DATE: 7-2-2026

TO: Commonwealth of Kentucky Medicaid Prescriber Network

FROM: MedImpact Healthcare Systems

Subject: **Somatostatin Analog Upcoming Drug Coverage Updates**

Status: Effective September 1, 2026, the Commonwealth of Kentucky Department for Medicaid Services (DMS) is making changes to the prior authorization (PA) criteria for the agents listed in the table below.

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.

Drug	Clinical Criteria
SANDOSTATIN **OCTREOTIDE ACETATE** **BYNFEZIA** **MYCAPSSA** **SIGNIFOR**	**1. INITIAL APPROVAL CRITERIA** • Patient has a diagnosis supported by the INDICATIONS AND USAGE section of the FDA package insert or listed in a nationally recognized compendium; **AND** • The requested dosage is within current FDA requirements. **2. RENEWAL CRITERIA** • Documentation (e.g., progress note, lab results, or imaging report) of positive clinical response or stabilization of disease, as evidenced by one or more of the following:

- Improvement or stabilization of disease-related signs and symptoms; **OR**
- Improvement, normalization, or stabilization of disease-specific biochemical markers; **OR**
- Stable disease or improvement on imaging (if applicable); **OR**
- No evidence of clinically significant disease progression; **AND**

- The requested dosage is within current FDA requirements.

SANDOSTATIN LAR DEPOT

SOMATULINE DEPOT

OCTREOTIDE ACETATE, MI-SPHERES

SIGNIFOR LAR

LANREOTIDE ACETATE

1. INITIAL APPROVAL CRITERIA

- The medication is being administered by a home infusion provider; **OR** physician attests that the medication is being self-administered and self-administration is appropriate per the FDA-approved prescribing information; **AND**
- Patient has a diagnosis supported by the INDICATIONS AND USAGE section of the FDA package insert or listed in a nationally recognized compendium; **AND**
- The requested dosage is within current FDA requirements.

2. RENEWAL CRITERIA

- The medication is being administered by a home infusion provider; **OR** physician attests that the medication is being self-administered and self-

administration is appropriate per the FDA-approved prescribing information; **AND**

- Documentation (e.g., progress note, lab results, or imaging report) of positive clinical response or stabilization of disease, as evidenced by one or more of the following:
    - Improvement or stabilization of disease-related signs and symptoms; **OR**
    - Improvement, normalization, or stabilization of disease-specific biochemical markers; **OR**
    - Stable disease or improvement on imaging (if applicable); **OR**
    - No evidence of clinically significant disease progression; **AND**
- The requested dosage is within current FDA requirements.

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	