



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

April 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 April 6, 2020, and April 15, 2020.

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

Additions

Effective April 6, 2020, the following newly marketed drugs have been added to the MassHealth Drug List.

- Amzeeq (minocycline foam) – **PA**
- Baqsimi (glucagon nasal powder) ^{PD}
- Brukinsa (zanubrutinib) – **PA**
- Drizalma (duloxetine sprinkle capsule) – **PA**
- Esperoct (factor VIII recombinant, glycopegylated-exei)
- Nourianz (istradefylline) – **PA**
- Oxbryta (voxelotor) – **PA**
- Padcev (enfortumab vedotin-ejfv) – **PA**
- Proair Digihaler (albuterol inhalation powder) – **PA**
- Relafen DS (nabumetone 1000 mg) – **PA**
- Secuado (asenapine transdermal) – **PA**
- Wakix (pitolisant) – **PA**
- Xenleta (lefamulin tablet) – **PA**
- Xenleta (lefamulin injection) – **PA**

New FDA “A”-Rated Generics

Effective April 6, 2020, the following FDA “A”-rated generic drug 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>
---------------------------------------	------------------------------

naproxen/esomeprazole – PA < 60 years	Vimovo #
---	----------

Changes in Prior-Authorization Status

- Effective March 26, 2020, the following antimalarials will require prior authorization.
 - chloroquine phosphate – **PA**
 - hydroxychloroquine – **PA**
- Effective April 6, 2020, the following antidepressants will no longer require prior authorization when used within newly established quantity limits. Pediatric Behavioral Health Medication Initiative criteria will still apply. For additional information, please see the Pediatric Behavioral Health Medication Initiative documents found at www.mass.gov/druglist.
 - Aplenzin (bupropion hydrobromide extended-release) – **PA < 6 years and PA > 30 units/month**
 - Pristiq # (desvenlafaxine succinate extended-release) – **PA < 6 years and PA > 30 units/month**

- c. Effective April 6, 2020, the following antidepressant will no longer require prior authorization when used within established quantity limits. Pediatric Behavioral Health Medication Initiative criteria will still apply. For additional information, please see the Pediatric Behavioral Health Medication Initiative documents found at www.mass.gov/druglist.
 - Fetzima (levomilnacipran) – **PA < 6 years and PA > 30 units/month**
- d. Effective April 6, 2020, the following antidepressant will no longer require prior authorization. Pediatric Behavioral Health Medication Initiative criteria will still apply. For additional information, please see the Pediatric Behavioral Health Medication Initiative documents found at www.mass.gov/druglist.
 - Sarafem # (fluoxetine 20 mg tablet for premenstrual dysphoric disorder) – **PA < 6 years**
- e. Effective April 6, 2020, the following intranasal corticosteroids will no longer require prior authorization when used within established quantity limits.
 - Beconase AQ (beclomethasone nasal spray) – **PA > 1 inhaler/month**
 - Zetonna (ciclesonide nasal aerosol, 37 mcg) – **PA > 1 inhaler/month**
- f. Effective April 6, 2020, the following immunosuppressant will require prior authorization.
 - Envarsus XR (tacrolimus extended-release tablet) – **PA**
- g. Effective April 6, 2020, the following ulcerative colitis agents will no longer require prior authorization.
 - Dipentum (olsalazine)
 - Pentasa (mesalamine controlled-release)
- h. Effective April 6, 2020, the following antidiabetic agent will no longer require prior authorization.
 - Trulicity (dulaglutide) ^{PD}

New or Revised Therapeutic Tables

- Table 5 – Immunological Agents
- Table 6 – Nutrients, Vitamins, and Vitamin Analogs
- Table 10 – Dermatologic Agents - Acne and Rosacea
- Table 11 – Nonsteroidal Anti-Inflammatory Drugs
- Table 14 – Headache Therapy
- Table 17 – Antidepressants
- Table 20 – Anticonvulsants
- Table 23 – Respiratory Agents - Inhaled
- Table 24 – Antipsychotics
- Table 25 – Corticosteroids - Intranasal
- Table 33 – Inflammatory Bowel Disease Agents
- Table 35 – Antibiotics and Anti-Infectives - Oral and Inhaled
- Table 42 - Immune Suppressants - Topical
- Table 45 – Antidiabetic Agents - Injectable and Insulin
- Table 48 – Antiparkinsonian Agents
- Table 50 – Narcolepsy and Miscellaneous Sleep Disorder Therapy Agents
- Table 57 – Oncology Agents
- Table 66 – Antibiotics - Injectable
- Table 71 – Pediatric Behavioral Health
- Table 72 – Agents Not Otherwise Classified
- Table 76 – Neuromuscular Agents - Duchenne Muscular Dystrophy and Spinal Muscular Atrophy
- Table 78 – Beta Thalassemia and Sickle Cell Disease Agents

