

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 MassHealth Members

Effective 03/04/2024

The following generic medications will become non-preferred. Please use the brand name alternative(s):

Generic Medication	Brand Name Alternative
risperidone 12.5 mg, 25 mg, 37.5 mg, 50 mg extended-release intramuscular injection	Risperdal Consta

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

Brand Name	Generic Medication
Lotronex tablet	Alosetron tablet

Effective 03/05/2024 – Reminders

Respiratory Agents – Inhaled	<p>As of Dec 2023, GSK discontinued branded Flovent HFA (all strengths) and Flovent Diskus (all strengths).</p> <p>Generic Flovent (<i>fluticasone propionate inhalation <u>aerosol</u></i>) will require a prior authorization if member is ≥ 5 years of age.</p> <p>Generic Flovent (<i>fluticasone propionate inhalation <u>powder</u></i>) will require a prior authorization.</p> <p>Current members that have been grandfathered through 03/04/2024 will now be subject to a prior authorization as of 03/05/2024.</p>
------------------------------	--

Effective 03/04/2024

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

Amyotrophic Lateral Sclerosis Agents	<p>Qalsody 100mg/15ml solution will be added to the medical benefit with prior authorization.</p>
Anesthetics – Topical	<p>Iheezo 3% gel (<i>chloroprocaine ophthalmic</i>) has been added to the pharmacy benefit with prior authorization.</p>
Anti-Allergy & Anti-Inflammatory Agents	<p>Miebo (<i>perfluorohexyloctane</i>) has been added to the pharmacy benefit with prior authorization and quantity limit of 3 mL per 30 days.</p>
Antibiotics - Injectables	<p>Xacduro (<i>sulbactam/durlobactam injection</i>) will be added to the pharmacy benefit with prior authorization and will be available <u>without</u> prior authorization on the medical benefit.</p> <p>Note: This medication <u>will not</u> be part of the federal rebate program. Additional restrictions may apply.</p>
Anticonvulsants	<p>Sezaby (<i>phenobarbital 100mg vial</i>) will be available <u>without</u> prior authorization on the medical benefit.</p>



Antidepressants	<p>Zurzuvae (<i>zuranolone</i>) has been added to the pharmacy benefit with prior authorization and the following quantity limits:</p> <ul style="list-style-type: none"> • 30mg – 14 capsules per 45 days • 20mg and 25mg – 28 capsules per 45 days <p>Ketalar (<i>ketamine injection</i>) <u>will only</u> be available on the medical benefit with prior authorization:</p>
Antidiabetic Agents: Non-Insulin and Combo Products	New drug, Inpefa (sotagliflozin), was added to the pharmacy benefit with prior authorization and quantity limit of 30 tablets per 30 days.
Anti-diarrhea Agents	Opium tincture will <u>remain</u> on the pharmacy benefit with prior authorization and additional quantity limit of 72 mL per 30 days.
Antifungals – Oral and Injectable	The following updates has been made to Rezzayo (<i>rezafungin injection</i>):
	<ul style="list-style-type: none"> • added to the pharmacy benefit with prior authorization and quantity limit of ≤ 6 vials for one course of therapy • added to the medical benefit with prior authorization
Antimalarials	The criteria for off-label diagnoses for Daraprim (pyrimethamine) were updated to ensure it is being used in combination with an additional anti-infective agent.
Anti-Obesity Agents	The criteria was updated to reflect that overweight is an acceptable diagnosis.
Antipsychotics	<p>Rykindo (<i>risperidone ER intramuscular injection</i>) will be added to the pharmacy benefit with prior authorization and quantity limit of 2 injections per 28 days.</p> <p>Note: <i>The MassHealth Pediatric Behavioral Health Medication Initiative may apply to members <18 years of age due to polypharmacy, age, and/or drug restrictions.</i></p>
Asthma and Allergy Monoclonal antibodies	The Xolair criteria was updated to include off-label diagnosis of systemic mastocytosis.



