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MassHealth Drug Utilization Review Program
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July 2026 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 rollouts effective July 1, 2026 and July 3, 2026.

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

Additions

Effective July 1, 2026, the following newly marketed drugs have been added to the MassHealth Drug List.

- Avtozma (tocilizumab-anoh vial) – **PA**; MB
- Avtozma (tocilizumab-anoh vial COVID); MB
- buspirone capsule – **PA**; A90
- Enbumyst (bumetanide nasal spray) – **PA**
- escitalopram capsule – **PA**; A90
- Exdensur (depemokimab-ulaa) – **PA**; MB
- Exxua (gepirone) – **PA**
- Fesilty (fibrinogen, human-chmt)
- Forzinity (elamipretide) – **PA**
- Hyrnuo (sevabertinib) – **PA**
- Inluriyo (imlunestrant) – **PA**
- Javadin (clonidine oral solution) – **PA**
- Komzifti (ziftomenib) – **PA**
- Lasix Onyu (furosemide on-body infusor) – **PA**
- Lopressor (metoprolol immediate-release 12.5 mg tablet) – **PA**
- Lopressor (metoprolol immediate-release oral solution) – **PA**
- Pokonza (potassium chloride oral solution) – **PA**
- potassium chloride 40 mEq powder packet – **PA**; A90
- Rybrevant Faspro (amivantamab/hyaluronidase-lpuj) – **PA**; MB
- Starjemza (ustekinumab-hmny prefilled syringe, 45 mg/0.5 mL vial) – **PA**
- Starjemza (ustekinumab-hmny 130 mg/26 mL vial) – **PA**; MB
- Unloxcyt (cosibelimab-ipdl) – **PA**; MB
- ustekinumab-aauz, unbranded – **PA**
- Veltassa (patiromer 1 g packet) – **PA ≥ 18 years and PA > 4 unit/day**
- Voyxact (sibeprenlimab-szsi) – **PA**

New FDA "A"-Rated Generics

Effective July 1, 2026, the following FDA "A"-rated generic drugs have been added to the MassHealth Drug List. The brand name is listed with a # symbol to indicate that PA is required for the brand.

New FDA "A"-Rated Generic Drug	Generic Equivalent of

tacrolimus extended-release capsule	Astagraf #

Change in Prior Authorization Status

a. Effective July 1, 2026, the following antitubercular agent will require PA.
   - cycloserine – **PA**; A90

b. Effective July 1, 2026, the following hematinic agent will require PA.
   - Velphoro (sucroferric oxyhydroxide) – **PA**

c. Effective July 1, 2026, the following hormone agent will require PA.
   - desmopressin acetate 1.5 mg/mL nasal spray – **PA**

d. Effective July 1, 2026, the following cardiovascular agent will no longer require PA within established quantity limits.
   - Entresto (sacubitril/valsartan tablet) – **PA > 2 units/day**

e. Effective July 1, 2026, the following cardiovascular agent will no longer require PA. Pediatric Behavioral Health Medication Initiative criteria will apply. For additional information, please see the Pediatric Behavioral Health Initiative documents found at www.mass.gov/druglist.
   - clonidine patch – **PA < 3 years**; A90

f. Effective July 1, 2026, the following cardiovascular agent will no longer require PA within updated age limits.
   - Inzirqo (hydrochlorothiazide suspension) – **PA ≥ 13 years**

g. Effective July 1, 2026, the following cardiovascular agents will require PA.
   - Exforge HCT (amlodipine/valsartan/hydrochlorothiazide) – **PA**; M90
   - Inspra (eplerenone) – **PA**; M90
   - quinidine sulfate – **PA**; M90

h. Effective July 1, 2026, the following insulin agent will no longer require PA.
   - Humulin N (insulin NPH)

i. Effective July 1, 2026, the following insulin agent will require PA.
   - Novolin N (insulin NPH) – **PA**

Change in Coverage Status

Effective July 3, 2026, the following anti-obesity agents are excluded per MassHealth regulation 130 CMR 406.413(B)(7) and will no longer be covered.

