Formulary Updates

DEFINITIONS

Formulary These drugs are included in Mass General Brigham's covered drug list.

Non-Formulary These drugs are not included in Mass General Brigham's formulary. The plan would only cover formulary alternatives. Providers can request Non-Formulary drugs as an exception, and the plan would require trial of all appropriate formulary alternatives prior to approving coverage of a Non-Formulary drug. If a Non-Formulary drug is approved, the member's cost sharing would be the highest tier.

Preferred These drugs are on Mass General Brigham's formulary and offer a lower cost to members.

Non-Preferred These drugs are on Mass General Brigham's formulary but offer a higher cost to members.

Excluded Mass General Brigham does not cover these drugs. Members will receive a denial for all Excluded drug requests.

Updates for Commercial Members

Effective 06/01/2025

The following changes are being made to the listed medications:

Jakafi	Jakafi will require prior authorization for new and current utilizers.
Actemra, Tyenne, Tofidence	Actemra and Tyenne will be managed at parity for all overlapping FDA-approved indications. Tofidence will require trial and failure with either Actemra or Tyenne for all overlapping FDA-approved indications. All three agents will continue to require prior authorization and will only be approved for their FDA-approved indications.
Ocular Disorders	Avastin, Eylea and Lucentis will be the preferred ocular VEGF inhibitors. They will continue to be restricted to the medical benefit and will require prior authorization. Criteria will require that the member has an FDA-approved diagnosis (Eylea, Lucentis) or a diagnosis supported by compendia (Avastin). Beovu, Byooviz, Cimerli, Eylea HD, Pavblu, Susvimo, Vabysmo, and Visudyne will be nonpreferred and will be restricted to the medical benefit with prior authorization. Criteria for new utilizers will require an FDA-approved diagnosis

<table>
<tr><td></td><td>and trial and failure with at least one preferred agent that has the same indication or use supported by compendia (Avastin).</td></tr>
<tr><td>Proton Pump Inhibitors (PPIs)</td><td>PPI policy will be updated to clarify step therapy requirements and quantity limits.
First-line: will be covered without prior authorization
Second-line: will pay if the member has filled at least two first-line medications or one second-line medication in the past 180 days
Third-line: will pay if the member has filled at least two second-line medications or one third-line medication in the past 180 days
<table><tr><th>FIRST-LINE</th><th>SECOND-LINE</th><th>THIRD-LINE</th></tr><tr><td>omeprazole capsules (Rx only)
pantoprazole tablets
omeprazole/sodium bicarbonate OTC capsules
lansoprazole 15mg & 30mg capsules (Rx only)
esomeprazole capsules & tablets (Rx and OTC)
rabeprazole tablets</td><td>omeprazole/sodium bicarbonate packets for suspension
Rabeprazole sprinkle capsules
Dexlansoprazole capsules
Esomeprazole packets for suspension*
Prilosec packets for suspension*
Pantoprazole packets for suspension*
Lansoprazole ODT</td><td>Konvomep</td></tr><tr><td colspan="3">*Prilosec packets for suspension, pantoprazole packets for suspension, esomeprazole packets for suspension will be covered for members <12 years of age without an authorization</td></tr></table></td></tr>
<tr><td>Rybrevant</td><td>Requests for Rybrevant will be reviewed against the policy titled “Oncology Medication Review – NCCN.” Rybrevant will continue to be restricted to the medical benefit with prior authorization. The medication-specific policy for Rybrevant will be retired.</td></tr>
<tr><td>Olumiant</td><td>Initial criteria for Olumiant in the treatment of alopecia areata will be updated to require that the member meets minimum age requirements that is aligned with the FDA-approved package labeling.</td></tr>
<tr><td>Xolair</td><td>Reauthorization criteria for the diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) will be updated to include examples of clinical response to therapy.</td></tr>
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Updates for MassHealth Members

Effective 06/01/2025

The following changes are being made to the listed medications to be in compliance with the MassHealth UPPL (Unified Pharmacy Product List):

Antiviral Agents	The following clinical updates were made to the **Prevymis** criteria:

	• Criteria was updated as it is a recommended first-line agent for cytomegalovirus (CMV) prophylaxis treatment among patients receiving an allogeneic hematopoietic stem cell transplant, per NCCN guideline recommendations. • Criteria for off-label use of Prevymis among members undergoing a solid organ (non-kidney, non-HSCT) transplant was added. ○ These members will need a trial with valganciclovir prior to this medication, but a note has been added that members may bypass valganciclovir if high risk for myelosuppression is documented. • The approval durations have also been updated.
Beta Thalassemia, Myelodysplastic Syndrome and Sickle Cell Disease Agents	Criteria for **Adakveo** and **Reblozyl** has been updated to remove the requirement of a trial with one erythropoiesis stimulating agent (ESA). Criteria for **Reblozyl** has been updated to remove the requirement of documentation that a member has had red blood cell (RBC) transfusions in the past 8 weeks.
C. difficile Prevention Agents	Criteria for **Rebyota** was updated to require two total episodes of Clostridioides difficile, including the initial infection, for diagnosis.
Complement Inhibitors	Criteria for **Empaveli** was updated to require a step-through trial with Soliris or Ultomiris and include a specified quantity limit. Criteria regarding the meningococcal vaccination requirement for complement inhibitors was removed.
Dermatologic Agents	Criteria for **Ycanth** was updated to remove the prescriber specialty requirement.
Gout Agents	Criteria for **Krystexxa IV** was updated to have a step-through dose threshold of allopurinol was increased to 800 mg per day from 600 mg per day according to clinical guidelines and FDA-approved maximum dosing.
Lipid Lowering Agents	Criteria for **Leqvio** was updated to reflect an expanded indication for members with increased cardiovascular risk.
Multiple Sclerosis Agents	Criteria for **Ocrevus** was updated to require a step-through trial with Briumvi for clinically isolated syndrome (CIS), relapse-remitting multiple sclerosis (RRMS), and active secondary-progressive multiple sclerosis (SPMS) diagnoses.
Targeted Immunomodulators	Criteria for **Stelara** was updated to remove the requirement of step-through trials for psoriatic arthritis and ulcerative colitis.
T-Cell Immunotherapy Agents	Criteria for **Lunsumio** was clarified to require only 2 lines of systemic therapies. The initial approval duration was increased to 12 months from 6 months.