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 02/19/2026

Fertility Prescription Specialty Pharmacy Update	• Effective 02/19/2026, Optum Specialty Pharmacy will no longer dispense fertility medications.
	• Any fertility order placed on or before 02/18/2026 will be filled by Optum Specialty Pharmacy.
	• **Effective 02/19/2026 for MGBHP Commercial members, Optum Specialty Pharmacy will transfer active fertility prescriptions with remaining refills to FuzeRx.**
	• The following medications are transitioning from Optum Specialty Pharmacy to FuzeRx:
	  ○ Cetrorelix
	  ○ Cetrotide
	  ○ Follistim
	  ○ Ganirelix
	  ○ Gonal-F
	  ○ human chorionic gonadotropin (HcG)
	  ○ Menopur
	  ○ Novarel
	  ○ Ovidrel
	  ○ Pregnyl

	• Additionally, adjunctive medications taken as part of a fertility regimen currently filled by Optum Specialty Pharmacy will also be transferred to FuzeRx. Adjunctive medications not being used as part of a fertility regimen will continue to be dispensed through Optum Specialty Pharmacy. • Optum Specialty Pharmacy and FuzeRx will partner to monitor this transfer. FuzeRx will initiate the refill process. If valid refills remain on the prescription, then the member will not need a new prescription. • On or after 02/19/2026, members will be contacted directly by FuzeRx on how to order or refill their medications after their prescriptions are transferred. • Providers can reach out to Optum Specialty Pharmacy with questions at 1-877-358-9016. • Beginning 02/19/2026, members and providers are encouraged to call FuzeRx at 1-800-305-0542 with any questions.

Effective 04/01/2026
The following changes are being made to the listed medications:

Gomekli (pharmacy benefit criteria)	• Updating initial criteria to require inadequate response, adverse reaction or contraindication to Koselugo for members of all ages.
Orencia (pharmacy benefit criteria)	• Updating initial criteria for acute graft versus host disease (aGVHD) to specify that only the IV formulation will be approved for this indication.
Nonformulary Medications (pharmacy benefit criteria)	• Updating previous trial language to require that the trial length was of adequate duration.
Adakveo (medical benefit criteria)	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods, and to Initial and Renewal criteria to update 'coverage' to 'prior authorization validity'. • To Universal Criteria, removing preclusion for use in combination with Oxbryta (voxelotor) due to market withdrawal. • Adding Appendix A - Non-Quantitative Treatment Limitations (NQTL) Factor Checklist • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Aflibercept (medical benefit criteria)	• Adding expanded indication for Eylea HD for the treatment of macular edema following retinal vein occlusion (MEfRVO). Also adding an additional, more frequent dosing regimen for the previously approved indications of treatment of neovascular age-related macular degeneration, diabetic macular edema, and diabetic retinopathy. Updating the Dosing Limits section and the dosing table to reflect these changes. • Updating the Length of Authorization section to include the number of days for approval. • Removing Aflibercept-yszy from the policy title, Billing Code/Availability, Max Units, the footnote in the Initial Criteria, and the dosing table.

