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 02/01/2026

The following changes are being made to the listed medications:

Long-Acting Granulocyte Colony Stimulating Factors (LA-GCSF) (medical benefit criteria)	• Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist to the policy. • Adding the indication of Pediatric Aggressive Mature B-Cell Lymphomas for all the pegfilgrastim products. • Updating the risk factors for febrile neutropenia table to align with NCCN. • Updating NDC codes for Ryzneuta, Fulphila, and Udenyca as applicable. • Adding ICD10 codes C65.1, C65.2, C65.9 (related to Wilms Tumor), C83.30-C83.39, C83.70-C83.79, C85.20-C85.29, and D47.Z1 (related to Pediatric Aggressive Mature B-cell Lymphomas). • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57
Short-Acting Granulocyte Colony Stimulating Factors	• Updating the Dosing Limits section to remove the Quantity Limit. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist to the policy.

(SA-GCSF) (medical benefit criteria)	• For acute myeloid leukemia (AML), updating criteria to remove re-induction therapy. • For Myelodysplastic Syndrome (MDS), adding that short-acting GCSFs may also be used following relapse after prior therapy. • For the Management of CAR-T Related Toxicity, removing examples of CAR-T. • Adding indication of Pediatric Aggressive Mature B-Cell Lymphomas. • Updating the risk factors for febrile neutropenia table to align with that of NCCN. • Removing obsolete HCPCs codes J3590 and C9173 (related to Nypozi). • Adding ICD10 codes C65.1, C65.2, C65.9 (related to Wilms Tumor), C83.30-C83.39, C83.70-C83.79, C85.20-C85.29, and D47.Z1 (related to Pediatric Aggressive Mature B-cell Lymphomas). • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57
Leukine (medical benefit criteria)	• Updating Dosing Limits section to remove quantity limit. • Updating Max Units to total dose to be received over a 14- or 28-day period and not individual dosages on specific days, including the new max dose for neuroblastoma. • Updating Renewal Criteria to apply to all indications. • Updating list of unacceptable toxicities. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57
Tremfya (medical benefit criteria)	• Adding of Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist to the policy. • Administrative changes to Initial and Renewal criteria to update 'coverage' to 'prior authorization validity.' • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57
Darzalex IV (medical benefit criteria)	• Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57
Denosumab (medical benefit criteria)	• Removing HCPCS code J3590 for Osenvelt, Stoboclo, Bomyntra, Conexxence, Denosumab-bnht, Denosumab-dssb, Ospomyv, and Xbryk as it was discontinued effective 10/01/25. • Updating Initial and Renewal criteria to update 'coverage' to 'prior authorization validity.' • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist to the policy • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57

Erbitux (medical benefit criteria)	• Adding Appendix A-Non-Quantitative Treatment Limitations (NQTL) Factor Checklist to policy. • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57
Evkeeza (medical benefit criteria)	• Adding the FDA approved expanded indication to include treatment of homozygous familial hypercholesterolemia (HoFH) in pediatric patients at least 1 year of age. • To the Universal Criteria, removing the exclusion for use in combination with lomitapide. • To HoFH indication, adding lomitapide to list of agents that might be used in combination (in the initial and renewal sections). • Adding additional option for tried/failed criteria to include at least a 6-month trial of lomitapide. • Updating the verbiage from "despite pharmacologic treatment, unless contraindicated, with PCSK9/ezetimibe/statin" to "despite receiving LDL-lowering therapy, unless contraindicated" within the LDL-C level criterion. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist to the policy. • Updating Covered Diagnosis Code section to remove outdated code E78.01 and replace with E78.010 (related to HoFH). • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57
IVIG (medical benefit criteria)	• Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist to the policy • Administrative changes to Initial and Renewal criteria to update 'coverage' to 'prior authorization validity.' • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57
Keytruda IV (medical benefit criteria)	• Reformatting Length of Authorization section to separate out approval durations for neoadjuvant and adjuvant treatment settings to align with Dosing Table. • Updating verbiage for Bladder Cancer/Urothelial carcinoma patients using agent as single agent first-line treatment in platinum-ineligible patients. • For Cervical Cancer, updating option for use in combination with tisotumab vedotin-tftv to now require patient to be immuno-oncology therapy naïve. • For Esophageal and Esophagogastric/Gastroesophageal Junction (EGJ) cancer, updating first-line treatment to require PD-L1 CPS ≥1 regardless of HER2 status or histology. • For Head and Neck Cancer, updating options for use in resectable locally advanced disease to incorporate both the package insert and new NCCN recommendations. • For Kaposi Sarcoma, adding option for use with antiretroviral therapy (ART). Also updating types of advanced disease. • For Renal Cell Carcinoma (RCC), updating subsequent therapy for clear cell histology to apply only to patients who are immune-oncology (IO) therapy naïve when used in combination with axitinib or lenvatinib. Removing footnote that

