



THE PRESCRIBER e-LETTER

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Neuraminidase inhibitors

The neuraminidase inhibitors zanamivir (Relenza[®]) and oseltamivir (Tamiflu[®]) are approved by the U.S. Food and Drug Administration (FDA) for the prophylaxis and treatment of influenza and have demonstrated activity against both influenza A and influenza B. These agents interfere with the release of progeny influenza virus from infected cells, thereby preventing new rounds of infection. A 2003 meta-analysis of 17 treatment and seven prevention trials concluded that these drugs reduced the median duration of symptoms by approximately one day and may reduce the odds of developing influenza by 70 to 90%. However, recent trials and meta-analyses have demonstrated conflicting results on the ability of these agents to reduce influenza-related complications. Therefore, prior authorization will be required for quantities greater than one treatment course per season.

The prior authorization process for neuraminidase inhibitors was implemented on October 26, 2015, and is outlined below. All agents require a PA from June 1 to September 30. From October 1 to May 31, a PA will be required for doses exceeding the quantity limit as noted in the table below. Zanamivir requires PA for members <5 years of age.

Drug	PA for Quantity Limits
Zanamivir (Relenza [®])	> 20 inhalations/season
Oseltamivir 30 mg (Tamiflu [®])	> 20 capsules/season
Oseltamivir 45 mg and 75 mg (Tamiflu [®])	> 10 capsules/season
Oseltamivir 6 mg/mL suspension (Tamiflu [®])	> 180 mL/season

Topical Corticosteroids

Topical corticosteroids are FDA-approved for the treatment of a variety of dermatological conditions. The topical corticosteroids were subdivided in the former classification system of four groups: low potency, medium potency, high potency and very high potency. The USA classification system subdivides topical corticosteroids into seven classes, with group one being super potent and group seven being least potent. MassHealth has determined that more costly topical corticosteroids will require PA, including all brand-name and generic products that are more costly than comparable alternatives.

Topical Corticosteroids (cont.)

The prior authorization process for topical corticosteroids was implemented on October 26, 2015. The PA status of the individual products is outlined below.

PA	No PA
<i>Class I. Super Potent</i>	
Clobetasol propionate cream, ointment (Temovate [®]) Clobetasol propionate foam (Olux [®]) Clobetasol propionate foam / emollient (Olux-E [®]) Clobetasol propionate lotion, shampoo, spray (Clobex [®]) Halobetasol cream, ointment (Ultravate [®])#	Betamethasone augmented gel Betamethasone dipropionate lotion, ointment Betamethasone dipropionate, augmented ointment (Diprolene [®])# Clobetasol propionate/emollient (Temovate E [®]) Clobetasol propionate gel, solution Clobetasol propionate shampoo kit Diflorasone ointment Fluocinonide 0.1% cream (Vanos [®]) Flurandrenolide tape (Cordran [®]) Halobetasol / lactic acid (Ultravate X [®])
<i>Class II. Potent</i>	
Amcinonide ointment Desoximetasone 0.25% cream, ointment, spray, 0.05% gel (Topicort [®]) Diflorasone cream/emollient (Apexicon-E [®]) Halcinonide cream, ointment (Halog [®])	Betamethasone dipropionate cream Betamethasone dipropionate, augmented cream (Diprolene AF [®])# Betamethasone dipropionate, augmented lotion (Diprolene [®])# Fluocinonide cream, gel, ointment, solution Mometasone ointment (Elocon [®]) Triamcinolone 0.5% ointment
<i>Class III. Upper Mid-Strength Potent</i>	
Amcinonide cream Betamethasone valerate foam (Luxiq [®]) Desoximetasone 0.05% cream, ointment (Topicort [®]) Diflorasone cream (Psorcon [®])	Amcinonide lotion Betamethasone valerate ointment Fluocinonide / emollient Fluticasone ointment Triamcinolone 0.1% ointment, 0.5% cream
<i>Class IV. Mid-Strength Potent</i>	
Clocortolone cream (Cloderm [®]) Fluocinolone ointment kit (Synalar [®]) Triamcinolone 0.05% ointment Triamcinolone spray (Kenalog [®])	Fluocinolone ointment (Synalar [®])# Hydrocortisone valerate ointment Mometasone cream, solution (Elocon [®])# Triamcinolone 0.1% cream

The Prescriber e-Letter is an update designed to enhance the transparency and efficiency of the MassHealth drug prior-authorization (PA) process and the MassHealth Drug List. Each issue **highlights key clinical information and updates** to the **MassHealth Drug List**. The Prescriber E-Letter was prepared by the MassHealth Drug Utilization Review Program and the MassHealth Pharmacy Program.

