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 and MassHealth Members

Effective 01/01/2025

The following changes are being made to the listed medications:

Ingrezza Spravato	These medications will be locked to Genoa Healthcare Pharmacy. Please note: Spravato will continue to be available only on the Medical Benefit for Commercial members.
Fensolvi Ocaliva Teriparatide 620 mcg/2.48 mL pen Leukeran	These medications will be locked to Optum Specialty Pharmacy.

Updates for Commercial Members

Effective 01/01/2025

The following changes are being made to the listed medications:

Neurotoxins	These medications will be considered preferred products: • Dysport • Xeomin For any overlapping FDA-approved diagnoses, initial and reauthorization approvals for Botox, Myobloc and Daxxify will require trial and failure with a preferred product. The policy for neurotoxin agents has been updated to reflect these changes.
Humira and biosimilars	These medications will be considered preferred products: • Amjevita (Nuvaila manufacturer) • Adalimumab-adaz • Adalimumab-fkjp • Hadlima • Humira (Abbvie manufacturer) Amjevita (Nuvaila manufacturer) will be added to the formulary at the preferred specialty tier. No changes will be made to the coverage of adalimumab-adaz, adalimumab-fkjp, Hadlima, or Humira (Abbvie manufacturer). All other adalimumab products will remain nonpreferred.
Immunomodulators	These medications will be considered preferred products: • Cimzia • Enbrel • Humira, adalimumab-adaz, adalimumab-fkjp, Hadlima, Amjevita (Nuvaila manufacturer) • Omvoh • Otezla • Rinvoq/LQ • Simponi, Simponi Aria • Skyrizi • Stelara, Wezlana • Taltz • Tremfya • Xeljanz/XR • Zeposia Actemra, Bimzelx, Cosentyx, Entyvio SC, Ilumya, Kevzara, Kineret, Litfulo, Olumiant, Orencia, Siliq, Sotyktu, and Velsipity will be considered nonpreferred. The number of trials required for each agent will vary depending on the indication and product. For all overlapping diagnoses, Taltz will now be preferred

	over Cosentyx. Cosentyx reauthorization criteria will require that the member meets the initial step therapy requirements. Criteria for all the preferred and nonpreferred listed immunomodulators will be updated to reflect FDA-approved indications and to align disease state requirements and reauthorization criteria as warranted.
Infliximab, Rituximab	Policies being updated to align disease state criteria with other immunomodulators as warranted.
Abilify MyCite	Prior authorization language pertaining to patient-specific adherence characteristics and long-acting aripiprazole trial updated.
Carbidopa/Levodopa Extended-Release (Crexont, Rytary)	Added Crexont to the formulary with prior authorization. Criteria require step through with Rytary.
Vyvgart/Vyvgart Hytrulo	Reauthorization criteria updated to specify documentation of positive response to therapy.
Epkinly, Pemfexy	Requests will be reviewed against the Oncology Medication Review – NCCN criteria.

Updates for MassHealth Members

Effective 01/01/2025

Anti-Obesity Agents	MassHealth recently designated Zepbound as a Preferred Drug. It will not require a trial with Wegovy or Saxenda within the prior authorization (PA) criteria. Wegovy and Saxenda will no longer be preferred and will not be covered for patients ≥18 years of age for an obesity/overweight diagnosis. Any active prior authorizations for these drugs will be updated to end on 12/31/24. The plan will add a new PA for Zepbound in its place. The new PA for Zepbound will have an end date 6 months from the original Wegovy/Saxenda start date. With the following exceptions, prior authorizations for Wegovy/Saxenda prior authorizations not be updated: • Pediatric patients (≥12 and <18 years of age) approved with a diagnosis of either obesity or overweight • Wegovy for the reduction of major adverse cardiovascular events in **adults** with established cardiovascular disease **and** either obesity/overweight. **For patients ≥18 years of age for the diagnosis of either obesity/overweight, a new prescription for Zepbound will be required on/after 1/1/25.**