	• Coding updates made to CMS reference A52451 (jurisdiction 6, K) along with adding Opuviz and Yesafili to the article title. Coding updates made to CMS reference A53387 (jurisdiction J, M). • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Bavencio (medical benefit criteria)	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods and to include number of days allowed. • To Universal Criteria, removing examples of PD-1/PD-L1 inhibitors for conciseness. • To MCC, updating options for use to align with updates in NCCN. • To Urothelial Carcinoma, updating criteria to allow use in the package insert settings only as NCCN no longer recommends anything as level 1 or 2A outside of what is covered within the packet insert. • To Endometrial carcinomas, adding option for use in combination with axitinib as subsequent treatment for recurrent pMMR tumors. Also updating criteria to exclude use in clinical settings categorized as 2B recommendations in NCCN. • To Thymic Carcinomas, removing option for use as preoperative systemic therapy for surgically resectable disease if R0 resection is uncertain per update in NCCN. • Adding Appendix A - Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Gemcitabine (medical benefit criteria)	• Adding other routes of administration listed as 1/2A in NCCN (intrapelvic, intravesical, intraurethral, and subcutaneous) to policy title. • Updating Length of Authorization section to include number of days allowed for authorization durations. • To Pancreatic Adenocarcinoma, adding a footnote indicating squamous and adenosquamous carcinomas can be treated the same way per NCCN. • To Kaposi Sarcoma, adding new indication of Kaposi-sarcoma associated herpesvirus (KSHV)-Associated Inflammatory Cytokine Syndrome (KICS) per NCCN. • Updating heading to just Bladder Cancer and moving urothelial carcinoma to applicable indications under this heading. Additionally, adding the specific non-urothelial subtype of pure adenocarcinoma including urachal per NCCN. • To B-Cell Lymphomas, adding option of indolent transformation to high-grade B-cell lymphoma with MYC and BCL6 rearrangements per NCCN. Removing "Primary" from Cutaneous Lymphomas heading per NCCN Guideline update. • To Vulvar Cancer, removing the 2B exclusion from criteria to align with how other indications are noted in policy. • To Covered Diagnosis (Appendix 1), adding C31.0, C31.1, D37.031, D37.032, D37.039, and Z85.818 (related to Head and Neck Cancers), D89.89, D89.9 (related to Kaposi Sarcoma – KSHV-Associated Inflammatory Cytokine Syndrome), and Z85.12 (related to SCLC).

	• To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Givlaari (medical benefit criteria)	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods and to include number of days allowed for authorization durations. • Adding Appendix A-Non-Quantitative Treatment Limitations (NQTL) Factor Checklist to policy. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Imdelltra (medical benefit criteria)	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods, • Updating Initial and Renewal criteria to update 'coverage' to 'prior authorization validity. • To Universal Criteria, removing the requirement precluding use in patients with CNS metastases as NCCN now allows use in patients with brain metastases from SCLC. • Adding new indication of CNS Cancers with pertinent criteria per NCCN. • To Billing Code/Availability, for J9026, removing "Effective 01/01/2025" and removing discontinued code J9999 and C9170. • Adding Appendix A - Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. Added ICD-10 codes Z85.118 & Z85.12 related to SCLC per NCCN. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Imfinzi (medical benefit criteria)	• Updating Length of Authorization section to include number of days allowed for authorization durations and editorial change to combine Gastric and Esophageal Cancer. • To NSCLC, removing exon 21 mutation from criteria based on NCCN compendia and removing verbiage on mediastinal lymph node recurrence with prior radiation therapy and excluding use in patients with locoregional recurrence or symptomatic local disease without evidence and disseminated disease since NCCN no longer lists as 2B. Updating biomarker footnoted text to align with latest NCCN recommendations/guidelines. • Adding newly approved FDA indication for use with FLOT chemotherapy as neoadjuvant and adjuvant treatment, followed by single agent therapy, for adults with resectable gastric or gastroesophageal junction adenocarcinoma (GC/GEJC). • Updating headings and Dosing Table for both Gastric and Esophageal Cancer and Esophagogastric Junction Cancer to align with package insert for this new indication. • To Endometrial Carcinoma (Uterine Neoplasms), aligning criteria for adjuvant and primary treatment for stage III-IV disease with NCCN recommendations. Also updating to allow for recurrent disease and any line of therapy with exclusions for NCCN 2B recommendations of use for locoregional recurrence in patients with no prior radiation therapy to site of recurrence, or previous vaginal brachytherapy only and after surgical exploration for locoregional

