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 1/4/2027

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

Generic Name	Brand Name Alternative
Nitisinone capsules, suspension	Orfadin capsules, suspension
Naltrexone injection	Vivitrol injection

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

Brand Name	Generic Medication
Bethkis nebulizer 300 mg/4 mL	Tobramycin nebulizer 300 mg/4 mL
Betimol 0.25% eye drops	Timolol ophth soln 0.25%
Minivelle transdermal patch	Estradiol transdermal patch
Ravicti 1.1 g/mL oral liquid	Glycerol phenylbutyrate 1.1 g/mL oral liquid
Travatan Z 0.004% eye drops	Travoprost 0.004% eye drops
Ventolin HFA Inhaler	Albuterol HFA Inhaler
Zituvio tablets	Sitagliptin tablets

Effective 1/4/2027

The following changes are being made to the listed medications to be in compliance with the MassHealth UPPL (Unified Pharmacy Product List). Criteria updates will include, but are not limited to, the changes listed for each category.

Angiogenesis Inhibitors	• The following medications will remain covered under the medical benefit and will no longer require prior authorization:
	  ○ Mvasi injection
	  ○ Vegzelma injection
	  ○ Zirabev injection
	• Criteria was updated to prefer Mvasi, Vegzelma, and Zirabev. Avastin, Jobevne, and Alymsys will require trials of preferred biosimilars.

Antibiotics – Oral	• **Cefixime 400 mg tablet** will be **added** to the pharmacy benefit **with** a prior authorization requirement **and** a quantity limit of 30 tablets per 30 days.
	  ○ The capsule formulation will be preferred, and medical necessity will be required for coverage of the tablet formulation.
	  ○ Criteria for suspension and oral solution formulations were updated to include medical necessity for its use as noted by age <13, tube feeding involvement, or condition affecting the ability to swallow.
	• **Doxycycline hyclate 75 mg capsule** will be **added** to the pharmacy benefit **with** a prior authorization requirement.
	• The following medications will remain covered under the pharmacy benefit and will no longer require prior authorization:
	  ○ Minocycline HCL 50 mg, 75 mg tablets
	  ○ Fidaxomicin 200 mg tablet
	• The following medications will remain covered under the pharmacy benefit and will now require prior authorization:
	  ○ clarithromycin suspension
	  ○ Eryped (erythromycin ethylsuccinate suspension)
	  ○ Erythromycin ethylsuccinate tablet
	  ○ Erythromycin stearate tablet
	  ○ Levofloxacin oral solution
	  ○ Sulfadiazine 500 mg tablet

Antidiabetics Agents - Non-Insulin and Combination products	• The following medications will remain covered under the pharmacy benefit **with** existing quantity limits and will no longer require prior authorization:
	  ○ Januvia (sitagliptin phosphate tablets)
	  ○ Zituvio (sitagliptin tablets)
	• New drug strength, **Glipizide 15 mg tablet**, will be **added** to the pharmacy benefit **with** a prior authorization requirement.

	• **Jardiance tablets** will remain covered under the pharmacy benefit and will now require prior authorization. • **Tzield** criteria was updated to reflect the expanded FDA approval for treatment of stage 2 Type 1 Diabetes Mellitus (T1DM) in patients 1 year of age and older and treatment of stage 3 T1DM in patients aged 8 to 17 years. • **Mounjaro** criteria was updated to reflect the expanded FDA approval for risk reduction of major adverse cardiovascular event (MACE) in Type 2 Diabetes Mellitus. • Criteria for **Soliqua, Xultophy, and Bydureon Bcise** was updated to change the list of high-potency GLP-1 agonist trials from Mounjaro and Ozempic to tirzepatide and semaglutide injection or tablet in addition to Trulicity 4.5 mg. • **Jentadueto, Jentadueto XR, and Tradjenta** were designated as preferred drugs. • Step-through trial with metformin used in combination with Trulicity and an SGLT2 inhibitor was added for Mounjaro, Ozempic, and Rybelsus for prediabetes. • **Jardiance** criteria will require a step through trial with dapagliflozin for T2DM, heart failure, and chronic kidney disease.

