



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
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May 2024 MassHealth Drug List Summary Update

MassHealth evaluates the prior authorization (PA) 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 May 6, 2024.

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

Additions

- a. Effective May 6, 2024, the following newly marketed drugs have been added to the MassHealth Drug List.
 - Agamree (vamorolone) – **PA**
 - Elrexfio (elranatamab-bcmm) – **PA**; MB
 - Fruzaqla (fruquintinib) – **PA**
 - Izervay (avacincaptad pegol) – **PA**; MB
 - Jesduvroq (daprodustat) – **PA**
 - Likmez (metronidazole suspension) – **PA**
 - Motpoly XR (lacosamide extended-release capsule) – **PA**
 - Sohonos (palovarotene) – **PA**
 - Suflave (polyethylene glycol/sodium sulfate/potassium chloride/magnesium sulfate/sodium chloride) – **PA**
 - Talvey (talquetamab-tgvs) – **PA**; MB
 - Vanflyta (quizartinib) – **PA**
 - Veopoz (pozelimab-bbfg) – **PA**; MB
 - Vevye (cyclosporine 0.1% ophthalmic solution) – **PA**
 - Voquezna (vonoprazan) – **PA**
 - Xdemvy (lotilaner) – **PA**
 - Zepbound (tirzepatide) – **PA**
- b. Effective May 6, 2024, the following preventative therapy has been added to the MassHealth Drug List.
 - Penbraya (pentavalent meningococcal groups A, B, C, W, and Y vaccine)

Change in Prior Authorization Status

- a. Effective May 6, 2024, the following agent will no longer require PA within newly established quantity limits.
 - Marinol (dronabinol capsule) – **PA > 2 units/day**; BP
- b. Effective May 6, 2024, the following Alzheimer's agent will require PA.
 - Namzaric (memantine/donepezil extended-release) – **PA**
- c. Effective May 6, 2024, the following osteoporosis agent will require PA.
 - alendronate solution – **PA**; M90
- d. Effective May 6, 2024, the following antiglaucoma agent will no longer require PA.
 - Lumigan (bimatoprost 0.01% ophthalmic solution)
- e. Effective April 8, 2024, the following inhaled respiratory agent will no longer require PA within the updated age limit.
 - fluticasone propionate inhalation aerosol – **PA ≥ 12 years**; A90

Change in Coverage Status

- a. Effective May 6, 2024, the following agents will be available through medical billing only and will no longer be available through pharmacy billing.
 - Mylotarg (gemtuzumab ozogamicin) – **PA**; MB
 - Portrazza (necitumumab) – **PA**; MB
 - Rybrevant (amivantamab-vmjw) – **PA**; MB
 - Zepzelca (lurbinectedin) – **PA**; MB
 - Zilretta (triamcinolone extended-release injectable suspension) – **PA**; MB
- b. Effective May 6, 2024, the following agents will no longer be restricted to medical billing.
 - Vyjuvek (beremagene geperpavec-svdt) – **PA**

New or Revised Therapeutic Tables

Table 3 – Gastrointestinal Drugs - Histamine H2 Antagonists, Proton Pump Inhibitors, and Miscellaneous Gastroesophageal Reflux Agents

Table 4 – Hematologic Agents - Hematopoietic and Miscellaneous Hematologic Agents

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Table 28 – Antifungal Agents - Topical

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Updated and New Prior Authorization Request Forms

- Androgen Therapy Prior Authorization Request
- Anticonvulsant Prior Authorization Request
- Antidiabetic Agents Prior Authorization Request
- Antiemetics Prior Authorization Request
- Anti-Obesity Agents Prior Authorization Request
- Antipsychotic Prior Authorization Request
- Diabetes Medical Supplies Prior Authorization Request
- Gastrointestinal Agents - Antidiarrheals and Bowel Preparation Agents Prior Authorization Request
- Glaucoma Agents Prior Authorization Request
- Headache Therapy (Ergot Alkaloids and Serotonin Receptor Agents) Prior Authorization Request
- Inhaled Respiratory Agents Prior Authorization Request
- Lung Cancer Agents Prior Authorization Request
- Neuromuscular Agents Prior Authorization Request
- Ophthalmic Anti-Allergy and Anti-Inflammatory Agents Prior Authorization Request
- Oral Antibiotics and Anti-Infectives Prior Authorization Request
- Osteoporosis Agents and Calcium Regulators Prior Authorization Request
- T-Cell Immunotherapies 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 May 6, 2024, the following agents will be added to the MassHealth Brand Name Preferred Over Generic Drug List.
 - Emflaza (deflazacort) – **PA**; BP
 - Farxiga (dapagliflozin); BP, M90
 - Isentress (raltegravir); BP
 - Marinol (dronabinol) – **PA > 2 units/day**; BP
 - Restasis (cyclosporine 0.05% ophthalmic emulsion); BP, A90
 - Sprycel (dasatinib); BP
 - Toujeo (insulin glargine); BP
 - Xigduo XR (dapagliflozin/metformin extended-release); BP, M90
- b. Effective May 6, 2024, the following agents will be removed from the MassHealth Brand Name Preferred Over Generic Drug List.
 - Fortesta (testosterone 2% gel pump) – **PA**
 - Kazano (alogliptin/metformin) – **PA**; M90
 - Luzu (luliconazole) – **PA**; A90
 - Nesina (alogliptin) – **PA**; M90
 - Oseni (alogliptin/pioglitazone) – **PA**; M90
 - Oxistat (oxiconazole cream) – **PA**; A90
 - Pennsaid (diclofenac topical solution); #; A90
 - Pristiq (desvenlafaxine succinate extended-release) – **PA < 6 years and PA > 1 unit/day**; #, A90
 - Rapamune (sirolimus solution); #, A90
 - Welchol (colesevelam); #, M90

