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 03/01/2025

The following changes are being made to the listed medications:

Adasuve (loxapine)	Adasuve will be restricted to the medical benefit. Adasuve will not require prior authorization on the medical benefit.
Enbrel, Humira	The diagnosis of non-radiographic axial spondyloarthritis (nr-axSpA) will be removed from the Enbrel and Humira policies.
Tyenne, Tofidence	Tyenne and Tofidence will be added to the formulary at the nonpreferred specialty tier with prior authorization and quantity limit restrictions. Criteria for Tyenne and Tofidence will require trial and failure with Actemra.
Bylvay Livmarli	Approval criteria for progressive familial intrahepatic cholestasis (PFIC) will be added to the Livmarli policy and approval criteria for Alagille syndrome (ALGS) will be added to the Bylvay policy. Disease state criteria for Bylvay and Livmarli will be aligned. Criteria for the diagnoses of ALGS and PFIC will be updated to require trial and failure with at least one of the following agents: ursodiol, antihistamine, rifampin, cholestyramine, sertraline, or naltrexone.

	Criteria for both indications are also being updated to require that the requested agent is prescribed by or in consultation with a specialist and that the member has pruritus.
Elfabrio	Initial criteria will be updated to require a specialist prescriber.
Fabrazyme	Initial criteria will be updated to require that the member will not use Fabrazyme in combination with Elfabrio or Galafold. Reauthorization criteria will require submission of documentation (e.g., medical charts, lab results) demonstrating a response to therapy.
Febuxostat	Criteria will be updated to allow for approval if the member has tried and failed a first-line medication or is currently administering the requested agent.
Filspari	Reauthorization criteria will be updated to require documentation of positive clinical response to therapy.
Ocrevus, Ocrevus Zunovo	Ocrevus Zunovo will be added to the existing Ocrevus policy. The diagnosis criteria for both agents will be aligned with FDA-approved package labeling, requiring the member either has relapsing forms of multiple sclerosis (including clinically isolate syndrome, relapsing-remitting and secondary progressive disease) or primary progressive multiple sclerosis.
Tarpeyo	Criteria will be updated to require at least a three-month trial with a renin-angiotensin (RAS) inhibitor (e.g., ACE inhibitor or angiotensin II receptor blocker [ARB]) prior to approval. Additionally, parameters for urine protein to creatinine ratio (UPCR) will be updated. Approval length will be updated to 9 months and requests for reauthorization will require provider attestation that treatment beyond nine month is clinically necessary for the member.
Growth Hormone: Genotropin, Humatrope, Norditropin, Nutropin AQ, Omnitrope, Saizen, Zomacton, Skytrofa, Sogroya, Ngenla	Ngenla, Skytrofa and Sogroya will be specified as nonpreferred growth hormone products, requiring step through with the two preferred agents; this applies to initial and reauthorization requests. Ngenla, Skytrofa, and Sogroya will only be approved for their FDA-approved indications. Genotropin and Norditropin remain the preferred growth hormone products. Diagnoses of chronic kidney disease, Noonan Syndrome, Prader-Willi Syndrome, Turner Syndrome, SHOX deficiency, Russell-Silver Syndrome, cystic fibrosis, cerebral palsy, and congenital adrenal hyperplasia will require documentation of growth failure or short stature associated with the diagnosis. Criteria for all other diagnoses will be updated to clarify underlying diagnoses and test results, as warranted. Reauthorization criteria for adult growth hormone deficiency will be updated to require documentation of ongoing monitoring within the past 12 months.
Krystexxa	Initial criteria will be updated to require that the member has one of the following: at least two gout flares in the past 12 months, presence of at least one tophus, or gouty arthritis.
Prevymis	Criteria for prophylaxis of CMV in kidney transplant recipients at high risk (donor CMV seropositive/recipient CMV seronegative) will be added to the policy. Criteria will require documentation of previous or upcoming kidney transplant and that member is at high risk of CMV infection (donor CMV

	seropositive/recipient CMV seronegative). Requests for the IV formulation will require documentation with clinical rationale why the member cannot take oral tablets.
Reblozyl	Criteria for the treatment of beta thalassemia will be updated to include baseline transfusion requirements. Additionally, criteria for supplemental indication of myelodysplastic syndrome (MDS) will be added to the policy.
Tepezza	Criteria will be updated to define mild hypo- or hyperthyroidism. Additionally, Clinical Activity Score requirement will be removed from criteria, as will attestation that Tepezza will not be used in combination with another biologic immunomodulator.
Symlin, Intrarosa, Oxervate	Language for members who are new to the Plan will be updated.
Carbaglu	Language for members who are new to the Plan will be updated and the supplemental indications of propionic acidemia and methylmalonic acidemia (MMA) will be added to the policy.