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 05/01/2024

The following changes are being made to the listed medications:

Durolane Sunlenca Visco-3	These medications are no longer considered specialty medications. They will move to the preferred brand tier.
Botox Dysport Euflexxa Gel-One Gelsyn-3 Genvisc Hyalgan Hymovis Monovisc Myobloc Orthovisc Supartz Fx	These medications are no longer considered specialty medications. They will move to the non-preferred brand tier.

Synojoynt Synvisc Synvisc One Triluron Trivisc Xeomin	
Bexarotene Pamidronate Penicillamine Pirfenidone Pyrimethamine Tiopronin Tobramycin Trientine	These medications are now considered specialty. They will move to the preferred specialty tier.
Chenodal Hyperrho s/d Lamzede Livmarli Lumakras Micrhogam Palforzia Prevymis Rhogam Ridaura Skyrizi Sucraid Thiola EC Vowst Welireg	These medications are now considered specialty. They will move to the non-preferred specialty tier.

Updates for MassHealth Members

Effective 05/06/2024

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

Generic Medication	Brand Name Alternative
deflazacort	Emflaza
dronabinol	Marinol
dapagliflozin	Farxiga
raltegravir	Isentress
cyclosporine 0.05% ophthalmic emulsion	Restasis
dasatinib	Sprycel
insulin glargine	Toujeo
dapagliflozin/metformin extended-release	Xigduo XR

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

Brand Name	Generic Medication
Pristiq	desvenlafaxine succinate extended-release tablet
Luzu	luliconazole cream
Oxistat	oxiconazole cream
Fortesta	testosterone gel pump
Kazano	alogliptin/metformin
Nesina	alogliptin
Oseni	alogliptin/pioglitazone
Pennsaid	diclofenac topical solution
Rapamune	sirolimus solution
Welchol	colesevelam

Effective 05/06/2024

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

Alzheimer's Agents	The following medication will require prior authorization **and** quantity limit on the pharmacy benefit: • **Namzaric** (*memantine/donepezil extended-release capsule*) - **QL** 30 capsules per 30 days. • **Namzaric Titration Pack - QL** 28 capsules per 28 days ***Note**: Namzaric may be subject to the MassHealth Pediatric Behavioral Health Medication Initiative.*
Androgen Therapy	The following medications had quantity limits **added**, however, prior authorization will remain on the pharmacy benefit: • **AndroGel** (*testosterone 1%, 1.62%-gram packets)* **QL** 30 packets per 30 days. • **Jatenzo** (*testosterone undecanoate 158mg, 198mg, 237mg*) – **QL** 60 capsules per 30 days.

Anti-Allergy and Anti-Inflammatory Agents – Ophthalmic	The following medications have been **added** to the pharmacy benefit **with** prior authorization **and** quantity limits: • **Xdemvy** 0.25% eye drop – **QL** 10 mL for one course of therapy • **Vevye** 0.1% eye drop – **QL** 2mL per 50 days
Antibiotics – Oral Agents	New drug, **Likmez** (*metronidazole suspension*), was **added** to the pharmacy benefit **with** prior authorization required.
Anticonvulsants Agents	The following medication has been added to the pharmacy benefit **with** prior authorization **and** quantity limit: • **Motpoly XR 100 mg** (*lacosamide extended-release*)– **QL** 30 capsules per 30 days. • **Motpoly XR 150mg, 200mg**– **QL** 60 capsules per 30 days.
Antidiabetic Agents, non-insulin and combination products.	New drug, **Brenzavvy** (*bexagliflozin tablet*), was **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 30 tablets per 30 days. Criteria for Victoza requests that exceed quantity limit was added for diagnoses of obesity or overweight. Criteria regarding lifestyle modifications have been updated to note that patients must be counseled.
Antiemetics Agents	New drug, **Anzemet** (*dolasetron tablet*), was **added** to the pharmacy benefit **with** prior authorization required.
Antifungals – Topical Agents	**Tolnaftate liquid** will have prior authorization through the pharmacy benefit. **Xolegel** (*ketoconazole 2% gel*) will have prior authorization through the pharmacy benefit.
Anti-Obesity Agents	Zepbound has been **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of **4 pens per 28 days** for the following strengths: • 2.5mg/0.5ml pen • 5mg/0.5ml pen • 7.5mg/0.5ml pen • 10mg/0.5ml pen