Antihistamines	• The following medications will remain covered under the pharmacy benefit and will now require prior authorization:
	  ○ Desloratadine solution
	  ○ Clemastine tablets
	  ○ Hydroxyzine solution
	  ○ Cetirizine 2.5 mg chewable tablet
	• **Clemastine** tablet was added to the same criteria as carbinoxamine solution, Ryvent, and Karbinal ER.
	• **Hydroxyzine hydrochloride solution** was added to the policy requiring an inadequate response to two antihistamine solutions available without PA. Additional requirement regarding swallowing ability has been added within the initial and recertification criteria: swallowing disorder, tube feeding use, age is <13, or trial of crushed hydroxyzine tablets.
	• **Desloratadine solution** was added to the policy requiring a trial with both fexofenadine and levocetirizine solution.

Antiretroviral Agents	• The following medications will remain covered under the pharmacy benefit and will no longer require prior authorization:
	  ○ Genvoya tablet
	  ○ Odefsey tablet
	  ○ Stribild tablet

Anti-VEGF Agents	• The following medications will remain covered under the medical benefit and will now require prior authorization:
	  ○ Cimerli injection
	  ○ Eylea/Eylea HD injection
	  ○ Lucentis injection
	  ○ Pavblu injection
	  ○ Beovu injection
	  ○ Byooviz injection
	  ○ Susvimo injection
	  ○ Vabysmo injection
	• **Avastin for ophthalmic indications** will only be required for new starts for diabetic macular edema (DME), diabetic retinopathy (DR), myopic choroidal neovascularization (mCNV), and retinal vein occlusion (RVO).

Asthma and Allergy Monoclonal Antibodies	• **Nucala** criteria for CRwNP, COPD, and eosinophilic asthma were updated to remove Dupixent as a step-trial requirement. Also, the step-through requirement of Fasenra was removed for EGPA, HES, and eosinophilic asthma. • The initial duration of authorization for **Nucala** was changed to 12 months. • Criteria for agents with asthma indications were updated to include beclomethasone HFA, Breztri, Bevespi, and Pulmicort as trials. *CRwNP: chronic rhinosinusitis with nasal polyps, EGPA: eosinophilic granulomatosis with polyangiitis, HES: hypereosinophilic syndrome*
Benign Prostatic Hyperplasia (BPH) Agents	• **Silodosin** criteria for diagnosis of kidney stones was updated to remove the calcium channel blocker trial requirement. The trial requirement of two alpha blockers or medical necessity due to a swallowing disorder or use of tube feeding was added.
Blastic Plasmacytoid Dendritic Cell Neoplasm Agents	• **Decnupaz injection** will be **added** to the medical benefit only **with** a prior authorization requirement. • Criteria will be updated to require members to be 18 years of age or older and confirm that the requested agent will be used as monotherapy or in combination with intrathecal chemotherapy for CNS disease.
Breast Cancer Agents Hedgehog Pathway Inhibitors	• **Veppanu tablets** will be **added** to the pharmacy benefit **with** a prior authorization **and** quantity limit of 30 tablets per 30 days. • **Ibrance** and **Kisqali** criteria were updated to include Verzenio as a required trial. • **Itovebi** criteria was updated to include Piqray as a required trial for PIK3CA mutations.

