Formulary 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

<table>
<tr><td></td><td>beginning 11/1/2025. Preparing prescriptions to be filled on or after that date will facilitate the transition.</td></tr>
<tr><td>ADHD Stimulants</td><td>The ADHD Stimulant step therapy program will be updated to include generic Mydayis as a second-line agent that will adjudicate at the point-of-sale if the member has filled at least two first-line medications or one second-line medication within the past 180 days. If the point-of-sale step therapy requirements are not met, prior authorization will be required.

Prior authorization criteria for all second-line agents will be updated to require trial and failure of two first-line or one second-line agent.

The following stimulants will have quantity limits added:
- Amphetamine/dextroamphetamine ER capsule (Mydayis): 1 capsule/day
- Dextroamphetamine ER capsule (Dexedrine) 5 mg, 15 mg: 4 capsules/day
- Dextroamphetamine ER capsule (Dexedrine) 10 mg: 5 capsules/day
- Methylphenidate ER tablet 10 mg, 20 mg: 1 tablet/day
- Dyanavel XR oral suspension: 8 mL/day
- Quillivant XR oral suspension: 12 mL/day
- QuilliChew ER chewable tablet 20 mg, 40 mg: 1 tablet/day
- QuilliChew ER chewable tablet 30 mg: 2 tablets/day</td></tr>
<tr><td>Tier Changes</td><td>The following tier changes will be made:

<table>
<tr><th>Drug Name and Dosage Form</th><th>3-Tier Formulary</th><th>4-Tier Formulary</th><th>6-Tier Formulary</th></tr>
<tr><td>Colchicine capsule</td><td>Current: Tier 1
Update: Tier 1</td><td>Current: Tier 1
Update: Tier 2</td><td>Current: Tier 1
Update: Tier 2</td></tr>
<tr><td>Colchicine tablet</td><td>Current: Tier 1
Update: Tier 1</td><td>Current: Tier 2
Update: Tier 1</td><td>Current: Tier 2
Update: Tier 1</td></tr>
<tr><td>Amphetamine/ dexamphetamine capsule (generic Mydayis)</td><td>Current: Tier 1
Update: Tier 2</td><td>Current: Tier 2
Update: Tier 3</td><td>Current: Tier 2
Update: Tier 3</td></tr>
<tr><td>Doxycycline delayed release 40 mg capsule (generic Oracea)</td><td>Current: Tier 1
Update: Tier 2</td><td>Current: Tier 2
Update: Tier 3</td><td>Current: Tier 2
Update: Tier 3</td></tr>
<tr><td>Lamotrigine orally disintegrating tablet (ODT) (generic Lamictal ODT)</td><td>Current: Tier 1
Update: Tier 2</td><td>Current: Tier 2
Update: Tier 3</td><td>Current: Tier 2
Update: Tier 3</td></tr>
<tr><td>Topiramate ER capsule (generic Qudexy XR, generic Trokendi XR)</td><td>Current: Tier 1
Update: Tier 2</td><td>Current: Tier 2
Update: Tier 3</td><td>Current: Tier 2
Update: Tier 3</td></tr>
</table></td></tr>
<tr><td>Briumvi</td><td>The policy will be updated to clarify that Briumvi is restricted to the medical benefit.</td></tr>
</table>