	allows review for agent as subsequent therapy on a case-by-case basis, as NCCN now notes prior IO use as a 2B recommendation. Also, in addition to nephrectomy, adding stereotactic body radiation therapy (SBRT) to adjuvant therapy in patients with state II or III disease • To Merkel Cell Carcinoma (MCC), adding in-transit N+ regional disease to use as a single agent in patient with primary or recurrent regional disease. • To Small Cell Lung Cancer (SCLC), removing requirement for chemotherapy-free interval of ≤6 months. Updating options for use to allow as subsequent treatment for progressive or relapsed disease. • To Dosing Table, adding until disease progression or unacceptable toxicity to Extranodal NK/T-Cell • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57
Kimmtrak (medical benefit criteria)	• Updating Dosing Limits section to remove quantity limit. • Updating Initial and Renewal criteria to update 'coverage' to 'prior authorization validity'. • To Uveal Melanoma, removing requirement that patients have no prior systemic treatment in the advanced or metastatic setting. • Adding Non-Quantitative Treatment Limitations (NQTL) Factor Checklist to appendix section. • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57
Krystexxa (medical benefit criteria)	• Adding the new Ready-to-Use 8 mg/50 mL (0.16 mg/mL) single-dose vial product to the policy and updating the description for the 8 mg/mL product to clarify that it is 'To-be-Diluted.' • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist to the policy. • Updating Initial and Renewal criteria to update 'coverage' to 'prior authorization validity'. • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57
Libtayo (medical benefit criteria)	• Adding FDA-approved expanded indication for the adjuvant treatment of patients with cutaneous squamous cell carcinoma (cSCC) at high risk of recurrence after surgery and radiation. Updating the Length of Authorization, dosing table, and dosing limits sections to reflect the addition of this new indication. • Also to cSCC, reformatting and updating criteria for neoadjuvant therapy to reflect its use in patients with regional or satellitosis/in-transit metastatic disease, very high-risk disease, and locally advanced disease, and updating the footnote for very high-risk features to align with NCCN. • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57

Niktimvo (medical benefit criteria)	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods. • Adding compendia symbol to aGVHD indication. • Updating current step through belumosudil to note this applies to ages 12 years and older based on the FDA-approved age of belumosudil. • To Billing Code/Availability, removing discontinued HCPCS code J3590. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57
Rytelo (medical benefit criteria)	• Updating an 'AND' to 'OR' in between criteria for patient has del(5q) mutation or patient does not have del(5q) mutation. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57
Tecentriq IV (medical benefit criteria)	• Adding the new FDA-approved use in combination with lurbinectedin for the maintenance treatment of adult patients with extensive-stage small cell lung cancer (ES-SCLC) whose disease has not progressed after first-line induction therapy with atezolizumab (IV/SC), carboplatin, and etoposide. • Adding new NCCN 2A recommendations for subsequent therapy for ES-SCLC disease progression/relapse after a prolonged disease-free interval for use in combination with carboplatin and etoposide followed by maintenance therapy as a single agent or in combination with lurbinectedin. • Adding ICD-10 code Z85.12 (related to SCLC). • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57
Tecentriq Hybreza (medical benefit criteria)	• Adding the new FDA approved use in combination with lurbinectedin for the maintenance treatment of adult patients with extensive-stage small cell lung cancer (ES-SCLC) whose disease has not progressed after first-line induction therapy with atezolizumab (IV/SC), carboplatin, and etoposide. • Adding new NCCN 2A recommendations for subsequent therapy for ES-SCLC disease progression/relapse after a prolonged disease-free interval for use in combination with carboplatin and etoposide followed by maintenance therapy as a single agent or in combination with lurbinectedin. • Adding ICD-10 code Z85.12 (related to SCLC). • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist to the policy. • Updating Initial and Renewal criteria to update 'coverage' to 'prior authorization validity'. • Updating Billing Code/Availability section to remove obsolete HCPCS codes. • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57