	recurrence in patients with disease confined to the vagina or paravaginal soft tissue. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Imjudo (medical benefit criteria)	• To NSCLC, removing verbiage on mediastinal lymph node recurrence with prior radiation therapy and excluding use in patients with locoregional recurrence or symptomatic local disease without evidence of disseminated disease since NCCN no longer lists as 2B. • Also to NSCLC, updating biomarker footnoted text to align with latest NCCN recommendations/guideline. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Jemperli (medical benefit criteria)	• Updating Length of Authorization section to include number of days allowed for authorization durations. • Adding dMMR/MSI-H Cancer to Max Units Section to account for Gastric, Esophageal and Esophagogastric Junction Cancers neoadjuvant dosing. • To Endometrial Carcinoma (Uterine Neoplasms) and under dMMR/MSI-H Endometrial Carcinoma, updating to allow for recurrent disease and any line of therapy with exclusions for NCCN 2B recommendations of use for locoregional recurrence in patients with no prior radiation therapy to site of recurrence, or previous vaginal brachytherapy only and after surgical exploration for locoregional recurrence in patients with disease confined to the vagina or paravaginal soft tissue. Also updating for use as maintenance therapy in stage III-IV tumors. • To dMMR/MSI-H and POLE/POLD1 Cancers, updating Appendiceal Adenocarcinoma to Appendiceal Neoplasms and Cancers to align with new NCCN nomenclature and updating criteria to align with current NCCN appendiceal recommendations. Also adding Gastric, Esophageal or Esophagogastric Junction Cancer to neoadjuvant therapy based on new NCCN rec and added new regimen to LOA and Dosing Table accordingly. • To Appendix 1 - Covered Diagnosis Codes, adding D37.3 and Z85.038 (related to Appendiceal Neoplasms and Cancers) per NCCN. • Updating ICD 10 crosswalk. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Libtayo (medical benefit criteria)	• Updating Length of Authorization section to include number of days allowed for authorization durations. • To Cutaneous Squamous Cell Carcinoma (cSCC), adding use as a single agent for unresectable or incompletely resected satellitosis/in-transit metastasis per NCCN and added to LOA/dosing table. • To NSCLC, removing verbiage on mediastinal lymph node recurrence with prior radiation therapy and excluding use in patients with locoregional recurrence or symptomatic local disease without evidence and disseminated disease since NCCN no longer lists as 2B. Also to NSCLC, updating biomarker footnoted text to align with latest NCCN recommendations/guidelines. • Updating heading and dosing table for 'Appendiceal Adenocarcinoma' to 'Appendiceal Neoplasms and Cancers' based on new separated NCCN guideline

	from Colon Cancer guideline. To this indication adding use as neoadjuvant therapy or use for recurrent, progressive, metastatic peritoneal-only or extraperitoneal disease. • To Appendix 1 (Covered Diagnosis), adding D37.3, Z85.038 (related to Appendiceal Neoplasms and Cancers). • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Loqtorzi (medical benefit criteria)	• Updating Length of Authorization section to include number of days allowed for authorization durations. • Updating Appendiceal Adenocarcinoma to Appendiceal Neoplasms and Cancers to align with new NCCN nomenclature and updating clinical settings within the criteria to align with NCCN updates. • To Appendix 1 - Covered Diagnosis Codes, adding D37.3 and Z85.038 (related to Appendiceal Neoplasms and Cancers), and C31.0, C31.1, and Z85.818 (related to Head and Neck Cancers) per NCCN. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Lunsumio (medical benefit criteria)	• Updating the indication heading from Follicular Lymphoma to B-Cell Lymphomas and adding use in DLBCL, HGBCL, HIV-Related B-Cell Lymphomas, and PTLD per NCCN 2A recommendations along with corresponding criteria and ICD-10 codes. • To the Renewal Criteria, updating the examples of unacceptable toxicity to more closely align with the Warnings and Precautions section of the package insert. • 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' and to the Length of Authorization to delineate between authorization durations for initial and renewal periods and to include the number of days for approval. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Penpulimab-kcqx (medical benefit criteria)	• Updating Length of Authorization section to include number of days allowed for authorization durations. • Adding indication of Appendiceal Neoplasms and Cancers per 2A recommendation in NCCN. Corresponding update was made to Dosage/Administration table. • To Appendix 1 – Covered Diagnosis Codes, adding C18.1, D37.3, and Z85.038 (related to Appendiceal Neoplasms and Cancers). • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Polivy (medical benefit criteria)	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods. • To B-cell lymphomas, adding option for use as first-line therapy in combination with R-CHP for stage I-II disease and IPI >1 per NCCN. Also adding option for