	Initial approval criteria will be updated to include minimum age requirement of 18 years. Reauthorization criteria will be updated to require documentation of disease stability or improvement on the requested medication.
Ocrevus, Ocrevus Zunovo	Initial criteria will be updated to include minimum age of 18 years or older and requirement that the requested medication is prescribed by or in consultation with a neurologist. Reauthorization criteria will require documentation the member is experiencing disease stability or improvement on the requested medication.
Tascenso ODT	Reauthorization criteria will require documentation the member is experiencing disease stability or improvement on the requested medication.
Tysabri	Initial approval criteria for Crohn's disease will be updated to require, in addition to diagnosis of moderately to severely active disease, that the member has had a trial and failure, intolerance or contraindication to at least one conventional therapy or that disease severity warrants a systemic biologic as first-line therapy. Initial criteria will also require that the member has had a trial and failure, intolerance, or contraindication to a TNF-alpha inhibitor. Initial approval criteria for multiple sclerosis will be updated to include requirement that the requested medication is prescribed by or in consultation with a neurologist. Reauthorization criteria for multiple sclerosis and Crohn's disease will be updated to require documentation of stability or improvement.
Lemtrada	Initial approval criteria will be updated to specify that Lemtrada will only be approved for relapsing-remitting multiple sclerosis or active secondary progressive disease. Additionally, initial criteria will be updated to include requirement that the requested medication is prescribed by or in consultation with a neurologist. Reauthorization criteria will require documentation of stability or improvement.
Terbinafine 250 mg tablet	The drug-specific policy to exceed the quantity limit for terbinafine 250 mg tablet will be retired. Requests to exceed the quantity limit will be reviewed against criteria in the Plan's Quantity Limit policy.
Ivabradine tablet Corlanor oral suspension	The policy for ivabradine tablet and Corlanor oral suspension will be updated to separate out criteria for heart failure in adults and cardiomyopathy in children. Criteria for heart failure in adults will require that the member has a diagnosis of stable symptomatic chronic heart failure with an ejection fraction less than or equal to 35% and resting heart rate greater than or equal to 70 beats per minute. Members must be 18 years of age or older and the requested medication should be prescribed by or in consultation with a cardiologist. Existing medication trial requirements will remain unchanged. Criteria for cardiomyopathy due to heart failure in children will require that the member is 6 months of age or older and is in sinus rhythm with normal heart rate. The requested medication must be prescribed by or in consultation with a cardiologist. Existing previous trial requirements will remain unchanged.

	Reauthorization criteria for both diagnoses will require a positive clinical response to treatment.
Diacomit Epidiolex Fintepla	Reauthorization criteria will be added, requiring documentation the member has had a positive response to therapy (e.g., decrease in number or frequency of seizures the member is experiencing)
Ztalmy	Initial criteria will be updated to include the requirement that the member is 2 years of age or older. Reauthorization criteria will be updated to require documentation that the member has had a positive response to therapy (e.g., decrease in number or frequency of seizures the member is experiencing)
Mifepristone 300 mg	Reauthorization criteria will be updated to require documentation of positive clinical response to therapy.
Recorlev	Reauthorization criteria will be updated to require documentation of positive clinical response to therapy.
Oriahnn and Myfembree	Criteria for uterine fibroids will be updated to include requirement of documentation of the diagnosis.
Off-Label Non-FDA Approved Indications	Criteria for non-oncology uses will be updated to include a requirement of documentation that the member has had an inadequate response, adverse reaction or contraindication to all other formulary products with an FDA-approved indication for the treated diagnosis. Reauthorization criteria for all diagnoses will be added to the policy and will require documentation that the member continues to require therapy as well as documentation demonstrating the member has had a positive clinical response to therapy.
Non-Formulary and Excluded Medications	Initial criteria will be updated to require documentation for all components of the criteria. Reauthorization criteria will be added to the policy, requiring that initial criteria continue to be met, documentation that the member requires continuation of therapy, and documentation demonstrating that the member has had a positive clinical response to therapy.
Zileuton ER	Prior authorization criteria will be updated to require that the member has had an inadequate response, side effect or contraindication to montelukast and zafirlukast.

Updates for MassHealth Members

Effective ASAP

The updates concerning prior authorization status for the brand name Alkeran vial and Gohibic (EUA), as communicated in the June newsletter, are no longer applicable and may be disregarded.

