# 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 04/01/2025**
**The following changes are being made to the listed medications:**

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| Vigabatrin tablet, packet | This medication will be locked to specialty and will need to be filled at a contracted specialty pharmacy. |

## Updates for Commercial Members

<table>
<tr>
<td>Liraglutide</td>
<td>In December 2024 the Food and Drug Administration (FDA) approved the first liraglutide generic referencing Victoza. With the approval of the referencing generic, the authorized generic of Victoza will now be nonformulary. Members who have previously filled the authorized generic may now have rejected claims at the pharmacy. Pharmacies should use the generic referencing Victoza to fill the prescription. Members do not need a new prescription for this change.
<table>
<tr><th>PRODUCT</th><th>NDCS</th><th>NOTES</th></tr>
<tr><td>LIRAGLUTIDE</td><td>00143914402<br>00143914403</td><td>Referencing Generic</td></tr>
<tr><td>LIRAGLUTIDE</td><td>00480366720<br>00480366722</td><td>Authorized Generic</td></tr>
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**Effective 04/01/2025**

**The following changes are being made to the listed medications:**

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| Nucala | For the treatment of eosinophilic granulomatosis with polyangiitis (EGPA):<br><br>• Criteria will be updated to include the requirement that member is currently administering a corticosteroid or has a contraindication or intolerance to corticosteroid therapy.<br>• Criteria will require that the member's disease has relapsed or is refractory to standard of care therapy.<br><br>Additionally, the criteria for severe asthma will be updated to require that the member has a baseline blood eosinophil count of at least 150 cells per microliter. |
| Fasenra | Criteria for severe asthma will be updated to require that the member has a baseline blood eosinophil count of at least 150 cells per microliter.<br><br>Criteria for the supplemental indication of EGPA will be added to the policy. |
| Adbry | For the treatment of atopic dermatitis:<br><br>• Topical trial with either medium or higher potency corticosteroid, pimecrolimus cream, tacrolimus ointment, or Eucrisa will be required. Minimal trial length for topical agents will be defined.<br>• Reauthorization criteria will be updated to require documentation of clinical improvement. |
| Dupixent | For the treatment of atopic dermatitis:<br><br>• Topical trial with either medium or higher potency corticosteroid, pimecrolimus cream, tacrolimus ointment, or Eucrisa will be required. Minimal trial length for topical agents will be defined.<br>• Reauthorization criteria will be updated to require documentation of clinical improvement.<br><br>Additionally, criteria for the supplemental indication of chronic obstructive pulmonary disease (COPD) will be added to the policy. |
| Cibinqo | For the treatment of atopic dermatitis:<br><br>• The approvable age will be updated from 18 to 12 years of age.<br>• Diagnosis criteria will be updated to require that disease is refractory.<br>• Topical trial with either medium or higher potency corticosteroid, pimecrolimus cream, tacrolimus ointment, or Eucrisa will be required. Minimal trial length for topical agents will be defined.<br>• Criteria will be updated to require trial with either Adbry or Dupixent. |

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| | • Reauthorization criteria will be updated to require documentation of improvement in the member's clinical condition. |
| Rinvoq | Criteria for atopic dermatitis will be updated to require trial with either Adbry or Dupixent. |
| Ocaliva | Criteria will be updated to require that the member does not have decompensated cirrhosis, the medication is prescribed by a specialist, and is not being used in combination with either elafibranor or seladelpar. |
| Restasis | Criteria will be updated to clarify NSAID requirements. |
| Tezspire | Initial criteria will be updated to require member has a diagnosis of severe asthma and to define parameters for inadequate asthma control.<br><br>Reauthorization criteria will be updated to require member is 12 years of age or older. This aligns with the initial criteria requirements. |
| Xifaxan 550 mg tablet | Criteria for all diagnoses will be updated to require documentation of diagnoses and previous trial requirements. Initial criteria for hepatic encephalopathy will be updated to remove allowance for approval if the member is currently on treatment. |
| Lumryz<br>Sodium oxybate<br>Xyrem<br>Xywav<br>Wakix | Criteria for the diagnosis of excessive daytime sleepiness associated with narcolepsy will be updated to require a trial with Sunosi for those members who are 18 years of age or older.<br><br>Criteria for the diagnosis of narcolepsy with cataplexy for approvals of Lumryz, Sodium oxybate, Xyrem, and Xywav will be updated to specify that a trial with Wakix applies to those members who are 18 years of age or older.<br><br>Criteria for Xywav will be updated to include the supplemental indication of idiopathic hypersomnia. |
| Opzelura | Criteria for atopic dermatitis will be updated to require a trial with either a medium or higher potency topical corticosteroid or topical calcineurin inhibitor or a contraindication to both classes.<br><br>Reauthorization criteria for treatment of atopic dermatitis or vitiligo will require documentation supporting clinical improvement. |

# Updates for MassHealth Members

**Effective 04/1/2025**

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

| Generic Medication | Brand Name Alternative |
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| Pyridostigmine bromide 60 mg tablet | Mestinon 60 mg tablet |
| Pyridostigmine bromide 180 mg ER tablet | Mestinon 180 mg ER tablet |
| Timolol eye drops | Betimol eye drops |
| Sitagliptin 25 mg, 50 mg, & 100 mg tablet | Zituvio 25 mg, 50 mg, & 100 mg tablet |

