eFormulary 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 11/01/2025

Test Strips and Meters	OneTouch test strips and glucometers will be nonformulary. Starting on 11/1/2025, the following Accu-Chek and FreeStyle test strips will be preferred and covered without prior authorization (quantity limits will apply): • Accu-Chek Aviva Plus • Accu-Chek Guide • Accu-Chek Smart View • FreeStyle Precision Neo • FreeStyle Insulinx • FreeStyle • FreeStyle Lite Compatible glucometers for the above test strips will be covered without prior authorization; quantity limits will apply. Please consider preparing members currently utilizing OneTouch test strips and glucometers. FreeStyle and Accu-Chek meters and test strips will be covered

	beginning 11/1/2025. Preparing prescriptions to be filled on or after that date will facilitate the transition.

Effective 12/01/2025

Beyfortus	Criteria for Beyfortus for the diagnosis of cystic fibrosis are being updated to require the member either has manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable) or weight-for-length that is less than the 10th percentile.
Litfulo	Reauthorization criteria for Litfulo are being updated to require documentation supporting improvement in the signs and symptoms of alopecia area from baseline (e.g., increased hair on scalp, eyebrows, eyelashes).
Xolair	Initial criteria for chronic spontaneous urticaria (CSU) are being updated to require diagnosis, age of 12 years or older, persistent symptoms for at least 6 consecutive weeks despite concurrent use of a second generation H1 antihistamine and a minimum 2-week trial of up-dosing of the second generation H1 antihistamine, and attestation the requested medication will be used concurrently with a second generation H1 antihistamine unless the member has an intolerance or contraindication. Reauthorization criteria for CSU are being updated to require member is 12 years of age or older and has experienced one or both of the following: reduction in itching severity from baseline and reduction in number of hives from baseline.
Synagis	Criteria are being updated to include the requirement that the member has not received a dose of Enflonsia during the current RSV season.
Tocilizumab Products: Actemra Tofidence Tyenne	Updating initial criteria for giant cell arteritis to require trial and failure, contraindication, or intolerance to a glucocorticoid (e.g., prednisone). For all indications approval language for Tofidence is being updated to require trial and failure, intolerance or contraindication to either Actemra or Tyenne.

Updates for MassHealth Members

Effective 01/01/2026

The following changes are being made as part of the MassHealth Medicaid Medical Benefit Alignment initiative and Prime implementation:

The following medications will now be available on the medical benefit with prior authorization and will remain on the pharmacy benefit with prior authorization:	Abrilada (adalimumab-afzb) Amjevita (adalimumab-atto) Cyltezo (adalimumab-adbm) Hadlima (adalimumab-bwwd) Hulio (adalimumab-fkjp) Humira (adalimumab) Hyrizmo (adalimumab-adaz)

	Idacio (adalimumab-aacf) Simlandi (adalimumab-ryvk) Yuflyma (adalimumab-aaty) Yusimry (adalimumab-aqvh) Enbrel (etanercept) Stelara (ustekinumab) Zymfentra (infliximab-dyyb)
The following medications will be available on the medical benefit without restrictions:	Ameluz 10% gel Blenrep injection Byfavo injection Faslodex (fulvestrant) injection Gamastan S/D, Gamastan injection Hydroprogesterone caproate injection Ibandronate injection Infugem injection Jesduvroq tablet Levulan Kerastick Lupaneta Pack Marqibo injection Nypozi injection Palynziq injection Prevymis injection Quzyttir injection Rebyota rectal suspension Rezzayo injection Rivfloza injection Sezaby injection Tpoxx injection Uptavi IV injection Vafseo tablet Zulresso injection Olinvyk injection
This medication will only be available on the pharmacy benefit with prior authorization:	Entyvio subcutaneous injection
Breast Cancer Therapies	Faslodex will remain on the medical benefit without restrictions.
Complement Inhibitors	• Enjaymo will require a step-through with a rituximab containing regimen. • Uplizna will require a step-through with Enspryng.

	• Prescriber specialty requirements were also added throughout the policy. • The following updates were made to Soliris: ○ For Myasthenia Gravis, Soliris will require additional step-through options with either Imaavy, Rystiggo, or Vyvgart/Vyvgart Hytrulo and both Ultomiris and Zilbrysq. ○ For NMOSD, PNH, and aHUS, Soliris will require a step through with Ultomiris. ○ For all indications, Soliris will require clinical rationale for its use instead of both Bkemv and Epysqli. • Piasky will now require an additional step-through with Ultomiris. • For generalized Myasthenia Gravis, Ultomiris will require additional step-through options with either Imaavy, Rystiggo, or Vyvgart/Vyvgart Hytrulo. • For Veopoz, the vaccine requirement was removed and a step-through with Bkemv Epysqli, or Soliris was added. *aHUS=atypical hemolytic-uremic syndrome (aHUS), NMOSD=neuromyelitis optica spectrum disorder, PNH=paroxysmal nocturnal hemoglobinuria*
Palynziq	Palynziq will now be available through the medical benefit without restrictions and will remain on the pharmacy benefit with a prior authorization.
Infliximab Agents: Avsola Inflectra Infliximab Remicade Renflexis Zymfentra	All agents will require to step-through the preferred drugs: unbranded infliximab and Avsola. Zymfentra will now be available through the medical benefit with a prior authorization and will remain on the pharmacy benefit with a prior authorization.
Intravenous Immune Globulin	Gamastan S/D was removed from the policy as this agent has been discontinued.
Multiple Myeloma Agents	Blenrep was removed from the policy due to FDA withdrawal.
Oncology Immunotherapy	For Keytruda, the Child-Pugh reference for the hepatocellular carcinoma (HCC) indication was removed following NCCN recommendations.
Systemic Chemotherapy	Infugem was removed from the policy due to FDA withdrawal.
Omvoh	Criteria for Crohn's Disease was added to the policy. Criteria will require appropriate diagnosis and dosing, and medical necessity for the use of the pen or syringe instead of the 300 mg dose pack.
Skyrizi IV	Fistulizing Crohn's Disease was added as an acceptable diagnosis.
Tremfya IV	The pityriasis rubra pilaris (PRP) diagnosis was removed from the policy as this indication is not applicable to the vial formulation.

Actemra IV	For polyarticular juvenile idiopathic arthritis (PJIA) indication, criteria for step-through with one anti-tumor necrosis factor agent was added. For uveitis indication, criteria for step-through with Humira or medical necessity for use of Actemra IV instead of Humira was added.
Cimzia IV	For all indications, criteria for medical necessity for use of Cimzia IV instead of Enbrel and Humira was added.
Cosentyx IV	Criteria for enthesitis related arthritis (ERA) diagnosis was added requiring diagnosis, age ≥ 4 to < 18 years, and appropriate dosing.
Entyvio	For ulcerative colitis and Crohn's disease indications, criteria for step-through with one anti-tumor necrosis factor agent was added. Fistulizing Crohn's disease was added to the policy as an acceptable diagnosis.
Ilumya	For plaque psoriasis indication, criteria for step-through with Stelara, Skyrizi, and Taltz, and one anti-tumor necrosis factor agent were added.
Tofidence Tyenne	Initial approval duration was updated to allow 3 months approval for higher or frequent dosing requests.