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, Medicaid, and Medicare Members

Starting January 1, 2026, Mass General Brigham Health Plan will partner with Prime Therapeutics for the management of certain specialty medications that may be covered under the medical benefit. As part of this transition, the following utilization management programs will be implemented:

Program Name	Line of Business	Description
Enhanced Drug Wastage Program	· Commercial · Exchange	Policy driven program that identifies instances in which rounding down the prescribed dose by no more than ten percent (10%) for certain drugs will allow for fewer vials to be used. Administration of the lower dosage will be required for prior authorization approval when clinically appropriate and consistent with the Plan's applicable policies.
Drug Wastage Program*	· Medicare · Medicaid	Program that identifies instances in which rounding down the prescribed dose by no more than ten percent (10%) will allow for fewer vials to be used. A recommendation is made to the prescriber. If the prescriber accepts the recommendation, the prior authorization will be

		updated to reflect the newly approved lower dosage, unless applicable policies require otherwise.
Weight-Based Dose Optimization Program for PD-1 Drugs*	· Commercial · Exchange · Medicaid · Medicare	Program that is part of the standard prior authorization procedure for PD-1 products. This program identifies instances in which using weight-based dosing for members with low body weight is clinically appropriate. If the prescriber accepts the recommendation, the prior authorization will be updated to reflect the newly approved lower dosage based on the member's body weight.
IVIG Dosage Optimization Program*	· Commercial · Exchange · Medicaid · Medicare	Program that is part of the standard prior authorization procedure around dosing for IVIG products. The program identifies instances in which using adjusted body weight (AjBW) will be recommended instead of actual body weight for members who are overweight or obese. A recommendation is made to the prescriber to change the dose based on the member's AjBW. If the prescriber accepts the recommendation, then the prior authorization will be updated to reflect the new dose and number of units.
High-Cost Therapy Program	· Commercial · Exchange	Policy-driven program that combines enhanced utilization management with access to supportive case management services to drive optimal outcomes for members who have been prescribed a high-cost medication. As part of the prior authorization process, submission of medical records is required and manual chart review is conducted. Recommendations are made based on clinical evidence and health plan policy with support from specialty-matched physicians. Once a coverage determination is made, members who may benefit from case management are referred to an internal health plan case management program.

*Program is voluntary

Updates for Commercial Members

Effective January 1, 2026

The following changes are being made to the listed medications:

Medical Benefit Criteria	Effective January 1, 2026, Mass General Brigham Health Plan will partner with Prime Therapeutics for the management of certain specialty medications that may be covered under the medical benefit. Effective January 1, 2026, with some exceptions

	(e.g., Azmiro, New to Market, Preyvmis, Sunlenca), new medical benefit drug criteria will be adopted. Please refer to the following link for the new medical benefit policies going into effect on January 1, 2026: https://gatewaypa.com/policydisplay/57. Some preferred product updates impacting the medical benefit criteria are noted throughout this newsletter. However, please refer to the previous link for a comprehensive review of the medical benefit criteria going into effect on January 1, 2026. Please note that starting January 1, 2026, drugs with both medical and pharmacy coverage (dual benefit) may have different criteria. The pharmacy benefit criteria will continue to be available on our website, while the medical benefit criteria can be found at www.gatewaypa.com as previously mentioned.
PCSK9 Inhibitors	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. 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.
Humira and Biosimilars	Humira (Abbvie), Hadlima, Simlandi and Yuflyma will be the preferred adalimumab products. Adalimumab-adaz, Adalimumab-fkjp and Amjevita (Nuvaila) will be moved to the nonpreferred specialty tier. All other adalimumab products will remain on the nonpreferred specialty tier. All adalimumab products will continue to require prior authorization. Members currently filling nonpreferred adalimumab products will require a new authorization to continue coverage for their current agent on or after January 1, 2026. They will not require a new prior authorization for the preferred products. To ensure continuity of care, it is recommended that providers write new prescriptions for one of the preferred products (Humira [Abbvie], Hadlima, Simlandi, Yuflyma). For nonpreferred adalimumab products, the trial and failure language in the approval criteria will be updated to require that the member has had a trial and failure, intolerance or contraindication with the preferred adalimumab agents.
Stelara and Biosimilars	The following biosimilars will be preferred on the pharmacy and medical benefits and will be placed on the preferred specialty tier on the pharmacy benefit (prior authorization will continue to be required): • Selarsdi • Steqeyma • Yesintek

	All other Stelara biosimilars (including Wezlana) as well as Stelara itself will be on the nonpreferred specialty tier on the pharmacy benefit and will continue to require prior authorization on both the pharmacy and medical benefits. Initial and reauthorization criteria for Stelara and nonpreferred biosimilars will require trial and failure with ALL of the following: Selarsdi, Steqeyma, and Yesintek. This update will apply to the medical and the pharmacy benefits. Members currently utilizing Stelara or a nonpreferred biosimilar will require a new authorization in order to stay on their current agent on or after January 1, 2026. They will not require a new prior authorization for the preferred biosimilars. To ensure continuity of care, it is recommended that providers write a new prescription for Yesintek, Selarsdi or Steqeyma. Pharmacy criteria for ulcerative colitis and Crohn's disease will be updated to require that the subcutaneous formulation of the requested Ustekinumab product will be used as maintenance following the IV induction doses. To review the medical benefit criteria in full, please refer to the Prime Therapeutics policy.
Bimzelx Cosentyx Entyvio SC Ilumya Kevzara Kineret Olumiant Orencia Siliq Tocilizumab products Zeposia	Pharmacy benefit criteria for Bimzelx, Cosentyx, Ilumya, Entyvio SC, Orencia, Siliq, and Zeposia are being updated to indicate that Selarsdi, Steqeyma and Yesintek will be the preferred Ustekinumab trial options. Pharmacy benefit criteria for Bimzelx, Cosentyx, Entyvio SC, Siliq, Ilumya, tocilizumab products, Orencia, Kevzara, Kineret Olumiant, and Zeposia are being updated to indicate that Humira (Abbvie), Hadlima, Yuflyma and Simlandi will be the preferred adalimumab trial options. Pharmacy criteria for Kevazara, Kineret and Olumiant are being updated to reflect that Tyenne will be the preferred tocilizumab trial option.
Tocilizumab Products: Actemra and Biosimilars	On both the pharmacy and medical benefits, Tyenne—an Actemra biosimilar—will be preferred over Actemra and all other biosimilars. Prior authorization will continue to be required on the pharmacy and medical benefits for all tocilizumab products. All tocilizumab products will remain on the nonpreferred specialty tier on the pharmacy benefit. Initial and reauthorization criteria for Actemra and all nonpreferred tocilizumab biosimilars (e.g., Tofidence) will be updated to require trial and failure with Tyenne. This update will apply to the medical and the pharmacy benefits. Members currently utilizing Actemra or another biosimilar besides Tyenne (e.g., Tofidence) will require a new authorization in order to stay on their current agent on or after January 1, 2026. They will not require a new prior authorization for Tyenne. To ensure continuity of care, it is recommended that providers write a new prescription for Tyenne.

