



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

## March 2021 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 March 22, 2021.

Additional information about these agents may be available within the MassHealth Drug List at [www.mass.gov/druglist](http://www.mass.gov/druglist).

---

### Additions

- a. Effective March 22, 2021, the following newly marketed drugs have been added to the MassHealth Drug List.
  - Alkindi (hydrocortisone sprinkle capsule) – **PA**
  - Blenrep (belantamab mafodotin-blmf) – **PA**
  - Bynfezia (octreotide prefilled syringe)
  - Cystadrops (cysteamine 0.37% ophthalmic solution) – **PA**
  - Gavreto (pralsetinib) – **PA**
  - Inqovi (decitabine/cedazuridine)
  - Lampit (nifurtimox) – **PA**
  - Monoferric (ferric derisomaltose) – **PA**
  - Nyvepria (pegfilgrastim-apgf)
  - Phesgo (pertuzumab/trastuzumab/hyaluronidase-zzxf) – **PA**
  - quinidine gluconate extended-release – **PA**
  - Sutab (sodium sulfate/magnesium sulfate/potassium chloride) – **PA**
  - Viltepso (viltolarsen) – **PA**
  - Xywav (calcium oxybate/magnesium oxybate/potassium oxybate/sodium oxybate) – **PA**
  - Zepzelca (lurbinectedin) – **PA**
  - Zilxi (minocycline 1.5% foam) – **PA**
- b. Effective for the date listed below, the following COVID-19 treatment therapy has been added to the MassHealth Drug List on February 24, 2021.
  - etesevimab (COVID EUA – February 9, 2021)
- c. Effective for the date listed below, the following COVID-19 preventative therapy has been added to the MassHealth Drug List on March 8, 2021.
  - Janssen COVID-19 Vaccine (COVID EUA – February 27, 2021)
- d. Effective for the date listed below, the following COVID-19 treatment therapy has been added to the MassHealth Drug List on March 16, 2021.
  - casirivimab/imdevimab (COVID EUA – November 21, 2021)

---

### Change in Prior-Authorization Status

- a. Effective March 22, 2021, the following acne and rosacea agent will no longer require prior authorization.
  - Noritate (metronidazole 1% cream)
- b. Effective March 22, 2021, the following topical NSAID agent will no longer require prior authorization.
  - Pennsaid (diclofenac topical solution)
- c. Effective March 22, 2021, the following benzodiazepine will no longer require prior authorization 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](http://www.mass.gov/druglist).

- clonazepam 2 mg orally disintegrating tablet – **PA < 6 years and PA > 2 units/day**
- d. Effective March 22, 2021, the following antiparkinson agents will no longer require prior authorization within quantity limits.
  - Azilect (rasagiline) – **PA > 1 unit/day**
  - Neupro (rotigotine transdermal system) <sup>BP</sup> – **PA > 1 unit/day**
- e. Effective March 22, 2021, the following acne and rosacea agent will require prior authorization.
  - Metro lotion (metronidazole lotion) – **PA**
- f. Effective March 22, 2021, the following anticoagulant will no longer require prior authorization.
  - Pradaxa (dabigatran etexilate mesylate 110 mg) <sup>BP</sup>
  - Pradaxa (dabigatran etexilate mesylate 75 mg, 150 mg) <sup>BP</sup>
- g. Effective March 22, 2021, the following bowel preparation agent will no longer require prior authorization.
  - Plenvu (polyethylene glycol-electrolyte solution)

---

## New or Revised Therapeutic Tables

Table 4 – Hematologic Agents - Hematopoietic and Miscellaneous Hematologic Agents

Table 5 – Immunological Agents

Table 8 – Opioids and Analgesics

Table 10 – Dermatologic Agents - Acne and Rosacea

Table 11 – Nonsteroidal Anti-Inflammatory Drugs

Table 14 – Headache Therapy

Table 18 – Cardiovascular Agents

Table 22 – Acromegaly, Carcinoid Syndrome, and Cushing's Syndrome Agents

Table 23 – Respiratory Agents - Inhaled

Table 35 – Antibiotics and Anti-Infectives - Oral and Inhaled

Table 39 – Influenza Prophylaxis and Treatment Agents

Table 43 – Pulmonary Arterial Hypertension Agents

Table 46 – Urinary Dysfunction Agents

Table 48 – Antiparkinsonian Agents

Table 50 – Narcolepsy and Miscellaneous Sleep Disorder Therapy Agents

Table 52 – Multiple Sclerosis Agents

Table 55 – Androgens

Table 57 – Oncology Agents

Table 58 – Anticoagulants and Antiplatelet Agents

Table 61 – Gastrointestinal Drugs - Antidiarrheals, Constipation, and Miscellaneous Gastrointestinal Agents

Table 63 – Dermatologic Agents - Topical Chemotherapy, Genital Wart Treatment, and Miscellaneous Dermatologic Agents

