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 02/01/2025

The following changes are being made to the listed medications:

CFTR Potentiators: Kalydeco Symdeko Trikafta	Criteria being updated to remove specific mutations. Instead, criteria will require member has at least one mutation that is responsive to the requested agent.
Glaucoma Step Therapy: Bimatoprost 0.01% Iyuzeh Rocklatan Rhopressa Talfuprost 0.0015% Travoprost 0.004%	A second-line medication will be approved after trial and failure with either a first-line or a second-line medication. A third-line medication will be approved after trial and failure with either a second-line or a third-line medication.
Tecentriq	Criteria are being retired. Requests will be reviewed against criteria in policy titled "Oncology Medication Review – NCCN."
Zulresso	Criteria are being retired due to product discontinuation.

Updates for MassHealth Members

Effective 02/18/2025

The following brand name medications will become non-preferred. Approval will require a trial of its generic medication:

Brand Name	Generic Medication
Valcyte powder	Valganciclovir powder for oral solution
Elidel cream	Pimecrolimus cream

Effective 2/18/2025

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

Asthma and Allergy Monoclonal Antibodies	**Fasenra** received approval for expanded age indication in eosinophilic asthma to now include members ≥6 years of age and expanded indication for the treatment of adults with eosinophilic granulomatosis with polyangiitis. **Fasenra 10mg/0.5ml syringe** will be **added** to the pharmacy benefit **with** prior authorization. **Dupixent** has been approved as an add-on maintenance therapy for adult patients with inadequately controlled COPD and an eosinophilic phenotype as well as an age expansion in members ≥12 years of age with inadequately controlled chronic rhinosinusitis with nasal polyposis.
Antiparkinsonian Agents	**Duopa** criteria was updated to require a trial with: • both of the following: carbidopa/levodopa immediate-release or extended-release tablet formulation and carbidopa/levodopa extended-release capsule, AND • carbidopa/levodopa in combination with all of the following: COMT inhibitor, dopamine agonist, monoamine oxidase-type B inhibitor Criteria for **carbidopa/levodopa ODT** and **Zelapar** was updated to include medical necessity for the ODT formulation instead of the conventional formulations and confirmation that patient is not taking other solid oral formulations. **Crexont ER capsule & Vyalev vial** will both be **added** to the pharmacy benefit **with** prior authorization.
Antipsychotics	The following new drugs will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 60 capsules per 30 days: • Cobenfy 50mg-20mg capsule • Cobenfy 100mg-20mg capsule • Cobenfy 125mg-30mg capsule

	Cobenfy starter pack will be **added** to the pharmacy benefit **with** prior authorization.
Antiviral Agents	The following updates were made to **Prevymis** criteria: • Criteria was updated for CMV prophylaxis among patients receiving allogenic hematopoietic stem cell transplant to align with NCCN guideline recommendations. • Additional criteria was added for members undergoing a solid organ transplant.
Cardiovascular: Antihypertensives and Miscellaneous Cardiovascular Medications	The specialist requirement was removed for the acute heart failure indication within the criteria for Entresto tablet. The age requirement was removed from Katerzia and Norliqva. Off-label criteria for migraine prevention was added for Atacand (candesartan). **Tryvio tablet** & **digoxin 62.5mg tablet** will require both a prior authorization **and** quantity limit of 30 tablets per 30 days on the pharmacy benefit. The following medications will require prior authorization on the pharmacy benefit: • Lanoxin (digoxin 62.5 mcg tablet) • Accupril (quinapril) • Accuretic (quinapril/HCTZ) • Entresto sprinkle pellet The following medications will remain on the pharmacy benefit and will now require prior authorization for members > 13 years of age. • digoxin oral solution • furosemide solution The following medications will be **removed** from the pharmacy benefit and will be made available through the medical benefit only without prior authorization: • Brevibloc injection • Chlorothiazide injection • Lanoxin injection • Nicardipine injection • Nitroglycerin injection
Complement Inhibitors and Miscellaneous Immunosuppressive Agents	Expanded label indications of IgAN and CIDP were added for Fabhalta and Vyvgart Hytrulo, respectively. Fabhalta will require step-through options with Filspari and Tarpeyo. **Piasky vial** will be **added** to the medical benefit **with** prior authorization.