	use as subsequent therapy in combination with mosunetuzumab for treatment of DLBCL, HGBL, HIV-related DLBCL, and PTLD. • To PTLD, adding option for use in combination with R-CHP for 1L or 2L for partial response, persistent or progressive disease. • Adding Appendix A - Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • To ICD-10 table removing C83.39 as this code is no longer supported by NCCN. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Rituximab IV (medical benefit criteria)	• Updating policy heading to add Intrathecal/Intraventricular routes of administration as the policy supports these compendia recognized routes of administration. • Updating Length of Authorization section to include number of days allowed. • To Oncology Indications heading, adding TA-TMA to be excluded from the requirement of CD20 antigen expression positive. • To CLL/SLL, for use as FLT for disease without del(17p)/TP53 mutation, clarifying use with bendamustine is only when BTK-I and BCL2-I are not available. • To CNS Cancers for treatment of primary CNS lymphoma, simplifying regimens for use as consolidation treatment. • For CLL/SLL with del(17p)/TP53 mutation, adding option for use in combination with venetoclax as subsequent therapy. • To B-Cell Lymphomas, for low-grade/follicular, removing requirement for grade 1-2 disease to align with NCCN. • To Castleman Disease, for treatment of unicentric disease, adding option for use in disease that has been incompletely resected. • To Pediatric Aggressive Mature B-Cell Lymphomas, for setting of PTLD, removing requirement of B-Cell type disease. • To Hairy Cell Leukemia, simplifying options for use in combination with vemurafenib. • Adding new indication for use in KSHV-associated inflammatory cytokine syndrome. • Updating dosing table, Length of Authorization, and max units sections accordingly. • Updating heading of Management of Immunotherapy Related toxicities to Management of Immune Checkpoint Inhibitor-Related toxicities to align with new verbiage in NCCN. • To MS, revising table for definitive diagnosis of RRMS to align with updated 2024 McDonald Criteria. • To renewal criteria for MS, updating MRI requirements. • To SLE renewal criteria, adding requirement for continued use in combination with standard SLE therapies. • To IgG4-Related Disease, adding sinonasal tract as a potential affected organ per literature support. • Adding new indication for use in Wiskott-Aldrich syndrome as pretreatment prior to etuvetidigene autotemcel infusion with corresponding dosing, max units and ICD-10 code.

	• To Appendix 1, adding ICD-10 codes C46.0-C46.4, C46.50-C46.52, C46.7, C46.9, D89.89, & D89.9 relating to KSHV-associated inflammatory cytokine syndrome. Removing ICD-10 code G35 for MS and replacing with G35.A, G35.B0, G35.B1, G35.B2, G35.C0. G35.C1, G35.C2 & G35.D. Added ICD-10 code D82.0 for Wiskott-Aldrich syndrome. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Rituxan Hycela SC (medical benefit criteria)	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods and to include number of days allowed. • To Universal Criteria, updating vaccine requirement. Also to Universal Criteria, to the bullet precluding use with IV chemotherapy, clarifying that restriction applies to all IV administered agents. • To CLL/SLL, adding note allowing use for histologic transformation (Richter) per NCCN. • Adding new indication for use in KSHV-associated inflammatory cytokine syndrome. Dosing table, Length of Authorization and max units sections updated accordingly. • Adding Appendix A - Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • To Appendix 1, adding ICD-10 codes C46.0-C46.4, C46.50-C46.52, C46.7, C46.9, D89.89, & D89.9 related to KSHV-associated inflammatory cytokine syndrome. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Spinraza (medical benefit criteria)	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods and to include number of days allowed for authorization durations. • Under Initial criteria, updating verbiage in the HCT/MRR box. • From Universal Criteria, removing requirement on not having received prior treatment with SMA gene therapy. • Adding Appendix A-Non-Quantitative Treatment Limitations (NQTL) Factor Checklist to policy. • To Appendix 2, removing LCD A58579 as it was retired on 10/02/2025 and combining Jurisdiction E and F as per active LCD. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Tecentriq IV (medical benefit criteria)	• Updating Length of Authorization section to include number of days allowed for authorization durations. • To NSCLC, updating criteria to align with NCCN updates. • Adding indications of Thymic Carcinoma and Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma per NCCN 2A recommendations with corresponding updates made to Length of Authorization, Max Units, and Dosage/Administration sections. • To Appendix 1 - Covered Diagnosis Codes, added C37, D15.0, D38.4, and Z85.238 (related to Thymic Carcinoma) and C83.00-C83.09, C83.30-C83.39, C91.10, and C91.12 (related to CLL/SLL). • Updating ICD-10 crosswalk (for PCM) list.