Effective 11/17/2025

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

Generic Medication	Brand Name Alternative
Levalbuterol Tartrate HFA inhaler	Xopenex HFA inhaler
Timolol maleate ophthalmic unit dose	Timoptic Ocudose
Rivaroxaban 1mg/mL suspension	Xarelto 1mg/mL suspension
Nitrofurantoin 25mg/5mL suspension	Furadantin 25mg/5mL suspension
Fidaxomicin 200mg tablet	Dificid 200mg tablet
Fluticasone furoate inhalation powder	Arnuity Ellipta inhaler
Doxazosin immediate-release tablet	Cardura immediate-release tablet

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

Brand Name	Generic Medication
AirDuo Respiclick inhaler	Fluticasone-salmeterol inhaler
Pradaxa capsule	Dabigatran capsule
Qudexy XR capsule	Topiramate extended-release capsule

Effective 10/01/2025

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

Dermatological Agents	**Carac (fluorouracil 0.5% cream)** will remain on the pharmacy benefit and will now require prior authorization.
Bausch and Lomb Products	Bausch and Lomb products will be considered a non-participating manufacturer and will require prior authorization. Members currently on any of the following **branded** product should be transitioned to the generic equivalent: • Retin-A Micro 0.04%, 0.1% gel • Retin-A Micro Pump 0.04%, 0.08%, 0.1% gel • Atralin 0.05% gel • Isordil 40 mg tablet • Onexton gel pump • Timoptic Ocudose 0.5% drop • Zyclara 3.75% cream, pump Members currently on a product that is available through the Bausch and Lomb Patient Assistant Program (PAP) will be expected to transition

	coverage over to the PAP. Additional information about the PAP is available on the Baush and Lomb website. Providers may submit an application to the manufacturer by mail, fax, or online for members continuing treatment with any of the following products: • Aplenzin (bupropion hydrobromide) extended-release tablet 174 mg, 348 mg, 522 mg • Cuprimine (penicillamine) 250 mg capsule • Demser (metyrosine) 250 mg capsule • Syprine (trientine HCL) 250 mg capsule • Tasmar (tolcapone) 100 mg tablet • Zelapar (selegiline HCL) 1.25 mg orally disintegrating tablet • Xifaxan (rifaximin) 550 mg tablet • Relistor (methylnaltrexone bromide) 150 mg tablet • Relistor (methylnaltrexone bromide) injection for subcutaneous use 8 mg/0.4 mL, 12 mg/0.6 mL Topical products: • Arazlo (tazarotene) lotion, 0.045% • Bryhali (halobetasol proprionate) lotion, 0.01% • Duobrii (halobetasol propionate/tazarotene) 0.01%/0.45% • Jublia (efinaconazole) topical solution, 10% • Luzu (luliconazole) cream, 1% • Noritate (metronidazole cream), 1% • Siliq (brodalumab) injection 210 mg/1.5 mL • Targretin (bexarotene) 75 mg capsule, gel 1%

Effective 11/17/2025

Alzheimer's Agents	**New drug**, **Zunveyl DR tablet**, will be **added** to the pharmacy benefit **with** a prior authorization **and** quantity limit of 60 tablets per 30 days.
Anti-Obesity Agents, Anti-Diabetic Agents	The list of acceptable contraindications to phentermine was updated to include conductive disorders and severe/end stage renal disease.
Antibiotics – Oral	The following medications **will remain** under the pharmacy benefit and will no longer require prior authorization: • Doxycycline hyclate 75mg **&** 150mg tablet • Minocycline ER 135mg tablet The following medications **will remain** under the pharmacy benefit; however, prior authorization will now be required: • amoxicillin/clavulanate chewable tablet • erythromycin delayed release 250 mg capsule • cephalexin tablet