Benzodiazepines & other Antianxiety Agents	The MassHealth Concomitant Opioid Benzodiazepine Initiative was updated to require a prior authorization of any benzodiazepine and opioid agent used concomitantly greater than 15 days within the past 45-day period.
Opioids and Analgesics	
Beta thalassemia, MDS, and SCD Agents	Reblozyl criteria was updated to include diagnosis of myelodysplastic syndromes associated anemia.
Breast Cancer Agents	<p>Enhertu (<i>fam-trastuzumab deruxtecan-nxki injection</i>) <u>will no longer</u> be available on the pharmacy benefit and will be restricted to <u>medical benefit only with</u> prior authorization.</p> <p>Trodely criteria was updated to be more in line with the FDA-labeled indications.</p>
Cardiovascular Antihypertensives and Miscellaneous Cardiovascular Medications	<p>Filspari (<i>sparsentan tablet</i>) will be added to the pharmacy benefit with prior authorization and quantity limit of 30 tablets per 30 days.</p> <p>Prior authorization was <u>removed</u> from diltiazem CD 360 mg capsule.</p> <p>Entresto will have a quantity limit of 60 tablets per 30 days and <u>will remain</u> on the pharmacy benefit with a prior authorization.</p>
Cerebral Stimulants & ADHD	<p>The following medications had quantity limits (QL) added and prior authorization <u>will remain</u> on the pharmacy benefit:</p> <ul style="list-style-type: none"> • Dyanavel XR (<i>amphetamine extended-release 2.5mg/mL oral suspension</i>) - QL ≤ 8 mL (20 mg) per day. • Dyanavel XR (<i>amphetamine extended-release chewable tablet</i>) – QL 30 tablets per 30 days. • Quillivant XR (<i>methylphenidate extended-release oral suspension</i>) – QL ≤ 12 mL (60 mg) per day. • Relexxii (18mg, 27mg, 36mg, 54mg) – QL 60 tablets per 30 days • Relexxii (45mg, 63mg and 72mg) – QL 30 tablets per 30 days <p>Clonidine ER 0.1 mg will require a prior authorization through the pharmacy benefit if member is less than 3 years of age and the requested quantity exceeds 4 tablets per day.</p>



CGRP Inhibitors	Zavzpret (<i>zavegepant nasal spray</i>) will be added to the pharmacy benefit with prior authorization and quantity limit of 12 units per 30 days.
Complement Inhibitors & Immunosuppressive Agents	The following new drugs will be available on <u>only the medical benefit</u> with prior authorization: <ul style="list-style-type: none"> • Rystiggo (<i>rozanolixizumab-noli</i>) • Vyvgart Hytrulo (<i>efgartigimod alfa and hyaluronidase-qvfc</i>)
Corticosteroids – oral agents	Tarpeyo criteria was updated to ensure consistency with Filspari criteria for the same indication, immunoglobulin A nephropathy (IgAN).
Dermatological Agents (Topical Chemo-Genital Wart Therapy)	New drug, Ycanth (<i>cantharidin</i>), will be added to the medical benefit only with prior authorization.
Diabetic Testing Supplies	Freestyle Neo criteria was updated to include Freestyle Libre 3 as a compatible CGM device.
Glaucoma Agents	Iyuzeh (<i>latanoprost PF solution</i>) will be added to the pharmacy benefit with prior authorization.
Glycopyrrolate Agents	Dartisla ODT was added as a step-through option for Cuvposa for members ≥ 17 years of age.
Growth Hormone Agents	New drug, Ngenla (<i>somatrogon-ghla</i>), will be added to the pharmacy benefit with prior authorization. Skytrofa will be a preferred agent. Requests for Sogroya or Ngenla will require a step-through of Skytrofa, while requests for other non-preferred agents will continue to require a step-through of Genotropin.



