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| | <ul style="list-style-type: none"> • 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. |
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Effective 7/1/2026

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

| Generic Medication | Brand Name Alternative |
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| Beclomethasone inhaler | Qvar Redihaler |
| Bimatoprost 0.01% ophthalmic solution | Lumigan 0.01% ophthalmic solution |
| Buprenorphine buccal film | Belbuca Film |
| Insulin NPH 100 unit/mL vial | Humulin N 100 unit/mL vial |
| Insulin NPH 100 unit/mL Kwik Pen | Humulin N 100 unit/mL Kwik Pen |
| Progesterone 100 mg vaginal insert | Endometrin 100 mg vaginal insert |
| Umeclidinium Ellipta Inhaler | Incruse Ellipta Inhaler |

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

| Brand Name | Generic Medication |
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| Fabior 0.1% Foam | Tazarotene 0.1% Foam |

Effective 7/1/2026

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

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| Agents for Menopausal Symptoms | Lynkuet criteria was updated to require a step-through trial with Veozah (requires prior authorization). |
| Amyloidosis Therapies | Vyndaqel and Vyndamax criteria were updated to require a step-through trial with Attruby. |
| Androgen Therapy | For any testosterone product, the diagnosis requirement was updated to include “other pediatric hypogonadism” indications in addition to delayed puberty. For this additional diagnosis, age requirement is $s \geq 12$ to < 18 years |



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| | old. And the number of lab results demonstrating low testosterone levels was updated from two to one. |
| Antidepressants | <ul style="list-style-type: none"> • Exxua tablet will be added to the pharmacy benefit with a prior authorization and quantity limit of 30 tablets per 30 days. Criteria will require a step-through trial with Trintellix. • Exxua titration pack will be added to the pharmacy benefit with a prior authorization requirement. • Escitalopram 15 mg capsules will also be added to the pharmacy benefit with a prior authorization requirement. Medical records will be required for a step-through trial of three escitalopram 5 mg tablets • The following clinical updates were made to Spravato: <ul style="list-style-type: none"> ○ Step-through trial of a mood stabilizer was further clarified to ONE of the following: carbamazepine, divalproex/valproate/valproic acid, lamotrigine, or lithium. Additional trials will include: second-generation antipsychotic, second antidepressant from a different class, or thyroid hormone. ○ Medical records will be required for a current assessment using any validated depression rating scale (e.g., Montgomery-Asberg Depression Rating Scale [MADRS], Hamilton Depression Rating Scale [HAM-D], Patient Health Questionnaire Depression Scale [PHQ-9], Beck Depression Inventory [BDI]). ○ Approval durations for Spravato were clarified based on dosing. Spravato dosed twice weekly was updated to a maximum of 6 months. ○ Dosing requirement was further specified within the criteria |
| Antidiabetic Agents – Non-Insulin and Combination products | For preferred GLP-1 agents (Ozempic and Trulicity), baseline A1c requirement was removed for type 2 diabetes mellitus and prediabetes indications. |
| Anti-Hemophilia Agents | Desmopressin 1.5 mg/mL nasal spray will be added to the pharmacy benefit with a prior authorization and quantity limit of 1 bottle per 30 days. Criteria will require a step-through trial of either intravenous or subcutaneous desmopressin acetate or clinical rationale for requesting the nasal formulation. Another step-through trial with aminocaproic acid and tranexamic acid will be required. |
| Antitubercular Agents | <ul style="list-style-type: none"> • Cycloserine 250mg capsule <u>will remain</u> covered under the pharmacy benefit and will now require prior authorization. Criteria will require that cycloserine be used in combination with at least three other antitubercular agents. • Sirturo criteria was updated to require appropriate dosing. |