	• 12.5mg/0.5ml pen • 15mg/0.5ml pen Criteria regarding lifestyle modifications have been updated to note that patients must be counseled.
Antioxidant Agents	Coenzyme Q10 products had age limit updated from ≥22 years of age to ≥21 years of age.
Antiparkinsonian Agents	Duopa criteria was updated to remove the step-through requirement of extended-release carbidopa/levodopa tablet formulation.
Bowel Preparations	New drug, **Suflave** (*peg 3350/sod sulf chlr/pot/mag*), was **added** to the pharmacy benefit **with** prior authorization required.
Cardiovascular: Antihypertensives and Miscellaneous Cardiovascular Medications	**Lodoco** (*colchicine 0.5mg tablet*) has been **added** to the pharmacy benefit **with** prior authorization **and** quantity limit of 30 tablets per 30 days. **Corlanor solution** for off-label indications was added to the criteria and the criteria point for requested dose was removed for adult heart failure patients.
Colorectal Cancer Agents	The following new drug was **added** to the pharmacy benefit **with** prior authorization **and** quantity limit: • **Fruzaqla** (*fruquintinib 5mg capsule*) – **QL** 30 capsules per 30 days • **Fruzaqla** (*fruquintinib 1 mg capsule*) – **QL** 120 capsules per 30 days Fruzaqla criteria will require treatment failures with standard regimens and an additional step through Stivarga and/or Lonsurf. Depending on the type, criteria will also require a step through Erbitux and/or Vectibix.
Complement Inhibitors and Miscellaneous Immunosuppressive Agents	New drugs, **Veopoz** (*pozelimab-bbfg) &* **Izervay** (*avacincaptad pegol sodium/PF*), were both **added** to the medical benefit only **with** prior authorization required. Soliris criteria was updated to include the off-label diagnoses of CD55-deficient protein-losing enteropathy (PLE) and complement hyperactivation, angiopathic thrombosis, and protein-losing enteropathy (CHAPLE) disease. Syfovre (pegcetacoplan 150 mg/mL vial) age criteria was updated from ≥ 60 to ≥ 50 years of age.

Continuous Glucose Monitoring	The following CGM has been **added** to the pharmacy benefit **with** prior authorization **and** quantity limit: • Freestyle Libre 3 Reader – **QL** of 1 receiver ***per*** 365 days.r ▪
Corticosteroids - Oral	New drug, **Agamree** (*vamorolone suspension*), was **added** to the pharmacy benefit **with** prior authorization.
Daprodustat (**Jesduvroq**)	This new drug has been **added** to the pharmacy benefit **with** prior authorization.
Dronabinol (**Marinol Syndros**)	Prior authorization has been removed for this medication, however, a quantity limit of 60 capsules per 30 days has been **added.** Criteria for Marinol requests that exceed quantity limit was added requiring medical necessity.
Gastrointestinal Drugs	**Voquezna** (*vonoprazan tablet*) has been added to the pharmacy benefit **with** prior authorization **and** quantity limit of 30 tablets per 30 days. • •
Gemtuzumab-ozogamicin (**Mylotarg**)	This medication has been removed from pharmacy benefit and will be available on the medical benefit only **with** prior authorization.
Glaucoma Agents	Prior authorization was removed from Lumigan 0.01% (*bimatoprost 0.01% ophthalmic solution*) on the pharmacy benefit.
Hereditary Angioedema Agents	The following new strength has been **added** to the pharmacy benefit **with** prior authorization and quantity limit • **Takhzyro** (*lanadelumab-flyo*) **150mg/ml** prefilled syringe – 2 mL per 28 days
Kinase Inhibitors	The following new drug was **added** to the pharmacy benefit **with** prior authorization **and** quantity limit: • **Vanflyta** (*quizartinib dihydrochloride tablet) 17.7mg & 26.5mg* – **QL** 60 tablets per 30 days.