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

| Brand Name | Generic Medication |
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| Marinol 2.5 mg capsule | Dronabinol 2.5 mg capsule |
| Emend Tripack | Aprepitant Trifold pack |
| Mycobutin 150 mg capsule | Rifabutin 150 mg capsule |
| Nucynta tablet | Tapentadol tablet |
| Nucynta ER tablet | Tapentadol ER tablet |

**Effective 4/1/2025**

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

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| Antidepressants | **Zulresso** criteria was updated to include additional step-through with preferred alternatives or requirement of clinical rationale for the requested medication. |
| Antidiabetics Agents – Non-Insulin & combination products | **Glimepiride 3 mg tablet** will be **added** to the pharmacy benefit **with** prior authorization.<br><br>**Brand Zituvimet tablet** will be **added** to the pharmacy benefit **with** prior authorization **and** the authorized generic sitagliptin/metformin will also be **added** to the pharmacy benefit with no restrictions.<br><br>**Zituvimet XR tablet** will be **added** to the pharmacy benefit **with** prior authorization.<br><br>**Soliqua** and **Xultophy** criteria were updated to prevent the concurrent use of requested medication with another GLP-1 agonist.<br><br>Policy has been updated to include criteria for GLP-1 or GIP/GLP-1 agonist transition requests. (update was also made to the anti-obesity policy for consistency) |
| Antiemetics | **Granisetron** tablet criteria was updated to include recommendations for daily or as needed use per the NCCN Antiemesis guideline. Requests exceeding the quantity limits in CINV/RINV will require the provider's clinical rationale. |
| Antifungals - Topical | **Ertaczo 2% cream** will remain on the pharmacy benefit and will have prior authorization **added**. |

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| | **Terbinafine HCL 1% cream** will be **added** to the pharmacy benefit with no restrictions. This medication has been added to the MH OTC drug list.<br><br>Throughout the policy, updates have been made to clarify specific diagnoses and treatment failure options are now listed for each agent within this class. Treatment failure options may include the following topicals: allylamine (e.g., terbinafine, tolnaftate), azole antifungal (e.g., clotrimazole, econazole, ketoconazole, miconazole), butenafine, or ciclopirox. |
| Antipsychotics & Miscellaneous Mental Health Therapies | The following **new medications** will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limits:<br>• **Erzofri syringe - QL** - 1 injection per 28 days.<br>• **Opipza Film** – **QL** 1 film per day.<br><br>**Aripiprazole oral solution** will remain on the pharmacy benefit. The age limit has been updated to **≥ 13 years of age** and the quantity limit has been updated to **≥ 10 ml per day**. Requests exceeding 10 mL per day will require a step-through with aripiprazole ODT at an equivalent dose.<br><br>Additional requirements were added for **Caplyta** criteria for bipolar depression, specifically for the strengths 10.5 mg or 21 mg capsules, where member would be required to meet one of the following:<br>• Hepatic impairment<br>• Utilization with a CYP3A4 inhibitor<br>• Side effects with the 42 mg dose<br>• High sensitivity to antipsychotic medications and the need for a lower dose |
| Asthma & Allergy Monoclonal Antibodies | **Dupixent** criteria for the treatment of moderate to severe atopic dermatitis was expanded to include one additional step through trial or a minimum BSA to be treated. Alternatively, the member may provide proof of an inadequate response to one potent corticosteroid unless the member is under 12 or the treatment area is considered a sensitive area, and an inadequate response to either Eucrisa or topical tacrolimus. |
| Breast Cancer Therapies | The following new medication will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limits:<br>• Itovebi 3mg tablet – **QL** 60 tablets per 30 days<br>• Itovebi 9mg tablet – **QL** 30 tablets per 30 days<br><br>**Kisqali** criteria was updated to include the expanded indication of use with an aromatase inhibitor for the adjuvant treatment of adults with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative stage II and III early breast cancer at high risk of recurrence.<br><br>**Truqap** approval criteria was updated to remove step-through Piqray (alpelisib). |