Zepzelca (medical benefit criteria)	• Adding the new FDA-approved indication for the treatment of adult patients with extensive-stage small cell lung cancer (ES-SCLC) whose disease has not progressed after first-line induction therapy with atezolizumab (IV/SC), carboplatin, and etoposide to be used as maintenance therapy in combination with atezolizumab (IV/SC). • Incorporating new NCCN 2A recommendations for disease progression/relapse after a prolonged disease-free interval as maintenance therapy with atezolizumab (IV/SC) following at least stable disease on carboplatin, etoposide and atezolizumab (IV/SC). • Updating single agent use to allow use as subsequent systemic therapy if not previously used for progression or relapse. • Removing Universal Criteria from the policy. • Updating Dosing/Administration table to include new package insert administration guidance on use of lurbinectedin in cases of atezolizumab IV/SC immune-related severe adverse events. • Adding the following ICD-10: Z85.118, Z85.12 (related to SCLC). • The medical benefit policy effective 2/1/2026 can be reviewed in full at the following location: https://gatewaypa.com/policydisplay/57

Effective 01/01/2026
As a reminder, coverage updates are being made in the following classes. This list is not all encompassing of updates effective 01/01/2026. Please refer to the November newsletter for a full list of updates effective 01/01/2026.

PCSK9 Inhibitors	As previously communicated, Repatha will be moved to the preferred brand tier and Praluent will be moved to the nonpreferred brand tier. Any active authorizations for Praluent will be terminated after December 31, 2025, and new prior authorization requests will need to be submitted to continue therapy with Praluent. To facilitate continuity of care, members with an active authorization for Praluent will have an authorization entered for Repatha starting January 1, 2026 and lasting through the end date of the authorization being terminated. Repatha and Praluent will continue to require prior authorization. Initial and reauthorization criteria for Praluent will require that the member step through Repatha for all shared indications. Effective January 1, 2026, Repatha will replace Praluent as MGBHP's designated brand medication for coronary artery disease under the PACT Act.
Injectable CGRP Inhibitors	As previously communicated, Ajovy will be moved to the nonpreferred brand tier. Emgality and Aimovig will remain on the preferred brand tier. All three agents will continue to require prior authorization. Initial and reauthorization criteria for Ajovy will be updated to require that the member has had a trial and failure with either Emgality or Aimovig for all shared indications. Any active authorizations for Ajovy will be terminated after December 31, 2025, and new prior authorization requests will need to be submitted to continue therapy with

	Ajovy. To facilitate continuity of care, members with an active authorization for Ajovy will have authorizations entered for Aimovig and Emgality 120 mg/mL starting January 1, 2026 and lasting through the end date of the authorization being terminated.

