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 11/16/2026

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

Generic Name	Brand Name Alternative
Dichlorphenamide tablet	Keveyis tablet
Dextromethorphan hydrobromide/quinidine sulfate	Nuedexta 20-10 mg capsule
Sitagliptin phosphate/metformin hydrochloride ER	Janumet XR tablet

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

Brand Name	Generic Medication
Carbatrol capsule	Carbamazepine extended-release capsule

Effective 11/16/2026

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

Androgen Therapy	Criteria was updated to require either lab results of 2 low testosterone levels or patient's stability on a testosterone product.
Anti-Allergy and Anti-Inflammatory Agents - Ophthalmic	• The following medications will remain covered **under** the pharmacy benefit, and their existing quantity limits will be updated as follows: ○ Byqlovi 0.05% ophthalmic suspension – **QL** 3.5 mL per 30 days

	○ Epinastine 0.05% ophthalmic drops – **QL** 5 mL per 30 days • Criteria for **Xdemvy** was updated to accept submissions or consultation notes from dermatologist to consider approval.
Antidiabetic Agents - Non-Insulin and Combination Products	**Ozempic injection** criteria was updated to include the diagnosis of type 2 diabetes mellitus and chronic kidney disease.
Antidepressants	• **Auvelity titration pack** (new strength) will be **added** to the pharmacy benefit **with** a prior authorization requirement. • Expanded indication of agitation associated with dementia due to Alzheimer's Disease was added for **Auvelity**.
Antiemetics and Appetite Stimulants	**Nereus 85 mg capsule** will be **added** to the pharmacy benefit **with** a prior authorization **and** quantity limit of 8 capsules per 28 days. A step-through trial with two of the following will be required: dimenhydrinate, diphenhydramine, meclizine, promethazine.
Anti-Obesity Agents	Following the recent update that occurred on **July 3, 2026**, **Foundayo** tablet will no longer be covered for the treatment of obesity or overweight. Members younger than 21 will be exempt when the medication is deemed medically necessary under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements.
Antipsychotics	**Rexulti** criteria for agitation associated with dementia due to Alzheimer's Disease was updated to require a trial of only one second generation atypical antipsychotic.
Antiretroviral Agents	• **Idvynso 100-0.25 mg tablet** will be **added** to the pharmacy benefit **with** a prior authorization **and** quantity limit of 30 tablets per 30 days. A step-through trial with one HIV-1 regimen available without prior authorization will be required. • **Efavirenz 400 mg/lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg** was added to the criteria.
Asparaginase Agents	**Asparlas** criteria was updated to remove the trial requirement with Oncaspar and age was changed from <21 to <22.
Welireg (belzutifan)	The following expanded indication was added: Welireg in combination with pembrolizumab or pembrolizumab and berahyaluronidase alfa-pmph, is indicated for the adjuvant treatment of adult patients with renal cell carcinoma with a clear cell component (ccRCC) at intermediate-high or high risk of recurrence following nephrectomy or following nephrectomy and resection of metastatic lesions.
Cardiovascular Agents (Antihypertensives)	• **Baxfendy tablets** 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 of all of the following: aldosterone receptor antagonist, calcium channel blocker, RAAS inhibitor, thiazide-type diuretic, and one other antihypertensive agent.

	• **Javadin** (clonidone oral solution) criteria was updated to include off-label indications such as Attention deficit hyperactivity disorder (ADHD), Autism spectrum disorder (ASD), sleep disorder, or other behavioral and neurologic conditions. A step-through trial with either clonidine patch or clonidine extended-release 0.1 mg tablet will be required. For the diagnosis of ADHD, a trial requirement with one stimulant available without prior authorization will be required first.
Cerebral Stimulants and ADHD Medications	• **Onyda XR criteria** was updated to include off-label diagnoses such as ASD, sleep disorder, other behavioral or neurologic condition (e.g. agitation, anxiety, dystonia, tic disorder). • **Onyda XR criteria for ADHD** was updated to remove requirement of a trial with a liquid stimulant and allow any stimulant available without prior authorization to be accepted.

Corticosteroids – Oral	• The following medications will be **added** to the pharmacy benefit **with** a prior authorization requirement:
	  ○ Dexlyt 0.25 mg tablet
	  ○ Khindivi 1 mg/mL oral solution
	  ▪ Additional criteria noting medical necessity (e.g., tube feed, swallowing disorder, age < 13 years, etc) for this formulation instead of tablets will be required.
	• **Alkindi sprinkle capsule** criteria was updated to reflect standard medical necessity verbiage (medical necessity [e.g., tube feed, swallowing disorder, age < 13 years, etc] for this formulation instead of tablets).

Corticosteroids - Topical	The following medications <u>will remain</u> covered under the pharmacy benefit and <u>will now</u> be subject to a prior authorization requirement: • Analpram-HC (hydrocortisone 1%/pramoxine 1%) cream, lotion • Analpram-HC (hydrocortisone 2.5%/pramoxine 1%) cream, lotion • Proctofoam-HC 1%-1% foam • Prednicarbate 0.1% cream

Dermatological Agents (Topical Chemotherapy-Genital Wart Therapy)	• Policy was updated to include quantity limit criteria and medical necessity if the requested quantity exceeds the limit placed on the medication (i.e., disease affecting a large surface area).
	• The following medications <u>will remain</u> covered under the pharmacy benefit and <u>will now</u> be subject to the following quantity limits:
	  ○ Diclofenac sodium 3% gel – **QL** 100 grams per 30 days
	  ○ Fluorouracil 5% cream – **QL** 40 grams per 30 days
	  ○ Fluorouracil 0.5% cream – **QL** 30 grams per 30 days
	  ○ Fluorouracil 2% **&** 5% solution – **QL** 10 mL per 30 days
	  ○ Imiquimod 5% cream – **QL** 24 packets per 30 days
	  ○ Podofilox 0.5% gel - **QL** 3.5 grams per 30 days

