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 05/01/2025

The following changes are being made to the listed medications:

Atypical Antipsychotics	The atypical antipsychotics step therapy program will be updated: • First-Line: aripiprazole tablet/oral solution/ODT, asenapine SL tablet, clozapine tablet/ODT, lurasidone tablet, olanzapine tablet/ODT, quetiapine tablet, quetiapine ER tablet, risperidone tablet/oral solution/ODT, ziprasidone capsule • Second-Line: paliperidone tablet, Rexulti tablet, Vraylar capsule • Third-Line: Caplyta capsule, Fanapt tablet, Lybalvi tablet, Secuado patch First-line agents will be covered without prior authorization. Second-line agents will pay at the point-of-sale if the member has filled at least one first-line or one second-line medication within the previous 180 days. Third-line agents will pay at the point-of-sale if the member has filled at least one second-line or one third-line medication in the previous 180 days. Prior authorization criteria for second- and third-line agents will mirror that of the automated step therapy requirements, with specific criteria for unique indications

	not shared with the lookback medications (e.g., agitation associated with dementia due to Alzheimer's disease). Injectable antipsychotics will no longer be included in the atypical antipsychotic step therapy program. However, any injectable antipsychotics that are currently covered without prior authorization will continue to be covered without PA.
GLP-1 Agonists for Type 2 Diabetes and Weight Loss Medications	The policies titled "Glucagon-like Peptide-1 (GLP-1) Agonists for Diabetes" and "Weight Loss Medications" will be updated to clarify that the plan will not authorize concomitant use of GLP-1s indicated for the treatment of weight loss with GLP-1s indicated for the treatment of type 2 diabetes. Reauthorization criteria for weight loss medications will be updated to require that members being treated for more than six months are continuing to maintain the minimal weight loss requirements and that the requested medication continues to be used in conjunction with lifestyle changes.

Updates for MassHealth Members

Effective 05/12/2025

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

Generic Medication	Brand Name Alternative
esomeprazole DR 2.5mg, 5mg packet	Nexium DR 2.5mg, 5mg packet
prucalopride tablet	Motegrity tablet
sacubitril/valsartan tablet	Entresto tablet
mesna tablet	Mesnex tablet

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

Brand Name	Generic Medication
Flovent Diskus	fluticasone propionate inhalation powder
Flovent HFA	fluticasone propionate inhalation aerosol

Effective 05/12/2025

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

Alzheimer's Agents	Criteria for **Kisunla** and **Leqembi** were updated to remove "medical record" requirements and will accept provider documentation of the required information on the submitted prior authorization. Following FDA approval for Leqembi's maintenance dosing, the second and subsequent re-authorizations (after 18 months) will require documentation

