Formulary Updates

DEFINITIONS

Formulary These drugs are included in Mass General Brigham's covered drug list.

Non-Formulary These drugs are not included in Mass General Brigham's formulary. The plan would only cover formulary alternatives. Providers can request Non-Formulary drugs as an exception, and the plan would require trial of all appropriate formulary alternatives prior to approving coverage of a Non-Formulary drug. If a Non-Formulary drug is approved, the member's cost sharing would be the highest tier.

Preferred These drugs are on Mass General Brigham's formulary and offer a lower cost to members.

Non-Preferred These drugs are on Mass General Brigham's formulary but offer a higher cost to members.

Excluded Mass General Brigham does not cover these drugs. Members will receive a denial for all Excluded drug requests.

Updates for Commercial Members

Effective 09/01/2025

Diabetic Supplies	InPens will be moved to nonformulary status. Members currently using InPens as well as members starting treatment with InPens will require prior authorization.
Quantity Limits	The following products will have quantity limits added: • Contrave: 4 tablets per day • Phentermine/topiramate extended-release (Qsymia): 1 capsule per day • Saxenda: 5 pens per 30 days
Crysvita	Prior authorization criteria will be updated to include language for members who are new to the Plan and to clarify documentation requirements throughout the policy.
Isturisa	Prior authorization criteria for initial approval will be updated to require diagnosis of Cushing's syndrome with endogenous hypercortisolemia. Criteria will also require that a member is either not a candidate for surgery or has had surgery that has not been curative. Trial and failure or contraindication with ketoconazole will be required.

	Reauthorization criteria will require documentation that the member has had a positive clinical response to therapy.
Kineret	Off-label use for systemic juvenile idiopathic arthritis will be removed from the criteria.
PCSK9 Inhibitors: Praluent Repatha	Criteria for Praluent and Repatha will be updated. Initial criteria for diagnoses of primary hyperlipidemia, heterozygous familial hypercholesterolemia (HeFH), and atherosclerotic cardiovascular disease (ASCVD) will require either a minimum 12 consecutive week trial of a statin at the highest tolerable dose, statin intolerance with at least two statins, or contraindication to all statins. Members must either meet minimum baseline LDL requirements or be currently receiving PCSK9 therapy as adjunct to maximally tolerated lipid-lowering therapy and have had LDL levels drawn within the past 12 months. Requests for HeFH must meet minimum FDA-approved age restrictions. Requests for Repatha will require trial and failure with Praluent for shared indications and ages. Initial criteria for homozygous familial hypercholesterolemia require diagnosis confirmed by either two genetic mutations or a baseline untreated LDL greater than 400 mg/dL and either xanthoma before 10 years of age or evidence of HeFH in both parents. Member must either be receiving lipid-lowering therapy or be unable to take other lipid-lowering therapies. Requests for Repatha will require trial and failure with Praluent for shared indications and ages. Reauthorization criteria will require that member has had a positive response to therapy, as evidenced by reduction in LDL from baseline. Members must also continue to take other lipid-lowering therapies or be unable to take other lipid-lowering therapies.

Updates for MassHealth Members

Effective 8/11/2025
The following generic medications will become non-preferred. Please use the brand name alternative(s):

Generic Medication	Brand Name Alternative
Exenatide 5mcg & 10mcg dose pen injector	Byetta 5mcg & 10mcg dose pen injector

Effective 08/11/2025

The following changes are being made to the listed medications to be in compliance with the MassHealth UPPL (Unified Pharmacy Product List):

Antidiabetic Agents – Non-Insulin and Combination Products	The following drugs will remain on the pharmacy benefit **with** quantity limits **and** will have prior authorization **added:** • **Byetta 5mcg, 10mcg** dose pen injector • **Victoza 2-Pak & 3 Pak** 18mg/3ml pen (*Brand preferred*) • **Trulicity pen injector** Mounjaro criteria for type 2 diabetes mellitus was updated to now only require diagnosis, quantity limits, and confirmation of no concurrent GLP-1 therapy. Mounjaro criteria for obesity will be updated to remove the step-through requirement with Zepbound. Bydureon Bcise, Byetta, Ozempic, and Rybelsus will require a step through with liraglutide (Victoza), Trulicity, and Mounjaro.

Effective 09/01/2025

Angiogenesis Agents	Following NCCN update for Avastin for hepatocellular carcinoma (HCC) diagnosis, the criteria point regarding Child-Pugh class was removed.
Cosela	Reauthorization criteria was clarified to require verification for continuation of chemotherapy cycles with either a platinum/etoposide-containing regimen or a topotecan-containing regimen.
Spravato	Criteria point requesting for documentation of an inadequate response to antidepressant augmentation strategies was further clarified as concomitant use of an augmenting agent plus antidepressant therapy.