Topical Corticosteroids (cont.)

<i>Class V. Lower Mid-Strength Potent</i>	
Fluocinolone cream kit (Synalar [®]) Fluocinolone shampoo (Capex [®]) Fluticasone lotion (Cutivate [®]) Hydrocortisone probutate cream (Pandel [®])	Betamethasone valerate cream Desonide lotion, ointment Fluocinolone 0.01% cream Fluocinolone 0.025% cream (Synalar [®])# Fluticasone cream (Cutivate [®])# Hydrocortisone butyrate/emollient Hydrocortisone butyrate cream, ointment, solution Hydrocortisone valerate cream Prednicarbate cream, ointment (Dermatop [®])# Triamcinolone 0.1% lotion, 0.025% ointment
<i>Class VI. Mild Potent</i>	
Fluocinolone solution kit (Synalar [®]) Desonide gel (Desonate [®])	Alclometasone cream, ointment Betamethasone valerate lotion Desonide cream Fluocinolone body oil, scalp oil (Derma-smoothe-FS [®])# Fluocinolone solution (Synalar [®])# Fluticasone cream, ointment (Cutivate [®])# Triamcinolone 0.025% cream, lotion

Hydrocortisone solution	Hydrocortisone cream, lotion, ointment
<i>Combination Products</i>	
Betamethasone/calcipotriene ointment, scalp suspension (Taclonex [®]) Neomycin/fluocinolone cream, cream kit	Hydrocortisone/pramoxine foam
#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.	

Recent MassHealth Drug List Updates

Drug/Drug Class	Addition/Deletion/Change	Rationale
Antihypertensives	Change in PA status; does not require PA Irbesartan/hydrochlorothiazide (Avalide [®])# Irbesartan (Avapro [®])# Valsartan (Diovan [®])# Valsartan/hydrochlorothiazide (Diovan HCT [®])# #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.	Given a recent decrease in the cost of the associated generic irbesartan, irbesartan/hydrochlorothiazide, valsartan and valsartan/hydrochlorothiazide products, these agents no longer require PA.
	Change in PA status; requires PA Captopril Captopril/hydrochlorothiazide Nadolol (Corgard [®])	
Anti-inflammatory Ophthalmic Agents	Change in PA status; does not require PA Fluorometholone acetate (Flarex [®]) Prednisolone sodium phosphate 1% ophthalmic solution	Given the rising cost of generic alternatives, fluorometholone acetate and prednisolone sodium phosphate no longer require PA.

<p>Antiviral Agents</p>	<p>Change in PA status; requires PA for exceeding new quantity limits Zanamivir (Relenza[®]) –PA < 5 years of age and > 20 inhalations/season Oseltamivir 30 mg (Tamiflu[®]) –PA > 20 capsules/season Oseltamivir 45 mg and 75 mg (Tamiflu[®]) –PA > 10 capsules/season Oseltamivir 6 mg/mL suspension (Tamiflu[®]) –PA > 180 mL/season</p>	<p>PA will be required for quantities greater than one treatment course per season. This will allow for the evaluation of the level of risk for complications of influenza infection for greater quantities.</p> <p>These agents require PA for all quantities from June 1 to September 30. From October 1 to May 31, a PA is required for doses exceeding the quantity limit as outlined. Zanamivir requires PA for members <5 years of age.</p>
<p>Dermatological Agents</p>	<p>Change in PA status; does not require PA</p> <p>Ammonium lactate (Lac-Hydrin[®])# Ammonium lactate (LAClotion[®])#</p> <p>#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.</p>	<p>Ammonium lactate is indicated for dry skin dermatitis and congenital ichthyosis of the skin and is a brand-name drug with FDA “A”-rated generic equivalents. These agents no longer require PA.</p>
<p>Insulin Products</p>	<p>Addition; requires PA</p> <p>Insulin glargine prefilled syringe (Toujeo[®])</p> <p>Addition; requires PA</p> <p>Insulin human inhalation powder (Afrezza[®])</p>	<p>Insulin glargine 300 units/mL prefilled syringe is a higher potency formulation of insulin glargine. This agent requires a PA based on established medical necessity for the prefilled pen.</p> <p>Insulin human inhalation powder is a rapid-acting insulin indicated to improve glycemic control in adult patients with diabetes mellitus. This agent requires PA based on established medical necessity for the formulation.</p>
<p>Headache Therapy Agents</p>	<p>Change in PA status; requires PA for all ages and quantities</p> <p>Butalbital 50 mg/acetaminophen 325 mg Butalbital/aspirin/caffeine/codeine (Fiorinal[®]/Codeine)</p>	<p>Butalbital-containing agents are FDA-approved to treat tension-type headaches. Due to the increased cost and the availability of butalbital/acetaminophen/caffeine as a less costly alternative, butalbital/acetaminophen and butalbital/aspirin/caffeine/codeine requires PA for all ages and quantities.</p>
<p>Kinase Inhibitors</p>	<p>Change in PA status; requires PA</p> <p>Everolimus (Afinitor[®]) for all quantities Everolimus tablets for oral suspension (Afinitor Disperz[®]) Sorafenib (Nexavar[®]) Sunitinib (Sutent[®])</p> <p>Addition; requires PA</p> <p>Lenvatinib (LENVIMA[®])</p>	<p>Everolimus, everolimus tablets for oral suspension, lenvatinib, sorafenib, and sunitinib are FDA-approved for a variety of cancers. Given the high cost and the potential for off-label use, these agents require PA.</p>
<p>Ophthalmic Allergy Agents</p>	<p>Addition; added to the MassHealth Over-the-Counter Drug List</p>	<p>MassHealth will cover both brand and generics of these ophthalmic allergy agents.</p>