	• To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Tecentriq Hybreza (medical benefit criteria)	• Updating Length of Authorization section to include number of days allowed for authorization durations. • To NSCLC, updating criteria to align with NCCN updates. • To HCC, removing adjuvant therapy criteria and replacing with subsequent therapy per NCCN updates. • To Cutaneous Melanoma, updating subsequent therapy criteria to align with NCCN updates. • To Alveolar Soft Part Sarcoma (ASPS), updating criteria to include expanded indication for use in pediatric patients 12 years of age and older who weigh at least 40 kg. Also updating Universal Criteria to include a note indicating the requirement for patient to be at least 62 kg does not apply to ASPS. • Adding indications of Colon Cancer, Thymic Carcinoma, and Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma per NCCN 2A recommendations with corresponding updates made to Length of Authorization and Dosage/Administration sections. • To Appendix 1 - Covered Diagnosis Codes, adding C18.0, C18.2-C18.9, and Z85.038 (related to Colon Cancer), C37, D15.0, D38.4, and Z85.238 (related to Thymic Carcinoma) and C83.00-C83.09, C83.30-C83.39, C91.10, and C91.12 (related to CLL/SLL). • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Tevimbra (medical benefit criteria)	• Updating Length of Authorization section to include number of days allowed for authorization durations. • To CLL/SLL, updating criteria to align with NCCN updates and adding a footnote indicating prior treatment could have included PD-1/PD-L1-directed therapy when used as additional therapy. • Updating Appendiceal Adenocarcinoma to Appendiceal Neoplasms and Cancers to align with new NCCN nomenclature and updating clinical settings within the criteria to align with NCCN updates. • Adding indications of Adult Classic Hodgkin Lymphoma (CHL) and Endometrial Carcinoma per NCCN 2A recommendations. Updating dosing table, length of authorization, and max units sections to accommodate new indication of CHL. • To Dosage/Administration table, adding additional option of 400 mg every 6 weeks to the All Other Indications row. • To Appendix 1 - Covered Diagnosis Codes, adding C54.0-C54.3, C54.8, C54.9, C55, and Z85.42 (related to Endometrial Carcinoma), C81.10-C81.19, C81.20-C81.29, C81.30-C81.39, C81.40-C81.49, C81.70-C81.79, C81.90-C81.99, and Z85.71 (related to Adult Classic Hodgkin Lymphoma), and D37.3 and Z85.038 (related to Appendiceal Neoplasms and Cancers), and Z85.818 (related to Head and Neck Cancers) per NCCN. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Tzield (medical benefit criteria)	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods. • To Initial criteria, updating hard vaccine requirement.

	• To Diabetes Mellitus (Type 1), updating criteria for dysglycemia to change fasting glucose value from 110mg/dL to 100mg/dL and to adding A1C criteria as an option to align with the 2026 ADA guidelines. • Adding Appendix A-Non-Quantitative Treatment Limitations (NQTL) Factor Checklist to policy. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Unloxcyt (medical benefit criteria)	• To cSCC, adding use in patients with satellitosis/in-transit metastasis per NCCN. • Updating Length of Authorization section to include the number of days for approval. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Zynyz (medical benefit criteria)	• Updating Length of Authorization section to include number of days allowed for authorization durations. • To Merkel Cell Carcinoma, clarifying that in-transit regional disease is required to be N+ per NCCN. • Updating Appendiceal Adenocarcinoma to Appendiceal Neoplasms and Cancers to align with new NCCN nomenclature and updated criteria to align with NCCN updates. • To Appendix 1 ICD-10 codes, adding D37.3 and Z85.038 (related to Appendiceal Neoplasms and Cancers). • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates