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| <p style="text-align: center;">Asthma and Allergy Monoclonal Antibodies</p> | <ul style="list-style-type: none"> • Exdensur 100 mg/mL injection will be added to the medical benefit only with a prior authorization requirement. A step-through trial with Dupixent and Fasenra will be required. • Fasenra and Nemluvio will become preferred drugs. • Tezspire: <ul style="list-style-type: none"> ○ Expanded labeling of CRwNP was added. A step-through trial with Dupixent and Nucala will be required. (applies to initial and reauthorizations) ○ For severe asthma updated to include requirement for documentation of whether member has an eosinophilic phenotype and if so, trials with preferred agents Dupixent and Fasenra will be required. (applies to initial and reauthorizations) • Nucala criteria for CRwNP was updated to require a step-through trial with Dupixent. • Nucala criteria for severe eosinophilic asthma was updated to require a step-through trial with Dupixent and Fasenra. (applies to initial and reauthorizations) • Nemluvio criteria for AD and PN were updated to remove trials of other biologics. • Off-label indication of weekly Dupixent in AD was added. • The initial approval duration for Fasenra was updated from 6 to 12 months. And the reauthorization approval duration was updated to 12 months. <p><i>AD: atopic dermatitis, PN: prurigo nodularis, CRwNP: chronic rhinosinusitis with nasal polyps</i></p> |
| <p style="text-align: center;">Welireg (belzutifan)</p> | <p>Expanded labeling for the treatment of adult and pediatric patients 12 years and older with locally advanced, unresectable, or metastatic pheochromocytoma or paraganglioma (PPGL) was added.</p> |
| <p style="text-align: center;">Benzodiazepines and other Antianxiety Agents</p> | <ul style="list-style-type: none"> • Bucapsol capsule strengths (buspirone 7.5 mg, 10 mg, and 15 mg) will be added to the pharmacy benefit with a prior authorization requirement and the following quantity limits: <ul style="list-style-type: none"> ○ 7.5 mg – QL: 60 capsules per 30 days ○ 10 mg – QL: 90 capsules per 30 days ○ 15 mg – QL: 120 capsules per 30 days • Bucapsol: Additional step-through trial with two SSRIs or SNRIs, and a trial to buspirone tablet at an equivalent dose to requested dose will be required. • Verbiage update was made throughout the policy where skeletal muscle spasms can also include movement disorders. |



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| | <ul style="list-style-type: none"> • Xifaxan was removed as a step-through trial for chlordiazepoxide/clinidium. • Brand name Ativan, Klonopin, Xanax criteria were updated to ensure appropriate use for respective indications (anxiety disorder/panic disorder, skeletal muscle spasm/movement disorder). |
| Breast Cancer Therapies | <ul style="list-style-type: none"> • Inluriyo 200mg tablet will be added to the pharmacy benefit with a prior authorization and quantity limit of 60 tablets per 30 days. • Datroway criteria for NSCLC will include additional EGFR mutations such as exon 19 deletion, L858R, S768I, L861Q, G719X mutations and exon 20 insertion per NCCN guidelines. <p><i>NSCLC = non-small cell lung cancer; EGFR = epidermal growth factor receptor</i></p> |
| Cardiovascular agents- Antihypertensives | <p>Lasix ONYU 80 mg/2.67 mL injection will be added to the pharmacy benefit with a prior authorization requirement and a quantity limit of 8 units per 30 days; it will be available <u>without</u> restrictions under the medical benefit.</p> <ul style="list-style-type: none"> • Enbumyst 0.5 mg Nasal Spray will be added to the pharmacy benefit with a prior authorization and quantity limit of 1 box (12-pack carton) per 30 days. • The following medications will be added to the pharmacy benefit with a prior authorization requirement: <ul style="list-style-type: none"> • Javadin oral solution 0.02 mg/mL <ul style="list-style-type: none"> ▪ A step-through trial with clonidine immediate release tablets or clinical rationale supporting the use of the oral solution will be required (e.g., swallowing disorder, tube feeding) ▪ Two step-through trials with other antihypertensive agents will also be required ○ Lopressor oral solution 10 mg/mL <ul style="list-style-type: none"> ▪ A clinical rationale supporting the use of the oral solution will be required (e.g., swallowing disorder, tube feeding) ○ Lopressor tablet (metoprolol tartrate 12.5 mg) <ul style="list-style-type: none"> ▪ A step-through trial with metoprolol immediate release tablet will be required • The following medications will remain covered under the pharmacy benefit and <u>will now</u> require prior authorization: <ul style="list-style-type: none"> ○ Inspra (<i>eplerenone tablets</i>) <ul style="list-style-type: none"> ▪ Step-through trial with spironolactone tablet will be required ○ Exforge HCT (amlodipine/valsartan/HCTZ tablets) |



