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 10/01/2025

GLP-1 Medications	**Some plans (e.g. Commercial - Large Group) will not include coverage for GLP-1 medications (e.g., Wegovy, Zepbound, Saxenda) that share an indication of obesity/weight management.**
Nexletol, Nexlizet	Initial approval criteria will be updated to require that the member has one of the following diagnoses: established cardiovascular disease (CVD), high risk for CVD but without established CVD (e.g., diabetes mellitus), heterozygous familial hypercholesterolemia, or primary hyperlipidemia. In addition to the member being at least 18 years of age and attestation that the member will use the requested medication as adjunct to diet, member will be required to meet one of the following: has been administering statin therapy at the maximally tolerated dose for at least three consecutive months, has been unable to tolerate at least two statins, or has a contraindication to all statins. Initial requests for Nexletol will require that the member has been receiving at least three consecutive months of generic ezetimibe therapy as adjunct to maximally tolerated statin therapy or has a history of contraindication or intolerance to ezetimibe. Initial requests for Nexlizet will require that the member has been receiving at least three consecutive months of generic ezetimibe therapy as adjunct to maximally tolerated statin therapy.

	Requests for reauthorization for both agents will require documentation of improvement in the member's condition (e.g., reduction in LDL).
Enspryng Uplizna	Initial approval criteria for neuromyelitis optica spectrum disorder (NMOSD) will be updated to include the requirement that the member is anti-aquaporin 4 (AQPR) antibody positive confirmed by use of immunoassay. Reauthorization criteria for NMOSD will be updated to include documentation of a positive clinical response to therapy (e.g., reduction in the number of relapses).

Effective 11/01/2025

Test Strips and Meters	Effective 11/1/2025, OneTouch test strips and glucometers will be nonformulary. Starting on 11/1/2025, the following Accu-Chek and FreeStyle test strips will be covered without prior authorization (quantity limits will apply): • Accu-Chek Aviva Plus • Accu-Chek Guide • Accu-Chek Smart View • FreeStyle Precision Neo • FreeStyle Insulinx • FreeStyle • FreeStyle Lite Compatible glucometers for the above test strips will be covered without prior authorization; quantity limits will apply. Please consider preparing members currently utilizing OneTouch test strips and glucometers. Accu-Chek and FreeStyle meters and test strips will be covered beginning 11/1/2025 and a new prescription will be required for this transition.

Updates for MassHealth Members

Effective 10/01/2025

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

Generic Medication	Brand Name Alternative
fluorometholone 0.1% eye drops	FML 0.1% eye drops
halcinonide 0.1% cream	Halog 0.1% cream
bupropion hydrobromide extended-release tablet	Aplenzin extended-release tablet
bosutinib tablet, capsule	Bosulif tablet, capsule
azilsartan medoxomil tablet	Edarbi tablet
brinzolamide/brimonidine 1%-0.2% eye drops	Simbrinza 1%-0.2% eye drops

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

Brand Name	Generic Medication
Lotemax 0.5% eye drops, ophthalmic gel	loteprednol etabonate 0.5% eye drops, ophthalmic gel
Carac 0.5% cream	fluorouracil 0.5% cream
Olux-E 0.05% foam/emollient	clobetasol emulsion 0.05% foam/emollient
Noxafil Injection	posaconazole Injection

Effective 10/01/2025

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

Acromegaly Agents, Carcinoid Syndrome Agents, and Cushing's Syndrome Agents	Expanded indication for Isturisa for the treatment of adults with all forms of endogenous Cushing's syndrome was added. Metopirone was added as an additional trial for Isturisa, Korlym, Recorlev, and Signifor for Cushing's syndrome.
Amyloidosis Therapies	**New drug**, **Attruby tablet**, will be **added** to the pharmacy benefit **with** prior authorization. Criteria to prevent concurrent use with other therapies used for the treatment of ATTR-CM for Vyndaqel and Vyndamax was added. ATTR-CM was added for Amvuttra following an expanded indication update. *ATTR-CM: cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidsis*
Angiogenesis Inhibitors	Cyramza criteria was updated to include additional trials of 1st line preferred options based on NCCN recommendations. The requirement for bevacizumab products to use in combination with interferon alfa was removed based on NCCN recommendations. Tecentriq Hybreza was added as a trial option to use in combination with bevacizumab products for hepatocellular carcinoma (HCC) and non-small cell lung cancer (NSCLC).
Anti-Allergy and Anti-Inflammatory Agents - Ophthalmic	Fluorometholone will be added as a step-through therapy option for Inveltys and Lotemax SM. Bromfenac 0.09% will be added as a step-through therapy option for Bromsite (bromfenac 0.075%).

