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 07/01/2025

Targeted Immunomodulators	As previously communicated, effective 7/1/2025 criteria for initial and continuation of therapy requests for Cosentyx will be updated to include trial and failure with Bimzelx for all shared indications; this is in addition to other diagnosis-specific immunomodulator trial requirements. Criteria for Ilumya and Siliq will also be updated to include trial and failure with Bimzelx, in addition to other immunomodulator trial requirements. The Bimzelx policy will be updated to include criteria for the supplemental indication of hidradenitis suppurativa, requiring FDA-approved diagnosis and trial and failure with a preferred adalimumab product. Criteria for other conditions already captured in the Bimzelx policy will remain the same.

Effective 08/01/2025

The following changes are being made to the listed medications:

CFTR Potentiators	Criteria for Alyftrek will be added to the policy. In addition to age and genetic testing/mutation requirements and restrictions on concomitant use with other CFTR potentiators, criteria will include trial and failure with Trikafta for any mutations shared between the two agents. Criteria for Kalydeco, Orkambi, Symdeko and Trikafta will be updated to include Alyftrek as an agent that is not to be used concomitantly with the requested medication.
Factor IX Products	Mononine will be removed from the policy due to product discontinuation.
Kynamro	Kynamro criteria will be retired due to product discontinuation.
Juxtapid	Initial criteria will be updated to remove trial and failure with Kynamro, as Kynamro has been discontinued. Reauthorization criteria will be added to the policy.
NovoSevenRT, SevenFact	Reauthorization criteria will be updated to include examples of a positive response to therapy.
Xiaflex	Criteria for Dupuytren's contracture will be updated to require member is 18 years of age or older, has finger flexion contracture with palpable cord in metacarpophalangeal joint or proximal interphalangeal joint prior to starting therapy, and contracture that is at least 20 degrees prior to therapy initiation.
Methadone Oral Solution	Requests for methadone oral solution will be reviewed against criteria in a new drug-specific policy. Criteria will be aligned with that of long-acting opioids in the existing Opioid Risk Management policy.

Updates for MassHealth Members

Effective 8/11/2025

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

Generic Medication	Brand Name Alternative
ketorolac 0.4% opthalmic solution	Acular LS 0.4% opthalmic solution
umeclidinium-vilantero 62.5-25 inhaler	Anoro Ellipta 62.5-25 MCG inhaler
carbamazepine extended-release capsule	Carbatrol capsule
ciprofloxacin 5%, 10% suspension	Cipro 5%, 10% suspension
tigecycline vial	Tygacil vial

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

Brand Name	Generic Medication
Byetta 5mcg, 10mcg pen injection	exenatide 5mcg, 10 mcg pen injection

Efudex 5% cream	fluorouracil 5% cream
Firvanq solution	vancomycin oral solution

Effective 8/11/2025

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

Alkeran vial Gohibic (EUA) vial	These medications will remain on the medical benefit; however, a prior authorization requirement will be **added.**
Antibiotics – Injectable	**Dalvance vial & Zyvox injection** will remain on the pharmacy benefit; however, the prior authorization requirement for both will be removed.
Antidepressants	**Raldesy 10mg/ml solution** will be **added** to the pharmacy benefit **with** prior authorization.
Antiprotozoals	The following clinical updates were made to **Alinia**: • A medical necessity requirement for the suspension over the tablet formulation was added • For Giardiasis indication, the tinidazole trial can be bypassed for members less than 3 years of age
Antitubercular Agents	**Pretomanid tablets** will remain on the pharmacy benefit **and** will have a quantity limit **added** of 30 tablets per 30 days.
C. Difficile Prevention Agents	Zinplava has been removed as a step-through trial for Rebyota and Vowst.
Constipation Agents	**Kristalose** and **Relistor** criteria were updated to require additional step-through trials (e.g., from traditional laxative therapy classes and preferred agents) For **Motegrity**, the policy was updated to include an indication for chronic idiopathic constipation (CIC) for pediatric patients. **Trulance 3mg tablet** will remain on the pharmacy benefit **with** a quantity limit of 30 tablets per 30 days; however, the prior authorization requirement will be removed.
COVID-19 Treatments and Prophylaxis	**New drug formulation, Paxlovid** (*nirmatrelvir/ritonavir 300/150-100 mg*) **tablet**, will be **added** to the pharmacy benefit **with** a quantity limit of 11 tablets per fill **and** a prior authorization for members **< 12 years of age**.
Iron Agents & Chelators	The following medications will remain on both the pharmacy and medical benefits; however, the prior authorization requirement will be removed: • **Feraheme** (*ferumoxytol 510mg/17 ml vial)* • **Monoferric** 1000mg/10ml vial **Injectafer vials** will continue to be covered under the medical benefit, and the prior authorization requirement will be removed.

