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 11/01/2024

The following changes are being made to the listed medications:

Aphexda (motixafortide)	**Aphexda** will require prior authorization on the medical benefit. Criteria will include age and diagnosis requirements, as well as concomitant use with filgrastim. Plerixafor will be preferred.
Durysta (bimatoprost intracameral implant)	**Durysta** criteria is being updated to require an inadequate response or adverse reaction to at least two ophthalmic prostaglandins or clinical rationale why the member cannot administer ophthalmic prostaglandins. Criteria will also require that Durysta is prescribed by or in consultation with an ophthalmologist. Durysta will not be approved for concurrent treatment with iDose TR.
Empaveli (pegcetacoplan)	**Empaveli** criteria is being updated to require diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by flow cytometry. Continuation of therapy will require documentation of a positive response to therapy.
Soliris (eculizumab), Ultomiris (ravulizumab)	**Soliris and Ultomiris** criteria are being updated:

	• Criteria for atypical hemolytic uremic syndrome will require diagnosis. • Criteria for PNH will require a diagnosis confirmed by flow cytometry. • Criteria for generalized myasthenia gravis (gMG) will require diagnosis of gMG with Myasthenia Gravis Foundation of America (MGFA) clinical classification II to IV and MG activities of daily living (MG-ADL) total score of at least 6. Member must be anti-acetylcholine receptor antibody positive and have had an inadequate response to at least two immunosuppressive therapies or IVIG. • Criteria for neuromyelitis optica spectrum disorder (NMOSD) require member has a diagnosis and is anti-aquaporin04 (AQP4) antibody positive, as confirmed by immunoassay. • Reauthorization criteria for all diagnoses will require documentation of a positive response to therapy.
Spevigo (spesolimab-sbzo)	**Spevigo SC injection** is being added to the formulary with prior authorization and quantity limit. Criteria will include age, weight, and diagnosis requirements, as well as a Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score of 0 or 1. Spevigo SC must be prescribed by or in consultation with a dermatology specialist and the member must not be experiencing a GPP flare. Reauthorization criteria will require documentation of a positive response to Spevigo. Criteria for **Spevigo IV** is being updated, requiring age, weight, and diagnosis requirements. Additionally, Spevigo IV must be prescribed by or in consultation with a dermatology specialist. Documentation the member is presenting with moderate to severe flare is required, as evidenced by one of the following: a. GPPPGA total score of 3 or greater, b. GPPPGA pustulation score of 2 or greater, c. at least 5% of body surface area is covered with erythema and presence of pustules, d. presence of fresh pustules (new or worsening), e. systemic symptoms or laboratory abnormalities commonly associated with GPP flare. Reauthorization will require documentation that an additional dose for the GPP flare is required.

Updates for MassHealth Members

Effective 11/12/2024

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

Generic Medication	Brand Name Alternative
brimonidine-timolol 0.2%-0.5% eye drops	Combigan 0.2%-0.5% eye drops
itraconazole 100mg capsule	Sporanox 100mg capsule
everolimus tablet	Zortress tablet
omeprazole/sodium bicarbonate packet	Zegerid packet
omeprazole/sodium bicarbonate capsule	Zegerid capsule

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

Brand Name	Generic Medication
Timoptic 0.25% ocudose eye drop	timolol maleate 0.25% eye drop
Daraprim tablet	pyrimethamine tablet
Lialda delayed-release tablet	mesalamine delayed-release tablet
Solodyn extended-release tablet	minocycline extended-release tablet
Eurax lotion	crotamiton lotion

Effective 11/12/2024

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

Aminoglycoside Agents – Inhaled	**Kitabis Pak** (*tobramycin inhalation solution*) will remain brand preferred however, prior authorization will be **added** to both brand and generic on the pharmacy benefit.
Antibiotics – Ophthalmic	**Azasite 1% eye drops** will have prior authorization removed and will remain on the pharmacy benefit. Criteria was updated to include this agent as a step-through.
Antidiabetics Agents - Non-Insulin and Combination products	The following medications will have prior authorization **added** to the pharmacy benefit: • Invokamet (*canagliflozin/metformin*) • Invokamet XR (*canagliflozin/metformin*) • Invokana (canagliflozin) The following brand preferred medications will have prior authorization **added** on the pharmacy benefit: • Kombiglyze XR (saxagliptin/metformin) • Onglyza (saxagliptin) The **Tzield** criteria was updated to require that for members with 10% increase in A1c in ≤12 months, A1c must still be <6.5% to ensure use is restricted to stage 2 type 1 diabetes mellitus. The quantity limit criteria was updated to require rationale why dose could not be consolidated.