Hepatitis Antiviral Agents FAQ and Guideline	Criteria was updated to remove the 12-week treatment recommendation for members if treatment-naïve with cirrhosis and HIV-coinfection.
Immunosuppressants	<p>The following medications will be available on the medical benefit only <u>without</u> prior authorization:</p> <ul style="list-style-type: none"> • Sandimmune IV (<i>cyclosporine injection</i>) • Simulect (<i>basiliximab</i>) <p>The criteria for Prograf granules and Sandimmune solution was updated to accept members < 13 years of age for medical necessity.</p>
Kinase Inhibitors	<p>Lytgobi (<i>futibatinib</i>) <u>will remain</u> on the pharmacy benefit with prior authorization and quantity limit of 5 tablets per day.</p> <p>Ayvakit criteria was updated to include the expanded indication of indolent systemic mastocytosis (ISM).</p>
Melanoma Agents	<p>Kimtrak (<i>tebentafusp injection</i>) will be removed from the pharmacy benefit and will <u>remain</u> on the medical benefit only with prior authorization.</p> <p>The following medications will be added to the pharmacy benefit with prior authorization and quantity limit:</p> <ul style="list-style-type: none"> • Tafinlar (<i>dabrafenib tablet for oral solution</i>) – QL ≤ 30 mL per day • Mekinist (<i>trametinib solution</i>) – QL ≤ 40 mL per day <p>The following medications were updated to include new indications, listed respectively:</p> <ul style="list-style-type: none"> • Cotellic – histiocytic neoplasms • Mekinist – low grade glioma • Tafinlar – low grade glioma
Narcolepsy Agents	<p>Lumryz ER (<i>sodium oxybate extended-release suspension</i>) will be added to the pharmacy benefit with prior authorization.</p> <p>Note: This medication <u>will not</u> be part of the federal rebate program. Additional restrictions may apply.</p>
Nonhormonal Agents for Menopausal Symptoms	<p>Veozah (<i>fezolinetant tablet</i>) will be added to the pharmacy benefit with prior authorization and quantity limit of 30 tablets per 30 days.</p>



Opioid Dependence and Reversal Agents	<p>Opvee (<i>nalmefene nasal spray</i>) will be added to the pharmacy benefit with prior authorization and quantity limit of 2 inhalers per year.</p> <p>Brixadi criteria was updated to allow more options to the treatment failure requirement.</p>
PARP Inhibitors	<p>The following medications will be added to the pharmacy benefit with prior authorization:</p> <ul style="list-style-type: none"> • Zejula tablet (<i>niraparib 100mg, 200mg, 300mg</i>) with quantity limit of 30 tablets per 30 days • Talzenna capsule (<i>talazoparib 0.1mg, 0.35mg</i>) <p>The following medications were updated to include new indications, listed respectively:</p> <ul style="list-style-type: none"> • Lynparza – metastatic castration-resistant prostate cancer (mCRPC) • Talzenna – BRCA-mutated locally advanced or metastatic breast cancer and metastatic castration-resistant prostate cancer (mCRPC)
Pharmaceutical Compounding	<p>Criteria was updated to specify that members who are dependent on feeding tubes should not use agents that contain sweeteners or flavorings.</p> <p>Topical compounds requiring a prior authorization will now include transdermal route of administration.</p>
Polivy (<i>polatuzumab</i>)	<p>Criteria was updated to include expanded indication of previously untreated diffuse large B-cell lymphoma (DLBCL).</p>
Prostate Cancer Agents	<p>Akeega (<i>niraparib/abiraterone tablets</i>) will be added to the pharmacy benefit with prior authorization and quantity limit of 60 tablets per 30 days.</p> <p>New indication for Xtandi was added for metastatic castration-resistant prostate cancer (mCRPC).</p>
Pulmonary Hypertension (PH) Agents	<p>New drug, Liqrev (<i>sildenafil oral suspension</i>), will be added to the pharmacy benefit with prior authorization.</p>
Respiratory Agents - Inhaled	<p>New drug, Airsupra (<i>albuterol/budesonide</i>), will be added to the pharmacy benefit with prior authorization.</p> <p>Prior authorization was <u>removed</u> from ProAir Respiclick (<i>albuterol inhalation powder</i>) from the pharmacy benefit.</p>