	• New expanded indication for **Ibrance** in combination with trastuzumab, with or without pertuzumab, and endocrine therapy for the maintenance treatment of adult patients with HR-positive, HER2-positive locally advanced or metastatic breast cancer following induction treatment was added.
CGRP Inhibitors	• Duration of approval for recertifications for migraine prevention was extended to 1 year. • **Aimovig, Ajovy, Emgality, and Vyepti** for migraine prevention will now require two trials of either a beta blocker, tri-cyclic antidepressant, topiramate, or valproate (i.e., valproic acid, divalproex). • Criteria for migraine prevention in patients ages ≥ 6 to <18 years old was added for **Aimovig, Emgality, Nurtec, and Qulipta.**

Colony Stimulating Factors	• Criteria was updated preferring **Neulasta vial, Fulphila, and Fylnetra** as the preferred pegfilgrastim products and **Nivestym, Releuko, and Zarxio** as the preferred filgrastim products.
	• The following medications will no longer be covered under the pharmacy benefit and will be covered under the medical benefit only, **with** a prior authorization requirement:
	  ○ Neulasta Onpro injector
	  ○ Udenyca on-body injector
	• **Neulasta 4/0.4 mL vial** will no longer be covered under the pharmacy benefit and will be covered under the medical benefit only without restrictions.
	• The following medications will be **added** to both the pharmacy benefit **and** medical benefit **with** a prior authorization requirement:
	  ○ Armlupeg injection
	  ○ Filkri injection
	  ○ Nypozi injection
	  ○ Rolvedon injection
	• The following medications will remain covered under the pharmacy benefit with a new prior authorization requirement and will also be **added** to the medical benefit **with** a prior authorization requirement:
	  ○ Granix injection
	  ○ Neulasta 6 mg/0.6 mL prefilled syringe
	  ○ Neupogen injection
	  ○ Nyvepria injection
	  ○ Ryzneuta injection
	  ○ Stimufend injection
	  ○ Udenyca prefilled autoinjector
	  ○ Ziextenzo injection

Colorectal Cancer Agents	• **Lonsurf** criteria for metastatic gastric or gastroesophageal junction adenocarcinoma was updated to better align with package labeling by clarifying that the two prior lines of chemotherapy should be fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, HER2/neu-targeted therapy.
Complement Inhibitors	• Criteria was updated to specify step-through trials with preferred eculizumab biosimilars. For **Bkemv**, a trial with Epysqli will be required. For **Soliris**, both trials with Bkemv and Epysqli will be required. Also, a clinical rationale as to why the requested non-preferred agent is expected to provide a different clinical outcome than the preferred agents will be required.
Continuous Subcutaneous Insulin Infusion	• Criteria for all products within this class were streamlined with respect to requests exceeding quantity limits, and recertification criteria was updated to require documentation of continued medical necessity for requests exceeding quantity limits. • **Cequr Simplicity 7-day patch** will be **added** to the pharmacy benefit **with** a prior authorization **and** a quantity limit of 1 patch per 7 days. • **Cequr simplicity inserter** will remain covered under the pharmacy benefit and will now require prior authorization. • **Omnipod 5 DexG7G6 5 Pack Pods (Gen 5)** will remain covered under the pharmacy benefit **and** will now require prior authorization **and** a quantity limit of 1 pod per 3 days.
Covid-19 Treatments and Prophylactic Agents	• **Xocova 125 mg tablet** will be **added** to the pharmacy benefit **and** will require prior authorization for members less than 12 years of age. A quantity limit of 7 tablets per fill will also apply. Medical necessity for exceeding this quantity limit will be required.
Enteral Nutritional Products and Thickening Agents	• Effective **January 4, 2027**, MassHealth will continue to allow formula, thickening agents, and enteral nutritional liquid products to be dispensed by pharmacy providers but will begin to require prior authorization. • Criteria requirements will include but are not limited to the following: ○ Criteria will require conditions affecting nutrition, digestion/absorption, caloric needs, or ability to eat that a regular diet cannot meet nutritional needs. Documentation will be required for diagnosis, current symptoms/impairment, and the medical need for formula. Formula requests may be considered when the member is not eligible for WIC, or when WIC coverage is insufficient because the needed quantity exceeds WIC limits or the requested special formula is not covered by WIC.