Updates for MassHealth Members

Effective 2/17/2026

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

Generic Medication	Brand Name Alternative
Tasimelteon suspension	Hetlioz suspension
Alosetron tablet	Lotronex tablet
estrogens, conjugated tablet	Premarin tablet

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

Brand Name	Generic Medication
Hetlioz 20mg capsule	Tasimelteon 20mg capsule
Adderall XR capsule	Amphetamine/dextroamphetamine capsule
Byetta Dose Pen Injection	Exenatide Injection
Motegrity	Prucalopride

Effective 2/17/2026

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

Antibiotics, Injectable	New drugs, **Emblaveo injection** and **Zevtera injection**, will be **added** to the pharmacy benefit **with** a prior authorization requirement.
Anti-Diarrhea Agents	• New drug formulation **dicyclomine 40mg tablet** will be **added** to the pharmacy benefit **with** a prior authorization requirement **and** quantity limit of 120 tablets per 30 days. • Criteria will include a step-through of other dicyclomine formulations used at an equivalent dose to the requested medication and treatment failure with two of the following agents: bile acid sequestrant, bismuth subsalicylate, bulk forming agent, diphenoxylate/atropine, loperamide, or tricyclic antidepressants.
Anti-Diabetic Agents	• Baseline A1c will be required for the initial review. • The step-through trial with metformin was further clarified for GLP-1 agents used for the treatment of prediabetes. • The recertification criteria for GLP-1 agents for diabetes or prediabetes was updated to look for documentation of meeting A1c treatment goals, reduction in A1c, or treatment plan addressing escalation of therapy for

	A1c reduction (e.g., dose escalation, addition of another agent [e.g., SGLT-2, sulfonylurea, insulin, etc.], care plan to address lifestyle modification). • Mounjaro and Ozempic will be covered for off-label treatment of obesity.
Anti-Hemophilia Agents	• New expanded indication for **Alhemo** was added for members with hemophilia A or B without inhibitors. Also, criteria was updated to require use of an FDA-cleared assay for monitoring. • **Hympavzi** was updated to remove the specific gender requirement.
Anti-Obesity agents	• The step-through requirement through phentermine and Mounjaro was removed for Zepbound. • The step-through requirement through phentermine for new starts was removed. • Wegovy will now be covered for treatment of obesity in adults and will have similar criteria as Zepbound. • The requirement of a trial with Ozempic 2 mg was removed for Wegovy for diagnosis of NASH/MASH in members with T2DM or prediabetes. • Saxenda for the treatment of obesity in pediatric members will require a step-through Wegovy. • Criteria for Wegovy and Zepbound were updated to include BMI thresholds (BMI ≥ 35, ≥ 30, ≥ 27 kg/m2) and weight-related comorbid conditions. *NASH/MASH: nonalcoholic steatohepatitis/ metabolic dysfunction-associated steatohepatitis ; T2DM: Type 2 Diabetes Mellitus*
Anti-Parkinsonian Agents	• Criteria was updated to remove the requirement of medical records for step-through trials. • Carbidopa/levodopa ER capsule (generic of Rytary) will require a treatment failure with Crexont.
Cerebral Stimulants	• Aptensio XR criteria was updated to remove step-through methylphenidate transdermal (Daytrana). • Vyvanse capsules and chewable tablets will become preferred <u>without</u> prior authorization **if** age is < 21 years and requested quantity is ≤2 units per day.
Chronic Myelogenous Leukemia Agents	• All nilotinib formulations were updated to differentiate between the different salt forms (e.g., tartrate, hydrochloride). • Scemblix was updated to reflect an expanded indication: chronic phase Philadelphia chromosome-positive (Ph+). • Iclusig was updated to better align with the FDA-approved indications for both chronic myelogenous leukemia (CML) and acute lymphoblastic leukemia (ALL).

	• The following new drug formulations will be **added** to the pharmacy benefit **with** a prior authorization requirement:
	  ○ Nilotinib tartrate capsule
	  ○ Phyrago tablet