	To review the medical benefit criteria for tocilizumab products, please refer to the Prime Therapeutics policy.
Tremfya	Pharmacy criteria for ulcerative colitis and Crohn's disease will be updated to require that the subcutaneous formulation of Tremfya will either be used as a loading dose or be used as maintenance following the IV induction doses.
Omvoh	Pharmacy criteria for ulcerative colitis and Crohn's disease will be updated to require that the subcutaneous formulation of Omvoh will be used as maintenance following the IV induction doses.
Skyrizi	Pharmacy criteria for ulcerative colitis and Crohn's disease will be updated to require that the subcutaneous formulation of Skyrizi will be used as maintenance following the IV induction doses.
VEGF Inhibitors	Bevacizumab for ocular disorders will be covered without PA on the medical benefit Byooviz will continue to be restricted to the medical benefit with PA. Beovu, Cimerli, Eylea and its biosimilars, Eylea HD, Lucentis, Susvimo, and Vabysmo will continue to be restricted to the medical benefit with PA. These agents will be considered nonpreferred and will require trial and failure with bevacizumab, as well as Byooviz for shared indications. To review the medical benefit criteria in full, please refer to the Prime Therapeutics policies.
Denosumab: Prolia, Xgeva and Biosimilars	Jubbonti and Stoboclo will be the preferred Prolia biosimilars, while Osenvelt and Wyost will be the preferred Xgeva biosimilars. This applies to the medical and pharmacy benefits. All denosumab products will continue to require prior authorization. Initial and reauthorization criteria for Prolia, Xgeva, and all other nonpreferred biosimilars will be updated to require a trial and failure with both preferred biosimilars for the agent being requested. This update applies to the medical and pharmacy benefits. Prolia, Xgeva and the nonpreferred biosimilars will be on the nonpreferred specialty tier on the pharmacy benefit. Members currently utilizing Prolia, Xgeva, or any nonpreferred denosumab biosimilar will require a new authorization in order to stay on their current agent on or after January 1, 2026. Members on Prolia will not require a new prior authorization for Jubbonti or Stoboclo and members on Xgeva will not require a prior authorization for Osenvelt or Wyost. To ensure continuity of care, it is recommended that providers write a new prescription for one of the preferred denosumab biosimilars. Pharmacy criteria will be updated to require diagnosis, diagnosis-specific risk factors, concomitant treatment with adjuvant therapies as indicated, as well as trial and failure with bisphosphonates for select diagnoses.

	To review the medical benefit criteria in full, please refer to the Prime Therapeutics policy.
Short-Acting Granulocyte Colony Stimulating Factors (GCSFs)	Reauthorization criteria for Granix, Leukine, Neupogen, Nivestym, Nypozi, and Releuko will be updated to require trial and failure with Zarxio. These updates apply to the pharmacy and medical benefit criteria. To review the medical benefit criteria in full, please refer to the Prime Therapeutics policy.
Long-Acting Granulocyte Colony Stimulating Factors (GCSFs)	Reauthorization criteria for Udenyca, Udenyca Onbody, Ziextenzo, Nyvepria, Rolvedon, Fylnetra, Ryzneuta, and Stimufend will be updated to require trial and failure with both Fulphila AND Neulasta/Neulasta Onpro. These updates apply to the pharmacy and medical benefit criteria. To review the medical benefit criteria in full, please refer to the Prime Therapeutics policy.
Injectable CGRP Inhibitors	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.
Copaxone	Brand Copaxone will be moved to nonformulary status. Generic glatiramer acetate will be added to the formulary on the preferred specialty tier and will be covered without prior authorization. Quantity limits will apply.
GLP-1 Agonists Approved for Type 2 Diabetes	Initial criteria for formulary GLP-1 agonists indicated for type 2 diabetes are being updated to require documentation confirming the member's diagnosis of type 2 diabetes, either through medical records in members requiring ongoing drug treatment for type 2 diabetes or via lab values. Additionally, the automated lookback on diabetes medications in the member's claims history is being removed and replaced with automated lookback for a medical claim for the diagnosis type 2 diabetes included in the member's claim history. Reauthorization criteria are being updated to require documentation of diagnosis of type 2 diabetes, as well as documentation that the member has had a positive response to therapy. In both initial and reauthorization criteria members continue to be restricted from using the requested GLP-1 agonist indicated for type 2 diabetes in combination with a GLP-1 agonist indicated for the treatment of weight loss.

<table>
<tr><td>Hypnotics</td><td>DayVigo, Quviviq and quazepam will be moved to nonformulary status. Prior authorization will be required to continue treatment.

Belsomra will be moved to the hypnotics step therapy program, requiring trial and failure with two generic hypnotics.

Step therapy restrictions will be removed from zolpidem ER tablet and eszopiclone. The following agents are being removed from the automated step therapy lookback for the hypnotics: trazodone, tricyclic antidepressants, and all benzodiazepines except estazolam, temazepam, and triazolam.

The hypnotics step therapy program will be configured as shown below. Members who do not meet the automated step therapy requirements can have a prior authorization request submitted, which will be reviewed against criteria that mirror the step therapy requirements.

First-Line: Medications listed as first-line are covered without prior-authorization.
Second-Line: Second-line medications will pay if the member has filled at least two first-line medications or a second-line medication within the past 180 days.

