP Inhibitors	Ajovy™ CC, AE, QL Emgality™ 120 mg/mL CC, AE, QL Ubrelvy™ CC, AE, QL	Aimovig™ CC, AE, QL Nurtec™ ODT CC, AE, QL		*Emgality™ 100 mg/mL* CC, AE, QL *Reyvow™* CC, AE, QL *Qulipta™* CC, AE, QL
Bone Resorption Suppression and Related	alendronate tablets QL ibandronate tablets QL raloxifene	Forteo™ CC, QL	*teriparatide* CC, QL	*Actonel®* QL *alendronate solution* QL *Atelvia™* QL *Boniva®* QL *calcitonin-salmon* *Evenity™* CC, AE, QL *Evista®* *Fosamax®* QL *Fosamax Plus D™* QL *Miacalcin®* *Prolia™*

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):
				Reclast® *risedronate* QL *Tymlos™* CC, AE, QL *zoledronic acid*
Colony Stimulating Factors	Neupogen® CC, QL	Nyvepria™ CC, QL		*Granix®* QL *Fulphila™* QL *Leukine®* QL *Neulasta®* QL *Neulasta Onpro®* QL *Nivestym™* QL *Releuko™* QL *Udenyca™* QL *Zarxio®* QL *Ziextenzo®* QL
Glucagon Agents	Baqsimi™ CC Proglycem®	glucagon emergency kit (Fresenius) Zegalogue® Autoinjector AE	*glucagon emergency kit (Lilly)*	diazoxide glucagon HCl (Lilly) Gvoke™ Zegalogue® Syringe AE
Oral Steroids	budesonide EC dexamethasone solution, tablets hydrocortisone methylprednisolone dose pack, tablets prednisolone sodium phosphate solution (generic for Pediapred® and Orapred®) prednisolone solution prednisone dose pack, tablets, solution		*prednisolone sodium phosphate solution (generic for Millipred® and Veripred®)*	Alkindi® Sprinkle Celestone Cortef® Decadron® dexamethasone elixir dexamethasone intensol Emflaza® CC, QL Entocort EC® Hemady® Medrol® methylprednisolone 8 mg, 16 mg tablets Millipred® Ortikos™ prednisone intensol prednisolone sodium phosphate ODT Rayos® TaperDex™ Tarpeyo™ Veripred 20®
Diabetes: DPP-4 Inhibitors	Janumet™ CC, QL Janumet XR™ CC, QL Januvia™ CC, QL Jentadueto® CC, QL Jentadueto® XR CC, QL Tradjenta™ CC, QL		*Glyxambi* QL	alogliptin QL alogliptin/metformin QL alogliptin/pioglitazone QL Kazano® QL Kombiglyze™ XR QL Nesina® QL Onglyza™ QL Oseni® QL Qtern® QL Steglujan™ AE, QL Trijardy® XR QL
Diabetes: Insulin and Related Agents	Humalog® cartridge, vial and KwikPen®		*Novolog® Mix vial*	Admelog® and Admelog Solostar® CC

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):
	Humalog® Junior (Jr) KwikPen® Humalog® Mix vial and KwikPen® Humulin® R vial Humulin® R U-500 vial and KwikPen® Humulin® 70/30 vial and KwikPen® insulin aspart cartridge vial and pen insulin aspart/insulin aspart protamine pen and vial insulin lispro pen, vial and Jr, KwikPen® insulin lispro/insulin lispro protamine KwikPen® Lantus® and Lantus® Solostar Levemir® and Levemir® FlexTouch® Novolog® vial, cartridge, and FlexTouch® Novolog® Mix FlexPen®			Afrezza® Apidra™ vial and Solostar® Basaglar® KwikPen® CC Fiasp® vial, pen and FlexTouch® CC Humalog® 200 unit/mL KwikPen® Humulin® N and Humulin® N KwikPen® insulin glargine vial insulin glargine solostar U100 insulin glargine-yfgn pen and vial CC Lyumjev™ pen and vial CC Novolin® R, N vial, pen Novolin® 70/30 vial, pen Semglee™ pen and vial CC Semglee (yfgn) ™ pen and vial CC Symlin® CC, AE Toujeo® Solostar® and Max Solostar® Tresiba® vial and FlexTouch®
Phosphate Binders	calcium acetate MagneBind® 400 RX Phoslyra™ Renvela™ tablets	Renvela™ powder packets		Auryxia™ Fosrenol® lanthanum carbonate Renagel® sevelamer carbonate powder packets sevelamer carbonate tablets sevelamer hydrochloride Velphoro®