	All agents covered for treatment of obesity in adults, except Contrave, phentermine 37.5 mg capsule, tablet, phentermine 15 mg, 30 mg, Qsymia, and Xenical, will require a step-through phentermine. The following medications will be managed with an age limit prior authorization for members **< 12 years of age** and quantity limits will remain on the pharmacy benefit: • **Phentermine 15mg and 30mg capsule**: **QL** - 30 per 30 days • **Phentermine 37.5mg *tablet/capsule:* QL** – 30 per 30 days **Lomaira (*phentermine 8mg tablet*)** will require prior authorization for members **< 12 years of age *or* ≥ 18 years of age** and quantity limit of 90 tablets per 30 days will remain on the pharmacy benefit.

Effective 01/06/2025

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

Generic Medication	Brand Name Alternative
ferric citrate	Auryxia
perampanel	Fycompa
memantine/donepezil extended-release	Namzaric
glycerol phenylbutyrate	Ravicti
carbidopa/levodopa extended-release capsule	Rytary
granisetron transdermal system	Sancuso
rivaroxaban 2.5 mg, 10 mg, 15 mg, 20 mg tablet, starter pack	Xarelto

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

Brand Name	Generic Medication
Revatio 10mg/ml oral suspension	Sildenafil 10mg/ml oral suspension
Afinitor tablet	Everolimus tablet
Focalin XR capsule	Dexmethylphenidate extended-release capsule
Vascepa capsule	Icosapent ethyl capsule
Samsca tablet	Tolvaptan tablet
Kombiglyze XR	saxagliptin/metformin
Gelnique	oxybutynin gel
Tirosint	levothyroxine capsule

Effective 1/6/2025

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	**New Drug, Kinsula vial**, will be **added** to both the pharmacy benefit **and** medical benefit **with** prior authorization.
Antibiotics – Topical	Mupirocin 2% cream was added as a step-through option for Altabax.
Anticoagulants	Medical necessity criteria for use of Pradaxa pellet formulation instead of capsule was updated.
Anticonvulsants	**New drug, Vigafyde** (*vigabatrin oral solution*), will be **added** to the pharmacy benefit **with** prior authorization.
Antidiabetic Agents – Non-insulin & Combo Products	Polycystic ovarian and prediabetes were added as an acceptable comorbid condition. Phentermine was added as a step-through option for all GLP-1 agents indicated for obesity or overweight. Ozempic was added as a step-through option for Mounjaro indicated for diabetes. The step-through options, Wegovy and Saxenda, were removed from the Mounjaro criteria and criteria was added regarding medical necessity for use instead of Zepbound.
Anti-Diarrhea Agents	**Motofen 1-0.025mg tablet** will have prior authorization removed from the pharmacy benefit. Lotronex and Viberzi criteria were updated to include antispasmodic agents as an alternative trial option.
Antimalarials	**New branded formulation**, **Sovuna** 200mg & 300mg tablets, will be **added** to the pharmacy benefit **with** prior authorization.
Asthma & Allergy Monoclonal Antibodies	**New drug, Nemluvio pen**, will be **added** to the pharmacy benefit **with** prior authorization.
Beta Thalassemia, Myelodysplastic Syndrome and Sickle Cell Disease Agents	**New drug, Rytelo vial,** will be **added** to the medical benefit **with** prior authorization.
Bile Acid Agents	The following medications will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limits: • Iqirvo tablet – **QL** 30 tablets per 30 days • Livdelzi capsule – **QL** 30 capsules per 30 days The following updates were made to the Ocaliva criteria: • Removed the check for decompensated cirrhosis or compensated cirrhosis with evidence of portal hypertension • Requirement of a member's ALP in order to align with clinical trial populations • Prevention of concurrent use with Iqirvo or Livdelzi