Updated and New Prior-Authorization Request Forms

- Antidepressant Prior Authorization Request
- Antidiabetic Agents Prior Authorization Request
- Antipsychotic Prior Authorization Request

- Benzodiazepines and Other Anti-Anxiety Agents Prior Authorization Request
- Beta Thalassemia and Sickle Cell Disease Agents Prior Authorization Request
- Gonadotropin-Releasing Hormone Prior Authorization Request
- Immunomodulators Prior Authorization Request
- Inhaled Respiratory Agents Prior Authorization Request
- Injectable Antibiotic Prior Authorization Request
- Intranasal Corticosteroids Prior Authorization Request
- Narcolepsy and Miscellaneous Sleep Disorder Therapy Agents Prior Authorization Request
- Neuromuscular Agents Prior Authorization Request
- Nonsteroidal Anti-Inflammatory Drugs (NSAID) Prior Authorization Request
- Opioid Dependence and Reversal Agents Prior Authorization Request
- Opioids/Acetaminophen Analgesic Prior Authorization Request
- Oral Antibiotics and Anti-Infectives Prior Authorization Request
- Progesterone Agents Prior Authorization Request
- Prostate Cancer Agents Prior Authorization Request

COVID-19 Pharmacy Program Emergency Response

The MassHealth Pharmacy Program, in coordination with agencies across the Executive Office of Health and Human Services, has released guidance in response to the new coronavirus - Coronavirus Disease 2019 (COVID-19). This guidance may be updated often and is subject to change at any time.

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.

- Effective April 6, 2020, the following agent will be added to the MassHealth Brand Name Preferred Over Generic Drug List.
 - Advair (fluticasone/salmeterol inhalation powder)^{BP} – **PA**
 - Daraprim (pyrimethamine)^{BP} – **PA**
 - Dymista (azelastine/fluticasone propionate)^{BP}
- Effective April 6, 2020, the following agents will be removed from the MassHealth Brand Name Preferred Over Generic Drug List.
 - Solodyn # (minocycline extended-release 80 mg, 105 mg tablet)
 - Treximet (sumatriptan/naproxen) – **PA**
 - Uceris (budesonide extended-release tablet) – **PA**

Updated MassHealth Supplemental Rebate/Preferred Drug List

The MassHealth Supplemental Rebate/Preferred Drug List has been updated to reflect recent changes to the MassHealth Drug List.

- Effective April 6, 2020, the following spinal muscular atrophy agent will be added to the MassHealth Supplemental Rebate/Preferred Drug List.
 - Zolgensma (onasemnogene abeparvovec-xioi)^{CO PD ^} – **PA**
- Effective April 6, 2020, the following anti-hypoglycemic agent will be added to the MassHealth Supplemental Rebate/Preferred Drug List.
 - Baqsimi (glucagon nasal powder)^{PD}
- Effective April 6, 2020, the following antidiabetic agent will be added to the MassHealth Supplemental Rebate/Preferred Drug List.
 - Trulicity (dulaglutide)^{PD}
- Effective April 6, 2020, the following interleukin antagonist will be added to the MassHealth Supplemental Rebate/Preferred Drug List.

- Taltz (ixekizumab) ^{PD} – **PA**
- e. Effective April 15, 2020, the following topical immune suppressant agent will be added to the MassHealth Supplemental Rebate/Preferred Drug List.
 - Eucrisa (crisaborole) ^{PD} – **PA**
- f. Effective April 15, 2020, the following immunomodulator agents will be added to the MassHealth Supplemental Rebate/Preferred Drug List.
 - Xeljanz (tofacitinib) ^{PD} – **PA**
 - Xeljanz XR (tofacitinib extended-release) ^{PD} – **PA**
- g. Effective April 15, 2020, the following antineoplastic agents will be added to the MassHealth Supplemental Rebate/Preferred Drug List.
 - Bosulif (bosutinib) ^{PD} – **PA**
 - Ibrance (palbociclib) ^{PD} – **PA**
 - Inlyta (axitinib) ^{PD} – **PA**
 - Sutent (sunitinib) ^{PD} – **PA**
- h. Effective April 15, 2020, the following anti-hemophilia agents will be added to the MassHealth Supplemental Rebate/Preferred Drug List.
 - Benefix (factor IX human recombinant) ^{PD}
 - Xyntha (antihemophilic factor, recombinant) ^{PD}