	Naphazoline/pheniramine (Naphcon-A [®]) Naphazoline/pheniramine (Opcon-A [®])	
Opioids and Analgesics	Deletion; no longer on MassHealth Drug List Butorphanol injection (Stadol [®]) Butorphanol nasal spray (Stadol [®]) Onsolis (fentanyl buccal film) Pentazocine/acetaminophen Rybix ODT (tramadol orally disintegrating tablet)	These products have been removed from the MassHealth Drug List because they have been discontinued by the manufacturer.
Topical Corticosteroids	Change in PA status; requires PA Amcinonide cream Amcinonide ointment Diflorasone cream Diflorasone ointment Clobetasol propionate cream, ointment (Temovate [®])	Topical corticosteroids are Food and Drug Administration (FDA)-approved for a variety of dermatological conditions. Due to the availability of several generic formations within each potency range, all brand-name topical corticosteroids and several high cost generics require PA.
	Deletion; no longer on MassHealth Drug List Alclometasone (Aclovate [®]) Betamethasone dipropionate augmented gel (Diprolene [®]) Clobetasol propionate gel, solution (Temovate [®]) Desonide cream (Desowen [®]) Hydrocortisone valerate cream, ointment (Westcort [®])	These products have been removed from the MassHealth Drug List because they have been discontinued by the manufacturer.
Vaginal Antibiotics	Change in PA status; requires PA Clindamycin vaginal suppository (Cleocin Vaginal Ovule [®]) Clindamycin vaginal cream (Clindesse [®])	Clindamycin vaginal suppository and clindamycin vaginal cream are more costly than traditional clindamycin formulations that are used for the treatment of bacterial vaginitis (BV). Due to the availability of less costly alternatives for the treatment of BV, clindamycin vaginal suppository and clindamycin vaginal cream require PA.
Alprazolam orally disintegrating tablet (Niravam [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Amiloride (Midamor [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Ammonium lactate 12%	Deletion; no longer on MassHealth Over-the-Counter Drug List	Ammonium lactate 12% will be covered as a prescription product and will not be covered over-the-counter.
Amphetamine sulfate	Addition; requires PA	Amphetamine sulfate is a branded-generic product that is FDA-approved for ADHD, narcolepsy and obesity. Given its approval for the treatment of obesity which is excluded from coverage by MassHealth regulations, as well as the availability of less costly alternative amphetamine products, this agent requires PA.
Aripiprazole	Addition; does not require PA* *PA required if member < 6 years or ≥ 18 years or quantity is >30 units/month	Aripiprazole is the new “A”-rated generic to Abilify [®] . This agent does not require PA if member is > 18 years and QL ≤30 per month. 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.