	Expanded indication in progressive familial intrahepatic cholestasis (PFIC) for patients ≥12 months old was added for Livmarli.
Breast Cancer Therapies	Expanded indication in adults with unresectable or metastatic HER2-positive (IHC 3+) solid tumors who have received prior systemic treatment and have no satisfactory alternative treatment options was added for **Enhertu**.
Cerebral Stimulants and ADHD Medications	**New Drug, Onyda XR suspension**, will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 120ml per 30 days. **Cotempla XR-ODT 25.9mg tablet** will remain on the pharmacy benefit **with** prior authorization **and** will have quantity limits updated to 60 tablets per 30 days. **Qelbree** criteria was updated to require a 30-day trial of atomoxetine.
C. Difficile Prevention Agents	**Rebyota** and **Vowst** will require two step-throughs with Dificid, vancomycin capsule/oral solution, or Zinplava. **Vowst** will require an additional step-through with Rebyota.
CGRP Inhibitors	Aimovig was removed as a step-through option.
Chemokine receptor type 4 (CXCR4) inhibitors	**New drug**, **Xolremdi capsule**, will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 120 capsules per 30 days.
Continuous Subcutaneous Insulin Infusion	**Omnipod 5 (Gen 6) Intro Kit** and **Omnipod 5 (Gen 6) 5 Pack Pods** will both be **added** to the pharmacy benefit **with** prior authorization.
Corticotropin Agents	**Acthar self-inject prefilled pen** will be **added** to the pharmacy benefit **with** prior authorization.
COVID Test Kits	The following two new NDCs for Genabio COVID-19 testing kits have been **added** to the pharmacy benefit **with** quantity limits of 2 tests per 28 days: • NDC 6000809586, 60008095487
Duchenne Muscular Dystrophy Disease Modifying Agents	**New Drug, Duvyzat oral suspension**, will be **added** to the pharmacy benefit **with** prior authorization.
Enzyme and Metabolic Disorder Therapies	**Vijoice granule packet** will be **added** to the pharmacy benefit **with** prior authorization.
Gastrointestinal Agents-H2 antagonists, PPIs and Misc. Agents	New indication of non-erosive reflux disease (NERD) was added to Voquezna.
Glycopyrrolate Agents	**Cuvposa** (*glycopyrrolate 1mg/5ml solution)* will remain on the pharmacy benefit **with** prior authorization **and** will have a quantity limit of 45mg per 30 days **added**. **Glycate** criteria will require step-through with glycopyrrolate 1 mg or 2 mg tablets.

Growth Hormone Agents	Sogroya will become preferred and will be added as a step-through option for Ngenla.
Hypnotics	**Doxepin tablet** will require a step-through with doxepin capsule or oral concentrate and melatonin has been removed as an acceptable alternative trial.
Immune Suppressants – Topical	Opzelura will no longer require a step through with a topical corticosteroid for both atopic dermatitis and vitiligo. Also, the trial with Eucrisa for atopic dermatitis was removed.
Intravesical Bladder Cancer Agents	**New drug**, **Anktiva vial**, will be **added** to the medical benefit **with** prior authorization.
Kinase Inhibitors	The following new drug will be **added** to the pharmacy benefit **with** prior authorization required: • Ojemda 25mg/ml oral suspension • Ojemda 100mg tablet The following <u>new drug formulations</u> will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limits: • Retevmo 40 mg tablet – QL 90 tablets per 30 days • Retevmo 80mg tablet – QL 120 tablets per 30 days • Retevmo 120mg tablet – QL 60 tablets per 30 days • Retevmo 160mg tablet – QL 60 tablets per 30 days The following drug strengths <u>will remain</u> on the pharmacy benefit **with** prior authorization **and** will have quantity limits updated: • Retevmo 40mg capsule – **QL** 90 capsules per 30 days • Retevmo 80mg capsule – **QL** 120 capsules per 30 days **Retevmo** was granted accelerated approval for adult and pediatric patients aged 2 years or older for the following indications: • advanced or metastatic medullary thyroid cancer (MTC) with a RET mutation, as detected by an FDA-approved test, who require systemic therapy; • advanced or metastatic thyroid cancer with a RET gene fusion, as detected by an FDA-approved test, who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate); and • locally advanced or metastatic solid tumors with a RET gene fusion, as detected by an FDA-approved test, that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options.
Narcolepsy and Miscellaneous Sleep Disorder Therapy Agents	Wakix was updated for narcolepsy in pediatric patients (≥6 years of age).

