



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
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October 2019 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 rollouts effective October 1, October 7, and October 9, 2019.

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

Additions

Effective October 1, 2019, the following newly marketed drug has been added to the MassHealth Drug List.

- Dovato (dolutegravir/lamivudine) ^{PD}

Effective October 7, 2019, the following newly marketed drugs have been added to the MassHealth Drug List.

- dexchlorpheniramine solution – **PA**
- Evenity (romosozumab-aqqg) – **PA**
- Ezallor (rosuvastatin sprinkle capsule) – **PA**
- Gamifant (emapalumab-lzsg) – **PA**
- Mavenclad (cladribine tablet) – **PA**
- Piqray (alpelisib) – **PA**
- pyridostigmine bromide 30 mg tablet – **PA**
- Skyrizi (risankizumab-rzaa) – **PA**
- Vyndaqel (tafamidis) – **PA**

Change in Prior-Authorization Status

- Effective October 1, 2019, the following antiretroviral agent will no longer require prior authorization.
 - Juluca (dolutegravir/rilpivirine) ^{PD}
- Effective October 7, 2019, the following urinary dysfunction agents will no longer require prior authorization.
 - Gelnique (oxybutynin gel)
 - Myrbetriq (mirabegron extended-release)
 - Oxytrol (oxybutynin transdermal system)
 - Toviaz (fesoterodine) ^{BP}
 - Vesicare # (solifenacin)
- Effective October 7, 2019, the following urinary dysfunction agent will no longer require prior authorization for exceeding quantity limits.
 - Detrol LA # (tolterodine extended-release 2 mg)
- Effective October 7, 2019, the following urinary dysfunction agent will require prior authorization.
 - trospium extended-release – **PA**
- Effective October 7, 2019, the following antihistamine agent will no longer require prior authorization for use above quantity limits.
 - azelastine 137 mcg nasal spray
- Effective October 7, 2019, the following antihistamine agents will no longer require prior authorization.
 - carbinoxamine 4 mg/5mL solution, 4 mg tablet

- Clarinex # (desloratadine syrup, tablet)
- Dymista (azelastine/fluticasone propionate)

New or Revised Therapeutic Tables

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- Table 13 – Lipid-Lowering Agents
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Updated and New Prior-Authorization Request Forms

- Anticonvulsant Prior Authorization Request
- Antiretroviral Agents Prior Authorization Request
- Asthma/Allergy Monoclonal Antibodies Prior Authorization Request
- Calcitonin Gene-Related Peptide (CGRP) Inhibitors Prior Authorization Request
- Corlanor and Entresto Prior Authorization Request
- Hereditary Angioedema Agents Prior Authorization Request
- Immunomodulators Prior Authorization Request
- Intranasal Corticosteroids Prior Authorization Request
- Lipid-Lowering Agents Prior Authorization Request
- Multiple Sclerosis Agents Prior Authorization Request
- Oral/Injectable Antifungal Agents Prior Authorization Request
- Oral/Intranasal Antihistamine Agents Prior Authorization Request
- Osteoporosis Agents and Calcium Regulators Prior Authorization Request
- Otic Antibiotics Prior Authorization Request
- Pediatric Behavioral Health Medication Initiative Prior Authorization Request
- Thrombocytopenic Agents Prior Authorization Request

Updated MassHealth Brand Name Preferred Over Generic Drug List

- a. Effective October 1, 2019, the following agents will be removed from the MassHealth Brand Name Preferred Over Generic Drug List.
 - Epclusa (sofosbuvir/velpatasvir) – **PA**
 - Harvoni (ledipasvir/sofosbuvir) – **PA**
- b. Effective October 7, 2019, the following agent will be added to the MassHealth Brand Name Preferred Over Generic Drug List.
 - Copaxone (glatiramer 40 mg) ^{BP}
- c. Effective October 7, 2019, the following agents will be removed from the MassHealth Brand Name Preferred Over Generic Drug List.
 - Delzicol DR # (mesalamine capsule)
 - Flector (diclofenac topical patch) – **PA**
 - Letairis (ambrisentan) – **PA**
 - Tamiflu # (oseltamivir 30mg) – **PA all quantities (June 1st to September 30th); PA > 20 capsules/season (October 1st to May 31st)**
 - Tamiflu # (oseltamivir 45 mg and 75 mg) – **PA all quantities (June 1st to September 30th); PA > 10 capsules/season (October 1st to May 31st)**
 - Vesicare # (solifenacin)
 - Xeloda # (capecitabine)

Updated MassHealth Over-the-Counter Drug List

Effective October 7, 2019, the following urinary dysfunction agent will be removed from the MassHealth Over-the-Counter Drug List.

- Oxytrol for Women (oxybutynin)

Updated MassHealth Supplemental Rebate/Preferred Drug List

- a. Effective October 1, 2019, the following antiretroviral agents will be added to the MassHealth Supplemental Rebate/Preferred Drug List.
 - Dovato (dolutegravir/lamivudine) ^{PD}
 - Juluca (dolutegravir/rilpivirine) ^{PD}
 - Triumeq (abacavir/dolutegravir/lamivudine) ^{PD}
- b. Effective October 1, 2019, the following hepatitis antiviral agents will be added to the MassHealth Supplemental Rebate/Preferred Drug List.
 - ledipasvir/sofosbuvir ^{PD} – **PA**
 - sofosbuvir/velpatasvir ^{PD} – **PA**
- c. Effective October 1, 2019, the following hepatitis antiviral agents will be removed from the MassHealth Supplemental Rebate/Preferred Drug List.
 - Epclusa (sofosbuvir/velpatasvir) – **PA**
 - Harvoni (ledipasvir/sofosbuvir) – **PA**
 - Sovaldi (sofosbuvir) – **PA**

MassHealth ACP/MCO Uniform Preferred Drug List

- a. Effective January 1, 2020, the following antiretroviral agents will be added to the MassHealth ACP/MCO Uniform Preferred Drug List.
 - Dovato (dolutegravir/lamivudine)
 - Juluca (dolutegravir/rilpivirine)
 - Triumeq (abacavir/dolutegravir/lamivudine)

- b. Effective January 1, 2020, the following hepatitis antiviral agents will be added to the MassHealth ACP/MCO Uniform Preferred Drug List.
 - ledipasvir/sofosbuvir
 - sofosbuvir/velpatasvir
- c. Effective January 1, 2020, the following hepatitis antiviral agents will be removed from the MassHealth ACP/MCO Uniform Preferred Drug List.
 - Epclusa (sofosbuvir/velpatasvir)
 - Harvoni (ledipasvir/sofosbuvir)
 - Sovaldi (sofosbuvir)

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

Effective October 9, 2019, the following CAR-T therapies have been added to the MassHealth Acute Hospital Carve-Out Drugs List as Adjudicated Payment per Episode of Care (APEC) Carve-Out Drugs.

- Kymriah (tisagenlecleucel) ^ – **PA**
- Yescarta (axicabtagene ciloleucel) ^ – **PA**

Deletions

- a. The following drugs have been removed from the MassHealth Drug List because they have been discontinued by the manufacturer.
 - Nutrestore (l-glutamine) – **PA**
 - Xyzal (levocetirizine solution) – **PA**
 - Xyzal # (levocetirizine tablet)
- b. The following drug 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.
 - Dyrenium (triamterene) – **PA**

Corrections / Clarifications

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

- carbinoxamine 6 mg tablet – **PA**
- cladribine injection

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.

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.