- Adipex-P (phentermine 37.5 mg capsule, tablet) – **PA < 12 years**; #
- benzphetamine – **PA**
- diethylpropion – **PA**
- diethylpropion extended-release – **PA**
- phendimetrazine – **PA**
- phendimetrazine extended-release – **PA**
- phentermine 15 mg, 30 mg capsule – **PA < 12 years**
- phentermine 8 mg tablet – **PA < 12 years or ≥ 18 years**
- phentermine/topiramate extended-release – **PA**
- Saxenda (liraglutide) – **PA**
- Xenical (orlistat) – **PA**

New or Revised Therapeutic Tables

a. Effective July 1, 2026, the following tables were updated.
   Table 5 – Immunological Agents
   Table 6 – Nutrients, Vitamins, and Vitamin Analogs
   Table 8 – Opioids and Analgesics
   Table 14 – Headache Therapy

Table 17 – Antidepressants
Table 18 – Cardiovascular Agents
Table 23 – Respiratory Agents - Inhaled
Table 26 – Antidiabetic Agents
Table 35 – Antibiotics and Anti-Infectives - Oral and Inhaled
Table 42 – Immune Suppressants - Topical
Table 45 – Beta Thalassemia, Myelodysplastic Syndrome, and Sickle Cell Disease Agents
Table 51 – Antiglaucoma Agents - Ophthalmic
Table 55 – Androgens
Table 56 – Alzheimer's Agents
Table 57 – Oncology Agents
Table 64 – Asthma/Allergy Monoclonal Antibodies
Table 65 – Enzyme Replacement and Substrate Reduction Therapies
Table 69 – Barbiturates, Benzodiazepines, and Miscellaneous Antianxiety Agents
Table 70 – Progesterone Agents
Table 71 – Pediatric Behavioral Health
Table 72 – Agents Not Otherwise Classified
Table 73 – Iron Agents and Chelators
Table 75 – T-Cell Immunotherapies
Table 76 – Neuromuscular Agents - Duchenne Muscular Dystrophy and Spinal Muscular Atrophy
Table 79 – Pharmaceutical Compounds
Table 80 – Anti-Hemophilia Agents
Table 83 – Renal Disorder Agents
Table 84 – Complement Inhibitors and Miscellaneous Immunosuppressive Agents

b. Effective July 3, 2026, the following tables were updated.
Table 72 – Agents Not Otherwise Classified
Table 79 – Pharmaceutical Compounds

c. Effective July 3, 2026, the following table was removed from the MassHealth Drug List.
Table 81 – Anti-Obesity Agents

Updated and New Prior Authorization Request Forms

a. Effective July 1, 2026, the following prior authorization request forms were updated.
- Androgen Therapy Prior Authorization Request
- Antidepressant Prior Authorization Request
- Antidiabetic Agents Prior Authorization Request
- Asthma/Allergy Monoclonal Antibodies Prior Authorization Request
- Benzodiazepines and Other Anti-Anxiety Agents Prior Authorization Request
- Breast Cancer Agents Prior Authorization Request
- Glaucoma Agents Prior Authorization Request
- Headache Therapy (Calcitonin Gene-Related Peptide (CGRP) Inhibitors) Prior Authorization Request
- Heart Failure Agents Prior Authorization Request
- Inhaled Respiratory Agents Prior Authorization Request
- Lung Cancer Agents Prior Authorization Request
- Neuromuscular Agents Prior Authorization Request
- One-Time Cell and Gene Therapies
- Progesterone Agents Prior Authorization Request
- Renal Disorder Agents Prior Authorization Request
- T-Cell Immunotherapies Prior Authorization Request

- Targeted Immunomodulators Prior Authorization Request
- Topical Immune Suppressants Prior Authorization Request

b. Effective July 3, 2026, the following prior authorization request form was added.
   - Non-Diabetic GIP/GLP-1 and GLP-1 receptor agonists Prior Authorization Request

c. Effective July 3, 2026, the following prior authorization request form was removed.
   - Anti-Obesity Agents 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 July 1, 2026, the following agents will be added to the MassHealth Brand Name Preferred Over Generic Drug List.
   - Belbuca (buprenorphine buccal film) – **PA**; BP
   - Endometrin (progesterone vaginal insert) – **PA**; BP
   - Humulin N (insulin NPH); BP
   - Incruse (umeclidinium); BP, A90
   - Lumigan (bimatoprost 0.01% ophthalmic solution); BP, M90

b. Effective July 1, 2026, the following agents will be removed from the MassHealth Brand Name Preferred Over Generic Drug List.
   - Fabior (tazarotene foam) – **PA**
   - Xenical (orlistat) – **PA**

Updated MassHealth 90-day Initiative

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

a. Effective July 1, 2026, the following agents may be allowed or mandated to be dispensed in up to a 90-day supply, as indicated below.
   - Astagraf XL (tacrolimus extended-release capsule); #, A90
   - Incruse (umeclidinium); BP, A90
   - Lumigan (bimatoprost 0.01% ophthalmic solution); BP, M90

b. Effective July 1, 2026, the following agents will no longer be allowed or mandated to be dispensed in up to a 90-day supply, as indicated below.
   - Revlimid (lenalidomide) – **PA**; BP
   - Samsca (tolvaptan) – **PA**
   - Xenical (orlistat) – **PA**

Updated Health Safety Net (HSN) Formulary Page

The Health Safety Net (HSN) Formulary page has been updated to reflect recent changes.