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| | <ul style="list-style-type: none"> ▪ Medical necessity for use of the combination drug instead of the commercially available separate agents will be required <ul style="list-style-type: none"> • Inzirgo oral solution 10 mg/mL <u>will remain</u> covered under the pharmacy benefit; prior authorization will apply only to members aged 13 years and older. • Norliqva solution will be preferred for Katerzia suspension requests. • Furoscix on-body infusor criteria was updated to remove requirement that oral diuretics were discontinued and include a requirement of one of the following: <ul style="list-style-type: none"> ○ Chronic kidney disease ○ Age < 18 years old ○ Step-through trial with Lasix Onyu |
| Cardiovascular agents- Miscellaneous Agents | <ul style="list-style-type: none"> • Entresto (sacubitril/valsartan tablets) <u>will remain</u> covered under the pharmacy benefit with existing quantity limits and <u>will no longer</u> require prior authorization. • Quinidine sulfate tablets <u>will remain</u> covered under the pharmacy benefit and <u>will now require</u> prior authorization. A step-through trial with quinidine gluconate ER was added. |
| CGRP Inhibitors | Ajovy received an expanded indication for the use in ages 6 to 17 years of age and who weight 45 kg or more in migraine prevention. |
| Complement Inhibitors | <ul style="list-style-type: none"> • Fabhalta criteria for IgAN was updated: <ul style="list-style-type: none"> ○ Decreased proteinuria thresholds to ≥ 0.5 g/day and decreased Urine protein-to-creatinine ratio (UPCR) threshold to ≥ 0.5 g/g ○ Step-through trials will require either Filspari or Vanrafia and either systemic glucocorticoid or Tarpeyo • Izervay criteria was updated to remove the 12-month maximum treatment duration |
| corticotropin | <ul style="list-style-type: none"> • Cortrophin Gel prefilled syringe (40 units/0.5 mL and 80 units/mL) will be added to the pharmacy benefit with a prior authorization requirement. Medical necessity for its use instead of Acthar will be required. • Acthar prefilled syringe will no longer require medical necessity for its use instead of the vial formulation. |
| Diabetic Testing Supplies | Freestyle Precision Neo test strips (NDC: 93815-0715-77, 93815-0715-79) will no longer be covered under the pharmacy benefit and will require prior authorization. |