	<p>Criteria for Pulmicort Respules for eosinophilic esophagitis (EoE) was updated to remove the step-through fluticasone propionate requirement.</p> <p>Off-label indication of EoE was added for fluticasone propionate.</p>
Skyrizi	<p>Skyrizi IV will be added to the medical benefit with prior authorization required.</p> <p>Skyrizi SC will <u>remain</u> on the pharmacy benefit with prior authorization required.</p>
Targeted Immunomodulators	<p>The following medications will be added to the pharmacy benefit with prior authorization:</p> <ul style="list-style-type: none"> • New adalimumab biosimilar agents and associated unbranded generics • Litfulo (<i>ritlecitinib</i>) capsule – QL of 30 capsules per 30 days <p>Subcutaneous Entyvio has been added to the same criteria as the IV formulation.</p> <p>Entyvio criteria for Crohn’s disease and ulcerative colitis was updated to require a step-through an anti-TNF agent.</p> <p>The step-through requirement of an anti-TNF agent has been removed from the following:</p> <ul style="list-style-type: none"> • Taltz criteria for psoriatic arthritis, non-radiographic axial spondyloarthritis, and ankylosing spondylitis • Stelara for psoriatic arthritis <p>Cibinqo (abrocitinib) criteria was updated to be in line with the current FDA labeling for use in members 12 years of age and older.</p>
T-cell immunotherapies	<p>The following medications will be added to the medical benefit only with prior authorization:</p> <ul style="list-style-type: none"> • Epkinly (<i>epcoritamab-bysp</i>) injection • Columvi (<i>glofitamab-gxbm</i>) injection
Vitamins	<p>ADEK Gummies (<i>multivitamins/zinc gummy</i>) will be added to the pharmacy benefit with prior authorization.</p>
Vesicular monoamine transporter 2 (VMAT2) Inhibitors	<p>The following medications will be added to the pharmacy benefit with prior authorization and quantity limit:</p> <ul style="list-style-type: none"> • Austedo XR (<i>deutetrabenazine extended-release</i>) (6mg, 12mg) – QL 90 tablets per 30 days.



	<ul style="list-style-type: none"> • Austedo XR (<i>deutetrabenazine extended-release</i>) (24mg) – QL 60 tablets per 30 days. <p>A new indication for Ingrezza was added for Huntington’s disease.</p>
Wound Care	Vyjuvek gel (<i>beremagene geperpavec-svdt</i>) will be added to the medical benefit only with prior authorization.

Upcoming Important Updates for MassHealth Members

Discontinuation of Levemir (<i>insulin detemir</i>)	<p>Novo Nordisk announced to the United States Food and Drug Administration (FDA) on November 8, 2023, the planned discontinuation of Levemir (<i>insulin detemir</i>) FlexPen and vials. Supply disruptions of the FlexPen are anticipated to begin mid-January 2024, followed by discontinuation of the FlexPen formulation on April 1, 2024, and discontinuation of the vial formulation on December 31, 2024.</p> <p>There are currently no commercially available biosimilars or authorized generics for insulin detemir.</p> <p>Alternative long-acting insulin products covered under the MassHealth UPPL (Unified Pharmacy Product List) include the following:</p> <p><u>Agents without Prior Authorization (PA)</u></p> <ul style="list-style-type: none"> • Lantus (<i>insulin glargine</i>) • Toujeo (<i>insulin glargine</i>) • Tresiba (<i>insulin degludec</i>) <p><u>Agents Requiring PA</u></p> <ul style="list-style-type: none"> • Basaglar (insulin glargine) • Semglee (insulin glargine-yfng)
Discontinuation of GlucaGen HypoKit (<i>glucagon</i>)	<p>Novo Nordisk announced to the FDA on November 18, 2023, the planned discontinuation of GlucaGen HypoKit (glucagon) in the United States. This discontinuation will be effective July 1, 2024.</p> <p>Generic formulations of glucagon are commercially available. Additionally, there are multiple branded alternative formulations. The following glucagon products are available through the MassHealth UPPL (Unified Pharmacy Product List).</p> <p><u>Agents without PA</u></p> <ul style="list-style-type: none"> • Baqsimi (glucagon nasal powder) • glucagon vial



	<ul style="list-style-type: none">• Gvoke (glucagon auto-injection, prefilled syringe, vial)• Zegalogue (dasiglucagon) – PA required until March 4, 2024
--	--