Updated MassHealth 90-day Initiative

The MassHealth 90-day Initiative has been updated to reflect recent changes to the MassHealth Drug List.

Effective May 6, 2024, the following agents may be allowed or mandated to be dispensed in up to a 90-day supply, as indicated below.

- Bromsite (bromfenac 0.075%) – **PA**; A90
- Farxiga (dapagliflozin); BP, M90
- Korlym (mifepristone 300 mg) – **PA**; A90
- Xigduo XR (dapagliflozin/metformin extended-release); BP, M90

Updated MassHealth Non-Drug Product List

The MassHealth Non-Drug Product List has been updated to reflect recent changes to the MassHealth Drug List.

Effective May 6, 2024, the following medical supply will be added to the MassHealth Non-Drug Product List.

- Freestyle Neo (test strips, blood glucose, preferred) ^{PND} – **PA**

Updated MassHealth Over-the-Counter Drug List

The MassHealth Over-the-Counter Drug List has been updated to reflect recent changes to the MassHealth Drug List.

- Effective May 6, 2024, the following antioxidant agent will require PA above newly updated age limits.
 - coenzyme Q10 – **PA ≥ 21 years**
- Effective May 6, 2024, the following antifungal agent will be removed from the MassHealth Over-the-Counter Drug List.
 - tolnaftate liquid; *, A90

Updated MassHealth Preferred Non-Drug Product List

The MassHealth Preferred Non-Drug Product List has been updated to reflect recent changes to the MassHealth Drug List.

Effective May 6, 2024, the following medical supply will be added to the MassHealth Preferred Non-Drug Product List.

- Freestyle Neo (test strips, blood glucose, preferred) ^{PND} – **PA**

Updated MassHealth Pharmacy Operational Page

The MassHealth Pharmacy Operational Page 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

The MassHealth Pharmacy Covered Professional Services List has been updated to reflect recent changes to the MassHealth Drug List.

Long-Acting Injectable Antipsychotic Medications Administered in Inpatient Psychiatry Units

Effective May 15, 2024, this identifies the current list of long-acting injectable antipsychotic medications for which administration in an inpatient psychiatry unit is reimbursable outside of the applicable per diem rates for acute, psychiatric, and CDR hospitals. Drug-specific prior authorization criteria may apply. Other requirements may also apply.

Deletions

- The following drugs have been removed from the MassHealth Drug List because they have been discontinued by the manufacturer.
 - Adlyxin (lixisenatide) – **PA**
 - Aloxi (palonosetron 0.25 mg/5 mL injection) – **PA > 2 units/28 days; #**

- Bydureon (exenatide extended-release pen)
 - D.H.E. 45 (dihydroergotamine injection) – **PA**
 - etidronate; M90
 - Loprox (ciclopirox 1% shampoo) – **PA**; A90
 - Natpara (parathyroid hormone) – **PA**
 - ondansetron 24 mg tablet – **PA**; A90
 - Varubi (rolapitant injection) – **PA > 2 vials/28 days**
 - Zomig ZMT (zolmitriptan orally disintegrating tablet) – **PA**; A90
- 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.
- ergotamine/caffeine tablet – **PA**; A90