	All GLP-1 agents will now require documentation that the requested agent will not be used in combination with a GLP-1 receptor agonist. Duration of approval was increased to 6 months for Mounjaro (tirzepatide) and Ozempic (semaglutide injection) for obesity/overweight. The **Mounjaro** criteria was updated to require both of the following if patient has not received a semaglutide agent: adverse reaction to semaglutide **and** inadequate response, adverse reaction, or contraindication to liraglutide.
Antiemetics Agents	**Ondansetron solution** will remain on the pharmacy benefit **and** will only require prior authorization for members **≥** 13 years. **Ondansetron ODT 16mg tablet** will be **added** to the pharmacy benefit **with** prior authorization. **Focinvez 150mg/50ml vial** will be **added** to: • pharmacy benefit **with** prior authorization **and** a quantity limit of 2 units per 28 days, and • medical benefit **with** prior authorization
Antifungals – Oral and Injectable	**Voriconazole 50mg tablet** will have prior authorization removed from the pharmacy benefit. Pediatric criteria for **Cresemba** was added following new FDA-approved indication: for the capsule formulation, member is ≥6 years of age AND weighs ≥ 16 kg and for the injection formulation, member is ≥1 year of age. An additional trial with fluconazole was added for **Oravig**. A medical necessity stipulation was added for **Noxafil** suspension and powder for oral suspension. Criteria for **Brexafemme** and **Vivjoa** was slightly updated regarding results of a diagnostic test to confirm diagnosis.
Antihistamines	**Carbinoxamine solution** will have prior authorization **added** to the pharmacy benefit. Criteria for liquids and other special formulations were updated to require medical necessity for the requested formulation, and to require a step through cetirizine syrup and loratadine solution. Criteria for **Clarinex-D** was updated to add fexofenadine/pseudoephedrine as an alternative trial.

	Criteria for nasal sprays were updated to require a trial with at least two of the following agents: intranasal steroid, azelastine 137 mcg, or Dymista.
Anti-Obesity Agents	The **Zepbound** criteria was updated to require both of the following if patient has not received a semaglutide agent: adverse reaction to semaglutide **and** inadequate response, adverse reaction, or contraindication to liraglutide. New criteria was added for **Wegovy** for the risk reduction of major adverse cardiovascular events (MACE) in members with established cardiovascular disease and obesity or overweight.
Beta Thalassemia, Myelodysplastic Syndrome and Sickle Cell Disease Agents	The approval duration for **Oxbryta** was extended to 6 months. **Oxbryta 300mg & 500mg tablet** will have a quantity limit of 90 tablets per 30 days **added** and prior authorization will remain on the pharmacy benefit.
Benign Prostatic Hyperplasia (BPH) Medications	**Jalyn** (*dutasteride/tamsulosin*) capsule will remain on the pharmacy benefit **with** prior authorization **and** will have quantity limit of 30 capsules per 30 days **added**. The step-through requirement was removed, and only medical necessity for combination product now remains. Policy was updated to include lower urinary tract symptoms (LUTS) as an acceptable diagnosis in regards to BPH. **Tadalafil** and **Entadfi** criteria were updated to include transurethral resection of the prostate (TURP) as an acceptable diagnosis. **Silodosin** criteria was updated to include all alpha blockers as step-through options.
Bile Acid Agents	**Livmarli** criteria was updated to include the expanded indication for treatment of cholestatic pruritis in patients ≥5 years old with progressive familial intrahepatic cholestasis (PFIC). There will be a required step-through Bylvay for Livmarli in PFIC requests.
Cerebral Stimulants and ADHD Medications	**Adderall XR** has been designated as a preferred long-acting stimulant formulation.
Chronic Myelogenous Leukemia (CML) Agents	**Scemblix 100mg tablet** will be **added** to the pharmacy benefit **with** prior authorization. The QL criteria for Scemblix was updated to ≤ 4 units/day. **Iclusig** criteria was updated for Ph+ Acute Lymphoblastic Leukemia to allow approval if the agent with be used with chemotherapy, regardless of T3151 mutation or past trials.