	• minocycline ER 55mg, 65mg, 80mg, and 115mg tablets Criteria of requiring medical necessity for the requested formulation was added for the following medications: • Furadantin (nitrofurantoin 25 mg/5 mL suspension) • Likmez (metronidazole oral suspension) • Zyvox (linezolid suspension)
Antibiotics – Ophthalmic	Criteria for levofloxacin ophthalmic solution and moxifloxacin ophthalmic solution (twice daily) was updated to include prescriber specialty involvement.
Antihemophilia Agents	**New drug**, **Qfitlia prefilled pen** and **vial**, will be **added** to both the pharmacy benefit **and** medical benefit **with** prior authorization.
Antihistamines	Criteria for clemastine syrup and Ryclora solution was updated to include an additional trial of fexofenadine suspension. Desloratadine tablets **will remain** under the pharmacy benefit **and** will no longer require prior authorization. Promethazine suppositories **will remain** under the pharmacy benefit; however, prior authorization will now be required.
Antiparkinsonian Agents	**New drug**, **Onapgo 98mg/20mL cartridge**, will be **added** to the pharmacy benefit **with** prior authorization. Criteria for **Duopa** and **Vyalev** were updated to remove medical record requirement for step-through trials.
Antipsychotic Agents	**Erzofri prefilled syringes** will remain under the pharmacy benefit **with** current quantity limits. A prior authorization will be added and only required if members are **<10 years of age**.
Antiretroviral Agents	**New drug**, **Yeztugo vial**, will be **added** to **both** the pharmacy benefit **and** medical benefit **with** prior authorization. **New drug, Yeztugo tablet**, will be **added** to the pharmacy benefit **with** prior authorization. Criteria requirements may include: diagnosis of PrEP, negative HIV-1 test, at risk for HIV, weight is 35kg or more, has a contraindication to cabotegravir, and appropriate dosing. Clinical rationale will be required for use of Yeztugo instead of Apretude.
Bile Acid Replacement Agents	**New drug release**: **Brand Ctexli tablet** will be **added** to the pharmacy benefit **with** prior authorization, consistent with generic chenodal tablet. Chenodal criteria was updated to include clinical rationale for use of this drug instead of Ctexli.

CGRP Inhibitors	Additional criteria was added for Qulipta and Nurtec ensuring that the requested quantity is as follows: • Nurtec: quantity is ≤ 16 units/30 days • Qulipta: quantity is ≤ 1 unit/day
Colorectal Cancer Agents	**Lonsurf** criteria for metastatic colorectal cancer (mCRC) was updated to note that Lonsurf can be used as monotherapy or in combination with bevacizumab. Diagnosis of gastrointestinal stromal tumor (GIST) for **Stivarga** was updated to align with FDA label. It now states "locally advanced, unresectable or metastatic GIST".
Complement Inhibitors and Miscellaneous Immunosuppressive Agents	Prefilled syringe form of **Vyvgart Hytrulo** will be **added** to the pharmacy benefit **with** prior authorization. The following new medications will be **added** to the medical benefit only **with** prior authorization: • Bkemv vial • Epysqli vial • Imaavy vial The following clinical updates were made: • Criteria for gMG was separated by subtype (AChR-ab+ and MuSK-ab+) • Rituximab was added as a trial for gMG (MuSK-ab+ subtype) • For all indications, Bkemv will require a rationale for use instead of Epysqli, while Soliris will require rationale for its use instead of both Bkemv and Epysqli • Age restriction was updated for Soliris and biosimilars in gMG (ACHR-ab+) to ≥ 6 years of age • Trials with other agents were removed from Zilbrysq criteria in gMG • Vanrafia was added as an additional trial for Fabhalta in IgAN • Approval durations for Rystiggo, Vyvgart, and Vyvgart Hytrulo in gMG were updated to 6 months (initial) and 12 months (reauthorization) New indications were added for the following medications: • Uplizna – IgG4-RD • Fabhalta – C3G • Empaveli – C3G and primary IC-MPGN in pediatric patients ≥ 12 years of age