Oncology Immunotherapies	**New Drug, Tevimbra vial**, will be **added** to the medical benefit **with** prior authorization. The following expanded indications were added: • Imfinzi (durvalumab) with carboplatin plus paclitaxel followed by single agent durvalumab for adult patients with primary advanced or recurrent endometrial cancer that is mismatch repair deficient (dMMR). • Imfinzi with platinum-containing chemotherapy as neoadjuvant treatment, followed by single-agent durvalumab as adjuvant treatment after surgery for adults with resectable (tumors ≥ 4 cm and/or node positive) non-small cell lung cancer (NSCLC) and no known epidermal growth factor receptor (EGFR) mutations or anaplastic lymphoma kinase (ALK) rearrangements. • Keytruda (pembrolizumab) in combination with carboplatin and paclitaxel, followed by pembrolizumab as a single agent, for the treatment of adult patients with primary advanced or recurrent endometrial carcinoma (first front-line immunotherapy for advanced endometrial cancer patients regardless of mismatch repair status).
Polivy	In addition to prescriber requirement of oncology or hematology, consult notes from a specialist are also accepted.
Psoralen Agents	**Methoxsalen 10mg soft gel** will have prior authorization **added** to the pharmacy benefit.
Respiratory Agents – Inhaled	**New drug**, **Ohtuvayre 3mg/2.5ml** inhaled suspension, will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 150ml per 30 days.
Respiratory Agents – Oral	**Daliresp** criteria was updated to require step-throughs with Anoro, Bevespi, Duaklir, Stiolto, Breztri, Trelegy.
Targeted Immunomodulators	The following medications will be **added** to the <u>medical benefit only</u> with prior authorization: • Tyenne Vial • Tofidence Vial **Tyenne (auto-injection, prefilled syringe)** will be **added** to the pharmacy benefit **with** prior authorization. **Rinvoq LQ** will be added to the pharmacy benefit **with** prior authorization **and** quantity limit of 360ml per 30 days. Skyrizi and Omvoh will become preferred drugs.

	Expanded indications were added for Skyrizi and Tremfya for ulcerative colitis, Rinvoq and Kevzara for polyarticular juvenile idiopathic arthritis (pJIA), Otezla for pediatric psoriasis, and subcutaneous Entyvio for Crohn's disease. Cimzia was updated to require clinical rationale of ruse of the vial over the syringe across all indications.
Tepezza	This medication will be **added** to the pharmacy benefit **with** prior authorization **and** will also remain on the medical benefit **with** prior authorization.
Thyroid Preparations	**Tirosint** (*levothyroxine capsule, solution*) will be **added** to the pharmacy benefit **with** prior authorization.
Topical Hyperhidrosis Agents	**Sofdra 12.45% gel** will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limits of 42.2ml per 30 days. Criteria will require step throughs with Drysol, Qbrexza, and Botox.
VMAT2 Inhibitors	The following new Austedo XR strengths will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limits of 30 tablets per 30 days: • **Austedo XR 18**mg/**30**mg/**36**mg/**42**mg/**48**mg **Austedo XR Titration Pack** (12-18-24-30mg) will be **added** to the pharmacy benefit **with** prior authorization. The following Austedo XR strengths will remain on the pharmacy benefit **with** prior authorization and will have quantity limits updated to 30 tablets per 30 days: • **Austedo XR 6**mg/**12**mg/**24**mg
Voxzogo	The age restriction was removed due to expanded indication approval.