Updates for MassHealth Members

Effective 4/1/2026

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

Generic Medication	Brand Name Alternative
Cladribine tablet pack	Mavenclad tablet pack
Mesalamine enema kit	Rowasa enema kit
Ciprofloxacin / hydrocortisone suspension	Cipro HC Otic Suspension

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

Brand Name	Generic Medication
Daytrana transdermal patch	Methylphenidate transdermal patch
Cardura tablet	Doxazosin tablet
Entresto tablet	Sacubitril/valsartan tablet
Sancuso 3.1 MG/24 HR Patch	Granisetron TD Patch 3.1 MG/24HR
Inspra tablet	Eplerenone tablet

Effective 1/1/2026

Antiretroviral Agents	Yeztugo vial will no longer require a prior authorization on the medical benefit.

Effective 4/1/2026

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, **Leqembi iQlick**, will be **added** to both the pharmacy benefit **and** medical benefit **with** a prior authorization requirement. Criteria will require that the member has been treated with Leqembi IV for at least 18 months along with other requirements.
Anti-acne and rosacea products	• Criteria for generic isotretinoin agents, Absorica, and Absorica LD was updated to include a contraindication component to alternatives. • The class policy was updated to remove the medical record requirement of previous trials. • Criteria for **Azelex** and **Finacea** in acne was updated to allow trial of benzoyl peroxide with a concurrent topical or oral antibiotic agent. • **Benzoyl peroxide 2.5% wash** will remain covered under the pharmacy benefit and will now require prior authorization.

Antibiotics, Oral	The following new drugs will be **added** to the pharmacy benefit **with** a prior authorization requirement **and** quantity limits:
	• Blujepa 750mg tablet – **PA, QL** 20 tablets per 5 days
	  ○ Blujepa will require a step-through trial with all alternatives: beta-lactam, fluoroquinolone, nitrofurantoin, sulfamethoxazole-trimethoprim
	• Orlynvah 500-500mg tablet – **PA, QL** 10 tablets per 5 days
	  ○ Orlynvah will require a step-through trial with all alternatives: beta-lactam, Blujepa, fluoroquinolone, nitrofurantoin, sulfamethoxazole-trimethoprim

Antimyasthenic/Cholinergic Agents	**Pyridostigmine solution** will remain covered under the pharmacy benefit and will have a prior authorization requirement **added**. Criteria will require medical necessity for the solution formulation instead of solid oral formulation.
Antipsychotics	• **Fanapt** criteria was updated to remove different criteria for age < 18 and age ≥ 18 and clarified that two required trials would need to be from the included list* and that one additional second-generation antipsychotic trial is required as well. Trial with a first generation antipsychotic was removed. • **Fanapt titration pack C & B** will both be **added** to the pharmacy benefit **with** a prior authorization requirement. • Perseris was removed as a step-through trial for **Rykindo**.

	• **Cobenfy** criteria was clarified that age ≥ 55 alone is sufficient to assume TD/EPS risk. • **Lybalvi** criteria was updated to require step-through trial with two agents (aripiprazole, lurasidone, ziprasidone, Vraylar, Caplyta, Rexulti) and one atypical or typical antipsychotic unless there is documentation of a positive clinical response to olanzapine with ≥10% gain in body weight. Also, there is confirmation that member is not being treated with an opioid or undergoing opioid withdrawal. **Included list: aripiprazole, clozapine, lurasidone, olanzapine, paliperidone, quetiapine, risperidone, ziprasidone; TD/EPS: tardive dyskinesia/extrapyramidal symptoms*
Antiretroviral Agents	• **Yeztugo tablet** will remain covered under the pharmacy benefit and will no longer require prior authorization. • **Stribild** criteria was updated to also require quantity being requested to be less than or equal to 1 unit per day.
Antiviral agents	• **Xerese 5%-1% cream** will remain covered under the pharmacy benefit and will now require prior authorization **and** quantity limit of 5 grams per 30 days. • New formulation, **Prevymis Pak 20mg & Prevymis Pak 120mg**, will both be **added** to the pharmacy benefit **with** a prior authorization requirement **and** a quantity limit of 4 units per day. Criteria was updated to include documentation of one of the following: utilization of tube feeds, have a swallowing disorder, or be less than 13 years of age. Stem cell transplant recipients who weigh 15 kg to less than 30 kg and are taking cyclosporine would also qualify for the pellets. • **Prevymis** criteria was updated to reflect expanded age range and weight requirements: CMV prophylaxis in pediatric patients 6 months of age and older, weighing at least 6 kg who are CMV-seropositive recipients of an allogeneic hematopoietic stem cell transplant, as well as CMV prophylaxis in pediatric patients 12 years of age and older, weighing at least 40 kg who are kidney transplant recipients at high risk.
Modeyso (dordavipron)	This new drug will be **added** to the pharmacy benefit **with** a prior authorization requirement.
Doxepin Cream	The trial criteria was clarified to accept topical anesthetics and systemic therapies in addition to other alternatives.
Epinephrine products	New drug strength of **Neffy nasal spray (1mg/0.1ml)** will be **added** to the pharmacy benefit **with** a prior authorization requirement. Criteria was updated to allow use in weight ≥ 15 kg.
Gamifant (emapalumab)	• The expanded indication for the treatment of patients with HLH/MAS in Still's disease was added.