	The age requirement for Xdemvy was removed due to lack of clinical alternatives. **Clobetasol propionate 0.05% ophthalmic suspension** and **Epinastine 0.05% eye drops** will both be **added** to the pharmacy benefit **with** prior authorization. **Bromfenac 0.09% eye drops** will no longer require prior authorization on the pharmacy benefit.
Antidiabetics Agents - Non-Insulin and Combination products	The following new formulations will be **added** to the pharmacy benefit **with** prior authorization: • Brynovin 25 MG/ML solution • Metformin 750mg tablet • Rybelsus 1.5mg, 4mg, & 9mg tablet The following medications <u>will remain</u> on the pharmacy benefit **and** will have prior authorization **added**: • Januvia tablet • Janumet tablet • Janumet XR tablet • Sitagliptin/metformin tablet (*authorized generic of Zituvimet*) • Glipizide 2.5mg tablet Ozempic for treatment of type 2 diabetes mellitus (T2DM) and chronic kidney disease (CKD) were added following an expanded FDA approval. The following criteria were updated to require a step-through both Tradjenta and Januvia: • Nesina • Onglyza • Zituvio Trijardy XR, Soliqua, and Xultophy criteria were updated to be consistent with other non-preferred agents. The off-label use in treatment of obesity criteria for non-preferred GLP-1 agents was updated to require a step-through with tirzepatide. Criteria for Mounjaro was separated based on two diagnoses:

	1. For members with obesity/overweight and comorbid condition of type 2 diabetes mellitus or prediabetes 2. For members with type 2 diabetes mellitus only
Antifungals – Oral and Injectable	Vfend suspension will require a medical necessity for the suspension instead of oral tablets. Criteria for Noxafil oral suspension/powder for oral suspension was updated to include members with a hematologic malignancy who are undergoing chemotherapy. **Fulvicin P/G** (*griseofulvin 165mg tablet*) will be **added** to the pharmacy benefit **with** prior authorization.
Anti-Obesity	Zepbound criteria was updated to include a step-through requirement with Mounjaro for embers with a comorbid condition of type 2 diabetes mellitus or prediabetes.
Antipsychotics and Miscellaneous Mental Health Therapies	The following clinical updates were made to the Caplyta criteria: • It was further specified that at least one trial for bipolar depression should be lurasidone, olanzapine or quetiapine, with the addition of required step-through Vraylar for bipolar I depression. • As for all other indications, the criteria will require 3 trials plus a Vraylar trial. The Cobenfy criteria was updated to further specify that two of the trials must be aripiprazole, lurasidone, ziprasidone or Vraylar. The Rexulti criteria was updated to include the specification that one trial should be aripiprazole, with the addition of step-through Vraylar.
Antiretroviral Agents	The following medications will be **added** to the pharmacy benefit **with** a prior authorization requirement: • Norvir softgel capsule • Norvir powder packet **Edurant tablets for oral suspension** will be **added** to the pharmacy benefit **with** a quantity limit of 180 tablets per 30 days.
Asthma and Allergy Monoclonal Antibodies	Policy was updated following several expanded indication updates: • Dupixent for individuals ≥12 years of age with chronic spontaneous urticaria (CSU) • Dupixent for adults with bullous pemphigoid • Nucala for add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive disease (COPD) and an eosinophilic phenotype

	Step-through criteria was further elaborated for Xolair for CSU.
Bile Acid Agents	Additional step-through therapy options were considered for Livmarli and Bylvay for the treatment of pruritus in progressive familial intrahepatic cholestasis (PFIC). **Livmarli tablets** will be **added** to the pharmacy benefit **with** prior authorization.
BPH Agents	**New drug**, **Tezruly 1 mg/mL solution**, will be **added** to the pharmacy benefit **with** prior authorization.
Cardiovascular Agents	**New drug**, **Rapiblyk vial**, will be **added** to the medical benefit **with** no restrictions. **New drugs**, **Arbli 10 mg/mL suspension** *&* **Inzirqo 10 mg/mL suspension**, will both be **added** to the pharmacy benefit **with** prior authorization. The following medications will be removed from the pharmacy benefit **and** will be covered on the medical benefit only with no restrictions: • Metoprolol injection • Propranolol injection • Diltiazem injection • Verapamil injection • Corvert (*ibutilide injection*) Reauthorization criteria was added to require documentation of continued medical necessity for use of the liquid/sprinkle formulations.
CFTR Modulators	The age requirement for the baseline percent predicted forced expiratory volume in one second was updated from >6 years to ≥ 7 years.
Cimzia	Indications of polyarticular juvenile idiopathic arthritis and fistulizing Crohn's disease have been added to the criteria.
Continuous Subcutaneous Insulin Infusion	The following continuous subcutaneous insulin devices will remain on the pharmacy benefit **with** prior authorization and will now have quantity limits **added**: • Omnipod Dash Intro Kit (Gen 4) - **QL:** 1 kit every 4 years • Omnipod Dash (Gen 4) 5-Pack Pods – **QL:** 10 pods per 30 days • Omnipod Dash PDM Kit (Gen 4) - **QL:** 1 kit every 4 years • Omnipod 5 Intro kit (Gen 5) - **QL:** 1 kit every 4 years • Omnipod 5 Intro Kit (Gen 6) – **QL:** 1 kit every 4 years • Omnipod 5 (Gen 5) 5-Pack Pods – **QL:** 10 pods per 30 days • Omnipod 5 (Gen 6) 5-Pack Pods – **QL:** 10 pods per 30 days • Cequr Simplicity (2 unit), 4-day patch - **QL:** 8 patches per 30 days

