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

September 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 September 21, 2020.

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

Additions

Effective September 21, 2020, the following newly marketed drugs have been added to the MassHealth Drug List.

- Fensolvi (leuprolide) – **PA**
- Jelmyto (mitomycin pyelocalyceal solution) ^ – **PA**
- Licart (diclofenac topical patch) – **PA**
- Pemazyre (pemigatinib) – **PA**
- Retevmo (selpercatinib) – **PA**
- Riomet ER (metformin extended-release solution) – **PA**
- Rybelsus (semaglutide tablet) – **PA**
- Tabrecta (capmatinib) – **PA**
- Tepezza (teprotumumab-trbw) – **PA**
- Tivicay PD (dolutegravir tablet for suspension)
- Vyepti (eptinezumab-jjmr) ^ – **PA**
- Zeposia (ozanimod) – **PA**

Change in Prior-Authorization Status

a. Effective September 21, 2020, the following cardiovascular agents will no longer require prior authorization.
   - Azor # (amlodipine/olmesartan)
   - Benicar # (olmesartan)
   - Benicar HCT # (olmesartan/hydrochlorothiazide)
   - Bystolic (nebivolol)
   - Corgard # (nadolol)
   - Edarbi (azilsartan)
   - Edarbyclor (azilsartan/chlorthalidone)
   - Exforge HCT # (valsartan/amlodipine/hydrochlorothiazide)
   - Inspra # (eplerenone)
   - Micardis # (telmisartan)
   - Micardis HCT # (telmisartan/hydrochlorothiazide)
   - Tekturna HCT (aliskiren/hydrochlorothiazide)

b. Effective September 21, 2020, the following medications will require prior authorization below newly established age limits. Pediatric Behavioral Health Medication Initiative criteria will apply. For additional information, please see the Pediatric Behavioral Health Medication Initiative documents found at www.mass.gov/druglist.
   - Aricept # (donepezil 10 mg tablet) – **PA < 6 years and PA > 2 units/day**

- Aricept # (donepezil 5 mg tablet) – **PA < 6 years and PA > 1 unit/day**
- donepezil orally disintegrating tablet – **PA < 6 years and PA > 1 unit/day**
- naltrexone tablet – **PA < 6 years**
- Namenda (memantine titration pack) – **PA < 6 years and PA > 49 units/month**
- Namenda # (memantine tablet) – **PA < 6 years and PA > 2 units/day**

c. Effective September 21, 2020, the following medications will require prior authorization for Pediatric Behavioral Health Medication Initiative criteria. For additional information, please see the Pediatric Behavioral Health Medication Initiative documents found at www.mass.gov/druglist.
   - Aricept (donepezil 23 mg tablet) – **PA**
   - Namenda (memantine solution) – **PA**
   - Namenda XR (memantine extended-release) [BP] – **PA**
   - Namzaric (memantine/donepezil extended-release) – **PA**

d. Effective September 21, 2020, the following medications will no longer require prior authorization within quantity limits. Prior authorization below newly established age limits will be required. Pediatric Behavioral Health Medication Initiative criteria will apply. For additional information, please see the Pediatric Behavioral Health Medication Initiative documents found at www.mass.gov/druglist.
   - Nuvigil # (armodafinil) – **PA < 6 years and PA > 1 unit/day**
   - Provigil # (modafinil 100 mg) – **PA < 6 years and PA > 1.5 units/day**
   - Provigil # (modafinil 200 mg) – **PA < 6 years and PA > 2 units/day**

e. Effective September 21, 2020, the following topical corticosteroid agent will require prior authorization.
   - Locoid Lipocream (hydrocortisone butyrate/emollient) – **PA**

f. Effective September 21, 2020, the following antidiabetic agents will no longer require prior authorization.
   - Actoplus Met # (pioglitazone/metformin)
   - Actoplus Met XR (pioglitazone/metformin extended-release)
   - Avandia (rosiglitazone)
   - Cycloset (bromocriptine 0.8 mg tablet)
   - Invokamet XR (canagliflozin/metformin extended-release)
   - Jentadueto XR (linagliptin/metformin extended-release)
   - Symlin (pramlintide)
   - Synjardy (empagliflozin/metformin)
   - Synjardy XR (empagliflozin/metformin extended-release)
   - Victoza (liraglutide)

g. Effective September 21, 2020, the following opioid dependence agent will no longer require prior authorization.
   - Sublocade (buprenorphine extended-release injection)

