DATE: March 13, 2026

TO: Commonwealth of Kentucky Medicaid Prescriber Network

FROM: MedImpact Healthcare Systems

Subject: Upcoming Drug Coverage Updates

Status: Please be advised, the Kentucky Department for Medicaid Services (DMS) will implement clinical criteria for the agents listed in the table below.

Prior authorizations (PAs) will be required starting on the effective date listed for the respective agents. Pharmacy providers are encouraged to work with prescribers and their impacted patients to obtain the necessary prior authorization information or find alternative therapies when appropriate.

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.

Effective Date	Agent(s) Subject to Criteria	Criteria for Approval
04/01/2026	**Galafold (migalastat)**	**Approval Duration:** 1 year (initial, renewal) **Initial Approval Criteria** • Diagnosis of Fabry disease; **AND** ○ Confirmed amendable galactosidase alpha gene (GLA) variant based on in-vitro assay data; **AND** • Medication is being prescribed by, or in consultation with, a neurologist or other specialist in the treatment of Fabry disease; **AND** • Agent will not be taken concurrently with Elfabrio or Fabrazyme; **AND** • Patient meets the minimum age recommended by the package insert for the FDA-approved indication. **Renewal Criteria** • Patient has experienced disease improvement or stabilization. **Quantity Limit**: 14 capsules per 28 days

Effective Date	Agent(s) Subject to Criteria	Criteria for Approval
05/01/2026	**Remodulin** **treprostinil sodium vials**	**Approval Duration:** 1 year (initial, renewal) **Initial Approval Criteria** • Diagnosis of pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1; **AND** • 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 to calcium channel blockers; **AND** • Patient meets the minimum age (i.e., at least 18 years old) recommended by the package insert for use in PAH **Renewal Criteria** • Prescriber attestation of clinically significant improvement or stabilization in clinical signs and symptoms.

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	