<table>
<tr><th>First-Line</th><th>Second-Line</th></tr>
<tr><td>Estazolam
Eszopiclone
Temazepam
Triazolam
Zaleplon
Zolpidem IR/ER</td><td>Belsomra
Ramelteon</td></tr>
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</td></tr>
<tr><td>Brilinta</td><td>Brand Brilinta will be moved to nonformulary status. Generic ticagrelor will continue to be covered on the generic tier with a quantity limit.</td></tr>
<tr><td>Jynarque</td><td>Generic equivalents of Jynarque will be moved to nonformulary status and the brand will be preferred instead. Brand Jynarque will be covered on the generic specialty tier with quantity limit.</td></tr>
<tr><td>Helicobacter pylori Treatment</td><td>Helidac and Omeclamox-Pak will be moved to nonformulary status, as will generic Pylera. Brand Pylera will be covered on the generic tier with a quantity limit.</td></tr>
<tr><td>CDK4/6 Inhibitors</td><td>Ibrance will require prior authorization. Criteria will require FDA-approved diagnosis (including mutations), concomitant utilization with other agents as included in the FDA-approved package labeling, and trial and failure with both Kisqali and Verzenio for all shared indications.

Kisqali and Verzenio will continue to be covered without prior authorization.</td></tr>
<tr><td>Oncology Bevacizumab Products</td><td>Vegzelma will no longer be available on the pharmacy benefit and will be restricted to the medical benefit; prior authorization restrictions will continue. All other oncology bevacizumab agents will continue to be restricted to the medical benefit with prior</td></tr>
</table>

	authorization. Mvasi will continue to be the preferred agent, and all other oncology bevacizumab products will require trial and failure with Mvasi as part of the initial and reauthorization criteria. To review the medical benefit criteria in full, please refer to the Prime Therapeutics policy.
Trastuzumab IV and SC Products	Trastuzumab products will continue to be restricted to the medical benefit. Kanjinti, Ogivri and Ontruzant will be the preferred trastuzumab agents. All nonpreferred trastuzumab products (Herceptin, Herceptin Hylecta, Hercessi, Herzuma, Trazimera) will require trial and failure with Kanjinti AND Ogivri AND Ontruzant as part of the initial and reauthorization criteria. To review the medical benefit criteria in full, please refer to the Prime Therapeutics policy.
Boruzu	Boruzu will continue to be restricted to the medical benefit with prior authorization. Criteria for Boruzu will be updated to require trial and failure with generic bortezomib. To review the medical benefit criteria in full, please refer to the Prime Therapeutics policy.
Pemetrexed Products	Pemetrexed products will continue to be restricted to the medical benefit with prior authorization. Axtle, Pemrydi and Pemfexy will require trial and failure with generic pemetrexed. To review the medical benefit criteria in full, please refer to the Prime Therapeutics policy.
Infliximab	On the medical benefit Avsola and Infectra will be the preferred infliximab products; both will continue to require prior authorization. Initial and reauthorization criteria for nonpreferred agents (Renflexis, Remicade, Infliximab) will include trial and failure with both Avsola AND Inflectra. To review the medical benefit criteria in full, please refer to the Prime Therapeutics policy.
Rituximab	Truxima will continue to be the preferred rituximab agent and will continue to require prior authorization. Initial and renewal criteria for nonpreferred products (Rituxan, Rituxan Hycela, Ruxience, Riabni) on the pharmacy and medical benefits will include trial and failure with Truxima. To review the medical benefit criteria in full, please refer to the Prime Therapeutics policy.
Cinqair	Cinqair will continue to be restricted to the medical benefit with prior authorization. Initial criteria for Cinqair will require trial and failure with either Fasenra or Nucala.

	To review the medical benefit criteria in full, please refer to the Prime Therapeutics policy.
Botulinum Toxins	Dypsort and Xeomin will continue to be the preferred neurotoxins on the pharmacy and medical benefits. Initial and renewal criteria for nonpreferred agents (Botox, Daxxify, Myobloc) will include trial and failure with one of the preferred agents for shared indications. To review the medical benefit criteria in full, please refer to the Prime Therapeutics policy.
Viscosupplements	Durolane and Visco-3 will continue to not require trial and failure with other viscosupplements on the pharmacy and medical benefits. Initial and renewal criteria for nonpreferred agents (Euflexxa, Gel-One, Gelsyn-3, GenVisc, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz/Supartz FX, Synojoynt, Synvisc, Synvisc-One, Triluron, TriVisc) will include trial and failure with both Durolane and Visco-3. To review the medical benefit criteria in full, please refer to the Prime Therapeutics policy.
Soliris	Soliris will be restricted to the medical benefit. Prior authorization will continue to be required and requests will be reviewed against the new criteria. To review the medical benefit criteria in full, please refer to the Prime Therapeutics policy.
Bimzelx, Somavert	Bimzelx and Somavert will no longer be covered under the medical benefit. They will continue to be covered on the pharmacy benefit on the nonpreferred specialty tier with prior authorization and quantity limit.
Acthar HP Cortrophin Takhyzyro (if not self-administered)	Acthar HP, Cortrophin and Takhzyro (if not being self-administered) will be covered under the medical benefit with prior authorization restrictions. Requests on the medical benefit will be reviewed against the new criteria. To review the medical benefit criteria in full, please refer to the Prime Therapeutics policies.
Exservan	Exservan is being removed from the formulary and prior authorization criteria due to product discontinuation.
Weight Loss Agents	Initial and reauthorization criteria for all formulary agents and indications are being updated to require documentation with medical records indicating the member has met criteria. Additionally, initial criteria for weight loss will include the requirement that the member is participating in a behavior modification program (e.g., health coaching, nutritional counseling, community-based program). Reauthorization criteria will be updated to include documentation that the member is continuing to participate in a behavior modification program.
Acne/Rosace Medications	The following agents are being removed from the policy as they are moving to nonformulary status: adapalene 0.1% lotion (Differin), tazarotene 0.1% gel (Tazorac), tazarotene 0.1% foam (Fabior) and metronidazole 1% cream (Noritate). Prior