	of either a reduced dosing frequency or clinical rationale for continued dose.
Amyotrophic Lateral Sclerosis Agents	The following new formulations will be **added** to the pharmacy benefit **with** prior authorization **and** will remain on the medical benefit **with** prior authorization: • Edaravone 60mg/100ml vial & bag • Edaravone 30mg/100ml vial & bag
Androgen Therapy	**Azmiro 200mg/ml syringe** will be **added** to the pharmacy benefit **with** prior authorization. All criteria were expanded to require two lab results documenting low testosterone levels dated ≥ 3 months apart and gender-based verbiage was updated throughout. **Jatenzo** (*testosterone undecanoate 158mg & 198mg capsule*) will remain on the pharmacy benefit **with** prior authorization and will have an updated quantity limit of 120 capsules per 30 days. Criteria was expanded to include quantity limits or clinical rationale for exceeding quantity limit.
Anti-Hemophilia Agents	**New drug**, **Hympavzi**, will be **added** to the pharmacy benefit **with** prior authorization.
Anti-Obesity Agents	**Zepbound** criteria was updated to include the expanded indication of moderate to severe OSA in adults with obesity. The reauthorization criteria was also updated to require one of the following: improvement in OSA symptoms or weight loss of ≥5% from baseline body weight or improvement in secondary measures.
Anticonvulsant Agents	Brand Spritam will become preferred. A trial of its generic equivalent, levetiracetam tablet for oral suspension, will be required.
Antidepressants	**Pristiq** (*desvenlafaxine succinate extended-release 100 mg tablet*) will remain on the pharmacy benefit **with** prior authorization and will have an updated quantity limit of 120 tablets per 30 days. The following clinical updates were made to **Spravato**: • treatment resistant depression was updated to allow for use as monotherapy per most recent label expansion • specific dosing schedules for Spravato was added to criteria • duration of initial approval was decreased to 1 month and reauthorization durations were clarified dependent on the treatment phase
Asthma and Allergy Monoclonal Antibodies	**Nemluvio** criteria was updated to include expanded indication of atopic dermatitis.
Cardiovascular Agents	**Candesartan** criteria was updated to clarify the diagnoses of hypertension and heart failure (NYHA class II-IV). **Eprosartan** criteria was updated to clarify the diagnosis of hypertension.
Chronic Myelogenous Leukemia (CML) Agents	**Danziten tablet** will be **added** to the pharmacy benefit **with** prior authorization. Additional criteria will require medical necessity for use of Danziten instead of Tasigna.

Dermatological Agents	**Ycanth** will become preferred and will no longer require prescriber specialty of dermatology or consult notes from a specialist.
Gamifant (emapalumab)	Updated criteria to clarify that one conventional HLH trial or contraindication to all HLH therapies is required.
GnRH Analogues	**Fensolvi 45mg Syringe Kit** will continue to require prior authorization **under** the medical benefit and will be **added** to the pharmacy benefit **with** prior authorization. Additionally, for the diagnosis of central precocious puberty (CPP), requests for **Triptodur** will now require inadequate response or adverse reaction to either Fensolvi or Lupron Ped or a contraindication to both.
Immune Suppressants – Topical	The following clinical updates were made: • Criteria for Zoryve cream will align with criteria for Opzelura for the indication of atopic dermatitis (AD). The requirement of a step-through a topical corticosteroid and Eucrisa was removed. Members will now only need to have an inadequate response, adverse reaction or contraindication to a topical calcineurin inhibitor. • Criteria for Zoryve cream and foam in seborrheic dermatitis and plaque psoriasis will no longer require a trial with two alternative agents. Members will now only need to trial one alternative agent, a topical antifungal, topical calcineurin inhibitor, topical corticosteroid, or vitamin D analog as appropriate based on indication.
Immunotherapy – Oral	All criteria were updated to specify diagnosis of allergic rhinitis with or without conjunctivitis. Treatment failure requirements were clarified that it should be with “oral” second generation antihistamines.
Multiple Sclerosis Agents	**Ocrevus Zunovo vial** will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 23ml every 6 months **and** will also be **added** to the medical benefit **with** prior authorization. **Ocrevus Zunovo vial** will also be considered as one of the preferred trial options for other drugs in this class.
Oncology Immunotherapies	**New drug, Ziihera vial,** will be **added** to the medical benefit only **with** prior authorization. Criteria will include a step-through with one prior gemcitabine-containing regimen.
Pharmaceutical Compounding	The criteria point was removed: "Medical necessity for use of the requested product for the requested route of administration" due to redundancy within the criteria.
Systemic Chemotherapy	**New drugs, Axtle vial** & **Pemrydi RTU** will be **added** to the medical benefit only without restrictions.
Egrifta (tesamorelin)	Clinical update was made to require that the current waist circumference measurement must be dated within 90 days prior to treatment initiation.
Thrombocytopenic Agents	Off-label criteria for **Nplate** in chemotherapy-induced thrombocytopenia was added.

Vitamin D Analogs	All criteria were updated to require prescriber specialty if member's age is less than the limit. Criteria for Vectical and Sorilux was updated to allow for steroid sparing agent if affected areas are at high risk for skin atrophy.