New Class Reviews

Class	Criteria for Prior Authorization
Immunomodulators, Asthma	**Class Selection & Guidelines** • DMS to select preferred agent(s) based on economic evaluation. • Agents not selected as preferred will be considered non-preferred and will require PA. • For any new chemical entity in *Immunomodulators, Asthma* class, require PA until reviewed by the P&T Committee. **Non-preferred drug criteria**

<table>
<tr><th>Class</th><th colspan="2">Criteria for Prior Authorization</th></tr>
<tr><td></td><td colspan="2">Approval of non-preferred agents requires ≥ 3-month trial and therapeutic failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance of at least 1 preferred agent.</td></tr>
<tr><td></td><td>Preferred Agents</td><td>Non-Preferred Agents</td></tr>
<tr><td></td><td>Xolair®
Nucala</td><td>Tezspire ™ CC, AE, QL
Fasenra®</td></tr>
<tr><th>Class</th><th colspan="2">Criteria for Prior Authorization</th></tr>
<tr><td>Uterine Disorder Treatments</td><td colspan="2">Class Selection & Guidelines
• DMS to select preferred agent(s) based on economic evaluation.
• Agents not selected as preferred will be considered non-preferred and will require PA.
• For any new chemical entity in Uterine Disorder Treatments class, require PA until reviewed by the P&T Committee.
Non-preferred drug 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 with the same indication for use.</td></tr>
<tr><td></td><td>Preferred Agents</td><td>Non-Preferred Agents</td></tr>
<tr><td></td><td>Myfembree®
Orilissa®</td><td>Oriahnn®</td></tr>
</table>

New Products to Market

Drugs Requiring PA	Criteria for Prior Authorization
Cibinqo™	**Non-prefer in the PDL class:** Cytokine and CAM Antagonists **Length of Authorization:** 6 months initial; 1 year renewal • Abrocitinib (Cibinqo) is a Janus kinase (JAK) inhibitor indicated for the treatment of adults with refractory, moderate-to-severe atopic dermatitis whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies is inadvisable. **Criteria for Approval** • Patient has moderate-to-severe atopic dermatitis (AD) defined by ≥ 1 of the following: ○ Involvement of ≥ 10% of body surface area (BSA); OR ○ Eczema Area and Severity Index (EASI) score of ≥ 16; OR ○ Investigator's Global Assessment (IGA) score of ≥ 3; OR ○ Scoring Atopic Dermatitis (SCORAD) score of ≥ 25; OR ○ Pruritus Numerical Rating Scale (NRS) score of ≥ 4; OR