	○ For full criteria, please check the MassHealth Drug List on January 4, 2027.
Erythropoietic Stimulating Agents	• Requirement for adverse reaction or contraindication was updated to clinical rationale for use instead of the preferred epoetin alfa product in addition to the step-through requirement with Retacrit under the pharmacy benefit.
Enzyme and Metabolic Disorder Therapies	• The following medications <u>will remain</u> covered under the pharmacy benefit and <u>will now</u> require prior authorization: ○ Nityr tablets ○ Orfadin (*nitisinone capsules, suspension*) ○ Pancreaze DR capsules ○ Pertzye capsules ○ Viokace tablets ○ Zenpep DR capsules • **Cerezyme** criteria was updated following expanded indication for use in type 3 Gaucher disease. • **Palynziq** criteria was updated to the lower age requirement to those at least 12 years old based on expanded labeling and the diet consideration was removed. • **Harliku** criteria in alkaptonuria was updated to step-through Orfadin 2 mg capsules. • **Xenpozyme** recertification criteria was updated to accept additional measures. • Criteria for **Pancreaze, Pertzye, Viokace, and Zenpep** will now require a step-through trial with Creon. • **Cerdelga and Zavesca** criteria in Gaucher disease was updated to now accept genetic testing. • **Olpruve** criteria will no longer require a step-through trial with Pheburane. However, Pheburane criteria will now require a trial of Olpruva. • Entire class policy was updated to require medical records for diagnosis or a copy of testing to support the diagnosis.
Rasonque (daraxonrasib)	• This medication will be **added** to the pharmacy benefit **with** a prior authorization **and** quantity limit of 60 tablets per 30 days. A step-through trial requirement of one or contraindication to all prior systemic therapies was added.
Vykat XR (diazoxide choline)	• Recertification criteria was updated to require updated weight in order to verify correct dosing.
Gamma-Aminobutyric Acid (GABA) Analogs	• The following new drug strengths will be **added** to the pharmacy benefit **with** a prior authorization requirement: ○ **Relgaabi** 200 mg capsule (*gabapentin 200 mg capsule*)

	○ **Relgaabi** 300 mg & 400 mg capsules
Glaucoma Agents	• The following medications be **added** to the pharmacy benefit **with** prior authorization: ○ **Zolymbus** gel 0.01% ○ **Phospholine iodide** 0.125% eye drops ▪ Criteria will require trial requirements based on indication: • For diagnosis of elevated intraocular pressure, three trials of carbonic anhydrase inhibitor, ophthalmic alpha-2 adrenergic agonist, ophthalmic beta-blocker, parasympathomimetic, prostaglandin analog, Rhopressa • For diagnosis of accommodative esotropia – two trials of Botulinum toxin A, corrective lenses ▪ Additional criteria will require preferred alternatives available on the MassHealth Drug List • **IDose TR** (*travoprost intracameral implant*) criteria was updated based on labeling that allows for re-administration. The approval durations were updated to 3 months.
Gynecologic Cancer Agents	• **Lifyorli capsules** will be **added** to the pharmacy benefit **with** a prior authorization requirement. A step-through trial requirement for one systemic therapy that includes bevacizumab was added.
Growth Hormone Disorder Agents	• Entire class policy was updated to clarify step-through requirements for all somatropin agents, Skytrofa, and Sogroya. • For **all somatropin agents** other than Genotropin, documentation of an adverse reaction or contraindication that cannot be expected or managed as part of growth hormone therapy to Genotropin will be required. • For **Skytrofa** or **Sogroya**, a step-through requirement with somatropin or significant comorbid behavioral health or psychiatric diagnoses that prevent daily administration or clinical rationale for use of the agent documenting the need for a once weekly formulation will be required.
Hepatitis Antiviral Agents	• **Hepcludex injection** will be **added** to the pharmacy benefit **with** a prior authorization requirement. Criteria will require Hepcludex be used in combination with Peg-IFN product (e.g., Pegasys) or an inadequate response to Peg-IFN product monotherapy. • The following medications <u>will remain</u> covered under the pharmacy benefit and <u>will no longer</u> require prior authorization. Existing