	authorization will be required to continue treatment. These agents will no longer be part of the acne/rosacea step therapy program. Trial and failure requirements throughout the policy will be updated to reflect these coverage changes.
Topical Antifungal Medications	Sulconazole, luliconazole, naftifine, Naftin, Oxistat, oxiconazole and Ertaczo (sertaconazole) are being removed from the policy and step therapy program as they are being moved to nonformulary status. Prior authorization will be required to continue treatment.
Doxylamine succinate/ pyridoxine delayed-release	Bonjesta is being removed from the policy as it is moving to nonformulary status. Prior authorization will be required to continue treatment.
Growth Hormone	The following agents are being removed from the policy as they are being moved to nonformulary status: Ngenla, Skytrofa, Sogroya. Prior authorization will be required to continue treatment.
Ophthalmic NSAIDs	Nevanac is being removed from the policy and step therapy program as it is being moved to nonformulary status. Prior authorization will be required to continue treatment.
Skeletal Muscle Relaxants	Metaxalone 400 mg is being removed from the policy and step therapy program as it is being moved to nonformulary status. Prior authorization will be required to continue treatment. Metaxalone 800 mg tablet will be moved from second-line to first-line in the step therapy program.
Testosterone Products	The following products are being removed from the policy and step therapy program as they are being moved to nonformulary status: Jatenzo, Kyzatrex, Xyosted. Prior authorization will be required to continue treatment.
Topical Corticosteroids	The following products are being removed from the policy and step therapy program as they are being moved to nonformulary status: triamcinolone 0.5% ointment, Capex shampoo. Prior authorization will be required to continue treatment.
Vitamin D Analogues	The following product is being removed from the policy as it is being moved to nonformulary status: betamethasone/calcipotriene lotion. Prior authorization will be required to continue treatment.
Tiglutik, Exservan	The policy will be updated to remove Exservan, as this agent has been discontinued and will therefore be moved to nonformulary status.
Abilify MyCite Doxepin cream Gimoti	Pharmacy policies for Abilify MyCite, doxepin cream, Gimoti and Sitavig will be retired, as these agents are moving to nonformulary status. Prior authorization will be required to continue treatment.

<table>
<tr><td>Sitavig</td><td></td></tr>
<tr><td>Methadone Oral Suspension</td><td>The policy for methadone oral suspension will be retired. This agent will remain on prior authorization and requests will be reviewed against criteria in the Opioid Risk Management policy.</td></tr>
<tr><td>Off-Label Non-FDA Approved Indications</td><td>Criteria for non-oncology uses will be updated to include a requirement of documentation that the member has had an inadequate response, adverse reaction or contraindication to all other formulary products with an FDA-approved indication for the treated diagnosis.

Reauthorization criteria for all diagnoses will be added to the policy and will require documentation that the member continues to require therapy as well as documentation demonstrating the member has had a positive clinical response to therapy.</td></tr>
<tr><td>Non-Formulary Medications</td><td>Initial criteria will be updated to require documentation for all components of the criteria.

Reauthorization criteria will be added to the policy, requiring that initial criteria continue to be met, documentation that the member requires continuation of therapy, and documentation demonstrating that the member has had a positive clinical response to therapy.</td></tr>
<tr><td>Drugs Moving to Nonformulary Status</td><td>The drugs listed in the tablet below are moving to nonformulary status. They will be removed from the pharmacy formulary. Prior authorization will be required to continue treatment. Prior authorization requests will be reviewed against criteria for nonformulary drugs.

<table>
<tr><th colspan="3">Drugs Names</th></tr>
<tr><td>Abilify MyCite (aripiprazole) tablet with sensor</td><td>Almotriptan tablet</td><td>Alocril (nedocromil) ophthalmic solution</td></tr>
<tr><td>Bepotastine ophthalmic solution</td><td>Betoptic S (betaxolol) ophthalmic suspension</td><td>Bonjesta (doxylamine/ pyridoxine) ER tablet</td></tr>
<tr><td>Brilinta (ticagrelor)* tablet</td><td>Buprenex (buprenorphine) injection*</td><td>Calcipotriene/betamethasone 0.005%-0.064% Ointment</td></tr>
<tr><td>Capex (fluocinolone) shampoo</td><td>Cephalexin 750 mg capsule</td><td>Cipro HC (ciprofloxacin/ hydrocortisone) otic suspension</td></tr>
<tr><td>Colesevelam packet</td><td>Crotan (crotamiton) lotion</td><td>Depo-Testosterone (testosterone cypionate) injection*</td></tr>
<tr><td>Desloratadine orally disintegrating tablet</td><td>Differin (adapalene) 0.1% lotion</td><td>Doxepin cream</td></tr>
<tr><td>Doxycycline hyclate 75 mg, 150 mg tablet</td><td>Doxycycline hyclate delayed-release 75 mg, 100 mg, 150 mg, 200mg tablet</td><td>Doxycycline monohydrate 75 mg capsule</td></tr>
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Equetro (carbamazepine) capsule	Ertaczo (sertaconazole) 2% cream	Fabior (tazarotene) 0.1% foam
Fenofibrate 40 mg tablet	Fenofibrate 50 mg, 150 mg capsule	Fenofibrate micronized 90 mg capsule
Fenoprofen 400 mg capsule	Fenoprofen 600 mg tablet	Fexmid (cyclobenzaprine) tablet*
Flolipid (simvastatin) suspension	Fluvastatin 20 mg, 40 mg, capsule	Fluvastatin ER 80 mg tablet
Frovatriptan tablet	Gimoti (metoclopramide) nasal spray	Helidac (metronidazole/ tetracycline/bismuth subsalicylate) chewable tablet
Jatenzo (testosterone undecanoate) capsule	Kyzatrex (testosterone undecanoate) capsule	Levothyroxine capsule (generic Tirostint)
Luliconazole cream	Meclizine 50 mg tablet	Mefenamic acid capsule
Meloxicam oral suspension	Metaxalone 400 mg tablet	Methylprednisolone succinate injection 40 MG, 125 mg, 1000 MG
Migergot (ERGOTAMINE W/ CAFFEINE) suppository	Minocycline HCl 50 mg, 100 mg tablet	Minocycline HCl 75 mg tablet
Minocycline HCl ER 45 mg, 135 mg tablet	Minocycline HCl ER 90 mg tablet	Motofen (atropine sulfate/difenoxin)
Naftifine 2% cream	Naftin (naftifine) 1% gel	Naproxen DR 500 mg tablet
Nevanac (nepafenac) ophthalmic suspension	Ngenla (somatrogen-ghla)	Noritate (metronidazole) 1% cream
Noritate (metronidazole) 1% cream	Oxiconazole cream	Oxistat (oxiconazole) lotion
Penciclovir cream	Quazepam tablet	Prednisolone sodium phosphate oral solution
Remodulin (Treprostinil) injection (1 mg/mL, 2.5 mg/mL, 5 mg/mL, 10 mg/mL)*	Sitavig (acyclovir) buccal film	Skytrofa (lonapegsomatropin-tcgd)
Sogroya (somapacitan-beco)	Solu-Medrol (methylprednisolone	Sotylize (sotalol) oral solution