Drugs Requiring PA	Criteria for Prior Authorization
	○ Incapacitation due to AD lesion location (head and neck, palms, soles, or genitalia); AND • Prescribed by, or in consultation with, a dermatologist, rheumatologist or other specialist in the treatment of atopic dermatitis; AND • Patient is up to date with all vaccinations, in accordance with current vaccination guidelines, prior to initiating therapy; AND • Patient will NOT receive live vaccines during therapy; AND • The medication will NOT be used in combination with other monoclonal antibody biologics; AND • Patient is NOT on concomitant antiplatelet therapies during the first 3 months of treatment (Note: excludes the use of low-dose aspirin) AND • Patient does NOT have any clinically relevant laboratory abnormalities (e.g., platelet count <150,000/mm3, an absolute lymphocyte count <500/mm3, an absolute neutrophil count <1,000/mm3, or a hemoglobin value <8 g/dL); AND • Patient has had a ≥ 3 month trial and failure, contraindication, or intolerance to ≥ 1 agent in each of the following categories: ○ Topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) unless inappropriate for the location (e.g., face, groin); AND ○ Topical calcineurin inhibitor (i.e., tacrolimus or pimecrolimus); AND ○ Immunomodulating systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, dupilumab) • Patient must meet the minimum age recommended by the package insert for this FDA approved indication. **Renewal Criteria** • Patient has disease response as indicated by improvement in signs and symptoms compared to baseline in ≥ 1 of the following: pruritus, the amount of surface area involvement, EASI, IGA, SCORAD, and/or NRS; AND • Patient has achieved clear or almost clear skin defined as achievement of an IGA 0/1 or EASI-75 at week 16; OR • Patient has had an inadequate response to standard doses of therapy after an adequate trial of ≥ 12 weeks OR patient experienced a disease flare and will require higher dosing; AND • Patient requires an increase in dose, in accordance with prescribing information recommended dosages (e.g., up to 200 mg daily) • Patient has NOT experienced a myocardial infarction or stroke; AND • Patient has NOT experienced any treatment-restricting adverse effects **Age Limit:** None

Drugs Requiring PA	Criteria for Prior Authorization
	Quantity Limit: 50 mg, 100 mg, and 200 mg: 1 per day

Adbry™	**Non-prefer in the PDL class:** *Immunomodulators, Atopic Dermatitis*
	Length of Authorization: 16 weeks initial, 1 year renewal
	• Tralokinumab-ldrm (Adbry) is an interleukin-13 antagonist indicated for the treatment of moderate-to severe atopic dermatitis (AD) in adult patients whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.
	Criteria for Approval:
	Initial Approval Criteria
	• Diagnosis of moderate to severe atopic dermatitis with at least 1 of the following:
	  • Involvement of at least 10% of body surface area (BSA); OR
	  • Eczema Area and Severity Index (EASI) score of 16 or greater; OR
	  • Investigator's Global Assessment (IGA) score of 3 or more; OR
	  • Scoring Atopic Dermatitis (SCORAD) score of 25 or more; OR
	  • Incapacitation due to AD lesion location (i.e., head and neck,palms, soles, or genitalia); AND
	• Prescribed by, or in consultation with, a dermatologist, allergist/immunologist, or other specialist in the treatment of atopic dermatitis; AND
	• Patient has had a trial and failure, contraindication, or intolerance to at least 1 agent from ≥ 2 of the following classes:
	  • Prescription strength topical corticosteroids (e.g., mometasone, fluocinolone) unless inappropriate for the location (e.g., face, groin); OR
	  • Topical calcineurin inhibitor (e.g., pimecrolimus or tacrolimus); OR
	  • Topical phosphodiesterase-4 inhibitor (e.g., crisaborole); OR
	  • Topical Janus kinase inhibitor (e.g., ruxolitinib); OR
	  • Immunomodulating systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, dupilumab)
	Renewal Criteria
	• Patient must have disease improvement and/or stabilization from baseline; AND
	• Patient has NOT experienced serious treatment-related adverse event
	Age Limit: ≥18 years
	Quantity Limit: 4 syringes per 28 days (0.143 per day)

Tavneos™	**Non-prefer in PDL Class:** *Immunosuppressants* **Length of Authorization:** 6 months initial, 1 year renewal • Avacopan (Tavneos) is a complement 5a receptor (C5aR) antagonist indicated as an adjunctive treatment of adult patients with severe active anti-neutrophil cytoplasmic

