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.

Effective 5/11/2026

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

Generic Medication	Brand Name Alternative
Besifloxacin 0.6% ophthalmic suspension	Besivance 0.6% ophthalmic suspension
Loteprednol etanobate/tobramycin ophthalmic suspension	Zylet 0.5-0.3% ophthalmic suspension

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

Brand Name	Generic Medication
Sporanox 100mg capsule	Itraconazole 100 mg capsule

Effective 5/11/2026

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

Acromegaly, Carcinoid Syndrome, Cushing Syndrome Agents	• **Palsonify tablet** will be **added** to the pharmacy benefit **with** a prior authorization requirement **and** quantity limit of 60 tablets per 30 days. Criteria will require a step-through trial with a somatostatin analog and Somavert. Also, confirmation whether there was history of no response to cabergoline or a somatostatin analog or there was a treatment failure to cabergoline in combination with a somatostatin analog. Other criteria requirements will apply.

	• **Bynzefia pen injector** will be **added** to the pharmacy benefit **without** restrictions.
Anticoagulants	**Eliquis sprinkle capsules** and **tablets for oral suspension** will both remain covered under the pharmacy benefit and will no longer require prior authorization.

Antiemetics and Appetite Stimulants	• The following medications will remain covered under the pharmacy benefit and a quantity limit is being **added**:
	  ○ **Cinvanti** 130mg/18mL vial – **QL** 2 vials per 28 days
	  ○ **Sancuso** 3.1mg/24hr patch – **QL** 2 units per 28 days
	• **Sustol 10mg/0.4mL syringe** will remain covered under the pharmacy benefit with existing quantity limits **and** will now require prior authorization. Criteria will require a step-through trial with Sancuso transdermal and granisetron injection, and will require that quantity is ≤ 2 injections/28 day.
	• **Emend** criteria was updated to include medical necessity for exceeding quantity limits.

Antifungals - Topical	• **Econazole 1% foam** will be **added** to the pharmacy benefit **with** a prior authorization and will require clinical rationale for use over the cream formulation and trial of at least two preferred antifungal alternatives (e.g., terbinafine, tolnaftate, clotrimazole, ketoconazole, butenafine, ciclopirox). • **Butenafine 1% cream** will be **added** to the pharmacy benefit with no restrictions.
Anti Hemophilia Agents	**Helimbra vial** will remain covered under the pharmacy benefit and will now require prior authorization.
Anti-Obesity Agents	**Wegovy tablets** will be **added** to the pharmacy benefit **with** a prior authorization **and** a quantity limit of 30 tablets per 30 days. Wegovy tablets will be preferred and managed consistently with Wegovy injection and Zepbound criteria for the treatment of obesity/overweight, reduction in MACE risk, and OSA in adults with obesity. *MACE: major adverse cardiovascular events; OSA: obstructive sleep apnea*
Antipsychotics	• New **Vraylar** strengths **0.75mg** and **0.5mg** capsules will be **added** to the pharmacy benefit **and** will require prior authorization.The criteria was updated to reflect the following expanded age indications: schizophrenia in pediatric patients 13 years of age and older and acute treatment of manic or mixed episodes associated with bipolar I disorder in pediatric patients 10 years of age and older. • Polypharmacy updates were made to **Cobenfy** - if there is an overlap of 60 days or more of Cobenfy within a 90 day period with another antipsychotic agent, a prior authorization review will apply.
Adcetris (brentuximab)	• New FDA-approved indication of large B-cell lymphoma (LBCLs) was added.

