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 07/01/2024

The following changes are being made to the listed medications:

Fluticasone HFA	This medication will be moving from a generic tier to a preferred brand tier.

Updates for MassHealth Members

Effective 07/01/2024
The following generic medications will become non-preferred. Please use the brand name alternative(s):

Generic Medication	Brand Name Alternative
Valganciclovir powder for oral solution	Valcyte powder for oral solution
Penciclovir cream	Denavir cream

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

Brand Name	Generic Medication
Sorilux Foam	calcipotriene Foam

Delzicol delayed-release capsule	Mesalamine delayed-release capsule
Noxafil oral suspension	Posaconazole oral suspension
Lexiva tablet	Fosamprenavir tablet
Prezista tablet	Darunavir tablet
Proventil HFA	Albuterol HFA
Proair HFA	Albuterol HFA

Effective Immediately

Inhaled Respiratory Agents	MassHealth has updated the age limit for **generic fluticasone HFA** from 5 years of age to 12 years of age effective immediately. Prior authorization for **generic fluticasone HFA** will now be required for **members ≥ 12 years of age** on the pharmacy benefit.

Effective 07/1/2024

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

Amyloidosis Therapies	**New drug, Wainua**, will be **added** to the pharmacy benefit **with** prior authorization required. The following medications will remain on the pharmacy benefit **with** prior authorization **and** the following quantity limits will be **added**: • Vyndamax capsule – **QL** 30 capsules per 30 days • Vyndaqel capsule – **QL** 120 capsules per 30 days
Antibiotics - Injectable	Criteria update to include off-label criteria for **Dalvance** in MRSA osteomyelitis and MRSA bacteremia, and criteria for **Kimyrsa** and **Orbactive** in non-MRSA SSTI.
Antidepressants	**Aplenzin** will have prior authorization **added** and quantity limit of 30 tablets per 30 days will remain on the pharmacy benefit. **Amoxapine tablet** will have prior authorization **added** on the pharmacy benefit. **Zurzuvae** has been designated as a preferred drug.

Antidiabetics Agents - Non-Insulin and Combination products	**New drug**, **Zituvio** will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 30 tablets per 30 days.
Anti-Obesity Agents	Reauthorization criteria for **Wegovy** was updated due to the new indication of cardiovascular risk reduction in obese or overweight patients.
Antiviral Agents	**Prevymis** had the following updates: • Medication will remain on the pharmacy benefit with prior authorization **and** a quantity limit of 30 tablets per 30 days will be **added.** • Criteria updated to address CMV prophylaxis post allogeneic hematopoietic stem cell transplantation (HSCT) and CMV prophylaxis post kidney transplant indications. **Valcyte** *(valganciclovir powder for oral solution)* will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of ≤ 18 mL/day.
Asthma and Allergy Monoclonal Antibodies	**Xolair** had the following updates: • The 300mg/2ml prefilled syringe & autoinjector will be **added** to the pharmacy benefit **with** prior authorization required. • Criteria for expanded FDA-labeled indication of IgE-mediated food allergy was added. Criteria for **Dupixent for eosinophilic esophagitis (EoE)** was updated to address the expanded age indication of 1 year and older.
Breast Cancer Agents	**New drug**, **Truqap,** will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 120 tablets per 30 days.
Adcetris	Criteria updated to address new indication of Previously Untreated High Risk Classical Hodgkin Lymphoma (cHL), in Combination with Chemotherapy in pediatric patients.
Butalbital containing agents	**butalbital/aspirin/caffeine tablet** will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 20 units per 30 days.

	butalbital/aspirin/caffeine capsule will remain on the pharmacy benefit **with** quantity limit of 20 units per 30 days **and** prior authorization will only apply for members **<** 18 years of age.
Chemokine receptor type 4 (CXCR4) inhibitors	**New drug, Aphexda,** will be added to the medical benefit only **with** a prior authorization. **New drug, Mozobil** (*plerixafor vial*), will be **removed** from the pharmacy benefit **and** will only be available on the medical benefit **without** prior authorization.
corticotropin	Criteria for acute multiple sclerosis was updated to allow short-duration (5-day) regimen.
Eylea HD	This medication will be **added** to the medical benefit only **without** prior authorization.
Duchenne Muscular Dystrophy Disease Modifying Agents	Approval durations for the following medications were updated from 3 months to 6 months: • Amondys • Exondys • Viltepso • Vyondys An additional criteria was added to Elevidys to allow its use in members who are not stable on steroids.
Enzyme and Metabolic Disorder Therapies	**New drug, Opfolda capsule,** will be **added** to the pharmacy benefit **with** prior authorization required. N**ew drug, Pombiliti vial,** will be available on the medical benefit only **with** prior authorization required.
Immune Suppressants - Topical	**New drug, Zoryve 0.3% foam**, will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 60 grams per 30 days. Seborrheic dermatitis and off-label use for psoriasis was added to the criteria. Existing criteria for **Zoryve cream** was updated to reflect expanded FDA-approved indication to ≥6 years of age (previously ≥12 years of age).
Immunotherapy - Oral	Criteria was updated to remove Oralair trial for Grastek and expanded specialists that may prescribe Grastek, Oraliar, Odactra, or Ragwitek.