Betaxolol (Kerlone [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Bimatoprost 0.03% ophthalmic solution	Addition; requires PA	Bimatoprost 0.03% ophthalmic solution is a new generic is A-rated to Lumigan [®] , however, the brand name in this particular strength is no longer available. This agent remains significantly more costly than other agents for the treatment of glaucoma and requires PA.
Bromfenac 0.09% (Bromday [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Calcitonin salmon injection (Miacalcin)	Change in PA status; requires PA	Calcitonin salmon injection is indicated for the treatment of symptomatic Paget's disease of bone, hypercalcemia and postmenopausal osteoporosis when alternative treatments are not suitable. Due to the significant cost and its limited place in therapy, this agent requires a PA.
Carbachol 3%	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Carbidopa/levodopa extended-release (Rytary [®])	Addition; requires PA	Carbidopa/levodopa extended-release is a new capsule formulation that is FDA-approved for the treatment of Parkinson's disease, post-encephalitic parkinsonism and parkinsonism that may follow carbon monoxide intoxication or manganese intoxication. Due to availability of generic carbidopa/levodopa as a less costly alternative, carbidopa/levodopa extended-release requires a PA.
Ceftazidime/avibactam (Avycaz [®])	Addition; requires PA	Ceftazidime/avibactam is a combination product containing a cephalosporin antibacterial drug and a β -lactamase inhibitor that was FDA-approved for the treatment of adults with complicated intra-abdominal infections (cIAI) in combination with metronidazole and for the treatment of adults with complicated urinary tract infections (cUTI). Due to the availability of less costly alternatives, ceftazidime/avibactam requires PA.
Chlorthalidone (Thalitone [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Cholic acid (Cholbam [®])	Addition; requires PA	Cholic acid is indicated for the treatment of bile acid synthesis disorders due to various single enzyme defects and adjunctive treatment of peroxisomal disorders. Given the high cost and to ensure appropriate utilization, cholic acid requires PA.
Deferasirox 90 mg, 180 mg, 360 mg (Jadenu [®])	Addition; does not require PA	Deferasirox is an iron chelator indicated for the treatment of chronic iron overload due to blood transfusions in patients two years of age and older and non-transfusion-dependent thalassemia (NTDT) syndromes in patients 10 years of age and older. Given the similarity in pharmacokinetics and simple method of administration, some members currently using deferasirox may desire to transition to deferasirox. Due to the similarity in cost between the two formulations, deferasirox does not require a PA.
Desonide foam (Verdeso [®])	Deletion; no longer on MassHealth Drug List	MassHealth does not pay for drugs that are manufactured by companies that have not signed rebate agreements with U.S. Secretary of Health and Human Services.
Duloxetine 40 mg	Addition; requires PA	Duloxetine is indicated for the treatment of non-psychiatric conditions such as chronic musculoskeletal pain, diabetic

		peripheral neuropathy and fibromyalgia in addition generalized anxiety disorder and major depressive disorder. Given the availability of less costly generic agents, duloxetine requires PA.
Ethinyl estradiol 2.5 mcg/norethindrone 0.5 mg	Addition; does not require PA	Ethinyl estradiol/norethindrone is the new “A”-rated generic to Femhr [®] . This agent does not require PA. 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.
Etonogestrel implant (Implanon [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Factor IX human recombinant (IXINITY [®])	Addition; does not require PA	Coagulation factor IX (recombinant) indicated in adults and children ≥ 12 years of age with hemophilia B for control and prevention of bleeding episodes and for perioperative management. This agent does not require PA.
Flurbiprofen (Ansaid [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Ganciclovir intravitreal implant (Vitrasert [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Isavuconazonium (CRESEMBA [®])	Addition; requires PA	Isavuconazonium is an azole antifungal indicated in adults for the treatment of invasive aspergillosis and invasive mucormycosis. Given the complicated nature of the disease states for which isavuconazonium is indicated and the availability of less costly alternatives, isavuconazonium requires PA.
Kanamycin	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Levoleucovorin 175mg/17.5 mL injection	Addition; requires PA	Levoleucovorin is FDA-approved as rescue therapy after high-dose methotrexate in osteosarcoma, to diminish toxicity and counteract effects of impaired methotrexate elimination and after inadvertent overdose of folic acid antagonists and to be used in combination chemotherapy with 5-fluorouracil (5-FU) in the palliative treatment of patients with advanced metastatic colorectal cancer. Given that levoleucovorin injection does not demonstrate a clear advantage over leucovorin tablets in efficacy, adverse events or comparative pricing, levoleucovorin injection requires PA.
Levonorgestrel (Plan B [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Levonorgestrel-releasing intrauterine system 52 mg (Liletta [®])	Addition; does not require PA	Levonorgestrel-releasing intrauterine system is indicated for the prevention of pregnancy for up to three years. This agent does not require PA.
Meningococcal group B vaccine (BEXSERO [®])	Addition; does not require PA	Meningococcal group B vaccine is indicated for active immunization in individuals 10 through 25 years of age to prevent a disease caused by <i>Neisseria meningitidis</i> serogroup B. This agent does not require PA.
Methyl aminolevulinate (Metvixia [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Metronidazole 1.3% vaginal gel (NUVESSA [®])	Addition; requires PA	Metronidazole vaginal gel is indicated for the treatment of BV. Due to the availability of lower cost alternatives and that the Centers for Disease Control guidelines have not addressed its role in BV treatment, metronidazole vaginal gel requires PA.