Table 64 – Asthma/Allergy Monoclonal Antibodies

Table 66 – Antibiotics - Injectable

Table 69 – Barbiturates, Benzodiazepines, and Miscellaneous Antianxiety Agents

Table 71 – Pediatric Behavioral Health

Table 72 – Agents Not Otherwise Classified

Table 73 – Iron Agents and Chelators

Table 76 – Neuromuscular Agents - Duchenne Muscular Dystrophy and Spinal Muscular Atrophy

---

## Updated and New Prior-Authorization Request Forms

- Androgen Therapy Prior Authorization Request
- Anticoagulant and Antiplatelet Prior Authorization Request

- Asthma/Allergy Monoclonal Antibodies Prior Authorization Request
  - Benzodiazepines and Other Anti-Anxiety Agents Prior Authorization Request
  - Constipation Agents Prior Authorization Request
  - Gastrointestinal Agents - Antidiarrheals and Bowel Preparation Agents Prior Authorization Request
  - Headache Therapy (Butalbital Combination Agents and Ergot Alkaloids) Prior Authorization Request
  - Headache Therapy (Serotonin Receptor Agents) Prior Authorization Request
  - Inhaled Respiratory Agents 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
  - Opioids/Acetaminophen Analgesic Prior Authorization Request
  - Oral Antibiotics and Anti-Infectives Prior Authorization Request
  - Pulmonary Arterial Hypertension Prior Authorization Request
  - Topical Vitamin D Analogues 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 March 22, 2021, the following agents will be added to the MassHealth Brand Name Preferred Over Generic Drug List.
    - Sorilux (calcipotriene foam)<sup>BP</sup> – **PA**
    - Veletri (epoprostenol)<sup>BP</sup> – **PA**
    - Zyclara (imiquimod 2.5%, 3.75% cream)<sup>BP</sup> – **PA**
  - b. Effective March 22, 2021, the following agent will be removed from the MassHealth Brand Name Preferred Over Generic Drug List.
    - Differin (adapalene 0.1% gel) – **PA**
- 

### **Updated MassHealth COVID-19 Pharmacy Program Emergency Response**

The MassHealth COVID-19 Pharmacy Program Emergency Response document has been updated to reflect recent changes to the MassHealth Drug List.

---

### **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 March 22, 2021, the following anticoagulant will be removed from the MassHealth Supplemental Rebate/Preferred Drug List.
- Eliquis (apixaban)
- 

### **Updated MassHealth ACP/MCO Unified Pharmacy Product List**

The MassHealth ACP/MCO Unified Pharmacy Product List has been updated to reflect recent changes to the MassHealth Drug List.

---

### **Updated MassHealth Quick Reference Guide**

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

---

### **Updated Pharmacy Covered Professional Services List**

---

### **Updated and New Pharmacy Initiatives**

- Opioid and Pain Initiative

---

## Deletions

- a. The following drugs have been removed from the MassHealth Drug List because they have been discontinued by the manufacturer.
  - Colyte # (polyethylene glycol-electrolyte solution)
  - Cordarone # (amiodarone)
  - Exalgo (hydromorphone extended-release) – **PA**
  - Iprivask (desirudin) – **PA**
  - Prepopik (sodium picosulfate/magnesium oxide/anhydrous citric acid)
  - Rythmol # (propafenone)
  - Striant (testosterone buccal system) – **PA**
  - Tambocor # (flecainide)
- 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.
  - Benzepro (benzoyl peroxide 7% microspheres) – **PA**
  - Benzepro (benzoyl peroxide foaming cloth) – **PA**
  - Noctiva (desmopressin) – **PA**

---

## Corrections / Clarifications

- a. The following drug has been added to the MassHealth Drug List. This change does not reflect any change in MassHealth policy.
  - Natesto (testosterone nasal gel) – **PA**
- b. 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.
  - Ativan # (lorazepam injection)
  - diazepam injection
  - Rythmol SR # (propafenone extended-release)
- c. The following listings have been clarified. These changes do not reflect any change in MassHealth policy.
  - Amzeeq (minocycline 4% foam) – **PA**
  - clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg orally disintegrating tablet - **PA < 6 years and PA > 3 units/day**
  - Cystaran (cysteamine 0.44% ophthalmic solution) – **PA**
  - Differin (adapalene cream, 0.3% gel, lotion)<sup>BP</sup> – **PA**
  - Epipen # (epinephrine 0.3 mg auto-injection)
  - Epipen Jr # (epinephrine 0.15 mg auto-injection)
  - estazolam – **PA < 6 years and PA > 1 unit/day**
  - flurazepam – **PA < 6 years and PA > 1 unit/day**
  - Halcion # (triazolam) – **PA < 6 years and PA > 1 unit/day**
  - midazolam injection
  - quinidine sulfate
  - Restoril # (temazepam 7.5 mg, 15 mg, 30 mg) – **PA < 6 years and PA > 1 unit/day**
  - Xanax XR # (alprazolam extended-release) – **PA < 6 years and PA > 2 units/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.

**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.