	• The requirement of not having active infections caused by specific pathogens favored by IFNγ neutralization was removed. *HLH: hemophagocytic lymphohistiocytosis; MAS: macrophage activation syndrome*

GnRH Analogues	• The following clinical updates were made:
	  ◦ For advance prostate cancer:
	  ▪ Prior to Lupron Depot, a step-through trial with Firmagon, Lutrate, Trelstar, and a clinical rationale for its use instead of Eligard will be required.
	  ▪ There will be an additional step-through trial with Trelstar for Orgovyx requests.
	  ◦ For endometriosis, a step-through trial with Lupron 3.75 mg monthly will be required for Lupron 11.25 mg every 3 month requests.
	  ◦ For idiopathic or neurogenic central precocious puberty (CPP):
	  ▪ A step-through trial with Lupron Ped 7.5 mg monthly will be required for the following requests: Lupron Ped 11.25 mg, 15mg, 30 mg.
	  ▪ A step-through trial with Fensolvi and Lupron Ped 7.5 mg will be required for Lupron Ped 45 mg requests.
	  ◦ For uterine leiomyomata (fibroids), a step-through trial with Lupron 3.75 mg monthly will be required for Lupron 11.25 mg every 3 month requests.
	• Reauthorization criteria for Lupron and Zoladex for Uterine leiomyomata (fibroids)/Endometrial thinning prior to endometrial ablation was updated to include members who are not a candidate for surgery to allow 1 year of approval.
	• Additional indications were added to Lutrate such as gender dysphoria and abnormal uterine bleeding.

Hereditary Angioedema Agents	• New drugs, **Andembry auto injector** & **Dawnzera pen**, will both be **added** to the pharmacy benefit **with** a prior authorization requirement.
	• New drug, **Ekterly 300mg tablet**, will be **added** to the pharmacy benefit **with** a prior authorization requirement **and** quantity limit of 8 tablets per 30 days. Medical necessity for use of Ekterly instead of alternative agents available without prior authorization or required step-through trial to two agents (Berinert, icatibant, Kalbitor, Ruconest) will be included in the criteria.
	• The following drugs <u>will remain</u> covered under the pharmacy benefit. The prior authorization requirement will be **removed**; however, new quantity limits will apply:
	  ◦ Berinert 500 unit kit – **QL:** 14 injections per 30 days
	  ◦ Firazir (icatibant) injection – **QL:** 6 injections per 30 days

