MassHealth Formulary Updates

DEFINITIONS

Formulary	These drugs are included in the MassHealth drug list.
Prior Authorization (PA)	Prior authorization is required. The prescriber must obtain PA for the drug. PA applies to both the brand-name and the FDA "A"-rated generic equivalent of listed product.
Brand Preferred (BP)	Brand Preferred over generic equivalents. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.
Preferred Drug (PD)	Preferred Drug. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class.

Reminder - Effective 7/1/2026

Anti-Obesity Coverage Update	**As shared in a recent MassHealth provider communication, effective July 1, 2026, MassHealth will no longer cover medications used solely for weight loss, including GLP-1 agents.** This applies to GLP-1 medications prescribed for weight loss (*including off-label use of diabetic GLP-1s*) as well as oral weight loss drugs, and affects all MassHealth members, including those enrolled in the Mass General Brigham Accountable Care Organization (**ACO**). Our members will be notified of this change prior to the effective date.
	
	Key points:
	• **Wegovy** (semaglutide) will be the sole non-diabetic GLP-1 preferred medication
	• **Wegovy** (semaglutide) **injection** is only covered for the following medically accepted conditions such as:
	  ○ **BMI >27 kg/m²** with established cardiovascular disease (*to reduce risk of major adverse cardiovascular events*)
	  ○ Metabolic dysfunction-associated steatohepatitis (**MASH**)
	  ○ **BMI >30 kg/m²** with moderate to severe obstructive sleep apnea (**OSA**)
	• **Wegovy** (semaglutide) **tablet** is only covered if there is a history of a heart attack, stroke, or symptomatic peripheral artery disease and for members younger than 21 years of age.
	• **Zepbound** (tirzepatide) will be non-preferred and will require a step-through with Wegovy injection for moderate to severe obstructive sleep apnea (**OSA**).
	• Members that qualify for a GLP-1 medication under Early and Periodic Screening, Diagnostic, and Treatment (**EPSDT**) will also require clinical rationale for not using Wegovy. However, for members between ages 12

	to 21 who are new to GLP-1 therapy, step-through with phentermine will be required in addition to Wegovy. • All other requests for members younger than 21 will continue to be reviewed for medical necessity in accordance with the **EPSDT** requirements. • Patients with a comorbid condition of diabetes or prediabetes will require a new written prescription from their prescriber for an appropriate diabetic medication. • Our MassHealth members with valid prior authorization approvals will continue to be able to fill their weight loss medication prescriptions through June 30, 2026. • Following this change, our MassHealth members who require a weight loss medication for another medical reason will need to review their options with their provider and receive a new prior authorization request. • The health of our members is a top priority. We are pleased to offer health and wellness programs to support their long-term wellbeing.

Effective 7/1/2026

Upcoming changes to MassHealth management of ustekinumab biosimilars	Effective July 1, 2026, the preferred ustekinumab biosimilars will be updated. • **Imuldosa** (ustekinumab-srlf), **Pyzchiva** (ustekinumab-ttwe), and **Steqeyma** (ustekinumab-stba) will no longer be preferred drugs, and will require a trial of all preferred biosimilars. • Preferred ustekinumab biosimilars will now be **Starjemza** (ustekinumab-hmny) and **unbranded** ustekinumab-aekn. **Key Points:** • **Starjemza** (ustekinumab-hmny) and **ustekinumab**-aekn are interchangeable biosimilars and can be automatically substituted for **Stelara** (ustekinumab), **Pyzchiva** (ustekinumab-ttwe), or **Steqeyma** (ustekinumab-stba) at the pharmacy. • Patients using **Imuldosa** (ustekinumab-srlf) will need a new prescription for either **Starjemza** (ustekinumab-hmny) or **ustekinumab-aekn**. **Imuldosa** (ustekinumab-srlf) cannot be automatically substituted. *For Additional Information*: MassHealth Pharmacy Facts, MassHealth Pharmacy Programs

Effective 8/10/2026
The following brand name medications will become non-preferred. Approval will require a trial of its generic medication:

Brand Name	Generic Medication
Condolyx 0.5% gel	Podofilox 0.5% gel

Farxiga tablet	Dapafliglozi tablet
Rowasa enema	Mesalamine enema

Effective 8/10/2026

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

Achondroplasia Agents	**Yuviwel injection** will be **added** to the pharmacy benefit **with** prior authorization **and** a quantity limit of 2 vials per 7 days. Criteria will require a step-through trial of Voxzogo.
Antibiotics - Injectable	• Expanded indication for **Zerbaxa** was added for pediatrics for the use in cIAI and cUTI. • **Doripenem** was removed as a step-through trial due to drug discontinuation. • **Contepo injection** will be **added** to the pharmacy benefit **with** a prior authorization and will be available without prior authorization under the medical benefit. Criteria will require a step-through trial with 2 alternatives. • Criteria for cUTI was expanded to accept pyelonephritis as one of the diagnoses and cefotaxime and tobramycin were added as an acceptable treatment alternative. • Age requirements for **Recarbio** and **Avycaz** in HABP/VABP were updated (now FDA approved for pediatric patients from birth to 18 years of age). • **Fetroja** was added to criteria for HABP/VABP caused by Acinetobacter baumannii-calcoaceticus complex (ABC) and a trial with at least 2 alternatives and Xacduro will be required. • Age restriction was removed from **Sivextro** in SSTI, non-MRSA/non-VRE infections, and VRE infections. *CIAI: complicated intra-abdominal infections; cUTI: complicated urinary tract infection; HABP/VABP: Hospital-Acquired or Ventilator -Associated Bacterial Pneumonia; SSTI: skin soft tissue infection; VRE: vancomycin resistant enterococci*
Antipsychotics	**Lybalvi** criteria was updated to include confirmation that patient is not being treated with an opioid or undergoing opioid withdrawal.
Cardiovascular agents: Antihypertensives	• **Sdamlo powder for oral solution** will be **added** to the pharmacy benefit **with** prior authorization **and** will require a step-through trial of Katerzia **and** Norliqva. • **Cardamyst 70mg nasal spray** will be **added** to the pharmacy benefit **with** a prior authorization **and** quantity limit of 2 units (140 mg total) per 30 days.

Cardiovascular agents: Miscellaneous Agents	• **Camzyos** criteria was updated to include LVEF thresholds (>55% or ≥ 50% and patient is stable on the medication). • **Myqorzo tablet** will be **added** to the pharmacy benefit **with** a prior authorization **and** quantity limit of 30 tablets per 30 days. Criteria will require Camzyos as a step-through trial prior to Myqorzo.

Constipation Agents	• **Linzess capsules** will remain covered under the pharmacy benefit with prior authorization and will now require a quantity limit of 30 capsules per 30 days.
	• **Linzess** criteria was updated to not require a step-through trial for members <18 years of age. A trial of lubiprostone is still required for members ≥18 years of age.
	• The following medications will remain covered under the pharmacy benefit with existing quantity limits and will no longer require prior authorization:
	  ○ Amitiza (lubiprostone capsule)
	  ○ Motegrity (prucalopride tablet)

Padcev	• For the locally advanced or metastatic urothelial cancer indication, criteria was clarified that combination therapy can be either with Keytruda or Keytruda Qlex. • The muscle invasive bladder cancer (MIBC) indication was added to criteria.
Enzyme and Metabolic Disorder Therapies	**Zycubo vial** will be **added** to the pharmacy benefit **with** a prior authorization requirement.
Herceptin Products	**Kanjinti** was added as a step-through trial for other trastuzumab agents.
Hereditary Angioedema Agents	**Orladeyo pellet packet** will be **added** to the pharmacy benefit **with** a prior authorization requirement.
Lupus Agents	• **Benlysta** criteria for lupus nephritis was updated to include cyclophosphamide for induction as an option as part of the triple therapy regimen. • **Saphnelo** criteria for systemic lupus erythematosus (SLE) was updated to require either a step-through trial with Benlysta or cutaneous manifestations of SLE. • **Lupkynis** criteria for lupus nephritis was updated to include a step-through mycophenolic acid analog acceptable to bypass triple therapy regimen, and added a step-through other calcineurin inhibitors and a step-through Benlysta or Gazyva OR pure class V LN or proteinuria. • The policy was updated to include criteria for specialist involvement.
Oncology Immunotherapies	The following expanded indications were added: • **Imfinzi** (durvalumab) in combination with FLOT (fluorouracil, leucovorin, oxaliplatin, and docetaxel) as neoadjuvant and adjuvant

