

# MassHealth Drug List (MHDL) Update Summary Effective October 1, 2026

## Key Changes

### MassHealth's Biosimilar Strategy

- MassHealth strongly supports the use of FDA-approved biosimilars as a cost-effective way to improve access to biologic therapies.
- Approved biosimilars have no clinically meaningful differences from their reference biologic products in terms of safety, purity, or effectiveness.
- MassHealth continues to designate preferred biosimilars, when appropriate, to promote access to high-value, evidence-based care. As preferred biosimilars change over time, existing approvals may apply to newly preferred biosimilar products, helping to minimize treatment disruptions.

### Denosumab Biosimilars—Additional Preferred Products

- Added Bıldıys (denosumab-nxxp) and Bilprevda (denosumab-nxxp) as preferred denosumab biosimilars, joining Enoby (denosumab-qbde) and Xtrenbo (denosumab-qbde).
- For non-preferred denosumab products, trials with preferred biosimilars will be required.

### Lipid-Lowering Agents—Criteria Updates

- Updated Praluent (alirocumab) and Repatha (evolocumab) criteria to reflect expanded approval for cardiovascular risk reduction, including primary prevention in adults at high risk of cardiovascular events.

### Entyvio (vedolizumab)—Step Therapy Update

- Updated Entyvio (vedolizumab) pen criteria to require clinical rationale for use instead of provider-administered Entyvio (vedolizumab) vials, which are restricted to medical billing.

## Additions to the Brand Name Preferred over Generic Drug List

The following brand name medications will need to be dispensed by pharmacies in place of the generic equivalent.

| Brand       | Generic/Biosimilar                  |
|-------------|-------------------------------------|
| Adempas     | riociguat                           |
| Astagraf XL | tacrolimus extended-release capsule |
| Infuvite    | multivitamin injection              |
| Janumet     | Sitagliptin/metformin               |
| Januvia     | sitagliptin                         |
| Trintellix  | vortioxetine                        |

## Removals from the Brand Name Preferred over Generic Drug List

The following brand-name medications will no longer need to be dispensed by pharmacies in place of the generic. Pharmacies will be required to dispense the generic unless a PA is on file for the brand-name product.

| Brand  | Generic                                            |
|--------|----------------------------------------------------|
| Frova  | frovatriptan                                       |
| Suprep | sodium sulfate/potassium sulfate/magnesium sulfate |

## Updates to the 90-day Supply Initiatives

The 90-day initiative has been updated to reflect the following recent changes to the MHDL.

| Drug Name                              | Updates                                             |
|----------------------------------------|-----------------------------------------------------|
| econazole 1% foam                      | Added to the allowable 90-day supply list (A90)     |
| Entresto (sacubitril/valsartan tablet) | Added to the allowable 90-day supply list (A90)     |
| phenoxybenzamine                       | Removed from the allowable 90-day supply list (A90) |
| Priftin (rifapentine)                  | Added to the allowable 90-day supply list (A90)     |

## MHDL Deletions

The following drugs will be removed from the MHDL because they have either been discontinued by the manufacturer or the manufacturer no longer participates in the Medicaid Drug Rebate Program (MDRP).

| Drug Name                                 |
|-------------------------------------------|
| Alimta (pemetrexed disodium)              |
| Brexafemme (ibrexafungerp)                |
| Cancidas (caspofungin)                    |
| Mycamine (micafungin)                     |
| Noxafil (posaconazole tablet)             |
| Ocaliva (obeticholic acid)                |
| pemetrexed                                |
| Tricor (fenofibrate 48 mg, 145 mg tablet) |
| Xeloda (capecitabine)                     |

## MHDL Updates

The following changes are being made to the MHDL.

| MHDL Therapeutic Class                                        | Additions                          | Summary of Change(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
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| Acromegaly, Carcinoid Syndrome, and Cushing's Syndrome Agents | <b>Metopirone (metyrapone)</b> —PA | <ul style="list-style-type: none"><li>• <b>Updated Mycapssa (octreotide)</b> criteria for acromegaly to require failure of or ineligibility for surgery.</li><li>• <b>Updated Signifor LAR (pasireotide pamoate) and Somavert (pegvisomant)</b> criteria for acromegaly to apply consistently in LCA trials regardless of disease severity.</li><li>• <b>Added</b> specialist requirements for select Cushing's disease agents and removed Lysodren (mitotane) as a LCA trial.</li></ul> |
| Antibiotics and Anti-Infectives—Oral and Inhaled              | --                                 | <ul style="list-style-type: none"><li>• <b>Added Blujepa (gepotidacin)</b> criteria for the expanded indication of uncomplicated urogenital gonorrhea.</li></ul>                                                                                                                                                                                                                                                                                                                         |