	IgAN = immunoglobulin A nephropathy; gMG = generalized myasthenia gravis; C3G = complement 3 glomerulopathy; IC-MPGN = immune-complex membranoproliferative glomerulonephritis; IgG4-RD = immunoglobulin G4-related disease
Continuous Glucose Monitoring Products	Criteria was expanded to allow use of CGM in members contraindicated to blood glucose monitoring with a condition that would support the need for regular blood glucose monitoring.
Gout agents	**Gloperba** criteria was updated to include criteria for members who require a dose that cannot be achieved by colchicine tablets. Criteria for **Krystexxa** was updated to require frequent gout flares or unresolving tophi.
Growth Hormone	The requirement of confirmatory GHD testing for transition members with Prader-Willi Syndrome was removed. Criteria was updated to require one trial of dronabinol or megestrol acetate oral suspension for wasting or cachexia due to decreased caloric intake.
Headache Therapy – Ergot Alkaloids and Serotonin Receptor Agents	The following medications <u>will remain</u> under the pharmacy benefit **with** prior authorization, **and existing** quantity limits will be updated as follows: • Almotriptan tablet – **QL** 16 tablets per 30 days • Frova (*frovatriptan)* tablet - **QL** 16 tablets per 30 days; brand preferred • Imitrex (*sumatriptan)* injection - **QL** 8mL per 30 days • Onzetra Xsail 11mg/actuation nasal powder – **QL** 28 units per 30 days • Relpax (*eletriptan)* tablet - **QL** 16 tablets per 30 days • Tosymra nasal spray – **QL** 16 units per 30 days • Treximet (*sumatriptan/naproxen)* tablet - **QL** 16 tablets per 30 days • Zembrace Symtouch Injection – **QL** 16mL per 30 days • Zomig (*zolmitriptan)* nasal spray - **QL** 16 units per 30 days • Zomig (*zolmitriptan*) orally disintegrated tablet – **QL** 16 tablets per 30 days The following medications <u>will remain</u> under the pharmacy benefit, **and existing** quantity limits will be updated as follows: • Naratriptan tablet – **QL** 16 tablets per 30 days • Imitrex (*sumatriptan)* nasal spray - **QL** 16 units per 30 days • Imitrex (*sumatriptan)* tablet - **QL** 16 tablets per 30 days • Maxalt (*Rizatriptan)* orally disintegrated tablet, tablet – **QL** 16 tablets per 30 days • Zomig (*zolmitriptan*) tablet – **QL** 16 tablets per 30 days

	New drug, Symbravo tablet, will be **added** to the pharmacy benefit with a prior authorization **and** quantity limit of 7 tablets per 30 days.
Idiopathic Pulmonary Fibrosis Agents	Criteria for Ofev in IPF was updated to have a step-through of pirfenidone for new starts. Criteria for Ofev in SSc-ILD was updated to list mycophenolate, rituximab and tocilizumab as recommended 1st -line agents according to new guidelines. *IPF = idiopathic pulmonary fibrosis; SSc-ILD = systemic sclerosis-associated interstitial lung disease*
Influenza Vaccines	The self-administered version of **FluMist Home 2025-2026** *(influenza vaccine live intranasal spray for home administration*) will be **added** to the pharmacy benefit **with** a prior authorization.
Lymphoma and Leukemia Agents	**Jaypirca 50 mg tablets** will remain under the pharmacy benefit **with** prior authorization, **and** the quantity limit will be updated to 30 tablets per 30 days. The following expanded indications were added for the following: • Calquence for mantle cell lymphoma (MCL) • Monjuvi for follicular lymphoma (FL) The following criteria were updated to clarify use in relapsed/refractory disease: • Jaypirca for MCL • Brukinsa for FL and marginal zone lymphoma (MZL) • Monjuvi for diffuse large B cell lymphoma (DLBCL)
Methotrexate Agents	Branded generic **Trexall** (*methotrexate*) 5 mg, 7.5 mg, 10 mg, and 15 mg tablets will now require prior authorization under the pharmacy benefit. A step-through trial with generic methotrexate 2.5 mg tablet will be required. **Jylamvo** criteria was updated to reflect FDA approval for the treatment of pediatric patients with pJIA and ALL. *pJIA - polyarticular juvenile idiopathic arthritis; ALL - acute lymphoblastic leukemia*
Neuromuscular Blocker Agents	The treatment of thoracic outlet syndrome and ventral hernia was added to Botox.
Osteoporosis Agents and Misc Calcium Regulators	The following medications will be added to **both** the pharmacy benefit **and** medical benefit **with** prior authorization:

	• Jubbonti 60 mg/mL injection
	• Bomyntra 120 mg/1.7 mL prefilled syringe, subcutaneous injection
	• Conexxence 60 mg/mL injection
	• Osenvelt 120 mg/1.7 mL subcutaneous injection
	• Stoboclo 60 mg/mL prefilled syringe
	• Wyost 120 mg/1.7 mL subcutaneous injection
	
	The following biosimilars have been added to the criteria:
	• Prolia biosimilars
	  ○ Jubbonti
	  ○ Stoboclo
	  ○ Conexxence
	• Xgeva biosimilars
	  ○ Wyost
	  ○ Osenvelt
	  ○ Bomyntra
	
	Within these criteria, Prolia and Xgeva will be preferred over their equivalent biosimilars.

Pediculicides and Scabicides Progesterone Agents	**Natroba (spinosad)** was added to criteria for the treatment of scabies. An age of 4 years or older will be required. Criteria for the treatment of head lice was updated to include community resistance in long term care (LTC) or residential facility. Off-label criteria was added for Ovide for the treatment of pubic lice.
Progesterone Agents	For Crinone 8%, the max dosing was updated to 800mg/day for the prevention of pre-term labor (through week 37) and/or prevention of early pregnancy loss (miscarriage) through week 16 according to NICE 2023 guidelines. Crinone 8% and Endometrin: Criteria was updated to include prevention of spontaneous preterm birth **with** singleton pregnancy, short cervix, and gestational age ≥16 weeks following the 2023 ACOG recommendations.
Respiratory Agents - Inhaled	There will be a step-through requirement with one of the following medications: Incruse, Spiriva Respimat, or tiotropium inhalation powder. **Tudorza Pressair 400 mcg inhaler** will have prior authorization **and** a quantity limit of 1 inhaler per 30 days **added** to the pharmacy benefit.
Respiratory Agents – Oral	Criteria for zafirlukast was updated to require a step-through of montelukast.

RSV Prophylaxis Agents	The following formulary updates were made to new drug, **Enflonsia 105 mg/0.7 mL injection:** • **added** to the pharmacy benefit **with** a prior authorization requirement for members aged **≥ 8** months. • will be available on the medical benefit with no restrictions. **Synagis** criteria was updated to include Enflonsia as one of the step-through options.

Skeletal Muscle Relaxants	The following medications will have prior authorization **added** on the pharmacy benefit:
	• **Metaxalone 640 mg tablet** (*new strength*)
	  ○ Criteria will require medical necessity for use instead of 400 mg or 800 mg tablets
	• **Methocarbamol 1000mg tablet**
	  ○ Criteria will require medical necessity for use instead of 500 mg or 750 mg tablets

Urinary Dysfunction Agents	**Darifenacin extended-release tablets** will remain under the pharmacy benefit, however, the quantity limit will be removed. Criteria for **Gemtesa** and **trospium ER** in overactive bladder with symptoms of urinary frequency, urgency, or incontinence was updated to require a step-through of mirabegron extended-release and a contraindication to an anticholinergic agent. The criteria requiring clinical rationale for exceeding quantity limits was removed.
Wound Care	Criteria for **Filsuvez** was updated to clarify that the requested medication may not be used on the same target wounds as other topicals or gene therapies for diagnosis of dystrophic epidermolysis bullosa.