MassHealth ACP/MCO Uniform Preferred Drug List

- a. Effective April 6, 2020, the following spinal muscular atrophy agent will be added to the MassHealth ACP/MCO Uniform Preferred Drug List. Please note that implementation for ACPs and MCOs for this agent may be staggered over the short term. This list will be updated accordingly as soon as possible.
 - Zolgensma (onasemnogene abeparvovec-xioi)
- b. Effective April 6, 2020, the following anti-hypoglycemic agent will be added to the MassHealth ACP/MCO Uniform Preferred Drug List. Please note that implementation for ACPs and MCOs for this agent may be staggered over the short term. This list will be updated accordingly as soon as possible.
 - Baqsimi (glucagon nasal powder)
- c. Effective April 6, 2020, the following antidiabetic agent will be added to the MassHealth ACP/MCO Uniform Preferred Drug List. Please note that implementation for ACPs and MCOs for this agent may be staggered over the short term. This list will be updated accordingly as soon as possible.
 - Trulicity (dulaglutide)
- d. Effective April 6, 2020, the following interleukin antagonist will be added to the MassHealth ACP/MCO Uniform Preferred Drug List. Please note that implementation for ACPs and MCOs for this agent may be staggered over the short term. This list will be updated accordingly as soon as possible.
 - Taltz (ixekizumab)
- e. Effective April 15, 2020, the following topical immune suppressant agent will be added to the MassHealth ACP/MCO Uniform Preferred Drug List. Please note that implementation for ACPs and MCOs for this agent may be staggered over the short term. This list will be updated accordingly as soon as possible.
 - Eucrisa (crisaborole)
- f. Effective April 15, 2020, the following immunomodulator agents will be added to the MassHealth ACP/MCO Uniform Preferred Drug List. Please note that implementation for ACPs and MCOs for these agents may be staggered over the short term. This list will be updated accordingly as soon as possible.
 - Xeljanz (tofacitinib)
 - Xeljanz XR (tofacitinib extended-release)
- g. Effective April 15, 2020, the following antineoplastic agents will be added to the MassHealth ACP/MCO Uniform Preferred Drug List. Please note that implementation for ACPs and MCOs for these agents may be staggered over the short term. This list will be updated accordingly as soon as possible.
 - Bosulif (bosutinib)

- Ibrance (palbociclib)
 - Inlyta (axitinib)
 - Sutent (sunitinib)
- h. Effective April 15, 2020, the following anti-hemophilia agents will be added to the MassHealth ACPP/MCO Uniform Preferred Drug List. Please note that implementation for ACPPs and MCOs for these agent may be staggered over the short term. This list will be updated accordingly as soon as possible.
- Benefix (factor IX human recombinant)
 - Xyntha (antihemophilic factor, recombinant)

Updated MassHealth Quick Reference Guide

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

Updated MassHealth Acute Hospital Carve-Out Drugs List

The MassHealth Acute Hospital Carve-Out Drugs list has been updated to reflect recent changes to the MassHealth Drug List.

Deletions

- a. The following drugs have been removed from the MassHealth Drug List because they have been discontinued by the manufacturer.
- Aerospan (flunisolide inhalation aerosol) – **PA**
 - Foradil (formoterol inhalation powder) – **PA**
 - Giazo (balsalazide 1.1 gram tablet) – **PA**
 - Hectorol (doxercalciferol capsule) – **PA**
 - Zincate (zinc sulfate)
- b. The following drugs has 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.
- Azelex (azelaic acid cream) – **PA**
 - Tivorbex (indomethacin 20 mg, 40 mg) – **PA**

Corrections / Clarifications

The following listings have been clarified. These changes do not reflect any change in MassHealth policy.

- Advair (fluticasone/salmeterol inhalation aerosol) – **PA**
 - Cymbalta # (duloxetine 20 mg, 30 mg, 60 mg capsule) – **PA < 6 years**
 - duloxetine 40 mg capsule – **PA**
 - Invega Sustenna (paliperidone extended-release 1-month injection) – **PA < 6 years, PA > 2 injections/month within the first 30 days of therapy and PA > 1 injection/month after 30 days of therapy**
 - Invega Trinza (paliperidone extended-release 3-month injection) – **PA < 6 years and PA > 1 injection/3 months**
 - Keppra XR # (levetiracetam extended-release)
 - nabumetone 500 mg, 750 mg
 - naproxen suspension – **PA ≥ 13 years**
 - Proventil (albuterol inhaler)
 - Risperdal Consta (risperidone extended-release intramuscular injection) – **PA < 6 years and PA > 2 injections/month**
 - Saphris (asenapine sublingual tablet) – **PA**
 - Solodyn (minocycline extended-release 55 mg, 65 mg, 115 mg tablet) ^{BP}
-

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.

^ 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.

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.

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.

CO Carve-Out. This agent is listed on the Acute Hospital Carve-Out Drugs List and is subject to additional monitoring and billing requirements.

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.