| MHDL Therapeutic Class                    | Additions                                   | Summary of Change(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
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| Anti-Diabetic Agents                      | <b>Ozempic (semaglutide tablet)</b> —PA; PD | <ul style="list-style-type: none"> <li>• <b>Added Ozempic (semaglutide) tablets</b> as a preferred GLP-1 agonist, with point-of-sale rules aligned with other preferred GLP-1 receptor agonists.</li> <li>• <b>Updated Rybelsus (semaglutide)</b> to reflect preferred drug designation while existing supply is being exhausted and added point-of-sales aligned with other preferred GLP-1 receptor agonists.</li> <li>• Novo Nordisk announced the discontinuation of all strengths of Rybelsus (semaglutide) tablets. Members will need to transition to Ozempic (semaglutide) tablets. Ahead of October 1, 2026, pharmacies unable to obtain Rybelsus (semaglutide) for a member with an approved Rybelsus (semaglutide) PA may call the member's plan for a one-time override for Ozempic (semaglutide) tablets.</li> </ul> |
| Antifungal Agents—<br>Oral and Injectable | --                                          | <ul style="list-style-type: none"> <li>• <b>Added Cresemba (isavuconazonium sulfate) and Noxafil (posaconazole)</b> off-label criteria for prevention of mucormycosis; added Cresemba (isavuconazonium sulfate) off-label criteria for prevention of invasive Aspergillus and Candida fungal infections.</li> <li>• <b>Updated Noxafil (posaconazole) and Vfend (voriconazole)</b> criteria for prevention of invasive Aspergillus and Candida fungal infections to require specialist involvement, expand accepted indications, and clarify antifungal prophylaxis use in stem cell transplant recipients.</li> <li>• <b>Clarified</b> stability criteria to allow continuation of therapy upon discharge for members started on antifungal treatment during an inpatient stay.</li> </ul>                                       |
| Anti-Hemophilia Agents                    |                                             | <ul style="list-style-type: none"> <li>• <b>Updated Hemgenix (etranacogene dezaparvovec)</b> criteria to require administration at a qualified treatment center.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Antipsychotics                            | <b>Bysanti (milsaperidone)</b> —PA          | <ul style="list-style-type: none"> <li>• <b>Updated Fanapt (iloperidone)</b> criteria to allow members stable on Bysanti (milsaperidone) to bypass LCA requirements.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

| MHDL Therapeutic Class                                           | Additions                                   | Summary of Change(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
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| Asthma/Allergy<br>Monoclonal Antibodies                          | --                                          | <ul style="list-style-type: none"> <li>• <b>Added Dupixent (dupilumab)</b> criteria for the expanded indication of allergic fungal rhinosinusitis.</li> <li>• <b>Added Fasenra (benralizumab)</b> criteria for expanded indication of hypereosinophilic syndrome (HES).</li> <li>• <b>Updated Nucala (mepolizumab)</b> criteria for HES to require an LCA trial of Fasenra (benralizumab).</li> <li>• <b>Updated Dupixent (dupilumab)</b> criteria for chronic spontaneous urticaria to reflect expanded age indication for use in members two and older.</li> <li>• <b>Clarified</b> criteria for agents indicated to treat chronic rhinosinusitis with nasal polyps, defining an inadequate response to corticosteroids as at least 90 days of therapy.</li> </ul> |
| Cardiovascular Agents                                            |                                             | <ul style="list-style-type: none"> <li>• <b>Updated Camzyos (mavacamten) and Myqorzo (aficamten)</b> criteria to streamline LCA trial requirements for obstructive hypertrophic cardiomyopathy.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Complement Inhibitors and Miscellaneous Immunosuppressive Agents | <b>Yartemlea (narsoplimab-wuug)</b> —PA; MB | <ul style="list-style-type: none"> <li>• <b>Added Yartemlea (narsoplimab-wuug)</b> criteria for hematopoietic stem cell transplant associated thrombotic microangiopathy. Billing is restricted to the medical benefit, with specialist requirements, age restrictions, and QLs.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Cystic Fibrosis Agents                                           | --                                          | <ul style="list-style-type: none"> <li>• <b>Updated Alyftrek (vanzacaftor/tezacaftor/deutivacaftor) and Trikafta (elexacaftor/tezacaftor/ivacaftor)</b> criteria to reflect expanded eligibility for members with cystic fibrosis and at least one responsive CFTR mutation or variant.</li> <li>• <b>Updated Kalydeco (ivacaftor), Orkambi (lumacaftor/ivacaftor), and Trikafta (elexacaftor/tezacaftor/ivacaftor)</b> criteria to clarify QLs for granules and require medical necessity for doses exceeding QLs.</li> </ul>                                                                                                                                                                                                                                       |