New or Revised Therapeutic Tables

Table 2 – Hormones - Gonadotropin-Releasing Hormone Analogs
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Updated and New Prior-Authorization Request Forms

- Antidiabetic Agents Prior Authorization Request
- Beta Thalassemia, Myelodysplastic Syndrome, and Sickle Cell Disease Agents Prior Authorization Request
- Gonadotropin-Releasing Hormone Prior Authorization Request
- Headache Therapy (Calcitonin Gene-Related Peptide (CGRP) Inhibitors) Prior Authorization Request
- Immunomodulators Prior Authorization Request
- Multiple Sclerosis Agents Prior Authorization Request
- Narcolepsy and Miscellaneous Sleep Disorder Therapy Agents Prior Authorization Request
- Nonsteroidal Anti-Inflammatory Drugs (NSAID) Prior Authorization Request
- Opioid Dependence and Reversal Agents Prior Authorization Request
- Otic Antibiotics Prior Authorization Request
- Pediatric Behavioral Health Medication Initiative Prior Authorization Request
- Proton Pump Inhibitor Prior Authorization Request
- Topical Corticosteroids Prior Authorization Request

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 September 8, 2020, the following agent was added to the MassHealth Brand Name Preferred Over Generic Drug List.
   - Tecfidera (dimethyl fumarate) [BP] – **PA**

b. Effective September 21, 2020, the following agents will be added to the MassHealth Brand Name Preferred Over Generic Drug List.
   - Atripla (efavirenz/emtricitabine/tenofovir) [BP]
   - Ciprodex (ciprofloxacin/dexamethasone) [BP]
   - Demser (metyrosine) [BP]
   - Emtriva (emtricitabine) [BP]
   - Flector (diclofenac topical patch) [BP] – **PA**
   - Humalog (insulin lispro 75/25) [BP]
   - Moviprep (polyethylene glycol-electrolyte solution) [BP]
   - Protonix (pantoprazole 40 mg suspension) [BP] – **PA**
   - Truvada (emtricitabine/tenofovir disoproxil fumarate) [BP]

c. Effective September 21, 2020, the following agent will be removed from the MassHealth Brand Name Preferred Over Generic Drug List.
   - Aggrenox # (aspirin/extended-release dipyridamole)

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 September 21, 2020, the following antiretroviral agents will be added to the MassHealth Supplemental Rebate/Preferred Drug List.

- Delstrigo (doravirine/lamivudine/tenofovir disoproxil fumarate) [PD]
- Pifeltro (doravirine) [PD]

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

- Pediatric Behavioral Health Medication Initiative

Updated Controlled Substances Management Program (CSMP): Pharmacy Selection Form

The MassHealth Controlled Substances Management Program (CSMP) Pharmacy Selection Form has been updated.

Deletions

a. The following drugs have been removed from the MassHealth Drug List because they have been discontinued by the manufacturer.
   - Byvalson (nebivolol/valsartan) – **PA**
   - Corzide # (nadolol/bendroflumethiazide)
   - Levatol (penbutolol) – **PA**
   - methyclothiazide
   - moexipril/hydrochlorothiazide
   - reserpine
   - Robinul (glycopyrrolate injection) – **PA**
   - Robinul (glycopyrrolate 1 mg tablet)
   - Robinul Forte (glycopyrrolate 2 mg tablet)
   - Sufenta (sufentanil injection)
   - Tenex (guanfacine)

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.
   - Prestalia (perindopril/amlodipine) – **PA**

Corrections / Clarifications

a. The following drugs has been added to the MassHealth Drug List. It was omitted in error. This change does not reflect any change in MassHealth policy.
   - biotin powder – **PA**
   - Locoid Lipocream (hydrocortisone butyrate/emollient) – **PA**
   - Locoid (hydrocortisone butyrate lotion) – **PA**

b. The following listings have been clarified. These changes do not reflect any change in MassHealth policy.
   - Flector (diclofenac topical patch) [BP] – **PA**
   - glycopyrrolate 1 mg, 2 mg tablet

- Ozempic (semaglutide injection) – **PA**
- Razadyne # (galantamine tablet) – **PA < 18 years and PA > 2 units/day**
- Razadyne ER # (galantamine extended-release capsule) – **PA < 18 years and PA > 1 unit/day**
- rivastigmine capsule – **PA < 18 years and PA > 2 units/day**
- Tivicay (dolutegravir tablet) – **PA > 1 unit/day**

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.