	Criteria requiring uncontrolled diabetes, frequent hypoglycemia, fluctuations in blood glucose before mealtime, dawn phenomenon or severe hypo- or hyperglycemia was removed. Reauthorization criteria was updated to require clinical rationale why replacement was not covered by manufacturer warranty for intro kits/personal diabetes managers. Criteria for Cequr Simplicity 4-day patch was updated to require medical necessity for requests exceeding 1 patch per 4 days.
Corticosteroids - Oral	The reauthorization criteria for **Eohilia** was updated for continued use beyond the initial 12-week course of therapy (may be approved up to 1 year). **Tarpeyo** proteinuria thresholds were updated to > 0.5 g/day or g/g.
Corticosteroids – Topical	**Taclonex suspension** will remain brand preferred on the pharmacy benefit and will no longer require prior authorization. **Olux-E** *(clobetasol propionate foam/emollient)* will remain on the pharmacy benefit and will now require prior authorization. Language was updated for maximum quantity amounts of betamethasone/calcipotriene ointment, Bryhali, halobetasol foam, Ultravate, and Wynzora to align with package inserts.
Dermatological Agents	**New drug**, **Zelsuvmi 10.3% gel**, will be **added** to the pharmacy benefit **with** prior authorization. Ycanth criteria was updated to include other topical alternatives such as potassium hydroxide, salicylic acid and topical retinoid. And concomitant atopic dermatitis was added as an acceptable reason for treatment in patients with molluscum.
Gamma-Aminobutyric Acid (GABA) Analogs	**New product**, **Gabarone 100 mg** & **400 mg** (*gabapentin tablet*) will be **added** to the pharmacy benefit **with** prior authorization.
GnRH Analogues	The following expanded indications were added to criteria for their respective medications: • Endometrial thinning prior to endometrial ablation - Lupron • Advanced breast cancer - Lupron, Trelstar, and Triptodur • Ovarian suppression/preservation - Trelstar and Triptodur The step-through requirement for the following indications has been updated to accept any formulation of leuprolide:

	• Advanced prostate cancer • Premenstrual Dysphoric Disorder (PMDD) • Abnormal uterine bleeding **Zoladex** for advanced breast cancer criteria was updated by including a step-through option of leuprolide and Triptorelin. **Trelstar vial** will remain on the medical benefit **with** prior authorization **and** will also be **added** to the pharmacy benefit **with** prior authorization.
Rivfloza	The age requirement was lowered from ≥9 years of age to ≥2 years of age following a labeling expansion.
Immune Globulin	Criteria for specialist involvement was added for all indications throughout the policy. The initial approval duration has been updated to 3 months for Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection (PANDAS).
Immune Suppressants – Topical	The following updates were made following an expanded FDA approval: • Vtama criteria was updated to include atopic dermatitis in adults and pediatrics ≥ 2 years of age • Zoryve 0.3% foam was updated to include plaque psoriasis in adults and pediatric members ≥ 12 years of age
JAK Inhibitors for Myelofibrosis, Graft Versus Host Disease, and Polycythemia Vera	Criteria for platelet count threshold was added to Jakafi and Inrebic and updated for Vonjo to align with NCCN recommendations. The diagnosis of myelofibrosis-associated anemia was added for Jakafi (ruxolitinib tablet), Ojjaara (momelotinib), and Vonjo (pacritinib). Prescriber specialty requirement has been added to all agents in the policy.
Kinase Inhibitors	**New drug**, **Gomekli** (*1 mg capsule, 2 mg capsule, & 1 mg tablet for oral suspension*) will be **added** to the pharmacy benefit **with** prior authorization. The initial duration of approval for Koselugo was updated to 6 months from 12 months.
Blincyto Besponsa	Criteria was updated for Blincyto to reflect expanded indication of B-cell precursor acute lymphoblastic leukemia (B-ALL) and address trial of combination therapy with tyrosine kinase inhibitors (TKIs such as dasatinib, imatinib, nilotinib etc) following the NCCN recommendations. The reauthorization approval duration was updated to 6 months.
Opioid Dependence and Reversal Agents	**Rextovy 4mg nasal spray** will remain on the pharmacy benefit **and** will no longer require prior authorization.

	Zubsolv criteria was updated to require step-through of both film and tablet formulations of buprenorphine/naloxone.
PARP Inhibitors	**Talzenna capsules** will remain on the pharmacy benefit **with** prior authorization **and** will have an additional quantity limit of 30 capsules per 30 days. **Lynparza** criteria for metastatic castration-resistant prostate cancer was updated to include option of Lynparza as monotherapy for those with deleterious or suspected deleterious germline or somatic BRCA1 or BRCA2 gene mutation.
Renal Disorder Agents	**New drug**, **Vanrafia tablet**, will be **added** to the pharmacy benefit **with** prior authorization.
Rituximab Agents	Mycophenolate was added as one of the trial options for polymyositis and dermatomyositis diagnosis.
T-Cell Immunotherapies	The step-through option of Columvi (in DLBCL) and Lunsumio (in FL) was removed for Epkinly. *DLBCL – diffuse large B-cell lymphoma, FL – Follicular Lymphoma*