	• Criteria for relapsed or refractory large B-cell lymphoma was updated to better align with the package insert.
GnRH Analogues	**Supprelin LA 50 mg Kit** will be **added** to the pharmacy benefit **with** prior authorization **and** a quantity limit of 1 kit per 365 days. It will remain on the medical benefit **with** prior authorization.
Insulin Products	• **Semglee** and **Rezvoglar** criteria were updated to require medical necessity for use instead of insulin glargine prefilled syringe or vial such as branded or unbranded Lantus SoloSTAR or Lantus vial. • **Kirsty** (insulin aspart-xjhz) and **Merilog** (insulin aspart-szjj), including their various vial and injection formulations, are being **added** to the pharmacy benefit **with** a prior authorization and will require medical necessity for use instead of Novolog (insulin aspart). • **Toujeo** (insulin glargine) and **Tresiba** (insulin degludec), both brand-preferred, will now require a prior authorization on the pharmacy benefit. Medical necessity for use instead of insulin glargine prefilled syringes or vials (e.g., Lantus SoloSTAR or Lantus vial) will be required. • **Humalog** (insulin lispro **200** units/mL) will require medical necessity for use of 200 units/mL formulation instead of 100 units/mL formulation and is now subject to prior authorization under the pharmacy benefit. • **Novolin 70/30** (*insulin NPH/regular insulin 70/30*) will remain on the pharmacy benefit **and** will now require prior authorization.
Lipid Lowering Agents	• **Redemplo 25mg/0.5ml syringe** will be **added** to the pharmacy benefit **with** a prior authorization requirement **and** quantity limit of 1 syringe per 90 days. • **Tryngolza** criteria was updated to include step-through trial with Redemplo. For Tryngolza renewal requests, an additional trial with Redemplo will now be required.
Lymphoma and Leukemia Agents	**Imkeldi 80mg/mL solution** will be **added** to the pharmacy benefit **with** a prior authorization requirement. Medical necessity will be required for **Imkeldi** oral solution such as feeding tube, swallowing disorder, age is < 13 years, or clinical rationale why imatinib tablet cannot be dissolved in water or apple juice.
Osteoporosis Agents and Miscellaneous Calcium Regulators	• **Enoby** was added as a step-through for Prolia and its biosimilars. • **Xtrenbo** was added as a step-through for Xgeva and its biosimilars. • **Bonsity** (teriparatide) was added to the policy with a step therapy requirement through Forteo and is now subject to prior authorization under the pharmacy benefit. • The indication of prevention of osteoporosis was removed for teriparatide, calcitonin injection, Evenity, and Tymlos. • The following medications will be **added** to both the pharmacy benefit **and** medical benefit **with** a prior authorization:

	○ Bildyos syringe ○ Bilprevda vial ○ Enoby syringe ○ Ospomyv injection ○ Xtrenbo vial
Over-the-counter (OTC)	The following over the counter medications will no longer be covered under the pharmacy benefit: • Witch Hazel pre-moistened medicated wipes • Cod Liver Oil soft gels • Glucosamine/chondroiton combinations • Sterile water • Magaldrate • Sodium biphasic enema
Pulmonary Fibrosis and Interstitial Lung Disease Agents	**Jascayd tablet** will be **added** to the pharmacy benefit **with** a prior authorization requirement **and** quantity limit of 60 tablets per 30 days. For idiopathic pulmonary fibrosis (IPF) indication, Jascayd will require a step-through trial with pirfenidone. For progressive pulmonary fibrosis indication (PPF), a step-through trial with or combination with Ofev will be required.
Spinal Muscular Atrophy Agents	• Criteria that allowed use after gene therapy was removed from Spinraza and Evrysdi. And a requirement to confirm if gene therapy was previously utilized was added. • Functional tests will be required for all renewal requests (regardless of response) for Spinraza and Evrysdi.
Targeted Immunomodulators	• The following medications will be **added** to the pharmacy benefit **with** prior authorization **and** quantity limits: ○ Otezla XR titration pack (*28-day initiation*) – **PA**, **QL** 1 titration pack (41 tablets) per 28 days ○ Otezla XR 75mg tablet – **PA**, **QL** 30 tablets per 30 days • **Otezla XR** will require medical necessity for its use instead of the immediate-release tablets. • New criteria was added regarding pediatric use of Tremfya to treat plaque psoriasis and psoriatic arthritis. • Actemra auto-injection or prefilled syringe will require clinical rationale for its use instead of Tyenne auto-injection or prefilled syringe
Egrifta (tesamorelin)	**Egrifta WR kit**, will be **added** to the pharmacy benefit **with** a prior authorization requirement.
Thrombocytopenic Agents	• **Wayrilz tablet** will be **added** to the pharmacy benefit **with** a prior authorization requirement **and** quantity limit of 60 tablets per 30 days. Criteria will be managed similar to Doptelet and Tavalisse. • New drug formulation, **Doptelet sprinkle 10mg capsule**, will be **added** to the pharmacy benefit **with** a prior authorization **and** quantity limit of 60

	capsules per 30 days. Criteria was updated to reflect the expanded indication for approval in ages one and older for the treatment of ITP. • **Alvaiz** criteria was updated to remove step-through Promacta (eltrombopag olamine). However, for Promacta (eltrombopag olamine) for selected age groups, medical necessity will be required for its use instead of Alvaiz. • **Cablivi** age indication was expanded to ages 12 and older.
Zilretta (triamcinolone extended-release)	Criteria was updated to include clinical rationale for use of Zilretta instead of long acting intra-articular corticosteroid injection preparations available without prior authorization (e.g., Celestone (betamethasone injection), Kenalog (triamcinolone injection)).