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 01/01/2024

Cimzia Evenity Evkeeza Infliximab Leqvio Prolia Reblozyl Revcovi Ryplazim Saphnelo Vyepti Vyvgart	These medications will be added to our mandatory site-of-care program. They will now require administration in the home or in a non-hospital outpatient setting. All medications included in this program are safe to be administered outside a hospital setting. For additional information regarding our site-of-care program, please visit MassGeneralBrighamHealthPlan.org. Please note: There will be no change to any infusions until the current authorization has expired. However, members will be required to switch to a home infusion provider or a doctor's office upon renewal of your authorization, should they need to continue the same medication.

Oncology Medications	Drug specific criteria for oncology medications that require a prior authorization will be updated to follow National Comprehensive Cancer Network (NCCN) guidelines. Allowing coverage with a Category of Evidence and Consensus of 1, 2A, or 2B. Criteria for non-oncology diagnosis will remain in place.
Immunomodulators	These medications will be considered preferred products: • Humira • Rinvoq • Skyrizi • Stelara • Cimzia • Simponi • Tremfya • Xeljanz/XR • Otezla Actemra, Cosentyx, Orencia, and Olumiant will be considered non-preferred. Number of trials of preferred products will vary based on indication.
Humira and Biosimilars	These medications will be considered preferred products: • Adalimumab-adaz • Adalimumab-fkjp • Hadlima • Humira Adalimumab-adaz, Hadlima, and Adalimumab-fkjp will be added to the formulary on a preferred specialty tier. No change to Humira. Amjevita, Cyltezo, Hyrimoz, Yuflyma, Abrilada, Hulio, Idacio, Yusimry, Adalimumab-adbm will remain non-formulary
Basal Insulin	Lantus, Toujeo Max Solostar, and Toujeo Solostar will remain preferred products.
Rapid Acting Insulin	Humalog and Lyumjev will remain preferred products.
Short Acting Insulin	Humulin will remain a preferred product.
Anti-Obesity Agents	This class will have updated criteria removing a failure to lose at least 5% in an outpatient weight loss program.
Inhaled Corticosteroids	Budesonide, Arnuity Ellipta, Qvar, and Pulmicort Flexhaler (requires PA) will be considered preferred products. Flovent Diskus and Flovent HFA will be considered non-formulary. Fluticasone HFA (generic Flovent HFA) will be added to formulary with an age limit of 11 years old. Members 12 years or older will require prior authorization.
Long-Acting Muscarinic Antagonist (LAMA)	Spiriva Handihaler, Spiriva Respimat, and Incruse will remain preferred products.

Inhaled Corticosteroid Combination Products	Fluticasone-salmeterol aerosol powder, fluticasone-salmeterol inhaler, Symbicort, Airduo HFA, and Breo will be considered preferred medications. Fluticasone-salmeterol aerosol powder will be added to the formulary as a non-preferred generic. Advair Diskus will be considered non-formulary.
Oral and Nasal CGRP	Nurtec, Quilipta, and Ubrelvy will be considered preferred products. Quilipta and Ubrelvy will have updated criteria removing the trial of Nurtec. Reyvow and Zavzpret will remain non-preferred and require trials of all preferred products.

Updates for MassHealth Members

Effective 01/02/2024

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

Generic Medication	Brand Name Alternative
orlistat	Xenical
pazopanib	Votrient

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

Brand Name	Generic Medication
Zyvox suspension	Linezolid suspension
Denavir	Penciclovir
Zegerid capsules/suspension	Omeprazole/sodium bicarbonate
Combigan	Brimonidine/timolol
Imitrex Nasal Spray	Sumatriptan Nasal Spray
Miacalcin	Calcitonin salmon injection
Restasis	Cyclosporine 0.05% ophthalmic emulsion
Ciprodex	Ciprofloxacin/dexamethasone
Glumetza	Metformin extended-release gastric tablet

Effective 12/04/2023 - Reminders

Vaccine Agents	As of **12/04/23**, the following vaccines will be **added** to the pharmacy benefit **with** prior authorization if member is < 60 years of age. • Abrysvo • Arexvy These medications **will continue** to be available on the medical benefit **without** prior authorization.