Constipation Agents	• **Linzess** will be **added** to the pharmacy benefit **with** a prior authorization requirement. Criteria will be updated to require a step-through trial with generic Amitiza, lubiprostone.
Enzyme and Metabolic Disorder Therapies	• Criteria will require a step-through trial with sapropterin or confirmed diagnosis of classic phenylketonuria. Additional requirements will include diagnosis, prescriber specialty, current weight, and therapy will be used in conjunction with a phenylalanine-restricted diet. • **Sephience powder packet** will be **added** to the pharmacy benefit **with** a prior authorization requirement.
Intravesical Bladder Cancer Agents	New drug **Inlexzo 225mg intravesical system** will be **added** to the medical benefit only, **with** a prior authorization requirement.
Kinase Inhibitors	• Criteria will require a step-through trial with one platinum-based systemic therapy along with diagnosis, age, prescriber specialty and appropriate dosing. • **Avmapki Fakzynja Co-Pack** will be **added** to the pharmacy benefit **with** a prior authorization requirement.
Lung Cancer Agents	• Emrelis and Hernexeos criteria will require a step-through trial with one first line systemic therapy. Note that additional criteria may be required such as diagnosis, age, prescriber specialty etc. • New drug **Emrelis Injection** will be **added** to the medical benefit only, **with** a prior authorization requirement. • New drug **Hernexeos tablet** will be **added** to the pharmacy benefit **with** a prior authorization requirement **and** quantity limit of 90 tablets per 30 days.
Multiple Sclerosis Agents	• New biosimilar **Tyruko vial** will be **added** to both the pharmacy benefit **and** medical benefit **with** a prior authorization requirement. Criteria will require clinical rationale for Tyruko vial instead of Tysabri. • **Ocrevus** was updated to allow exception to Briumvi trial in pregnancy and lactation. • **Kesimpta** was updated to require at least one of the trials be Briumvi, Ocrevus, Ocrevus Zunovo, or Tysabri.
Oncology Immunotherapies	• New subcutaneous formulation **Keytruda Qlex Injection** will be **added** to the medical benefit only, **with** a prior authorization requirement. • **Bavencio** was updated to require a trial with either Keytruda or Keytruda Qlex. • New expanded indication was added for the following medications: ○ **Imfinzi** - muscle invasive bladder cancer (MIBC)

	○ **Opdivo** – unresectable or metastatic heptocellular carcinoma and mismatch repair–deficient (dMMR) or microsatellite instability–high (MSI-H) unresectable or metastatic colorectal cancer (CRC) ○ **Zynyz** - inoperable locally recurrent or metastatic squamous cell carcinoma of the anal canal (SCAC) and locally recurrent or metastatic SCAC with disease progression on or intolerance to platinum-based chemotherapy ○ **Keytruda** - PD-L1-positive resectable locally advanced head and neck squamous cell carcinoma • Following label changes issued by the FDA, **Keytruda** and **Opdivo** in gastric, gastroesophageal junction (GEJ) and esophageal cancers are to be limited for use in those with PD-L1 positive tumors.
Pavblu (aflibercept-ayyh)	This new medication will be **added** to the medical benefit with no restrictions
Renal Disorder Agents	• The following updates were made to the Kerendia criteria: ○ Expanded indication for the treatment of heart failure was added ○ For chronic kidney disease (CKD) indication, criteria was updated to require appropriate dosing • New drug strength, **Kerendia 40mg tablet**, will be **added** to the pharmacy benefit **with** both a prior authorization requirement **and** quantity limit of 30 tablets per 30 days.
Targeted Immunomodulators (TIMs)	New drug strength **Selarsdi 45 mg/0.5 mL vial** will be **added** to both the pharmacy benefit **and** medical benefit **with** a prior authorization requirement.
Topical Immune Suppressants	• Criteria will require step-through trials with: ○ one superpotent or potent topical corticosteroids, and ○ a topical calcineurin inhibitor, and ○ Eucrisa or Zoryve, and ○ Opzelura and Vtama ○ Note that additional criteria may be required such as diagnosis, age, prescriber specialty, etc. • Elidel criteria was updated to have diagnosis removed and tacrolimus trials were clarified (for patients < 16 years of age can trial either the 0.01% or 0.1% and patients ≥ 16 years of age must trial the 0.1% strength). • The age requirement for Opzelura was updated to include patients ≥ 2 years of age for diagnosis of atopic dermatitis. • The following medications will be **added** to the pharmacy benefit **with** a prior authorization requirement **and** quantity limits: ○ Anzupgo 2% cream – QL ≤ 60 grams per 30 days. ○ Zoryve 0.05% cream – QL 60 grams per 30 days.