Minocycline tablets (Dynacin [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Moexipril/hydrochlorothiazide (Uniretic [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Naloxegol (Movantik [®])	Addition; requires PA	Naloxegol was FDA-approved for the treatment of opioid-induced constipation (OIC) in adult patients with chronic non-cancer pain. Due to the availability of less costly alternatives, naloxegol requires PA.
Oxytetracycline (Terramycin [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Oxytetracycline/polymyxin B	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Palbociclib (IBRANCE [®])	Addition; requires PA	Palbociclib is a novel, oral cyclin-dependent kinase (CDK) 4 and 6 inhibitor indicated in combination with letrozole for the treatment of postmenopausal women with estrogen receptor (ER)-positive, human epidermal growth factor receptor-2 (HER2)-negative advanced breast cancer as initial endocrine-based therapy for their metastatic disease. Due to its cost, specific indication and potential for off-label use, palbociclib requires PA.
Pasireotide injectable suspension (Signifor LAR [®])	Addition; requires PA	Pasireotide is a somatostatin analog (SSA) indicated for the treatment of acromegaly in patients with an inadequate response to surgery and/or who are not candidates for surgery. Due to its currently undefined role in consensus guidelines and the availability of less costly alternatives, pasireotide requires PA.
Pegloticase (Krystexxa [®])	Deletion; no longer on MassHealth Drug List	MassHealth does not pay for drugs that are manufactured by companies that have not signed rebate agreements with U.S. Secretary of Health and Human Services.
Phenylephrine/ketorolac (OMIDRIA [®])	Addition; does not require PA [^] [^] 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.	Phenylephrine/ketorolac is an alpha 1-adrenergic receptor agonist and nonselective cyclooxygenase inhibitor indicated for maintaining pupil size by preventing intraoperative miosis and reducing postoperative pain. This agent does not require PA.
Polymyxin B	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Potassium citrate 15 mEq (Urocit-K [®])	Change in PA status; does not require PA	Potassium citrate is a brand-name drug with FDA “A”-rated generic equivalents that is indicated for nephrolithiasis. This agent no longer requires PA. 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.
Prednisolone 15 mg/5 mL oral solution (Orapred [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Protriptyline (Vivactil [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Samarium SM 153 lexidronam (QUADRAMET [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.

Secukinumab (Cosentyx [®])	Addition; requires PA	Secukinumab is an interleukin-17A (IL-17A) antagonist indicated for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy. Due to the undefined role of secukinumab in consensus guidelines, secukinumab requires PA.
Sotalol solution (Sotylize [®])	Addition; requires PA	Sotalol solution is FDA-approved for the treatment of documented life-threatening ventricular arrhythmias as well for the maintenance of normal sinus rhythm in patients with symptomatic atrial fibrillation or atrial flutter who are currently in normal sinus rhythm. Due to the availability of less costly alternatives, sotalol solution requires PA.
Sulfamethoxazole/trimethoprim (Septra [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Suvorexant (Belsomra [®])	Addition; requires PA	Suvorexant is a first in class orexin receptor antagonist, FDA-approved for the management of insomnia, characterized by difficulties with sleep onset or sleep maintenance, in patients 18 years of age or older. Due to the availability of less costly alternative for the management of chronic insomnia, suvorexant requires a PA.
Testosterone enanthate (Delatestryl [®])	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
Testosterone nasal gel (Natesto [®])	Addition; requires PA	Testosterone nasal gel is FDA-approved for replacement therapy in males for conditions associated with a deficiency or absence of endogenous testosterone: primary hypogonadism or hypogonadotropic hypogonadism. To ensure that this medication is being used appropriately, testosterone nasal gel requires PA.
Water for inhalation	Deletion; no longer on MassHealth Over-the-Counter Drug List	This product is obsolete and was removed from the MassHealth Over-the-Counter Drug List.