Colorectal Cancer Agents	Per NCCN guidance, the criteria for **Stivarga** was updated to no longer requiring documentation of Child-Pugh class A for the treatment of hepatocellular carcinoma.
Corticosteroids - Intranasal	**Zetonna** will remain on the pharmacy benefit **with** quantity limit of 6.1 grams per 30 days **and** will have prior authorization **removed**. **Flonase Sensimist** will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 1 inhaler per 30 days. The criteria for **Xhance** (fluticasone propionate 93 mcg nasal spray) was updated to reflect expanded indication for adults with chronic rhinosinusitis without nasal polyps (previously only approved in those with polyps).
Continuous Glucose Monitoring Products	Criteria was updated for diabetes to allow access for all members using insulin and for members not using insulin with problematic hypoglycemia. Quantity limits were added to criteria for off-label indication of hypoglycemia not associated with diabetes mellitus. **Freestyle Libre 3 Sensor Plus** will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 1 sensor per 15 days.
Continuous Subcutaneous Insulin Infusion	Initial approval duration was extended to 6 months.
Cystic Fibrosis Transmembrane Conductance Regulator Modulators	**Kalydeco 5.8mg packet** will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 60 packets per 30 days.
Gastrointestinal Agents-H2 antagonists, PPIs and Misc. Agents	The following medications will have prior authorization **and** quantity limit **added** to the pharmacy benefit: • Cimetidine solution – **QL** 8ml per day • Metoclopramide vial – **QL** 8ml per day The following medications are **brand preferred** and will have prior authorization **added** to the pharmacy benefit: • **Dexilant** (*dexlansoprazole delayed-release capsule*) • **Nexium** (*esomeprazole delayed-release 10 mg, 20 mg, 40 mg packet*) - **QL** 30 packets per 30 days. The following medications are **brand preferred** and will have prior authorization removed on the pharmacy benefit: • **Protonix** (*pantoprazole delayed-release suspension*) • **Prevacid Solutab** **Zegerid** packet for suspension criteria was removed from the policy.

Glaucoma Agents	**Idose TR** (*travoprost intracameral implant*) will be **added** to the medical benefit **with** prior authorization. Lumigan (bimatoprost) was added as a trial option for **bimatoprost 0.03%**. Prior authorization was removed from **Combigan** (brimonidine/timolol) on the pharmacy benefit.
Gout Agents	The allopurinol step-through dose threshold was updated to 800 mg per clinical guidelines and FDA-approved maximum dosing.
Headache Therapy: Ergot Alkaloids and Serotonin Receptor Agents	Sumatriptan **5mg & 20mg** nasal spray will remain on the pharmacy benefit with current quantity limits (18 units per 30 days) and will require a prior authorization if age **< 6 years old.** **Naratriptan** was added as an alternative trial option throughout the policy.
Hyperoxaluria Agents	**New drug**, **Rivfloza**, will be **added** to both the pharmacy benefit **and** medical benefit **with** prior authorization required.
Immunosuppressants	**Myhibbin 200mg/ml suspension** will be **added** to the pharmacy benefit **with** prior authorization. **Cellcept injection** will be **removed** from the pharmacy benefit **and** will be available on the medical benefit only.
Insulin Products	The following medications will have prior authorization **added** to the pharmacy benefit: • **Apidra** 100 unit/ml vial • **Apidra Solostar** 100 unit/ml The following updates were made to the criteria: • Policy was updated to remove Apidra as a step-through for Admelog, Fiasp, and Lyumjev. • Criteria was clarified that insulin aspart and insulin lispro step-through trials are specifically Humalog or Novolog or their respective therapeutically equivalent generics. • Based on the expanded indication, Lyumjev age restriction was lowered to 1 year of age or older. • Criteria was updated for Tempo pens to require medical necessity for use such as documentation that the patient has access to the Tempo smart button and accompanying app.
Lipid Lowering Agents	**Fenofibrate 90mg** capsule will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 30 capsules per 30 days. The following updates were made to the criteria: • Lovaza was removed as a step-through for Vascepa. • Criteria for Leqvio, Nexletol and Nexlizet were updated to reflect expanded indication for members with increased cardiovascular