Effective 01/02/2024

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

Anti-Obesity Agents	The following medications have been **added** to the pharmacy benefit **with** prior authorization **and** quantity limit: • **Adipex-P** (*phentermine 37.5 mg*) capsule, tablet – **QL** 30 per 30 days • Benzphetamine tablet – **QL** 90 per 30 days • **Contrave** (*naltrexone/bupropion*) tablet - **QL** 120 per 30 days • **Qsymia** (*phentermine/topiramate ER*) capsule - **QL** 30 per 30 days • **Diethylpropion** tablet**– QL** 90 per 30 days • Diethylpropion **ER** tablet**– QL** 30 per 30 days • **Lomaira** (*phentermine 8 mg*) tablet - **QL** 90 per 30 days • **Phendimetrazine** tablet **- QL** 90 per 30 days • Phendimetrazine **ER** capsule **- QL** 30 per 30 days • **Phentermine** (15mg, 30mg) capsule - **QL** 30 per 30 days • **Saxenda** (*liraglutide injection*) - **QL** 5 pens per 30 days • **Wegovy** (*semaglutide injection*) - **QL** 4 pens per 30 days • **Xenical** (*orlistat)* capsule - **QL** 90 per 30 days (***brand preferred***) Note: The following medications will not be part of the federal rebate program. Additional restrictions may apply. • **Contrave** (*naltrexone/bupropion*) • **Qsymia** (*phentermine/topiramate ER*)
Antidiabetic Agents - Non-Insulin and Combination Products	Criteria added for GLP-1/GLP-1-GIP agonist requests for the treatment of obesity. Initial approval durations were updated to 4 months for off-label requests and will remain at 12 months for all other requests. The following medications have been **added** to the pharmacy benefit **with** quantity limit: • **Byetta** (exenatide) 5mg injection – 1.2 mL per 30 days • **Byetta** (exenatide) 10mg injection – 2.4 mL per 30 days • **Trulicity** (dulaglutide) – 2 mL per 30 days • **Victoza** (liraglutide) – 9 mL per 30 days
Antiviral Agents	The following medication has been **added** to the pharmacy benefit **with** prior authorization and a quantity limit: • **Denavir** (*penciclovir*) – 5 grams per 30 days
CGRP Inhibitors	Aimovig requests will require a step-through either Ajovy or Emgality.

Continuous Subcutaneous Insulin Infusion	The following medications have been **added** to the pharmacy benefit **with** prior authorization and quantity limit: • **Cequr Simplicity patch** – 1 patch per 3 days • **Cequr Simplicity inserter** – 1 inserter per 365 days
Enzyme and Metabolic Disorder Therapies	The Ravicti® (glycerol phenylbutyrate) criteria was updated to include Olpruva® (sodium phenylbutyrate) as another alternative. The following medication has been **added** to the pharmacy benefit **with** prior authorization: • **Joenja** (*leniolisib*) • **Olpruva** (*sodium phenylbutyrate pellets for suspension*) The following medication has been **added** to **both** the pharmacy benefit **and** medical benefit **with** prior authorization: • **Elfabrio** (*pegunigalsidase-alfa iwxj*)
Gastrointestinal Drugs – PPI H2 Antagonist and Misc. Agents	The Konvomep criteria was updated to add an additional trial. The following medications has been **added** to the pharmacy benefit **with** prior authorization: • **Zegerid suspension packet** (*omeprazole/sodium bicarbonate*)
Glaucoma Agents	Combigan (brimonidine/timolol) will require a step through of dorzolamide/timolol. A trial with latanoprost or Travatan Z will now be required for Lumigan® (bimatoprost) 0.01% and bimatoprost 0.03%. The following medications have been **added** to the pharmacy benefit **with** prior authorization: • **Combigan** (*brimonidine/timolol*) • **Lumigan** (*bimatoprost*) 0.01%
Lymphoma and Leukemia Agents	New drug, **Jaypirca** (*pirtobrutinib*), was **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 60 tablets per 30 days.
Osteoporosis Agents	Calcitonin nasal spray was added as a step-through to calcitonin salmon injection for the indication of osteoporosis treatment/prevention.

Respiratory Agents – Inhaled	**Breo Ellipta** (*fluticasone/vilanterol*) will be available without prior authorization on the pharmacy benefit.
Targeted Immunomodulators	Taltz was added as a step-through agent for the following: • Cosentyx in ankylosing spondylitis • Cosentyx, Ilumya, Siliq, Skyrizi, and Tremfya for plaque psoriasis • Cosentyx, Skyrizi, and Tremfya for psoriatic arthritis
Daybue (trofinetide)	This new medication was **added** to the pharmacy benefit **with** prior authorization.