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| | **Trodelvy**: Diagnosis for urothelial carcinoma was removed due to the FDA withdrawal of Trodelvy. |
| Covid-19 Vaccines | Policy was updated based on updated guidance from the CDC for administration of 2 doses of 2024-25 vaccines to individuals ≥ 65 years of age who were previously vaccinated before availability of the newer vaccine formulation. |
| Cystic Fibrosis Transmembrane Conductance Regulator Modulators | The following new medication will have prior authorization **and** quantity limits **added** on the pharmacy benefit:<br>• **Alyftrek 4-20-50mg tablet – QL** 90 tablets per 30 days<br>• **Alyftrek 10-50-125mg tablet – QL** 60 tablets per 30 days |
| Marinol (dronabinol) | Criteria for **Marinol** exceeding quantity limits was updated to clarify appropriate diagnoses:<br>• Chemotherapy-induced nausea and vomiting (CINV)<br>• AIDS-related anorexia<br>• Anorexia of non-AIDS- relRated etiology or require appetite stimulation (off-label)<br>• Nausea/vomiting of any etiology (not associated with chemotherapy or cyclic vomiting) (off-label)<br>• Appetite stimulation or relief from nausea/vomiting associated with a comorbid cancer diagnosis (off-label) |
| Enzyme and Metabolic Disorder Therapies | Diagnosis of Niemann-Pick disease type C was added for Zavesca.<br><br>**Aqneursa 1 gram granule packet** will have prior authorization **added** and <u>will remain</u> on the pharmacy benefit.<br><br>**Miplyffa capsule** will have prior authorization **added** on the pharmacy benefit. |
| Gastrointestinal Agents-H2 antagonists, PPIs and Misc. Agents | Prior authorization for **Nexium 2.5 mg, 5 mg, and 10 mg suspension** was <u>removed</u> for members **<2 years of age *or*** when the requested quantity is **≤1 packet/day.** |
| Hereditary Angioedema Agents | Takhzyro's reauthorization criteria was adjusted to assess for appropriate dosing frequency based on membe response. |
| Hypoxia-Inducible Factor Prolyl Hydroxylase Inhibitors | **New drug**, **Vafseo**, will be **added** to the <u>medical benefit only</u> **with** prior authorization.<br><br>**Jesduvroq tablet** will be <u>removed</u> from the pharmacy benefit and will be available through the <u>medical benefit only</u> **with** prior authorization. |
| Inflammatory Bowel Disorder Agents | **Lialda** (*mesalamine 1.2gram delayed-release tablet*) will have prior authorization **added** and <u>will remain</u> on the pharmacy benefit.<br><br>The following criteria updates were made:<br>• Delzicol criteria was updated to accept a trial with any mesalamine product available without PA rather than specifically requiring a trial with Lialda |

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| | • Specific subcategorization of diagnosis (induction vs maintenance) will no longer be required for pediatric approvals of Delzicol |
| Influenza Treatment and Prophylaxis Agents | **Xofluza** criteria was updated to reflect updated age range based on the package insert (≥5 years of age). |
| Insulin Products | **Insulin Aspart** *(Novolog authorized generic)* will have prior authorization **added** and will remain on the pharmacy benefit. A step-through with Insulin lispro (Humalog or therapeutically equivalent generic) will be required for these requests. |
| Lung Cancer Agents | The following new drug strengths will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limits:<br>• Augtyro 160mg capsule – **QL** 60 capsules per 30 days<br>• Lumakras 240mg tablet – **QL** 120 tablets per 30 days |
| Oncology Immunotherapies | **New drug**, **Vyloy vial**, will be **added** to the medical benefit **with** prior authorization. |
| Opioids & Analgesics | The following medications will remain on the pharmacy benefit **and** will have prior authorization **added**, requiring treatment failure with preferred alternatives or clinical rationale for the use of the requested medication:<br>• Nucynta<br>• Nucynta ER<br>• Xtampza ER<br><br>**Belbuca** criteria was updated to include an optional condition for a treatment plan to microdose buprenorphine with the intent to taper off full agonist opioid therapy (e.g., opioid taper plan, buprenorphine dosing, and tapering schedule). |
| Osteoporosis Agents & Miscellaneous Calcium Regulators | The following **new medication**, will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limits**:**<br>• **Yorvipath 168mcg/0.56ml pen – QL** 1.12ml per 28 days<br>• **Yorvipath 294mcg/0.98ml pen – QL** 1.96ml per 28 days<br>• **Yorvipath 420mcg/1.4ml pen – QL** 2.8ml per 28 days<br><br>Off-label criteria was added for the following:<br>• treatment of hypoparathyroidism was added for teriparatide<br>• treatment/prevention of osteoporosis was added for calcitonin salmon injection and Evenity<br><br>Requirement to provide medical records was removed for remaining products in the policy (calcitonin salmon injection, Evenity [romosozumab-aqqg], Tymlos [abaloparatide]). |
| Targeted Immunomodulators | **New drug, Ebglyss,** will be **added** to the pharmacy benefit **with** prior authorization.<br><br>**Tremfya 200mg/20mL vial** will have prior authorization **added** to both the pharmacy benefit **and** medical benefit. |

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| | **Bimzelx** criteria was updated to reflect the FDA approval for the treatment of adults with ankylosing spondylitis, non-radiographic axial spondyloarthritis, psoriatic arthritis, and hidradenitis suppurativa.<br><br>The reauthorization criteria for **Ebglyss** and **Adbry** will be adjusted to favor every four week dosing rather than indefinite bi-weekly dosing. Requests for bi-weekly dosing will require documentation of partial response to therapy, failed trial with every four week dosing, or request is for Adbry for a pediatric. |
| Gattex (teduglutide) | Criteria was updated to require specialist prescribing and the requirement of two alternatives (e.g., anti-diarrheal, H2 antagonist, octreotide, proton pump inhibitor (PPI), ursodiol). |

*CINV – chemotherapy-induced nausea and vomiting, RINV – radiation-induced nausea and vomiting*