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November 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 November 1, 2021.

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

Additions

Effective November 1, 2021, the following newly marketed drugs have been added to the MassHealth Drug List.

- Azstarys (serdexmethylphenidate/dexmethylphenidate) – **PA**
- Kloxxado (naloxone 8 mg nasal spray) – **PA**
- Lumakras (sotorasib) – **PA**
- Rylaze (asparaginase erwinia chrysanthemi-rywn) ^ – **PA**
- Rybrevant (amivantamab-vmjw) – **PA**
- Vaxneuvance (pneumococcal 15-valent conjugate vaccine)

Change in Prior-Authorization Status

a. Effective November 1, 2021, the following oncology agent will no longer require prior authorization.
   - Soltamox (tamoxifen solution)

b. Effective November 1, 2021, the following antimalarial agent will require prior authorization when exceeding newly established quantity limits.
   - Krintafel (tafenoquine) – **PA > 2 units/365 days**

c. Effective November 1, 2021, the following cerebral stimulant and ADHD agent 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.
   - Daytrana (methylphenidate transdermal) – **PA <3 years and PA > 1 unit/day**

d. Effective November 1, 2021, the following cerebral stimulant and ADHD agent will no longer require prior authorization within updated 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.
   - dextroamphetamine solution – **PA < 3 years and PA > 40 mL/day**

e. Effective November 1, 2021, the following antidiabetic agent will require prior authorization.
   - miglitol – **PA**

f. Effective November 1, 2021, the following inhaled respiratory agent will require prior authorization.
   - Proair Respiclick (albuterol inhalation powder) – **PA**

g. Effective November 1, 2021, the following topical corticosteroid agents will require prior authorization.
   - desonide lotion – **PA**
   - hydrocortisone valerate ointment – **PA**

h. Effective November 1, 2021, the following topical corticosteroid agents will no longer require prior authorization.
   - desoximetasone 0.25% cream

- Luxiq # (betamethasone valerate foam)
- Pandel (hydrocortisone probutate cream)

i. Effective November 1, 2021, the following ophthalmic anti-inflammatory agents will no longer require prior authorization.
   - Durezol (difluprednate) [BP]
   - Lacrisert (hydroxypropyl cellulose ophthalmic insert)
   - Prolensa (bromfenac 0.07%)

j. Effective November 1, 2021, the following vaginal antibiotic agents will no longer require prior authorization.
   - Cleocin Vaginal Ovule (clindamycin vaginal suppository)
   - Nuvessa (metronidazole 1.3% vaginal gel)

k. Effective November 1, 2021, the following ophthalmic antibiotic agents will no longer require prior authorization.
   - Besivance (besifloxacin ophthalmic suspension)
   - Blephamide (sulfacetamide/prednisolone sodium acetate ophthalmic suspension)
   - Ciloxan (ciprofloxacin ophthalmic ointment)
   - Pred-G (gentamicin/prednisolone ophthalmic suspension)
   - Tobradex (tobramycin 0.3%/dexamethasone 0.1%, ophthalmic ointment)
   - Tobrex (tobramycin ophthalmic ointment)

l. Effective November 1, 2021, the following ophthalmic antibiotic agents will require prior authorization.
   - bacitracin ophthalmic ointment – **PA**
   - levofloxacin ophthalmic solution – **PA**
   - neomycin/polymyxin B/hydrocortisone ophthalmic suspension – **PA**

New or Revised Therapeutic Tables

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- Inhaled Respiratory Agents Prior Authorization Request
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- Oral Antibiotics and Anti-Infectives Prior Authorization Request
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- Targeted Immunomodulators Prior Authorization Request
- Topical Anesthetics 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 November 1, 2021, the following agents will be added to the MassHealth Brand Name Preferred Over Generic Drug List.
   - Absorica (isotretinoin) BP – **PA**
   - Androgel (testosterone 1.62% gel packet) BP – **PA**
   - Depo-Testosterone (testosterone cypionate) BP – **PA**
   - Exelon (rivastigmine patch) BP – **PA > 1 unit/day**
   - Fortesta (testosterone 2% gel pump) BP – **PA**
   - Prometrium (progesterone capsule) BP
   - Testim (testosterone 1% gel tube) BP – **PA**
   - Zovirax (acyclovir suspension) BP

b. Effective November 1, 2021, the following agents will be removed from the MassHealth Brand Name Preferred Over Generic Drug List.
   - Belbuca (buprenorphine buccal film) – **PA**
   - Chantix # (varenicline)