		succinate) injection 40 mg, 125 mg, 1000 mg, 2000 mg	
	Sulconazole cream	Sulconazole solution	TaperDex 1.5 mg 12-Day Tablet
	TaperDex 1.5 mg 7-Day (dexamethasone) tablet	TaperDex 1.5mg 6-Day, HiDex 1.5 mg 6-Day, Dexamethasone 1.5 mg 6-Day tablets	Tazarotene 0.1% foam
	Tazarotene 0.1% gel	Tirosint (levothyroxine) capsule	Tolmetin 400 mg capsule
	Tolmetin 600 mg tablet	Tretinoin microsphere 0.08% gel	Triamcinolone acetonide 0.05% ointment
	Trianex (triamcinolone acetonide) 0.05% ointment	Tritocin (triamcinolone acetonide) 0.05% ointment	Vardenafil tablet
	Xyosted (testosterone cypionate) autoinjector	Zenzedi (dextroamphetamine sulfate) tablet*	
	*Coverage of generic not impacted		

Drugs Restricted to Medical Benefit

The following drugs are being removed from the pharmacy benefit and will be restricted to the medical benefit.

Drug Names		
Cefuroxime sodium 750 mg IV solution	Cefuroxime sodium 1.5 mg IV solution	Tobramycin sulfate injection
Diazepam 5 mg/mL injection, cartridge, prefilled syringe	Oxacillin sodium for injection, 1 gram, 2 gram	Oxacillin IV
Lincomycin injection	Sivextro IV	Orbactiv IV
Digoxin injection	Procainamide injection	Lidocaine injection
Hydralazine injection	Acetazolamide injection	Terbutaline injection
Tigan (trimethobenzamide) injection	Hydroxyzine injection	Chlorpromazine injection
Prochlorperazine injection	Nalbuphine injection	Bupivacaine injection
Ropivacaine injection	Bupivacaine/ epinephrine injection	Sensorcaine with epinephrine (bupivacaine/ epinephrine) injection
Epinephrine/ lidocaine injection	Amikacin injection	Gentamicin injection
Fosphenytoin injection	Orphenadrine injection	Magnesium sulfate injection

Medical Benefit Drug Coverage Updates – Prior Authorization Required	The following medications will have prior authorization restrictions added on the medical benefit. Please note, this list does not include drugs that are currently new to market and will have drug-specific prior authorization criteria added in 2026. Requests will be reviewed against the medical benefit policies going into effect on January 1, 2026: https://gatewaypa.com/policydisplay/57.

HCPCS	Drug Name	Generic Name
J9264	Abraxane	paclitaxel albumin-bound
J0801	Acthar_HP	corticotropin
J9042	Adcetris	brentuximab vedotin
J1454	Akynzeo IV	fosnetupitant/palonosetron
J9118	Asparlas	calaspargase pegol-mknl
J9036	Belrapzo	bendamustine
J9034	Bendeka	bendamustine
J9039	Blincyto	blinatumomab
J9064	Cabazitaxel	cabazitaxel (Sandoz)
J9286	Columvi	glofitamab-gxbm
J0802	Cortrophin	repository corticotropin
J9308	Cyramza	ramucirumab
J9145	Darzalex	daratumumab
J9144	Darzalex Faspro	daratumumab+hyaluronidase-fihj
J9269	Elzonris	tagraxofusp-erzs
J9358	Enhertu	fam-trastuzumab deruxtecan-nxki
J9331	Fyarro	sirolimus-albumin-bound
J9301	Gazyva	obinutuzumab
J9179	Halaven	eribulin
J9198	Infugem	gemcitabine
J1439	Injectafer	ferric carboxymaltose
J9281	Jelmyto	mitomycin
J9043	Jevtana	cabazitaxel
J9354	Kadcyla	ado-trastuzumab emtansine
J0642	Khapzory	levoleucovorin sodium
J1437	Monoferric	ferric derisomaltose
J1458	Naglazyme	galsulfase
J0219	Nexviazyme	avalglucosidase alfa-ngpt
J1809	Nulibry	fosdenopterin
J9266	Oncaspar	pegaspargase
J9205	Onivyde	irinotecan liposome
J9264	Paclitaxel Albumin-Bound	paclitaxel albumin-bound (Teva)
J9177	Padcev	enfortumab vedotin-ejfv
J9314	Pemetrexed	pemetrexed (teva)
J9296	Pemetrexed	pemetrexed (accord)
J9294	Pemetrexed	pemetrexed (hospira)
J9297	Pemetrexed	pemetrexed (sandoz)

	J9316	Phesgo	Pertuzumab, trastuzumab, hyaluronidase-zzxf	
	J2468	Posfrea	palonosetron (Avyxa)	
	J9227	Sarclisa	isatuximab-irfc	
	J1627	Sustol	granisetron extended-release	
	J0593	Takhzyro (only if not self-admin)	lanadelumab-flyo	
	J9033	Treanda	bendamustine	
	J9303	Vectibix	panitumumab	
	J9056	Vivimusta	bendamustine	
	J9352	Yondelis	trabectedin	
	J9223	Zepzelca	lurbinectedin	
	J3304	Zilretta	triamcinolone acetonide	
	J9359	Zynlonta	loncastuximab tesirine-lpyl	
	J9345	Zynyz	retifanlimab-dlwr	

Effective November 1, 2025

Test Strips and Meters	As previously communicated, OneTouch test strips and glucometers will be nonformulary. Starting on November 1, 2025, the following Accu-Chek and FreeStyle test strips will be preferred and 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. FreeStyle and Accu-Chek meters and test strips will be covered beginning November 1, 2025.