Drugs Requiring PA	Criteria for Prior Authorization

	autoantibody (ANCA)-associated vasculitis (granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA]) in combination with standard therapy including glucocorticoids.
	Criteria for Approval:
	Initial Approval Criteria
	• Patient has severe active antineutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis; AND
	  ○ Patient has autoantibodies for proteinase 3 (PR3) or myeloperoxidase (MPO), as detected using indirect immunofluorescence (IIF) assay or antigen-specific enzyme linked immunosorbent assays (ELISAs); OR
	  ○ Disease is confirmed by tissue biopsy at the site of active disease; AND
	• Patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment; AND
	• Physician has assessed disease severity utilizing an objective measure/tool (e.g., Birmingham Vasculitis Activity Score [BVAS]) and patient has a baseline score of ≥ 16 with 1 of the following:
	  ○ Patient has 1 major item; OR
	  ○ Patient has ≥ 3 non-major items; OR
	  ○ Patient has ≥ 2 renal items of proteinuria and hematuria; AND
	• Patient does NOT have an active infection, including clinically important localized infections; AND
	• Patient has failed on ≥ 1 of the following regimens:
	  ○ Patient has failed immunosuppressant therapy (e.g., cyclophosphamide, azathioprine, methotrexate, mycophenolate), unless contraindicated or intolerant; OR
	  ○ Patient has failed on anti-CD20 monoclonal antibody therapy (e.g., rituximab), unless contraindicated or intolerant; AND
	• Avacopan (Tavneos) will be used as adjunctive therapy in combination with standard therapy (e.g., corticosteroids, cyclophosphamide, azathioprine, mycophenolate, rituximab).
	Renewal Criteria
	• Disease response from pre-treatment baseline as indicated by the following:
	  ○ Absence of new symptoms; AND
	  ○ Minimal use of glucocorticoids (e.g., < 5 mg of prednisone or equivalent); AND
	  ○ One or more of the following:
	  ▪ Decrease in relapses/flares and/or ANCA levels; OR

Drugs Requiring PA	Criteria for Prior Authorization
	▪ Improvement in organ manifestations (e.g., those with pulmonary renal syndrome should improve in PFTs, proteinuria, creatinine); OR ▪ Remission (defined as a composite scoring index of 0 on the BVAS); AND • Patient has NOT experienced any treatment-restricting adverse effects (e.g., hepatoxicity, severe hypersensitivity reactions, serious infections). **Age Limit:** ≥ 18 years **Quantity Limit:** 6 capsules per day
Leqvio®	**Non-prefer in the PDL class:** *Lipotropics: Other* **Length of Authorization:** 6 months initial; 1 year renewal • Inclisiran, a small interfering RNA (siRNA) directed to PCSK9 (proprotein convertase subtilisin kexin type 9) mRNA, is indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (ASCVD), who require additional lowering of low-density lipoprotein cholesterol (LDL-C). **Criteria for Approval:** **Initial Approval Criteria** • Prescribed initially by, or in consultation with a cardiologist, lipid specialist, endocrinologist, vascular medicine, or other specialist in the treatment of hyperlipidemia; AND • Documentation of low-density lipoprotein cholesterol (LDL-C) prior to/without PCSK9 inhibitor therapy; AND • Medication is used to reduce the risk of cardiovascular (CV) events (e.g., myocardial infarction, stroke) in a patient with established CV disease; OR • Diagnosis of primary hyperlipidemia, including heterozygous and homozygous familial hypercholesterolemia; AND • Trial and failure to achieve LDL goal after 3 months of high intensity statin therapy; OR • Patient does not tolerate statins (≥ 2 statin trials of any length were unsuccessful due to adverse effects); AND • Maximum tolerated doses of lipid-lowering therapies will continue to be used in combination with PCSK9 therapy. **Renewal Criteria:** • Documentation of most recent LDL-C while on treatment that demonstrate a reduction in LDL-C when compared to the baseline values. **Age Limit:** ≥ 18 years
Vyvgart™	**Non PDL class:** *Immunomodulators, miscellaneous* **Length of Authorization:** 3 months initial, 1 year renewal