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| DMD Disease Modifying Agents | Initial and reauthorization criteria for Amondys 45, Exondys 51, Vyondys 53, and Viltepso were updated to restrict use with other disease modifying therapies for Duchenne Muscular Dystrophy (DMD). |
| Enzyme and Metabolic Disorder Therapies | Forzinity 280 mg/3.5 mL vial will be added to the pharmacy benefit with a prior authorization requirement. |
| Glaucoma Agents | Omlonti 0.002% ophthalmic solution will be added to the pharmacy benefit with a prior authorization requirement. Criteria will require documented trial and failure of three agents from the following classes: prostaglandin analog, ophthalmic beta-blocker, ophthalmic alpha-2 adrenergic agonist, carbonic anhydrase inhibitor, parasymphomimetic, or Rhopressa. |
| Gynecologic Cancer Agents | <ul style="list-style-type: none"> • Tivdak was updated to remove Keytruda step-through to align with NCCN Category 1 recommendations. • Elahere was updated to include age limit of 18 years or older. |
| Hepatitis Antiviral Agents | Mavyret 100 mg/40 mg tablet (NDC 00074-2625-84) will be added to the pharmacy benefit and will follow existing prior authorization and quantity limit criteria. |
| Immune Suppressants – Topical | <ul style="list-style-type: none"> • The following medications <u>will remain</u> covered under the pharmacy benefit with an existing prior authorization requirement. Quantity limits will be updated as follows: <ul style="list-style-type: none"> ○ Vtama 1% cream – QL 60 grams per 60 days ○ Opzelura 1.5% cream – QL 60 grams per 60 days <ul style="list-style-type: none"> ▪ Criteria update included total BSA involvement of ≤ 20% in atopic dermatitis and vitiligo ○ Eucria 2% ointment – QL 60 grams per 60 days (60 gram tube), 100 grams per 50 days (100 gram tube) ○ Zoryve (0.05% cream, 0.15% cream, 0.3% cream, 0.3% foam) – QL: 60 grams per 60 days • Criteria updates were made throughout the policy to allow exceptions for an affected BSA of ≥ 2% and ≥ 4% for twice and once daily applications. • Initial approval durations were updated from 3 to 4 months. |
| Immunological Agents – Topical | Fabior was updated to align with Arazlo and will require an inadequate response or adverse reaction to a topical tretinoin agent and a topical tazarotene agent. |
| Immunotherapy - Oral | The age limit for Odactra was updated from 12 years old to 5 years old. |
| Insulin Products | <ul style="list-style-type: none"> • The following medications will remain covered under the pharmacy benefit and <u>will now require</u> prior authorization: <ul style="list-style-type: none"> ○ Novolin N 100 units/mL vial ○ Novolin N FlexPen 100 units/mL ○ Novolin 70/30 100 units/mL vial ○ Novolin 70/30 FlexPen 100 units/mL |



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| | <ul style="list-style-type: none"> A step-through trial with Humulin N will be required prior to Novolin N. Similarly, a step-through trial with Humulin 70/30 will be required prior to Novolin 70/30. |
| Iron Agents and Chelators | Auryxia for hyperphosphatemia in chronic kidney disease on dialysis was updated to remove Velphoro from one of the step-through options. |
| Kinase Inhibitors | <ul style="list-style-type: none"> Koselugo 5 mg and 7.5 mg sprinkle capsules will be added to the pharmacy benefit with a prior authorization requirement. The following clinical updates were made to the policy: <ul style="list-style-type: none"> Added an expanded age indication for Koselugo for the treatment of adult and pediatric members ≥ 1 year of age with neurofibromatosis type 1 (NF1) Added 2 expanded indications for Cabometyx: treatment of adult and pediatric members 12 years of age and older with previously treated, unresectable, locally advanced or metastatic, well-differentiated pancreatic neuroendocrine tumors (pNET) and well-differentiated extra-pancreatic neuroendocrine tumors (pNET) Remove requirement for cell histology from the RCC (renal cell carcinoma) criteria for Cabometyx Sutent for RCC was updated to be more aligned with the package insert |
| Lung Cancer Agents | <ul style="list-style-type: none"> Hyrnuo tablet will be added to the pharmacy benefit with a prior authorization and quantity limit of 120 tablets per 30 days. It will require a step-through trial with a first-line systemic therapy. Rybrevant Faspro will be added to the medical benefit only and <u>will require</u> prior authorization. Expanded labeling for Hernexeos for treatment of unresectable or metastatic non-squamous non-small cell lung cancer (NSCLC) whose tumors harbor human epidermal growth factor receptor 2 (HER2/ERBB2) tyrosine kinase domain-activating mutations in the first-line setting was added. |
| Lymphoma and Leukemia Agents | <ul style="list-style-type: none"> Komzifti 200 mg capsule will be added to the pharmacy benefit with a prior authorization and quantity limit of 90 capsules per 30 days. An expanded indication for Gazyva for lupus nephritis was added. Revuforj criteria for acute myeloid leukemia with NPM1 gene mutation will require a step-through trial with Komzifti for patients ≥ 18 years of age. |
| Ogsiveo (nirogacestat) | <p>The following clinical update was added:</p> <ul style="list-style-type: none"> If there has not been a treatment failure to sorafenib, then additional clinical rationale will be required for Ogsiveo instead of sorafenib. (e.g. medical necessity for quicker onset of action due to disease |