	risk, and criteria for Praluent was updated to reflect age expansion for use in members eight years of age and older. • For Vascepa and Juxtapid criteria, inadequate response to alternatives was clarified to be at least 3 months of therapy.
Lymphoma and Leukemia Agents	Criteria for **Arzerra** was updated to more accurately reflect all FDA-labeled indications, and prior trial requirements were added to bring management more in line with NCCN guidelines. Criteria was added for the recent FDA approval of **Jaypirca** to treat Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL). Criteria was added for the recent FDA approval of **Brukinsa** to treat follicular lymphoma.
Methotrexate Agents	Criteria for **Reditrex** was removed as this agent is no longer available.
Multiple Myeloma Agents	Criteria for **Pomalyst** was updated to ensure quantity is appropriate: ≤ 21 capsules/28 days for multiple myeloma and ≤ 42 capsules/28 day for Kaposi sarcoma.
Neuromuscular Blockers	**New drug**, **Daxxify**, will be **added** to both the pharmacy **and** medical benefits **with** prior authorization required. The following updates were made to the **Botox** criteria: • criteria for *overactive bladder* were updated to include "urinary urgency, with or without incontinence", "nocturia", and "urinary frequency" as diagnoses. • criteria for *migraine prophylaxis* were updated to require "migraine" headache frequency (not just headache frequency). • criteria for *migraine prophylaxis concomitant therapy with a CGRP inhibitor* were updated to require appropriate dosing and to clarify requirement of partial, but incomplete, response to CGRP inhibitor. • *Off-label criteria* were added for trigeminal neuralgia, severe craniofacial hyperhidrosis, and escalated dosing in axillary hyperhidrosis. **Dysport, Myobloc,** and **Xeomin** criteria were updated to align age and indication requirements with package inserts.
Opioids and Analgesics	The following medications will be **added** to the pharmacy benefit **with** prior authorization: • Hydromorphone suppository • RoxyBond • Tramadol 25mg tablet The following medications will have prior authorization removed from the pharmacy benefit:

	• Nucynta (*tapentadol*) • Nucynta ER (*tapentadol extended-release*) • Xtampza (*oxycodone myristate*) • Vicodin/Vicodin ES/Vicodin HP (*hydrocodone/acetaminophen 300mg*) The following medication will have **both** prior authorization **and** quantity limits removed from the pharmacy benefit: • Tramadol/acetaminophen The high dose criteria was updated to include an additional point that requires the co-prescribing of naloxone within the previous year and is unused.
PARP Inhibitors	Off-label criteria for triple negative breast cancer (TNBC) was added for **Lynparza** and **Talzenna**.
Respiratory Agents – Inhaled	**Asmanex Twisthaler** will have age limits removed and **will remain** on the pharmacy benefit.
Respiratory Agents – Oral	Criteria for **Singulair granules** was clarified to include budesonide and fluticasone propionate as a trial for eosinophilic esophagitis.
Skeletal Muscle Relaxants	**Baclofen 15mg tablet** will be **added** to the pharmacy benefit **with** prior authorization. **Lyvispah** 5mg/10mg/20mg granule packet will remain on the pharmacy benefit **with** prior authorization **and** will have a quantity limit of 4 packets per 30 days **added.** Baclofen solution was removed as a trial for **baclofen suspension** and **Lyvispah**.
T-Cell Immunotherapies	**New drug**, **Imdelltra**, will be **added** to the medical benefit with prior authorization.
Urinary Dysfunction Agents	**Oxybutynin chloride solution** will have prior authorization **removed** and will remain on the pharmacy benefit. For **Vesicare LS** criteria, oxybutynin solution will be added as an appropriate step-through option. For **Gemtasa** and **trospium ER** criteria, trospium IR will be added as an acceptable trial. Off-label criteria for **oxybutynin 2.5mg** tablets for primary focal hyperhidrosis was added to the policy.