Updates for MassHealth Members

Effective 01/05/2026

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

Generic Medication	Brand Name Alternative
Colestipol hydrochloride granule packet, tablet	Colestid granule packet, tablet
Apixaban tablet, starter pack	Eliquis tablet, starter pack
Mifepristone 300mg tablet	Korlym 300mg tablet

Milnacipran titration pack	Savella titration pack

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

Brand Name	Generic Medication
Copaxone 40mg/mL Injection	Glatiramer 40mg/mL Injection

Effective 01/05/2026

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

Amyloidosis Therapies	• For **Wainua** hATTR (hereditary transthyretin-mediated) polyneuropathy criteria, a step-through requirement for either Amvuttra or Onpattro was added. • For **Amvuttra** hATTR polyneuropathy criteria, genetic testing and appropriate prescribing will be required.
Anesthetics – Topical	**Iheezo 3% gel** will be removed from the pharmacy benefit and will only be available on the medical benefit without restrictions.
Anti-Allergy and Anti-Inflammatory Agents - Ophthalmic	• **New drug**, **Tryptyr ophthalmic solution**, will be **added** to the pharmacy benefit **with** a prior authorization **and** quantity limit of 60 single dose vials per 30 days. A trial of either Miebo or Tyrvaya will be required first. • **Vevye 0.1% drops** will remain covered under the pharmacy benefit, and the quantity limit will be updated to 2mL per 30 days.
Anti-obesity Agents	• Generic Qsymia, **phentermine-topiramate ER capsules**, will be **added** to the pharmacy benefit **with** a prior authorization requirement **and** a quantity limit of 30 capsules per 30 days. • Reauthorization criteria was updated to look for improvement in BMI rather than bodyweight. • Treatment of MASH/NASH was added to **Wegovy**. • The list of **phentermine** contraindications has new additions: ○ Hypertensive emergency within the past 12 months ○ Intracranial hypertension ○ Left ventricular hypertrophy ○ Postural tachycardia syndrome (POTS) ○ Pulmonary hypertension ○ Valvular heart disease (e.g., valvular stenosis, valvular prolapse, valvular regurgitation) *MASH=Metabolic dysfunction-associated steatohepatitis; NASH=Non-alcoholic steatohepatitis*
Anticoagulants	**Eliquis capsule** & **Eliquis tablet for oral suspension** will both be **added** to the pharmacy benefit **with** prior authorization requirement.

	Criteria for the treatment or reduction of risk of recurrent DVT and/or PE in pediatric members was added to **Eliquis tablet for suspension and capsule**. If member is ≥ 35 kg, then a step-through with the tablet formulation or clinical rationale why the tablet formulation cannot be used (e.g., swallowing disorder, inability to swallow, or age is <13).
Anticonvulsants	• The following medications will be **added** to the pharmacy benefit **with** prior authorization requirement: ○ Carbamazepine 200mg chew tablet ○ Topiramate 50mg sprinkle capsule ○ Qudexy XR (*topiramate*) 25 mg capsule • **Eprontia** was updated to no longer require crushed tablets for ages <13. • **Xcopri** was updated to confirm if the requested dose is once daily and that doses are consolidated. • **Trokendi XR** was updated to remove medical necessity for use instead of topiramate ER sprinkle capsule. • **Lamictal XR starter pack** was updated to require medical necessity for use instead of ER tablets.
Antidiabetic agents - non-insulin and combination products	• **Glyxambi tablet** <u>will remain</u> covered under the pharmacy benefit and will no longer require prior authorization. • Criteria for **Invokamet, Invokamet XR, Segluromet, and Steglujan** were updated to include additional trials: ○ Invokamet, Segluromet – trial with Synjardy ○ Invokamet XR – trial with Synjardy XR ○ Steglujan – trial with Glyxambi • Off-label treatment of MASH/NASH was added to the **Ozempic** criteria. Confirmation whether Ozempic will be used in combination with Rezdiffra or monotherapy for MASH/NASH. • The list of **phentermine** contraindications has new additions: ○ Hypertensive emergency within the past 12 months ○ Intracranial hypertension ○ Left ventricular hypertrophy ○ Postural tachycardia syndrome (POTS) ○ Pulmonary hypertension ○ Valvular heart disease (e.g., valvular stenosis, valvular prolapse, valvular regurgitation) *MASH=Metabolic dysfunction-associated steatohepatitis; NASH=Non-alcoholic steatohepatitis*
Antimalarials	Criteria for **Sovuna** (hydroxychloroquine tablet) was updated to include all FDA approved indications: • Treatment of rheumatoid arthritis in adults • Treatment of systemic lupus erythematosus in adults • Treatment of chronic discoid lupus erythematosus in adults

	Artesunate vial will be removed from the pharmacy benefit and will only be available on the medical benefit **without** restrictions.
Antiretroviral Agents	The following medications will remain covered under the pharmacy benefit and will now require prior authorization: • Complera (*emtricitabine/rilpivirine/tenofovir disoproxil fumarate*) tablets – brand is preferred • Genvoya tablet • Odefsey tablet • Stribild tablet **Genvoya** and **Stribild** criteria will also require a step-through with one or contraindication to all HIV-1 regimens available without prior authorization.
Antibiotics – Vaginal	**Oral clindamycin** was added as an alternative step-through trial for all medications within this class. The specification of **metronidazole** tablets over the suspension formulation was removed.
Breast Cancer Therapies	**Faslodex injection** will remain covered under the medical benefit and will no longer require prior authorization.
Cardiovascular Agents	• The following medications will be **added** to the pharmacy benefit **with** prior authorization requirements: ○ Bisoprolol Fumarate 2.5mg tablet ○ Hemiclor 12.5mg tablet ○ Labetalol 400mg tablet ○ Vecamyl 2.5mg tablet • Step-through trials with all other tablet formulations available without a prior authorization will be required for bisoprolol, labetalol, and Hemiclor. • Criteria for **Vecamyl**, in addition to other requirements, it will also require a step-through trial with ONE of the following: ○ Calcium channel blocker ○ Mineralocorticoid receptor antagonist ○ RAAS inhibitor (ACE inhibitor or ARB) ○ Thiazide-type diuretic (e.g., hydrochlorothiazide, chlorthalidone, indapamide) ○ One other antihypertensive agent (beta-blocker, alpha-1 blocker, centrally acting agent, vasodilator, amiloride, aliskiren)
Continuous Subcutaneous Insulin Infusion	**V-Go disposable** devices will no longer be a preferred product and will no longer be covered.
Corticosteroids - Intranasal	For any requests that exceed quantity limits, an additional dosing criterion of the manufacturer's recommended dosing will be required.