	quantity limits will remain in place, with additional quantity limits being **added** as outlined below: ○ Mavyret 100-40 mg tablet – **QL** 168 tablets per 180 days ○ Mavyret 50-20 mg oral pellet packet – **QL** 280 tablets per 180 days ○ Harvoni 45-200 mg tablet, oral pellet packet – **QL** of 28 tablets per 28 days **and** 84 tablets per 180 days ○ Ledipasvir/sofosbuvir 90/400 mg tablet - **QL** of 28 tablets per 28 days **and** 84 tablets per 180 days ○ Epclusa 200-50 mg tablet, oral pellet packet – **QL** 84 tablets per 180 days. ○ Sofosbuvir-Velpatasvir 400-100 mg tablet – **QL** 84 tablets per 180 days. • Quantity limit criteria for exceeding and within limit were added throughout the policy.
Herceptin Products	• Policy was updated for all agents within this class to require a step-through trial with Kanjinti and clinical rationale why the requested non-preferred agent is expected to provide a different clinical outcome than the preferred agent, Kanjinti.
Insulin Products	• **Novolog 70/30** *(insulin aspart 70/30)* <u>will remain</u> covered under the pharmacy benefit and <u>will no longer</u> require prior authorization.
Kinase Inhibitors	• **Pazopanib 400 mg tablet** will be **added** to the pharmacy benefit **with** a prior authorization **and** quantity limit of 60 tablets per 30 days. • **Votrient** criteria was updated to prefer the 200 mg tablet over the 400 mg tablet. Medical necessity is required for use of the 400 mg tablet.
Lupus Agents	• **Saphnelo autoinjector, prefilled syringe** will be **added** to the pharmacy benefit **with** a prior authorization requirement. Criteria was updated to remove the step-through requirement with Benlysta and option to bypass documentation of cutaneous systemic lupus erythematosus (SLE). A trial of Saphnelo **vial** formulation will be required prior to the auto-injection or prefilled syringe formulation.
Multiple Sclerosis Agents	• **Tyruko** criteria was updated to include trial requirement with Tysabri and clinical rationale why the requested non-preferred agent is expected to provide a different clinical outcome than the preferred agent.
Neuromuscular Blocker Agents	• **Botox** criteria for chronic migraine was updated to include a step-through requirement with a CGRP inhibitor (e.g., Aimovig, Ajovy, Emgality, Nurtec, Qulipta) and beta blockers as one of the multiple step-through options.

	• **Xeomin** criteria for upper limb spasticity was updated to remove the requirement for spasticity to not be caused by cerebral palsy in pediatric members following a package insert label update. • Off-label Botox indications of anal stenosis, chronic constipation, encopresis were changed to pediatric chronic constipation (ages <18). • Within the **Botox** criteria, erythromycin was added as a required trial along with appropriate dosing criteria for gastroparesis. • Dosing limits were added to Botox and Dysport criteria for anal fissures. • Recertification criteria for gastroparesis was updated to require positive response to therapy.
Opioid Dependence and Reversal Agents	• **Zurnai injection** will be **added** to the pharmacy benefit **with** a prior authorization **and** quantity limit of 2 units (1 mL) per year. • Approval duration for high dose requests has been updated to allow up to 3 months.
Osteoporosis Agents and Miscellaneous Calcium Regulators	• **Jubereq injection** & **Osvyrti injection** will be **added** to both the pharmacy benefit **and** medical benefit **with** a prior authorization requirement. Both of these agents were added as additional preferred denosumab biosimilars.
Otic Agents	• **Xtoro 0.3% otic suspension drops** will be **added** to the pharmacy benefit **with** a prior authorization requirement.
Prostate Cancer Agents	• Erleada has been added as a step-through option for new starts with non-metastatic castration-resistant prostate cancer (NM-CRPC) for either **Nubeqa** or **Xtandi**.
Pulmonary Fibrosis and Interstitial Lung Disease Agents	• **Pirfenidone** criteria was updated to prefer the 267 mg tablet formulation. Medical necessity is required for use of the capsule formulation and 534 mg tablet.