Drugs Requiring PA	Criteria for Prior Authorization

	• Efgartigimod alfa-fcab (Vyvgart), a neonatal Fc receptor blocker, is indicated for the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.
	Criteria for Approval:
	Initial Approval Criteria
	• Diagnosis of Myasthenia Gravis (MGFA Class II to IV disease); AND
	• Patient has a positive serologic test for anti-acetylcholine receptor (AChR) antibodies; AND
	• Patient has a baseline immunoglobulin G (IgG) level of ≥ 6 g/L (600 mg/dL); AND
	• Patient does NOT have an active infection, including clinically important localized infections; AND
	• Patient had an inadequate response after a minimum 1-year trial with ≥ 2 immunosuppressive therapies (e.g., corticosteroids plus an immunosuppressant such as azathioprine, cyclosporine, mycophenolate) OR
	• Patient required chronic treatment with plasmapheresis or plasma exchange (PE) or intravenous immunoglobulin (IVIG) in addition to immunosuppressant therapy; AND
	• Efgartigimod will NOT be used in combination with other immunomodulatory biologic therapies; AND
	• Live-attenuated or live vaccines will NOT be administered during treatment; AND
	• Patient has a thymoma; OR
	• Patient does not have a thymoma and is ≤ 50 years of age AND has had a thymectomy
	• Physician has assessed objective signs of neurological weakness and fatiguability on a baseline neurological examination (e.g., including, but not limited to, the Quantitative Myasthenia Gravis [QMG] score); AND
	• Patient has a baseline MG-Activities of Daily Living (MG-ADL) total score of ≥ 5.
	Renewal Criteria
	• Patient must have disease improvement as indicated by:
	  ○ reduction in MG-ADL total score of ≥ 2-points from baseline that is sustained for ≥ 4-weeks; OR
	  ○ improvement of ≥ 3-points from baseline in the Quantitative Myasthenia Gravis (QMG) total score sustained for ≥ 4-weeks; AND
	• Patient experiences improvement in muscle strength testing with fatigue maneuvers as evidenced on neurologic examination when compared to baseline; AND
	• Patient requires continuous treatment, after an initial beneficial response, due to new or worsening disease activity (Note: a minimum of 50 days must have elapsed from the start of the previous treatment cycle)
	• Patient has NOT experienced any treatment-restricting adverse effects
	Age Limit: ≥18 years

Drugs Requiring PA	Criteria for Prior Authorization
	Quantity Limit: 3 vials per week (8.6mL per day) for 4 doses per 50 days

Besemri™	**Non PDL class:** Immunomodulators, miscellaneous
	Length of Authorization: 1 year
	• Ropeginterferon alfa-2b-njft (Besremi) is an interferon alfa-2b indicated for the treatment of adults with polycythemia vera.
	Criteria for Approval:
	Initial Approval Criteria
	• Patient has a confirmed diagnosis of polycythemia vera; AND
	• Patient does NOT have hypersensitivity to other interferons including interferon alfa2b or any of the product's inactive ingredients; AND
	• Patient does NOT have a history of severe psychiatric disorders (e.g., severe depression, suicidal ideation, suicide attempt(s)); AND
	• Patient does NOT have moderate-to-severe hepatic impairment (e.g., Child-Pugh B or C); AND
	• Patient does NOT have a history of active serious or untreated autoimmune disease; AND
	• Patient is NOT a transplant recipient on immunosuppressive therapy; AND
	• Patient does NOT have stage 4 renal impairment (e.g., eGFR is < 30 mL/min); AND
	• Ropeginterferon alfa-2b-njft must be used as single agent therapy (note: excludes use when transitioning from hydroxyurea); AND
	• Ropeginterferon alfa-2b-njft will NOT be used in combination with any of the following:
	  ○ myelosuppressive agents;
	  ○ interferon type products (e.g., alfa-, beta-, gamma- interferon);
	  ○ narcotics, hypnotics, or sedatives; AND
	• Patient has a documented failure, contraindication, or ineffective response to maximum tolerated doses of hydroxyurea for a minimum 3-month trial; AND
	• Patient will have ophthalmological examinations prior to start and during therapy; AND
	• Patient will have a complete blood count (CBC) at baseline, during titration, and every 3 to 6 months during the maintenance phase; AND
	• Patient will have liver function tests (LFTs) at baseline and during therapy; AND
	• Patient will be monitored for serum triglycerides (TG) at baseline and intermittently during therapy; AND
	• Females of reproductive potential must have a negative pregnancy test prior to use and use effective contraception during therapy and for a minimum of 8 weeks following the last dose.
	Renewal Criteria