Vykat XR (diazoxide tablet)	This new drug will be **added** to the pharmacy benefit **with** a prior authorization requirement. Criteria will consist of diagnosis of moderate to severe hyperphagia with Prader-Willi syndrome (PWS), age of ≥ 4 years of age, appropriate prescriber specialty, copy of genetic testing, and appropriate dosing.
Enzyme Disorder Therapies	**New Drug**, **Harliku tablet**, will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 30 tablets per 30 days.
Erythropoiesis-Stimulating Agents (ESAs)	• Clarification was added that GFR documented for anemia due to CKD can be estimated or measured. • Hemoglobin thresholds were updated within the continuation criteria based on indication. • **Retacrit injection** will remain covered under **both** the pharmacy benefit and medical benefit **without** prior authorization.
Gastrointestinal Agents-H2 antagonists, PPIs and Misc. Agents	• Criteria for **Konvomep** and **omeprazole/sodium bicarbonate** in pediatric patients were added. • Criteria for **Voquezna Dual/Triple pack** was updated to prefer use of the single agent product. • Criteria for **Voquezna** was updated to include diagnosis of helicobacter pylori infection. This medication will be required to be used with amoxicillin and confirmation if patient is treatment naive or there is medical necessity for its use over other regimens. • The following medications will remain covered under the pharmacy benefit; they will have a **quantity limit of 30 units per 30 days** and a prior authorization required for members **≥13 years of age**: ○ Omeprazole/sodium bicarbonate capsule ○ Prevacid Solutab (*lansoprazole ODT tablet*) - brand is preferred
Growth Hormone Agents	• New strengths of **Skytrofa injection** will be **added** to the pharmacy benefit **with** a prior authorization requirement. Expanded indication of adult growth hormone deficiency (GHD) was added for Skytrofa. ○ Step-through trials with Sogroya and Ngenla will be required for pediatric indications, while a trial with only Sogroya will be required for adult indications. ○ Both the initial and renewal criteria have been updated to reflect the step-through update. • Approval durations for adult GHD were updated to 6 months.
Immunosuppressants	**Nulojix vial** will remain covered under the pharmacy benefit and will no longer require a prior authorization.
Kinase Inhibitors	• Criteria for **Gomekli** was updated to remove Koselugo as a step-through following NCCN CNS guideline updates. • The following medications will remain covered under the pharmacy benefit and will have the prior authorization and quantity limit requirements **removed**: ○ **Afinitor** (*everolimus*) 2.5mg, 5mg, 7.5mg, 10mg tablet

	○ **Afinitor Disperz** (*everolimus*) tablet for oral suspension
Lipid Lowering Agents	• Criteria for **Vascepa** was updated to add Lovaza as a step-through trial unless patient has noted LDL levels ≥ 100mg/dL or high ASCVD risk. • **Leqvio** will no longer require specialist involvement within its criteria. • The following medications <u>will remain</u> covered under the pharmacy benefit and will have a prior authorization **and** quantity limit restrictions **added**: ○ **Lipofen** (*fenofibrate*) 50mg, 150mg capsule – **QL** 30 capsules per 30 days ○ **Fenofibrate** 130mg capsules – **QL** 30 capsules per 30 days ○ **Fenofibric acid** 35mg, 105mg tablets – **QL** 30 tablets per 30 days
Lung Cancer Agents	**New drug**, **Ibtrozi capsule**, will be **added** to the pharmacy benefit **with** a prior authorization **and** quantity limit of 90 capsules per 30 days.
Multiple Myeloma Agents	• **Darzalex Faspro** and **Sarclisa** criteria were updated based on new expanded indications: ○ Patient is newly diagnosed and eligible for transplant and either Darzalex Faspro or Sarclisa will be used in combination within a regimen. • **New drug**, **Boruzu**, will be **added** to the medical benefit **with** prior authorization. • **Velcade Injection** (*bortezomib*) <u>will remain</u> covered under the medical benefit only and will have a prior authorization requirement added.
Osteoporosis Agents and Calcium Regulators	**Yorvipath** was updated to remove the step-through with teriparatide and diagnostic criteria was updated to specify use in chronic hypoparathyroidism only.
Pulmonary Hypertension (PH) Agents	**New drug**, **Yutrepia inhalation capsule**, will be **added** to the pharmacy benefit and <u>will require</u> prior authorization. Yutrepia will require a step-through trial with Tyvaso inhalation solution unless there is an inability to use an inhalation solution (e.g., dexterity/coordination issues, physical impairment, or cognitive issues).
Rezdiffra (resmetirom)	For the MASH/NASH indication, step-through trial with Wegovy was added and confirm whether Rezdiffra will be used in combination with Wegovy or not or in combination therapy with Wegovy to those already stabilized on Rezdiffra. *MASH=Metabolic dysfunction-associated steatohepatitis; NASH=Non-alcoholic steatohepatitis*
Targeted Immunomodulators	• The following new medications will be **added** to the pharmacy benefit **with** a prior authorization requirement. ○ Imuldosa 45/0.5 mL & 90 mg/mL prefilled syringe ○ Otulfi 45mg/0.5 mL Injection • **Leselvi** will be **added** to the pharmacy benefit **with** a prior authorization and a quantity limit of 60 tablets per 30 days. The criteria will require 2C9 testing per labeling and a step-through trial with Litfulo. • The following new medication will be added to the <u>medical benefit only</u> **with** prior authorization requirement: ○ Imuldosa 130/26mL Injection

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Rinvoq criteria updates included:

Included giant cell arteritis indication following FDA approval and a step-through trial with tocilizumab
Added step-through trials
Atopic dermatitis – Cibinqo
Crohn’s disease and ulcerative colitis – Stelara or clinical rationale such as prior IL-23 trial
Non-radiographic axial spondyloarthritis – Xeljanz
Polyarticular juvenile idiopathic arthritis (pJIA) and rheumatoid arthritis – tocilizumab
Psoriatic arthritis – Taltz and Otezla
Added off-label criteria in pediatric inflammatory bowel disease

Hadlima, unbranded adalimumab-adaz, Imuldosa and Pyzchiva will be preferred drugs.
Off- label criteria in pediatric inflammatory bowel disease was added for Omvoh, Stelara, and Skyrizi.
Criteria for psoriatic arthritis, rheumatoid arthritis, and pJIA indications will include step-through with either a traditional or biologic disease modifying antirheumatic drug (DMARD).
Appropriate dosing criterion was updated throughout the policy to require dose consolidation or rationale as to why dose cannot be consolidated.