Continuous Glucose Monitoring Products	**Freestyle Libre 2 Plus Sensor** (new NDC: 57599-0835-00) will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 1 sensor per 15 days.
Diabetes Testing Supplies	**Freestyle Neo test strips** will have prior authorization **removed** and will remain on the pharmacy benefit **with** quantity limit of 100 strips per 30 days.
Epinephrine Products	**New Drug, Neffy nasal spray**, will be **added** to the pharmacy benefit **with** prior authorization.
Epkinly	The following criteria updates were made: • Added expanded indication of follicular lymphoma • A trial with Lunsumio will be required for the indication of follicular lymphoma • A trial with Columvi will be required for the indication of diffuse large B-cell lymphoma
Immune Suppressants - Topical	**Elidel 1% cream (pimecrolimus)** will remain on the pharmacy benefit **with** prior authorization **and** will have quantity limit **added** of 100 grams per 30 days. **New strength** for **Zoryve 0.3% cream** will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 60 grams per 30 days. Off-label criteria added for the use of Opzelura in adolescents ≥2 and <12 years of age for atopic dermatitis.
Isocitrate Dehydrogenase (IDH) Inhibitors	The following medications will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit: • Voranigo 10mg tablet – **QL** 60 tablets per 30 days • Voranigo 40mg tablet – **QL** 30 tablets per 30 days
Lipid Lowering Agents	The following updates were made: • Praluent and Repatha criteria were updated to allow bypassing a trial with ezetimibe for members on maximally tolerated statin doses if >25% LDL lowering is needed. • The specialist prescribing requirement for Nexletol and Nexlizet was removed.
Lung Cancer Agents	The following new drug will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limits: • Lazcluze 80mg tablet – **QL** 60 tablets per 30 days • Lazcluze 240mg tablet – **QL** 30 tablets per 30 days The following expanded label indications were added: • **Augtyro** (repotrectinib) for adult and pediatric patients 12 years and older with solid tumors that have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion, are locally advanced or metastatic or where surgical resection is likely to result in severe morbidity, and

	that have progressed following treatment or have no satisfactory alternative therapy. • **Krazati** (adagrasib) plus cetuximab for adults with KRAS G12C-mutated locally advanced or metastatic colorectal cancer (CRC), as determined by an FDA-approved test, who have received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy. • **Rybrevant** (amivantamab-vmjw) in combination with carboplatin and pemetrexed for adult patients with locally advanced or metastatic NSCLC harboring EGFR exon 19 deletions or exon 21 L858R substitution mutations whose disease has progressed on or after treatment with an EGFR tyrosine kinase inhibitor (TKI). • **Tagrisso** (osimertinib) for the treatment of adult patients with locally advanced, unresectable (stage III) NSCLC whose disease has not progressed during or following concurrent or sequential platinum-based chemoradiation therapy and whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations. • **Lorbrena** (lorlatinib) criteria for metastatic NSCLC updated to remove step through of Alecensa (alectinib).
Melanoma Agents	The following updates were made: • The age requirement was updated to ≥1 year old for Mekinist and Tafinlar for Glioma. • Diagnosis for Mektovi was updated to be more specific in NRAS mutation-positive unresectable or metastatic melanoma per the NCCN guidelines.
Oncology Immunotherapies	**New drug**, **Tecentriq Hybreza**, will be **added** to the medical benefit **with** prior authorization.
Respiratory Agents – Inhaled	The following updates were made to **Ohtuvayre** criteria: • clarification on severity of COPD (moderate to severe) • prescriber specialty to include allergist and immunologist in addition to pulmonologist • updated inadequate response time frame of inhaled therapy trials to defined as ≥ 90 days of therapy within a 120-day time period
Vaccines	**Abrysvo** *(respiratory syncytial virus vaccine*) will now require prior authorization for members **< 18** years of age on the pharmacy benefit.