	treatment, followed by single-agent durvalumab, for adult patients with resectable gastric and gastroesophageal junction (GEJ) adenocarcinoma
	• **Libtayo** (cemiplimab-rwlc) as adjuvant treatment of adult patients with cutaneous squamous cell carcinoma (CSCC) at high risk of recurrence after surgery and radiation
	• **Keytruda** (pembrolizumab) and **Keytruda Qlex** (pembrolizumab-berahyaluronidase alfa-pmph)
	  ○ in combination with Padcev (enfortumab vedotin-ejfv) as neoadjuvant treatment followed by adjuvant treatment after cystectomy for adults with muscle invasive bladder cancer (MIBC) who are ineligible for cisplatin
	  ○ in combination with paclitaxel +/- bevacizumab for adults with platinum-resistant epithelial ovarian, fallopian tube or primary peritoneal carcinoma whose tumors express PD-L1 (CPS≥1) and who have received one or two prior systemic treatment regimens
	• **Opdivo** (nivolumab) in combination with doxorubicin, vinblastine, and dacarbazine (AVD) for adult and pediatric patients ≥ 12 years with previously untreated Stage III or IV classical Hodgkin lymphoma (cHL)
	• **Tecentriq Hybreza** for the treatment of adult patients and pediatric patients (12 years of age and older who weigh 40 kg or greater) with unresectable or metastatic ASPS (Alveolar Soft Part Sarcoma)
	
	Additional updates were made to the criteria to better align with the package insert's indications for use:
	• **Keytruda/Keytruda Qlex** and **Opdivo/Opdivo Qvantiq** criteria were separated for melanoma and classical Hodgkin lymphoma
	• **Opdivo Qvantig**: removed trial with sorafenib due to approval in 1st -line setting
	• **Opdivo** and **Opdivo Qvantiq** for neoadjuvant and adjuvant treatment of resectable NSCLC
	• **Tecentriq Hybreza** in HCC: Child-Pugh status as no longer required in NCCN was removed
	• **Yervoy** criteria for ESCC: tumor expression of PD-L1 (≥1) criterion was added
	• **Yervoy** in unresectable or metastatic melanoma: age was updated to ≥ 12 years of age
	NSCLC: non-small cell lung cancer, HCC: hepatocellular carcinoma, ESCC: esophageal squamous cell carcinoma

Prostate Cancer Agents	The following expanded indications were added:

	• **Akeega** with prednisone is indicated for the treatment of adult patients with deleterious or suspected deleterious BRCA2-mutated (BRCA2m) metastatic castration-sensitive prostate cancer (mCSPC) • **Nubeqa** monotherapy for metastatic castration-sensitive prostate cancer. Step-through trial with abiraterone, Erleada, or Xtandi will be required. The following criteria were updated to confirm if the requested agent will be used in combination with a GnRH analog or there was previous bilateral orchiectomy. • **Nubeqa** for M1 metastatic castration-resistant prostate cancer (mCRPC) • **Jevtana** for mCRPC • **Akeega** for mCRPC and mCSPC
Pulmonary Hypertension (PH) Agents	**Winrevair** criteria was updated to include the WHO functional class IV in accordance with updated package labeling.
Spinal Muscular Atrophy Agents	**Spinraza high dose (HD) vial** will be **added** to the medical benefit only **with** a prior authorization. Criteria will remain the same as the low dose formulation.
T-cell Lymphoma Agents	**Lymphir injection** will be **added** to the medical benefit only **with** a prior authorization.
Thalassemia, Myelodysplastic Syndrome and Sickle Cell Disease Agents	**Aqvesme tablet** will be **added** to the pharmacy benefit **with** a prior authorization **and** quantity limit of 60 tablets per 30 days. Within this criteria, for members with transfusion-dependent beta-thalassemia, a step-through trial with Reblozyl or attestation that Aqvesme will not be used in combination with Reblozyl will be required.
Wound Care	• **Vyjuvek** criteria was updated to include expanded indication for patients from birth to 6 months of age (previously, 6 months of age or older). • **Santyl** criteria was updated to clarify that the Santyl may be used in combination with surgery and/or debridement.