Corrections / Clarifications

- a. The following drugs have been added to the MassHealth Drug List. These changes do not reflect any change in MassHealth policy.
- Binosto (alendronate effervescent tablet) – **PA**
 - Qdolo (tramadol solution) – **PA**
 - Voquezna Dual Pak (vonoprazan/amoxicillin) – **PA**
 - Voquezna Triple Pak (vonoprazan/amoxicillin/clarithromycin) – **PA**
- b. The following listings have been clarified. These changes do reflect a change in MassHealth policy.
- Anzemet (dolasetron) – **PA**
- c. The following non-drug products have been added to the MassHealth Drug List. They were omitted in error. This change does not reflect any change in MassHealth policy.
- Cequr Simplicity (insulin bolus delivery patch) ^{PND} – **PA**
 - Dexcom G6 (continuous glucose monitoring system) ^{PND} – **PA**
 - Dexcom G7 (continuous glucose monitoring system) ^{PND} – **PA**
 - Freestyle (test strips, blood glucose, preferred) ^{PND} – **PA > 100 units/30 days**
 - Freestyle Insulinx (test strips, blood glucose, preferred) ^{PND} – **PA > 100 units/30 days**
 - Freestyle Libre 14 day (continuous glucose monitoring system) ^{PND} – **PA**
 - Freestyle Libre 2 (continuous glucose monitoring system) ^{PND} – **PA**
 - Freestyle Libre 3 (continuous glucose monitoring system) ^{PND} – **PA**
 - Freestyle Lite (test strips, blood glucose, preferred) ^{PND} – **PA > 100 units/30 days**
 - Freestyle Neo (test strips, blood glucose, preferred) ^{PND} – **PA**
 - Omnipod Classic (insulin continuous subcutaneous infusion pump) ^{PND} – **PA**
 - Omnipod Dash (insulin continuous subcutaneous infusion pump) ^{PND} – **PA**
 - Omnipod Go (insulin continuous subcutaneous infusion pump) ^{PND} – **PA**
 - Omnipod 5 (insulin continuous subcutaneous infusion pump) ^{PND} – **PA**
 - Precision Xtra (test strips, blood glucose, preferred) ^{PND} – **PA > 100 units/30 days**
 - test strips, blood glucose, all other non-preferred – **PA**
 - V-Go (insulin continuous subcutaneous infusion patch) ^{PND} – **PA**
- d. The following listings have been clarified. These changes do not reflect any change in MassHealth policy.
- Akynzeo (fosnetupitant/palonosetron injection) – **PA > 2 units/28 days**
 - Akynzeo (netupitant/palonosetron capsule) – **PA > 2 units/28 days**
 - aprepitant 40 mg, 125 mg capsule – **PA > 2 units/28 days**; A90
 - ciclopirox 1% shampoo, 0.77% gel – **PA**; A90
 - Emend (aprepitant 80 mg) – **PA > 4 units/28 days**; #, A90
 - Emend (fosaprepitant injection) – **PA > 2 units/28 days**; #

- Forteo (teriparatide 600 mcg/2.4 mL) – **PA**; BP
- granisetron tablet – **PA > 2 units/28 days**; A90
- Loprox (ciclopirox 0.77% suspension) – **PA**; A90
- Paxlovid (nirmatrelvir/ritonavir for members ≥ 12 years of age)
- Rapamune (sirolimus solution, tablet); #, A90
- teriparatide 620 mcg/2.48 mL – **PA**
- tolnaftate cream, powder; *, A90
- Vfend (voriconazole suspension, 50 mg tablet) – **PA**; A90
- Vimpat (lacosamide tablet, solution, vial); #, A90
- Zofran (ondansetron tablet); #, A90

Abbreviations, Acronyms, and Symbols

This designates a brand-name drug with FDA “A”-rated generic equivalents. PA 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.

^{MB} This drug is available through the health care professional who administers the drug or in an outpatient or inpatient hospital setting. MassHealth does not pay for this drug to be dispensed through the retail pharmacy. If listed, PA does not apply through the hospital outpatient and inpatient settings. Please refer to 130 CMR 433.408 for PA requirements for other health care professionals. Notwithstanding the above, this drug may be an exception to the unified pharmacy policy; please refer to respective MassHealth Accountable Care Partnership Plans (ACPPs) and Managed Care Organizations (MCOs) for PA status and criteria, if applicable.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without PA.

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

^{A90} Allowable 90-day supply. Dispensing in up to a 90-day supply is allowed. May not include all strengths or formulations. Quantity limits and other restrictions may apply.

^{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.

^{M90} Mandatory 90-day supply. After dispensing up to a 30-day supply initial fill, dispensing in a 90-day supply is required. May not include all strengths or formulations. Quantity limits and other restrictions may also apply.

^{PND} Preferred Non-Drug Product. This product is a preferred non-drug product for which MassHealth has entered into a rebate agreement with product manufacturer.