- Health Safety Net Prior Authorization Request
- Patient Assistance Program Resource
- Health Safety Net Reimbursable Pharmacy Services - Highly Utilized Therapeutic Classes

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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 July 1, 2026, the following agents were removed from the MassHealth Over-the-Counter Drug List.

- cherry syrup; *
- gelatin capsule, empty; *
- hydrophilic ointment; *, A90
- Ora-Plus suspending vehicle; *

- Ora-Sweet oral syrup; *
- Ora-Sweet-SF oral syrup; *
- simple syrup; *

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.

a. Effective July 1, 2026, the following biological agents will be added to the MassHealth Supplemental Rebate/Preferred Drug List.
   - Fasenra (benralizumab) [PD] – **PA**
   - Nemluvio (nemolizumab-ilto) [PD] – **PA**

b. Effective July 1, 2026, the following topical immunosuppressant agent will be added to the MassHealth Supplemental Rebate/Preferred Drug List.
   - Vtama (tapinarof) [PD] – **PA**

c. Effective July 1, 2026, the following targeted immunomodulators will be removed from the MassHealth Supplemental Rebate/Preferred Drug List.
   - Imuldosa (ustekinumab-srlf prefilled syringe) – **PA**
   - Imuldosa (ustekinumab-srlf vial) – **PA**; MB
   - Pyzchiva (ustekinumab-ttwe 130 mg/26 mL vial) – **PA**; MB
   - Pyzchiva (ustekinumab-ttwe prefilled syringe, 45 mg/0.5 mL vial) – **PA**

d. Effective July 3, 2026, the following GIP/GLP-1 receptor agonist agent will be removed from the MassHealth Supplemental Rebate/Preferred Drug List.
   - Zepbound (tirzepatide) – **PA**

Updated Medicare Part D Exclusion Drug List

Effective July 3, 2026, the Medicare Part D Exclusion Drug 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 and New Pharmacy Initiatives

- Pediatric Behavioral Health Medication Initiative

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.
   - Androgel (testosterone 1.62% gel packet) – **PA**
   - Androgel (testosterone 1% gel packet) – **PA**
   - Beqvez (fidanacogene elaparvovec-dzkt) – **PA**; CO
   - Cosmegen (dactinomycin); MB
   - Cymbalta (duloxetine 20 mg, 30 mg, 60 mg capsule) – **PA < 6 years**; #, A90
   - Exservan (riluzole film) – **PA**
   - Namenda (memantine titration pack) – **PA < 6 years and PA > 49 units/28 days;** A90
   - Namenda XR (memantine extended-release) – **PA < 6 years and PA > 1 unit/day**; #, A90

- Prozac (fluoxetine 10 mg, 20 mg, 40 mg capsule, solution) – **PA < 6 years**; #, A90
- Qtern (dapagliflozin/saxagliptin) – **PA**
- Rilutek (riluzole tablet); #, A90
- Roctavian (valoctocogene roxaparvovec-rvox) – **PA**; CO
- Trecator (ethionamide)

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.
- Qlosi (pilocarpine 0.4% ophthalmic solution) – **PA**
- Vizz (aceclidine ophthalmic solution) – **PA**

Corrections/Clarifications

a. The following drugs have been added to the MassHealth Drug List. These changes do not reflect any change in MassHealth policy.
- Tofidence (tocilizumab-bavi vial COVID); MB
- Tyenne (tocilizumab-aazg vial COVID); MB

b. The following listings have been clarified. These changes do not reflect any change in MassHealth policy.
- buspirone tablet – **PA < 6 years**; A90
- DDAVP (desmopressin injection, 10 mcg/0.1 mL nasal spray, tablet); #, A90
- Klor-Con (potassium chloride 20 mEq powder packet, extended-release tablet); #, A90
- Lexapro (escitalopram solution, tablet) – **PA < 6 years**; #, A90
- Lopressor (metoprolol immediate-release 25 mg, 37.5 mg, 50 mg, 75 mg, 100 mg tablet); #, M90
- Stelara (ustekinumab prefilled syringe, 45 mg/0.5 mL vial) – **PA**
- Veltassa (patiromer 8.4 g, 16.8 g) – **PA > 1 unit/day**

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 acute hospital inpatient setting, unless on the APAD/APEC carve out drug list, or in the emergency, trauma, or urgent acute hospital outpatient 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.

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.