Inflammatory Bowel Disorder Agents	**Delzicol DR** (*mesalamine 400 mg delayed-release capsule*) will remain on the pharmacy benefit **with** prior authorization required. Mesalamine 800mg delayed-release tablet will be **added** to the pharmacy benefit **with** prior authorization required. Step-through criteria for Ortikos was made more clear by specifying budesonide "oral formulation".
JAK Inhibitors for Myelofibrosis	**New drug, Ojjaara** tablet, will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 30 tablets per 30 days. Criteria for **Vonjo** was updated: • to accept anemia or inadequate response to Jakafi as an alternative to low platelet count to be consistent with NCCN • to add symptomatic low-risk myelofibrosis as an approvable diagnosis Besremi was added as an allowed trial for **Jakafi** for polycythemia vera criteria per the NCCN guidelines.
Kinase Inhibitors	**Balversa** criteria was updated based on the changes to the labeling from full FDA-approval. **Rydapt** criteria was updated to include potential use as monotherapy for maintenance therapy in AML. **Gavreto**, **Retevmo** and **Xospata** criteria were updated to match FDA-approved labeling.
Lung Cancer Agents	**New drug**, **Augtyro** capsule, will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 240 capsules per 30 days.
Medical Foods	Brand **Deplin** (*levomethylfolate/algal oil capsule*) will be **added** to the pharmacy benefit with a quantity limit of 30 capsules per 30 days. Generic **Deplin** (*levomethylfolate/algal oil capsule*) will remain on the pharmacy benefit **with** prior authorization **and** quantity limits of 30 capsules per 30 days. L-methylfolate tablet will remain on the pharmacy benefit **with** quantity limit of 30 tablets per 30 days.

Purixan	Criteria was updated to include off-label indications and expanded medical necessity for use of solution over tablet criteria.
Methotrexate Agents	**New drug**, **Jylamvo** (*methotrexate oral solution*), will be **added** to the pharmacy benefit **with** prior authorization required. BSA criteria was clarified for **Xatmep** to further confirm appropriate dosing is based on BSA.
Lumoxiti	This medication will have prior authorization removed and **will remain** on the medical benefit only.
NSAIDs – Injectable, Intranasal and Oral	The following medications will be **added** to the pharmacy benefit **with** prior authorization required: • Indomethacin 50mg suppository • Coxanto 300mg capsule • Meloxicam 7.5mg/5ml suspension
Oncology Immunotherapies	**New drug**, **Loqtorzi** (*toripalimab-tpzi vial*), will be **added** to the medical benefit only **with** prior authorization required.
Otic Agents	Ciprofloxacin/dexamethasone otic suspension will be **added** to the pharmacy benefit **with** prior authorization required.
Pharmaceutical Compounding	Criteria was updated to incorporate intradermal route of administration to require prior authorization.
Spinal Muscular Atrophy	**Evrysdi** had the following updates: • restrictions was updated to allow use in members with 2 or 3 copies of SMN2 or in certain patients with 4 copies of SMN2 (symptomatic, or presymptomatic infants). • reauthorization criteria was adjusted to allow current functional tests to be >3 months (up to 12 months) when being followed regularly. • additional functional test requirements will no longer be required for stable members transitioning from another payor. • criteria for Evrysdi was added for situations “after utilization of Zolgensma”.

	Spinraza had the following updates: • standardize diagnosis verbiage was added and subtype restriction was removed • restrictions was updated to allow use in members with 2 or 3 copies of SMN2 or in certain patients with 4 copies of SMN2 (symptomatic, or pre-symptomatic infants) • reauthorization criteria was adjusted to allow current functional tests to be >3 months (up to 12 months) old in situations where member is getting tested on a regular basis • criteria for Spinraza was added for situations "after utilization of Zolgensma".
Bimzelx autoinjector & prefilled syringe	This medication will be **added** to the pharmacy benefit **with** prior authorization. It was added to criteria to mirror the same criteria as Cosentyx for plaque psoriasis.
Velsipity tablet	This medication will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 30 tablets per 30 days. It was added to criteria to mirror the same criteria as Zeposia for ulcerative colitis.
Xphozah tablet	**New drug**, **Xphozah** (*tenapanor tablet*), will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 60 tablets per 30 days.
Vitamin D Analogs in SHPT	**Rocaltrol** *(calcitriol 1 mcg/mL oral solution)* will now require prior authorization on the pharmacy benefit.
Vitamins	**Nascobal** nasal spray (*cyanocobalamin vit B-12 500mcg spray*) will be **added** to the pharmacy benefit **with** prior authorization required.