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| | severity, location and/or size of tumor with potential for destruction or functional impairment of adjacent vital structures and/or organs) |
| Oncology Immunotherapies | Unloxcyt 300 mg/5 mL vial will be added to the medical benefit only and <u>will require</u> prior authorization. Unloxcyt will require a step-through trial with one of the following: Keytruda, Keytruda Qlex, or Libtayo. |
| Presbyopia, Myopia, and Mydriasis Agents | Yuvezzi 2.75%-0.1% eye drops will be added to the pharmacy benefit with a prior authorization and quantity limit of 1 single dose vial per day. A step-through trial with Vuity will be required. |
| Renal Disorder Agents | <ul style="list-style-type: none"> • Velphoro chewable tablet <u>will remain</u> covered under the pharmacy benefit and will now require prior authorization. Velphoro will require a step-through of two trials with calcium acetate, lanthanum carbonate, or sevelamer hydrochloride or sevelamer carbonate. • The following medications will be added to the pharmacy benefit and <u>will require</u> prior authorization: <ul style="list-style-type: none"> ○ Voyxact 400 mg/2 mL prefilled syringe ○ Pokonza 5% (10 MEQ/15 mL) oral solution <ul style="list-style-type: none"> ▪ Pokonza criteria was updated to require medical necessity for use over potassium replacement products that are available without PA ○ Potassium chloride 40 mEq powder packet • Veltassa 1 gram powder packet will be added to the pharmacy benefit with a prior authorization requirement for members <u>18 years and older</u> and will also have a quantity limit of 120 packets per 30 days. • Kerendia criteria for heart failure was updated to include Inpefa as another acceptable step-through trial. • Quantity limits within criteria for Lokelma and Veltassa 8.6 g, 16.8 g packets were updated to allow maximum FDA-approved maintenance dosing without a prior authorization. • Urinary Protein Creatinine Ratio (UPCR) and proteinuria thresholds were updated to ≥ 0.5 for all immunoglobulin A nephropathy (IgAN) agents. |
| Spinal Muscular Atrophy Agents | Reauthorization criteria for Spinraza and Evrysdi were updated to limit use in patients who have previously received gene therapy. |
| T-Cell Immunotherapies | Epkinly criteria was updated to include lenalidomide and rituximab in combination therapy for adult patients with relapsed or refractory follicular lymphoma. |
| Targeted Immunomodulators | <ul style="list-style-type: none"> • The following medications will be added to the medical benefit only with a prior authorization requirement: <ul style="list-style-type: none"> ○ Avtozma vial ○ Starjemza 130 mg/26 mL vial |



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| | <ul style="list-style-type: none"> • The following medications will be added to both the pharmacy benefit and medical benefit with a prior authorization requirement: <ul style="list-style-type: none"> ○ Starjemza 45 mg/0.5 mL vial, prefilled syringe ○ Starjemza 90 mg/mL prefilled syringe ○ Unbranded ustekinumab-aauz 45 mg/0.5 mL prefilled syringe ○ Unbranded ustekinumab-aauz 90 mg/mL prefilled syringe • Starjemza and unbranded ustekinumab-aekn will become <u>preferred</u> biosimilars for Imuldosa (ustekinumab-srlf), Otulfi (ustekinumab-aauz), Pyzchiva (ustekinumab-ttwe), Selarsdi (ustekinumab-aekn), Stelara (ustekinumab), Steqeyma (ustekinumab-stba), Wezlana (ustekinumab-auub), Yesintek (ustekinumab-kfce), unbranded ustekinumab, unbranded ustekinumab-aauz, and unbranded ustekinumab-ttwe requests. <ul style="list-style-type: none"> ○ Imuldosa, Pyzchiva, and Steqyma will no longer be preferred. • Cibinqo and Rinvoq will require a step-through trial with Nemluvio in addition to either Adbry, Ebglyss, or Dupixent in atopic dermatitis. • Actemra and Tofidence will require a step-through trial with Avtozma and Tyenne or clinical rationale for the requested medication. |
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