Respiratory Agents - Inhaled	• **Beclomethasone HFA inhaler** & **Breztri Aerosphere inhaler** will both be **added** to the pharmacy benefit **with** a prior authorization requirement.
	• The following medications <u>will remain</u> covered under the pharmacy benefit and <u>will now</u> require prior authorization:
	  ○ ProAir Respiclick
	  ○ Pulmicort Flexhaler
	  ○ Ventolin HFA Inhaler (brand and generic)
	• The following medications <u>will remain</u> covered under the pharmacy benefit and <u>will no longer</u> require prior authorization:
	  ○ Stiolto Respimat inhaler
	  ○ Albuterol HFA inhaler (generic Proventil)
	  ○ Albuterol HFA inhaler (generic ProAir)

	• **Breztri** criteria was updated to include expanded indication for asthma. The COPD criteria was updated to remove step-through trials. • **Trelegy** criteria was updated to include criteria for new starts with the additional trial of Breztri. • **Airsupra** criteria was updated to replace trial of albuterol and Pulmicort with trial of an inhaled corticosteroid (ICS) and short acting beta agonist (SABA) concomitantly.
Rituximab Agents	• Rituxan criteria was updated to prefer Rituxan Hycela, Riabni, Ruxience, or Truxima for initial and recertification requests.

Skeletal Muscle Relaxants	• The following medications will be **added** to the pharmacy benefit **with** a prior authorization requirement:
	  ○ **Atmeksi 750 mg/5 mL oral suspension**
	  ▪ Requirement of a trial with methocarbamol tablets or medical necessity for the requested formulation was added to criteria
	  ○ **Ontralfy 2 mg/5 mL oral suspension**
	  ▪ Requirement of a trial with tizanidine tablets or medical necessity for the requested formulation was added to criteria
	  ○ **Tonmya 2.8 mg sublingual tablet**
	  ▪ Requirement of a trial with cyclobenzaprine 5mg or 10mg tablets or medical necessity for the requested formulation was added to criteria
	  ○ **Zanaflex (tizanidine) 8 mg capsule**
	  ▪ Medical necessity for the use of requested formulation will be required

Targeted Immunomodulators	• **Icotyde tablet** will be **added** to the pharmacy benefit **with** a prior authorization requirement **and** quantity limit of 30 tablets per 30 days. For plaque psoriasis indication, step-through requirements with ustekinumab, Taltz, Skyrizi, and anti-TNF (tumor necrosis factor) agents will be required. • For **Ilumya** and **Tremfya** for plaque psoriasis, Icotyde will be required as a step-through trial. • Entire class policy was updated to now include an additional requirement of clinical rationale for the use of the non-preferred medication along with the trial of the preferred alternatives.
T-cell Lymphoma (TCL) Agents	• Criteria updates were made to Beleodaq and Poteligeo to better define place in therapy such as defining if disease is relapsed or refractory for Beleodaq and whether mycosis fungoides is stage IB to IV for Poteligeo.

	• Initial approval duration was updated from 2 to 6 months.
Thyroid Eye Disease Agents	• **Lumvoa injection** will be **added** to both the pharmacy benefit **and** medical benefit **with** a prior authorization requirement. A step-through trial requirement for glucocorticoids and confirmation of no historical treatment with Tepezza were included. • **Tepezza** criteria was updated to require clinical rationale for use of Tepezza instead of Lumvoa and confirmation of no historical treatment with Lumvoa was also added.
Vaccines	• **Arexvy respiratory syncytial virus vaccine** will remain covered under the pharmacy benefit and will have the age limit **updated** to require PA for members less than 18 years of age. Criteria was updated for Arexvy to reflect this age expanded indication to <18 years (previously was <50 years old).