	○ Podofilox 0.5% solution – **QL** 3.5 mL per 30 days ○ Valchlor 0.016% gel – **QL** 60 grams per 30 days ○ Klisyri 1% ointment – **QL** 5 packets per 5 days ○ Tolak (fluorouracil) 4% cream – **QL** 40 grams per 30 days ○ Zyclara 2.5% **&** 3.75% cream pump – **QL** 7.5 grams per 30 days ○ Imiquimod 3.75% cream packets – **QL** 30 packets per 30 days ○ Veregen 15% ointment – **QL** 30 grams per 30 days
Padcev (enfortumab vedotin)	• Criteria was updated to reflect the expanded labeling for Keytruda or Keytruda Qlex, in combination with enfortumab vedotin-ejfv, as neoadjuvant treatment and then continued after cystectomy as adjuvant treatment, is indicated for the treatment of adult patients with muscle invasive bladder cancer (MIBC). • The requirement for cisplatin trial or failure was removed from criteria.
Growth Hormone Disorder Agents	Criteria was updated to clarify acceptance of evidence of short stature or growth failure documented within the last 90 days.
Hereditary Angioedema Agents	• **Kalbitor** criteria was updated to require a step through trial with either Berinert or icatibant. • **Ruconest** will remain covered under the pharmacy benefit **with** existing quantity limits and will now require prior authorization. Criteria was also updated to require a step-through trial with Berinert. • Criteria for **Andembry, Haegarda, and Orladeyo** were updated to require step through with Cinryze, Dawnzera, or Takhzyro. For Orladeyo, medical necessity for its use instead of alternative agents will also be required. • The following initial approval durations were updated (dependent on quantity needed): ○ **Ekterly**: 1 year for 8 tablets/30 days, or 3 months for >8 tablets/30 days ○ **Kalbitor**: 1 year for 12 vials/30 days, or 3 months for >12 vials/30 days ○ **Ruconest**: 1 year for 8 vials/30 days, or 3 months for >8 vials/30 days
Iron Agents and Chelators	• The following medications will no longer be covered under the pharmacy benefit and will now be available without restrictions under the **medical benefit only**: ○ Feraheme (ferumoxytol injection) ○ Ferrlecit (sodium ferric gluconate complex injection) ○ Infed injection

	○ Monoferric injection • Age requirements were added to Accrufer (≥10 years of age) and Auryxia (≥18 years of age). • **Auryxia** criteria was updated to include iron deficiency indication. • **Ferriprox** criteria was updated to clarify provider specialty (hematologist or oncologist) and age requirements (for oral solution, ≥ 3 years of age) and added medical necessity requirement for use of the requested agent instead of other formulations.
Multiple Myeloma Agents	• The following medications will be **added** to the <u>medical benefit only</u> and **with** a prior authorization requirement: ○ Blenrep injection ▪ Criteria will require trials with 2 prior chemotherapy regimens, a proteasome inhibitor, and an immunomodulatory agent, and ▪ Confirmation that Blenrep will be used in combination with Boruzu, Velcade, or bortezomib/dexamethasone ○ Sarclisa Escena injection ▪ Clinical riteria will be similar to Sarclisa • **Darzalex Faspro** criteria were updated to reflect a new expanded indication for the treatment of high-risk smoldering multiple myeloma.
NSAIDs – Injectable, Intranasal and Oral	• **Vyscoxa 10 mg/mL oral suspension** will be **added** to the pharmacy benefit **with** a prior authorization requirement. Medical necessity requirement was added for Vyscoxa and a step-through trial with both ibuprofen suspension and naproxen suspension will be required. • The following medications <u>will remain</u> covered under the pharmacy benefit and <u>will now</u> require prior authorization: ○ Ketoprofen capsules ○ Ibuprofen 300 mg tablet ○ Flurbiprofen tablet ○ EC-Naprosyn tablet (naproxen enteric coated)
Oncology Immunotherapies	• Expanded indications for **Keytruda** and **Keytruda Qlex** were added: ○ in combination with enfortumab vedotin-ejfv, as neoadjuvant treatment and then continued after cystectomy as adjuvant treatment, is indicated for the treatment of adult patients with muscle invasive bladder cancer (MIBC) ○ in combination with belzutifan, is indicated for the adjuvant treatment of adult patients with RCC with a clear cell component (ccRCC) at intermediate-high or high risk of

	recurrence following nephrectomy or following nephrectomy and resection of metastatic lesions • **Keytruda Qlex** has been added as a step-through trial for Keytruda requests.
Rezdiffra (resmetirom)	• Diagnostic test criteria was updated to accept copies of test results which includes liver biopsy, enhanced liver fibrosis (ELF) score, FibroScan, or magnetic resonance elastography (MRE) liver stiffness measurement (LSM). • Criteria for assessing use in combination with Wegovy was removed.
Respiratory Agents - Oral	• **Daliresp** (roflumilast) tablet will remain covered under the pharmacy benefit **with** existing quantity limits and will no longer require prior authorization. • **Zileuton ER** criteria was updated to remove step-through of Zyflo (zileuton) and instead require patients new to therapy to have an inadequate response, adverse reaction or contraindication to BOTH montelukast and zafirlukast.