Drugs Requiring PA	Criteria for Prior Authorization

	• Patient has maintained hematological stability as evidenced by all of the following parameters:
	  ○ Hematocrit < 45% and no phlebotomy in the preceding 2 months; AND
	  ○ Platelets ≤ 400 x 109/L; AND
	  ○ Leukocytes ≤10 x 109/L; AND
	  ○ Patients who have maintained a complete hematological response or hematological stability after 1 year of treatment, at stable doses, will attempt a dosing interval increase to 4 weeks; AND
	• Patient has NOT experienced any treatment-restricting adverse effects
	Age Limit: ≥ 18 years

Tezspire™	**Non-prefer in the PDL class:** *Immunomodulators, Asthma*
	Length of Authorization: 1 year
	• Tezepelumab-ekko (Tezspire), a thymic stromal lymphopoietin (TSLP) inhibitor, is indicated for the add-on maintenance treatment of adult and pediatric patients aged ≥ 12 years with severe asthma.
	Criteria for Approval:
	Initial Approval Criteria
	• Patient must have a diagnosis of severe asthma; AND
	• Must be used for add-on maintenance treatment in patients regularly receiving BOTH of the following:
	  ○ Medium- to high-dose inhaled corticosteroids; AND
	  ○ An additional controller medication (e.g., long-acting beta agonist, leukotriene modifiers); AND
	• Patient must have had, in the previous year, at least 2 exacerbations requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) OR one exacerbation resulting in a hospitalization; AND
	• Baseline measurement of ≥ 1 of the following for assessment of clinical status:
	  ○ Use of systemic corticosteroids; OR
	  ○ Use of inhaled corticosteroids; OR
	  ○ Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition; OR
	  ○ FEV1; AND
	• Must not be used in combination with anti-IgE, anti-IL4, or anti-IL5 monoclonal antibody agents (e.g., benralizumab, omalizumab, mepolizumab, reslizumab, dupilumab); AND
	• Patient does not have an active or untreated helminth infection; AND
	• Will not be administered concurrently with live vaccines; AND

Drugs Requiring PA	Criteria for Prior Authorization

	• Patient has had a trial and failure, contraindication, or intolerance to at least 1 preferred agent.
	Renewal Criteria
	• Improvement in asthma symptoms, asthma exacerbations, or airway function as evidenced by decrease in ≥ 1 of the following:
	  ○ Use of systemic corticosteroids; OR
	  ○ Two-fold or greater decrease in inhaled corticosteroid use for at least 3 days; OR
	  ○ Hospitalizations; OR
	  ○ ER visits; OR
	  ○ Unscheduled visits to healthcare provider; OR
	  ○ Improvement from baseline in FEV1 of ≥ 15%; AND
	  ○ Patient has not experienced any treatment-restricting adverse effects
	Age Limit: ≥ 12 years old
	Quantity Limit: 1 prefilled syringe per 28 days (0.07mL per day)

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.

• Antimigraine Agents – Triptans (Antimigraine Agents - 5-HT1Receptor Agonists) • Erythropoiesis Stimulating Proteins • Growth Hormone • Hypoglycemics, Alphaglucosidase inhibitors (Diabetes: AlphaGlucosidase Inhibitors) • Hypoglycemics, Incretin Mimetics/Enhancers (Diabetes: GLP-1 Agonists) • Hypoglycemics, Meglitinides (Diabetes: Meglitinides) • Hypoglycemics, Metformins (Diabetes: Metformins) • Hypoglycemics, SGLT2 Inhibitors (Diabetes: SGLT2 Inhibitors) • Hypoglycemics, Sulfonylureas (Diabetes: Sulfonylureas)	• Hypoglycemics, Thiazolidinediones (Diabetes: Thiazolidinediones) • Narcotics: Agonist/Antagonists • Narcotics: Fentanyl Buccal Products • Neuropathic Pain • Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) • Opiate Dependence Treatments • Pancreatic Enzymes • Progestins for Cachexia • Skeletal Muscle Relaxants • Thrombopoiesis Stimulating Proteins (Thrombopoiesis Stimulating Agents)

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 May 19, 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

ShaLeigh Hammons, CPhT
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.