



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
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February 2020 MassHealth Drug List Summary Update

MassHealth evaluates the prior-authorization status for drugs on an ongoing basis and updates the MassHealth Drug List accordingly. This Summary Update document identifies changes to the MassHealth Drug List for the rollout effective February 24, 2020.

Additional information about these agents may be available within the MassHealth Drug List at www.mass.gov/druglist.

Additions

Effective February 24, 2020, the following newly marketed drugs have been added to the MassHealth Drug List.

- Adakveo (crizanlizumab-tmca) – **PA**
- Asceniv (immune globulin IV, human-slra) – **PA**
- Asparlas (calaspargase pegol-mknl) ^ – **PA**
- Beovu (brolucizumab-dbll) ^
- Duaklir (aclidinium/formoterol) – **PA**
- Gloperba (colchicine solution) – **PA**
- Inrebic (fedratinib) – **PA**
- Reblozyl (luspatercept-aamt) – **PA**
- Tosymra (sumatriptan 10 mg nasal spray) – **PA**
- Xembify (immune globulin subcutaneous injection, human-klhw) – **PA**
- Ziextenzo (pegfilgrastim-bmez)

New FDA “A”-Rated Generics

Effective February 24, 2020, the following FDA “A”-rated generic drugs have been added to the MassHealth Drug List. The brand name is listed with a # symbol, to indicate that prior authorization is required for the brand.

<u>New FDA “A”-Rated Generic Drug</u>	<u>Generic Equivalent of</u>
deferasirox 90 mg, 180 mg, 360 mg	Jadenu #
etonogestrel/ethinyl estradiol	Nuvaring #
penicillamine tablet	Depen #

Change in Prior-Authorization Status

- Effective February 24, 2020, the following antiparasitic will no longer require prior authorization.
 - Eurax (crotamiton cream)
- Effective February 24, 2020, the following antiplatelet agents will no longer require prior authorization.
 - Brilinta (ticagrelor)
 - Effient # (prasugrel)
- Effective February 24, 2020, the following hematinic agents will no longer require prior authorization.
 - Fulphila (pegfilgrastim-jmdb)
 - Udenyca (pegfilgrastim-cbqv)

New or Revised Therapeutic Tables

Table 1 – Immune Globulins

Table 4 – Hematologic Agents - Hematopoietic and Miscellaneous Hematologic Agents
Table 6 – Nutrients, Vitamins, and Vitamin Analogs
Table 8 – Opioids and Analgesics
Table 14 – Headache Therapy
Table 15 – Hypnotics
Table 18 – Cardiovascular Agents
Table 20 – Anticonvulsants
Table 23 – Respiratory Agents – Inhaled
Table 26 – Antidiabetic Agents - Oral
Table 31 – Cerebral Stimulants and Miscellaneous Agents
Table 45 – Antidiabetic Agents - Injectable and Insulin
Table 49 – Osteoporosis and Bone Metabolism Agents
Table 54 – Pediculicides and Scabicides
Table 57 – Oncology Agents
Table 58 – Anticoagulants and Antiplatelet Agents
Table 62 – Anti-Gout Agents
Table 66 – Antibiotics - Injectable
Table 71 – Pediatric Behavioral Health
Table 72 – Agents Not Otherwise Classified
Table 73 – Iron Agents and Chelators
Table 78 – Beta Thalassemia and Sickle Cell Disease Agents

Updated and New Prior-Authorization Request Forms

- Anti-Gout Agents Prior Authorization Request
 - Anticoagulant and Antiplatelet Prior Authorization Request
 - Anticonvulsant Prior Authorization Request
 - Antidiabetic Agents Prior Authorization Request
 - Benign Prostatic Hyperplasia (BPH) Agents Prior Authorization Request
 - Beta Thalassemia and Sickle Cell Disease Agents Prior Authorization Request
 - Cerebral Stimulant and ADHD Drugs Prior Authorization Request
 - Dermatological Agents (Topical Chemotherapy and Genital Wart Therapy) Prior Authorization Request
 - Headache Therapy (Triptan) Prior Authorization Request
 - Hypnotic Agents Prior Authorization Request
 - Immune Globulin Prior Authorization Request
 - Inhaled Respiratory Agents Prior Authorization Request
 - Pediculicides and Scabicides Prior Authorization Request
 - Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors Prior Authorization Request
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Updated MassHealth Brand Name Preferred Over Generic Drug List

The MassHealth Brand Name Preferred Over Generic Drug List has been updated to reflect recent changes to the MassHealth Drug List.

- a. Effective February 24, 2020, the following agent will be added to the MassHealth Brand Name Preferred Over Generic Drug List.
 - Symbicort (budesonide/formoterol) ^{BP} – **PA**
 - b. Effective February 24, 2020, the following agent will be removed from the MassHealth Brand Name Preferred Over Generic Drug List.
 - Zytiga (abiraterone 250 mg, 500 mg) – **PA**
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Updated MassHealth Quick Reference Guide

The MassHealth Quick Reference Guide has been updated to reflect recent changes to the MassHealth Drug List.

Updated and New Pharmacy Initiatives

- Opioid and Pain Initiative
 - Pediatric Behavioral Health Medication Initiative
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Deletions

- a. The following drugs have been removed from the MassHealth Drug List because they have been discontinued by the manufacturer.
 - Carimune NF (immune globulin IV, human) – **PA**
 - Gemzar (gemcitabine)
 - Sumavel (sumatriptan injection) – **PA**
 - Zurampic (lesinurad) – **PA**
 - b. The following drugs have been removed from the MassHealth Drug List. MassHealth does not pay for drugs that are manufactured by companies that have not signed rebate agreements with the U.S. Secretary of Health and Human Services.
 - Durlaza (aspirin extended-release) – **PA**
 - Duzallo (lesinurad/allopurinol) – **PA**
 - Zolpimist (zolpidem oral spray) – **PA**
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Corrections / Clarifications

- a. The following drugs have been added to the MassHealth Drug List. They were omitted in error. These changes do not reflect any change in MassHealth policy.
 - ascorbic acid powder – **PA**
 - levocarnitine powder – **PA**
 - pyridoxine crystals – **PA**
 - b. The following listings have been clarified. These changes do not reflect any change in MassHealth policy.
 - Adzenys ER (amphetamine extended-release 1.25 mg/mL oral suspension) – **PA**
 - Asclera (polidocanol) [^] – **PA**
 - Cuprimine (penicillamine capsule) ^{BP}
 - Dyanavel XR (amphetamine extended-release 2.5 mg/mL oral suspension) – **PA**
 - Ethyol # (amifostine)
 - Eurax (crotamiton lotion) – **PA**
 - Imitrex (sumatriptan 5 mg, 20 mg nasal spray) – **PA**
 - gemcitabine vial
 - glucagon vial
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Abbreviations, Acronyms, and Symbols

This designates a brand-name drug with FDA “A”-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA “A”-rated generic equivalent.

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the provider to receive reimbursement. Note: Prior authorization applies to both the brand-name and the FDA “A”-rated generic equivalent of listed product.

[^] This drug is available through the health care professional who administers the drug. MassHealth does not pay for this drug to be dispensed through a retail pharmacy.

^{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.