	• Ruconest vial – **QL:** 8 injections per 30 days
Immunological Agents-Topical	The **Arazlo** and **Tazorac** criteria for acne were updated to remove the necessity for medical records documenting an inadequate response or adverse reaction to another alternative.
Lung Cancer Agents	New drug, **Ensacove capsule**, will be **added** to the pharmacy benefit **with** a prior authorization requirement **and** quantity limit of 90 capsules per 30 days. A step-through trial with Alecensa, Alunbrig, or Lorbrena will be required along with diagnosis, prescriber specialty, cancer type, and appropriate quantity being requested.
Melanoma Agents	• **Braftovi** criteria was updated to include the expanded indication for mCRC (initial therapy) and trials with Erbitux or Vectibix was added. • Criteria was updated for metastatic CRC (subsequent therapy) to align with initial mCRC approvals. • Criteria for the combination of **Mekinist** and Tafinlar in unresectable or metastatic solid tumors was updated by adding disease progression following prior treatment and that member has no satisfactory alternative treatment options. *mCRC: metastatic colorectal cancer*
Nonhormonal Agents for Menopausal Symptoms	• New drug, **Lynkuet capsule**, will be **added** to the pharmacy benefit **with** a prior authorization requirement **and** quantity limit of 60 capsules per 30 days. • **Veozah** and **paroxetine mesylate** criteria were updated to align with clinical guidelines. Clonidine was removed as one of the step-through trials. There will be a requirement of two step-through trials of the following: citalopram, escitalopram, desvenlafaxine, duloxetine, venlafaxine, gabapentin, or oxybutynin.
Non-rebated Oncology Medications	The following criteria changes were made to the **Proleukin** criteria: ○ Opdualag has been added as one of the trial options for diagnosis of metastatic melanoma ○ A step-through trial with systemic glucocorticoids will be required for diagnosis of chronic graft versus host disease (cGVHD). A clinical rationale of why other treatments cannot be used will also be required.
Oncology Immunotherapies	Criteria was updated to include the expanded indication, Zepzelca in combination with Tecentriq or Tecentriq Hybreza for ES-SCLC as maintenance therapy following induction chemoimmunotherapy. *ES-SCLC: Extensive-stage small cell lung cancer*
Opioid Dependence Agents	Buprenorphine sublingual tablets will remain covered under the pharmacy benefit. The prior authorization requirement will be **removed**; however, requests for more than 5 days of treatment over every 180 days (within the dose threshold) will require a prior authorization.

Opioids and Analgesics	• New drug strength, **Tramadol HCL 75mg tablet**, will be **added** to the pharmacy benefit **with** a prior authorization requirement. • **Combogesic 325-97.5mg tablet** will be **added** to the pharmacy benefit **with** a prior authorization requirement. Clinical rationale to support the use of the combination product instead of the individual agents will be required. Other step-through preferred trials will apply.
Presbyopia, Myopia, and Mydriasis Agents	**Vizz 1.44% eye drop** will be **added** to the pharmacy benefit **with** a prior authorization **and** quantity limit of 25 single dose vials per 25 days. A step-through trial with Vuity and additional preferred trials will be required.
Pulmonary Hypertension Agents	• **Uptravi 200-800 mcg titration pack** will remain covered under the pharmacy benefit with a prior authorization and will have the quantity limit updated to 200 tablets per 28 days. • **Uptravi 200mcg tablet** will remain covered under the pharmacy benefit with a prior authorization requirement. The quantity requirement was updated to include new starts who completed less than 56 days of therapy (≤140 tablets per 28 days). The quantity for maintenance therapy will remain as ≤ 56 tablets per 28 days.
Respiratory Agents- Oral	New drug, **Brinsupri tablet**, will be **added** to the pharmacy benefit **with** a prior authorization requirement **and** quantity limit of 30 tablets per 30 days.
Targeted Immunomodulators	• New drug, **Rhapsido tablet**, will be **added** to the pharmacy benefit **with** a prior authorization requirement. • Criteria was updated to remove Humira and Stelara as preferred agents. Requests for Humira will now require a step-through with Hadlima and adalimumab-adaz. Requests for Stelara will now require a step-through with Imuldosa, Pyzchiva, and Steqeyma.
Thyroid Preparations	Criteria for **Tirosint solution** was updated to include malabsorption as one of the medical necessity requirements for requests that require a more precise thyroxine dosing.
VMAT2 Inhbitors	• For diagnosis of tardive dyskinesia, baseline and current AIMS score requirement was added to the initial and reauthorization criteria. • For **Austedo** and **Austedo XR**, a dose consolidation requirement was added to the criteria.