Updated MassHealth COVID-19 Pharmacy Program Emergency Response

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

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 November 1, 2021, the following digital therapeutics will be added to the MassHealth Non-Drug Product List.

- Reset (prescription digital therapeutic, substance use disorder)
- Reset-O (prescription digital therapeutic, opioid use disorder)

Updated MassHealth ACPP/MCO Unified Pharmacy Product List

The MassHealth ACPP/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 and New Pharmacy Initiatives

- Opioid and Pain Initiative
- Pediatric Behavioral Health Medication Initiative

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.

Certain MassHealth Outpatient Physician Administered Drugs to be Paid by Fee Schedule

This List identifies the current list of "Fee Schedule Drugs" and hospital reimbursement for outpatient administration of certain physician administered drugs. The List of "Fee Scheduled Drugs" may be updated from time-to-time.

Deletions

a. The following drugs have been removed from the MassHealth Drug List because they have been discontinued by the manufacturer.
   - Actoplus Met XR (pioglitazone/metformin extended-release)
   - Aggrenox # (aspirin/extended-release dipyridamole)
   - Diamox # (acetazolamide)
   - Glucophage # (metformin)
   - Glucophage XR # (metformin extended-release)
   - Glyset # (miglitol)
   - Metadate CD (methylphenidate extended-release) – **PA**
   - Microzide # (hydrochlorothiazide)
   - Norvir (ritonavir capsule)
   - Omnipred # (prednisolone acetate 1% ophthalmic suspension)
   - Prandin # (repaglinide)
   - Razadyne # (galantamine tablet) – **PA > 2 units/day**
   - Rescriptor (delavirdine)
   - Stimate (desmopressin)
   - Taxotere # (docetaxel)
   - Videx # (didanosine)
   - Vitekta (elvitegravir)
   - Zerit # (stavudine)

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.
   - Zingo (lidocaine powder intradermal injection system) – **PA**

Corrections / Clarifications

a. 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.
   - lidocaine topical jelly, solution

- Xylocaine # (lidocaine vial)

b. The following listings have been clarified. This change does reflect a change in MassHealth policy.
   - Zeposia (ozanimod for multiple sclerosis) – **PA**
   - Zeposia (ozanimod for ulcerative colitis) – **PA**

c. The following listings have been clarified. These changes do not reflect any change in MassHealth policy.
   - acyclovir capsule, tablet
   - Cortisporin-TC (neomycin/colistin/thonzonium/hydrocortisone)
   - desonide lotion – **PA**
   - desonide ointment
   - desoximetasone 0.25% cream
   - Dexedrine Spansule # (dextroamphetamine 5 mg, 10 mg, 15 mg capsule) – **PA < 3 years and PA > 3 units/day**
   - Fortamet (metformin extended-release, osmotic tablet) – **PA**
   - Glumetza (metformin extended-release, gastric tablet) BP – **PA**
   - metformin immediate-release tablet
   - metformin extended-release, XR tablet
   - Narcan (naloxone 4 mg nasal spray) BP
   - Riomet # (metformin immediate-release solution) – **PA ≥ 13 years**
   - Riomet ER (metformin extended-release suspension) – **PA**
   - Tivicay PD (dolutegravir tablet for oral suspension)
   - Topicort (desoximetasone 0.25% ointment, spray, 0.05% gel) – **PA**
   - Xylocaine-MPF # (lidocaine vial, preservative free)
   - Zovirax (acyclovir suspension) BP

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.