Lung Cancer Agents	The following medication has been **added** to the pharmacy benefit **with** prior authorization: • **Xalkori** (*crizotinib pellets*) 20mg, 50mg, and 150mg The following medications have been removed from the pharmacy benefit and will only be available on the medical benefit **with** prior authorization: • **Portrazza, Rybrevant, Zepzelca** Off-label criteria was added to the policy for the use of Krazati (adagrasib) and Lumakras (sotorasib) for advanced or metastatic colorectal cancer. **Exkivity** criteria was removed due to its removal from the U.S. market. **Xalkori:** The age range was removed for the indication of systemic ALCL per NCCN guidelines. Medical necessity criteria for use of the oral pellet formulation instead of the capsules was added.
Melanoma Agents	Criteria for Braftovi (encorafenib) plus Mektovi (binimetinib) was updated for the treatment of adult patients with metastatic non-small cell lung cancer (NSCLC) with a BRAF V600E mutation.
Oncology Immunotherapies	Criteria for **Keytruda** was updated to include the following expanded indications: • resectable Non-Small Cell Lung Cancer (NSCLC) • unresectable or metastatic HER2- negative gastric or gastroesophageal junction (GEJ) adenocarcinoma • locally advanced or metastatic biliary tract cancer (BTC) Criteria for **Jemperli** was updated for the use in combination with carboplatin and paclitaxel, followed by Jemperli as a single agent for the treatment of adult patients with primary advanced or recurrent endometrial cancer that is mismatch repair deficient (dMMR), as determined by an FDA-approved test, or microsatellite instability-high (MSI-H).
Osteoporosis Agents	**Alendronate solution 70mg/75ml** has been **added** to the pharmacy benefit **with** prior authorization. Criteria was updated to reflect tha**t Tymlos** is now FDA-approved for the treatment of osteoporosis in men. Teriparatide listings was updated with strengths to differentiate between generic Forteo and the 620 mcg/2.48 mL formulation.

Sohonos (*palovarotene capsule*)	This new drug was **added** to the pharmacy benefit **with** prior authorization.
Tepezza (teprotumumab-trbw)	Criteria was updated to reflect expansion of FDA-approval to include all thyroid eye disease (TED) regardless of CAS score. The CAS score requirement was removed.
Turalio (*pexidartinib capsule*)	The provider specialty requirement was expanded to include oncologist consult notes.
Potassium Binding Agents	The following medications have been **added** to the pharmacy benefit **with** prior authorization **and** quantity limits: • **Lokelma** (*sodium zirconium cyclosilicate*) *5gm & 10gm* – **QL** 30 packets per 30 days. • **Veltassa** (*patiromer calcium sorbitex*) *8.4gm & 16.8gm 25.2gm* – **QL** 30 packets per 30 days.
Prostate Cancer Agents	Diagnosis of non-metastatic castration-sensitive prostate cancer (NM-CSPC) was added to Xtandi criteria.
T-cell Immunotherapies (CAR-T Monitoring Program)	The following medications have been **added** to the medical benefit only **with** prior authorization: • **Elrexfio** (*elranatamab-bcmm*) • **Talvey** (*talquetamab-tgvs*)
Thrombocytopenic Agents	The diagnosis criteria was updated for **Doptelet** and **Mulpleta**: "Diagnosis of thrombocytopenia due to chronic liver disease (CLD) in a member scheduled to undergo a procedure"
Tropomyosin Receptor Kinase (TRK) Inhibitors	The following new formulation was **added** to the pharmacy benefit **with** prior authorization **and** quantity limit: • **Rozlytrek** (*entrectinib oral pellet 50mg*) – QL ≤ 12 packets/day Rozlytrek had an expanded age indication for use in the treatment of adult and pediatric patients older than 1 month of age with solid tumors that: • have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion, as detected by an FDA-approved test without a known acquired resistance mutation,

	• are metastatic or where surgical resection is likely to result in severe morbidity, and • have progressed following treatment or have no satisfactory alternative therapy
Vaccine Guideline	The following new vaccine has been **added** to the pharmacy benefit with quantity limit: • **Penbraya** (*pentavalent meningococcal vaccine*) **QL** < 1 dose in the last 5 months and a total of < 2 doses per lifetime.
Zilretta (triamcinolone extended-release)	This medication has been removed from the pharmacy benefit and will only be **available** on the medical benefit **with** prior authorization.