	Exjade (*deferasirox dispersible tablet*) will remain brand preferred; however, a prior authorization will be **added** to the pharmacy benefit. **Jadenu** *(deferasirox granule packet)* will remain on the pharmacy benefit and will have a prior authorization **added**.
Kinase Inhibitors	**New drug, Romvimza capsule,** will be **added** to the pharmacy benefit **with** prior authorization.
Lipid Lowering Agents	**New drug, Tryngolza auto-injector**, will be **added** to the pharmacy benefit **with** prior authorization.
Lupus Agents	• Systemic Lupus Erythematosus (SLE) criteria for **Benlysta** was updated to include a step-through with hydroxychloroquine. • Lupus Nephritis (LN) criteria for **Benlysta and Lupkynis** were updated to specify a trial requirement of an oral glucocorticoid in addition to either mycophenolic acid analog or azathioprine.
Gleostine Margenza Proleukin	The prescriber specialty requirement was updated to also accept consult notes from oncologists.
NSAIDs – Injectable, Intranasal, and Oral	The following drugs will be **added** to the pharmacy benefit **with** prior authorization: • **Dolobid** *(diflunisal)* **250mg** & **375mg** tablet • **Fenopron** *(fenoprofen)* **300mg** capsule • The approval criteria will require a step-through trial with diflunisal 500 mg tablet or fenoprofen 400 mg capsule, respectively. Criteria for **Indocin** will now require medical necessity for use of the solution formulation.
Oncology Immunotherapies	**New drug, Niktimvo vial,** will be **added** to the medical benefit **with** prior authorization.
Oncology Interferon Agents	The prescriber specialty requirement was updated to also accept consult notes from hematologists.
Osteoporosis Agents and Misc Calcium Regulators	Criteria was updated to clarify the listing for the Forteo strength 560 mcg/2.24 mL.
Prostate Cancer Agents	Policy was updated to incorporate examples of contraindications for Xtandi, abiraterone, and docetaxel.
Pulmonary Hypertension Agents	**Veletri** (*epoprostenol sodium*) will remain on the pharmacy benefit and will no longer require prior authorization.

	Criteria for **Tyvaso DPI** was updated to state that dexterity/coordination issues or physical impairment would be accepted as rationale to bypass Tyvaso inhalation solution.
Imcivree (setmelanotide)	Criteria was updated to reflect new age range of ≥ 2 years of age.
Systemic Chemotherapy	**New drug**, **Ivra vial** will be **added** to the medical benefit only **without** prior authorization.
Targeted Immunomodulators (TIMs)	The following drugs will be **added** to the pharmacy benefit **and** will require prior authorization: • **Simlandi 20 mg/0.2 mL** syringe • **Simlandi 80 mg/0.8 mL** syringe/autoinjector • **Ustekinumab,** *unbranded,* **45mg/0.5ml** prefilled syringe/vial • **Cimzia** 200mg/ml syringe kit • **Tremfya** 100mg/ml pen **Ustekinumab**, *unbranded,* **130 mg/26 mL vial** will be **added** to the medical benefit **with** a prior authorization requirement. The following clinical updates were made: • **Cimzia** was added for polyarticular juvenile idiopathic arthritis (pJIA) requiring rationale for use instead of Enbrel and Humira. • **Tremfya** was added for Crohn's disease requiring trials with anti-TNF (tumor necrosis factor) agents, such as Stelara, Skyrizi, and Omvoh. • The step-through with Humira for **Simponi** in ulcerative colitis (UC) was removed.