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>
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Briumvi	The policy will be updated to clarify that Briumvi is restricted to the medical benefit. 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 had an inadequate response, side effect or contraindication to montelukast and zafirlukast.