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 MassHealth Members

Effective 08/12/2024

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

Generic Medication	Brand Name Alternative
Estradiol patch	Minivelle patch
Estradiol patch	Vivelle-Dot patch
Oxcarbazepine ER tablet	Oxtellar XR tablet
Prednisolone acetate 1% ophthalmic suspension	Pred Forte 1% ophthalmic suspension
Eltrombopag tablet	Promacta tablet
Nilotinib capsule	Tasigna capsule

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

Brand Name	Generic Medication
Amitiza capsule	Lubiprostone capsule

Effective 08/12/2024

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

Anti-Allergy and Anti-Inflammatory Agents – Ophthalmic	**Lastacaft once daily 0.25% drops** will be available on the pharmacy benefit but prior authorization will be removed. **Alocril 2% eye drops** will have prior authorization **added** on the pharmacy benefit.
Antiprotozoals	Criteria for **Alinia** was updated to include the off-label indication of H. pylori and the initial approval duration was updated to 10 days for this indication.
Antipsychotics	The following medications will have prior authorization removed however current quantity limits will remain on the pharmacy benefit: • **Latuda tablet** (*Lurasidone 20mg, 40mg, 60mg ,120mg*) **QL** - 30 tablets per 30 days • **Latuda tablet** (*Lurasidone 80mg*) **QL** – 60 tablets per 30 days • **Invega tablet** (*paliperidone 1.5mg, 3mg, 9mg*) **QL** – 30 tablets per 30 days • **Invega tablet** *(paliperidone 6mg)* **QL** – 60 tablets per 30 days The following medications will have quantity limits **updated** on the pharmacy benefit: • **Risperdal tablet** (*risperidone 0.25mg, 0.5mg, 1mg, 2mg, 3mg*) **QL** – 90 tablets per 30 days • **Zyprexa tablet** (*olanzapine 2.5mg, 5mg, 7.5mg,10mg*) **QL** – 90 tablets per 30 days
Crysvita	Criteria was updated to require current weight in order to verify appropriate dosing.
Constipation Agents	**Linzess 72mcg capsule** will have prior authorization removed on the pharmacy benefit, while the quantity limit will remain at 30 capsules per 30 days. Criteria for **Relistor** was updated to require medical necessity for injection formulation instead of the tablet formulation.
Corticosteroids	**New drug**, **Eohilia** 2mg/10ml oral suspension, will be **added** to the pharmacy benefit **with** prior authorization. Criteria for **Rayos** was updated to require medical necessity for the delayed release formulation instead of other glucocorticoid formulations.

Cystinosis Agents	Criteria was updated to include consult notes from a nephrologist or ophthalmologist and medical necessity for Procysbi granules formulation.
Enzyme and Metabolic Disorder Therapies	**Adzynma** vial/kit will be **added** to **both** the pharmacy **and** medical benefits **with** prior authorization.
Gamifant	Criteria requiring documentation of baseline clinical parameters and laboratory values was removed.
Iron Agents & Chelators	**Auryxia** will require a step through of 2 lower cost phosphate binders in the treatment of hyperphosphatemia. An expanded indication for **Injectafer** in the treatment of heart failure was added to the criteria.
Neuroblastoma Agents	**Iwilfin tablet** will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 240 capsules per 30 days.
Ogsiveo	This medication will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 60 tablets per 30 days.
Osteoporosis Agents and Miscellaneous Calcium Regulators	**Duavee tablet** will have prior authorization **and** quantity limit of 30 tablets per 30 days **added** to the pharmacy benefit. **Ibandronate vial and syringe** will be removed from the pharmacy benefit **and** will be available on the medical benefit only **with** prior authorization. **Pamidronate vial** will be removed from the pharmacy benefit **and** will be available on the medical benefit only.
Panretin	Criteria updated to include additional chemotherapy examples for AID-related Kaposi's sarcoma.
Pokonza	This medication will be **added** to the pharmacy benefit **with** prior authorization.
Probiotic Agents	The age limit will be updated from ≥22 years of age to now ≥21 years of age for the following probiotics: • Align • Culturelle • Florastor

Targeted Immunomodulators (TIMS)	The following medications will be **added** to the pharmacy benefit **with** prior authorization: • Simlandi 40mg/0.4ml Autoinjector • unbranded adalimumab-ryvk • unbranded adalimumab-aaty • Zymfentra 120mg/ml syringe kit & pen • Spevigo 150mg/ml syringe The following medication will be **added** to the medical benefit only **with** prior authorization: • Cosentyx 125mg/5ml vial Following FDA-approved labeling, the following medications were updated to include additional indications: • Ilaris – gout • Cosentyx – hidradenitis suppurativa • Spevigo – generalized pustular psoriasis (maintenance) Criteria was updated to include pediatric dosing for **Spevigo** and **Adbry**. **Zymfentra** will require rationale for use instead of the IV product and documentation of 10 weeks of treatment with an IV product per the package insert.
Wilson's Disease Agents	**Trientine 500mg capsule** will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 120 capsules per 30 days.
Wound Care	**New drug**, **Filsuvez 10% gel**, will be **added** to the pharmacy benefit **with** prior authorization.