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<tr><td>Vaccines</td><td>

Vimkunya 40 mcg/0.8 mL syringe will remain covered under the pharmacy benefit and will now be limited to 1 injection per lifetime.
MRESVIA 50 mcg/0.5 mL syringe will remain covered under the pharmacy benefit. The prior authorization age requirement will be updated from 60 years of age to members younger than 18 years of age following expanded indication approval.

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<tr><td>HCPCS Code Coverage Updates</td><td>
Prior authorization requirements will be updated for the following HCPCS codes and will be available under pharmacy and medical benefits.
<table>
<tr><th>HCPCS</th><th>Drug Name</th><th>HCPCS Description</th></tr>
<tr><td>Q5145</td><td>Abrilada</td><td>Injection, adalimumab-afzb (Abrilada), biosimilar, 1 mg</td></tr>
<tr><td>Q5144</td><td>Idacio</td><td>Injection, adalimumab-aacf (Idacio), biosimilar, 1 mg</td></tr>
<tr><td>Q5144</td><td>Adalimumab-aacf</td><td>Injection, adalimumab-aacf (Idacio), biosimilar, 1 mg</td></tr>
<tr><td>Q5141</td><td>Yuflyma</td><td>Injection, adalimumab-aaty, biosimilar, 1 mg</td></tr>
<tr><td>Q5141</td><td>Adalimumab-aaty</td><td>Injection, adalimumab-aaty, biosimilar, 1 mg</td></tr>
<tr><td>Q5143</td><td>Cyltezo</td><td>Injection, adalimumab-adbm, biosimilar, 1 mg</td></tr>
<tr><td>Q5143</td><td>Adalimumab-adbm</td><td>Injection, adalimumab-adbm, biosimilar, 1 mg</td></tr>
<tr><td>Q5140</td><td>Hulio</td><td>Injection, adalimumab-fkjp, biosimilar, 1 mg</td></tr>
<tr><td>Q5140</td><td>Adalimumab-fkjp</td><td>Injection, adalimumab-fkjp, biosimilar, 1 mg</td></tr>
<tr><td>Q5142</td><td>Simlandi</td><td>Injection, adalimumab-ryvk biosimilar, 1 mg</td></tr>
<tr><td>Q5142</td><td>Adalimumab-ryvk</td><td>Injection, adalimumab-ryvk biosimilar, 1 mg</td></tr>
</table>
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J0139	Humira	Injection, adalimumab, 1 mg
J1438	Enbrel	Injection, etanercept, 25 mg
J3357	Stelara	Ustekinumab, for subcutaneous injection, 1 mg
J1748	Zymfentra	Injection, infliximab-dyyb (Zymfentra), 10 mg
J3490*	Amjevita	Injection, adalimumab-atto for subcutaneous use
J3490*	Hadlima	Injection, adalimumab-bwwd for subcutaneous use
J3490*	Hyrizmo	Injection, adalimumab-adaz for subcutaneous use
J3490*	Adalimumab-adaz	Injection, adalimumab-adaz for subcutaneous use
J3490*	Yusimry	Injection, adalimumab-aqvh for subcutaneous use

The following HCPCS codes will no longer require prior authorization and will remain available under the medical benefit.

HCPCS	Drug Name	HCPCS Description
J3490*	Ameluz	Aminolevulinic acid hydrochloride gel 10%, for topical use
J2249	Byfavo	Injection, remimazolam, 1 mg
J1460	Gamastan S/D Gamastan	Injection, gamma globulin, intramuscular, 1 cc
J1560	Gamastan S/D Gamastan	Injection, gamma globulin, intramuscular, over 10 cc
J1729	hydroxyprogesterone caproate	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg
J1740	Ibandronate Sodium	Injection, ibandronate sodium, 1 mg
J0889	Jesduvroq	Daprodustat, oral, 1 mg, (for ESRD on dialysis)
J7308	Levulan Kerastick	Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)
J3490*	Palynziq	Injection, pegvaliase-pqpz, for subcutaneous use
J3490*	Prevymis	Injection, letermovir, for intravenous use
J1201	Quzyttir	Injection, cetirizine HCl, 0.5 mg
J1440	Rebyota	Fecal microbiota, live – jslm, 1 ml
J0349	Rezzayo	Injection, rezafungin, 1 mg
J3490*	Rivfloza	Injection, nedosiran for subcutaneous use
J3490*	Tpoxx	Injection, tecovirimat for intravenous use
J0901	Vafseo	(vadadustat) tablets, for oral use
J1632	Zulresso	Injection, brexanolone, 1 mg
C9101	Olinvyk	Injection, oliceridine, 0.1 mg
J9198	Infugem	Injection, gemcitabine HCl, (Infugem), 100 mg
J9037	Blenrep	Injection, belantamab mafodontin-blmf, 0.5 mg
J9395	Faslodex	Injection, fulvestrant, 25 mg
J9393	Fulvestrant	Injection, fulvestrant (Teva) not therapeutically equivalent to J9395, 25mg
J9394	Fulvestrant	Injection, fulvestrant (Fresenius Kabi) not therapeutically equivalent to J9395, 25 mg
J3490*	Lupaneta Pack	Leuprolide (1 Mth) Inj 3.75 mg & Norethindrone Tab 5 mg Kit

		Leuprolide (3 Mth) Inj 11.25 mg & Norethindrone Tab 5 mg Kit
J9371	Marqibo	Injection, vincristine sulfate liposome, 1 mg
Q5148	Nypozi	Injection, filgrastim-txid (Nypozi), biosimilar, 1 mcg
J2561	Sezaby	Injection, phenobarbital sodium (sezaby), 1 mg
J3490*	Uptravi IV	Injection, selexipag for intravenous use

The following product will no longer be available under the medical benefit and will only be available under the pharmacy benefit with a prior authorization.

HCPCS	Drug Name	HCPCS Description
J3490*	Entyvio SQ	Injection, vedolizumab for subcutaneous use

Additional information of these clinical updates were shared in the October Newsletter.