| MHDL Therapeutic Class                                                                           | Additions                                                                                                                                              | Summary of Change(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
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| Enzyme and Metabolic Disorder Therapies                                                          | <p><b>Kygevvi (doxecitine/doxribtimine)</b>—PA</p> <p><b>Loargys (pegzilarginase-nbln)</b>—PA</p> <p><b>Avlayah (tvidenofusp alfa-eknm)</b>—PA; MB</p> | <ul style="list-style-type: none"> <li>• <b>Added</b> criteria for <b>Avlayah (tvidenofusp alfa-eknm)</b> for Hunter syndrome, <b>Kygevvi (doxecitine/doxribtimine)</b> for thymidine kinase 2 deficiency (TK2d), and <b>Loargys (pegzilarginase-nbln)</b> for arginase 1 deficiency (ARG1-D).</li> <li>• General criteria include appropriate diagnosis confirmed by genetic testing, age, specialist involvement, and appropriate dosing. For <b>Avlayah (tvidenofusp alfa-eknm)</b>, a trial of <b>Elaprase (idursulfase)</b> is generally required unless neurologic involvement is present.</li> <li>• <b>Updated Kebilidi (eladocagene exuparvovec-tneq)</b> criteria to accept medical records or a copy of genetic testing and remove documentation of treatment dates as a required criterion for approval.</li> </ul> |
| Gastrointestinal Drugs — Antidiarrheals, Constipation, and Miscellaneous Gastrointestinal Agents |                                                                                                                                                        | <ul style="list-style-type: none"> <li>• <b>Added</b> criteria for <b>polyethylene glycol/sodium sulfate/potassium chloride/sodium chloride/sodium ascorbate/ascorbic acid</b> requiring medical necessity for use.</li> <li>• <b>Updated</b> criteria for all PA-required bowel preparations to add QLs.</li> <li>• <b>Updated Bylvay (odevixibat) and Livmarli (maralixibat)</b> criteria for progressive familial intrahepatic cholestasis to remove portal hypertension and decompensated cirrhosis safety documentation requirements.</li> <li>• <b>Updated Iqirvo (elafibranor) and Livdelzi (seladelpar)</b> criteria for primary biliary cholangitis (PBC) to remove medical records requirements and allow additional PBC-specific autoantibodies to support diagnosis.</li> </ul>                                     |
| Headache Therapy                                                                                 | --                                                                                                                                                     | <ul style="list-style-type: none"> <li>• <b>Added butalbital/acetaminophen/caffeine oral solution</b> criteria.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Hormones—Gonadotropin-Releasing Hormone Analogs                                                  |                                                                                                                                                        | <ul style="list-style-type: none"> <li>• <b>Updated Lupron Depot-Ped (leuprolide acetate)</b> criteria for central precocious puberty to require a trial with the appropriate monthly formulation before use of the 11.25 mg, 30 mg, or 45 mg extended-duration formulations.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

| MHDL Therapeutic Class | Additions                                                  | Summary of Change(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
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| Immune Globulins       | <b>Qivigy (immune globulin intravenous, human-kthm)—PA</b> | <ul style="list-style-type: none"> <li>• <b>Added</b> off-label criteria for use of immune globulin in autoimmune blistering disorders, BK polyomavirus-associated nephropathy, idiopathic inflammatory myopathies/myositis, and localized scleroderma and for the prevention of recurrent infections in oncology-related immunodeficiency.</li> <li>• <b>Updated</b> criteria for antibody-mediated rejection to remove the LCA trial with corticosteroids.</li> <li>• <b>Updated</b> criteria for cytomegalovirus in solid organ transplant to require use of treatment-dose antiviral therapy and documentation of either severe/refractory disease or hypogammaglobulinemia.</li> <li>• <b>Updated</b> criteria for immune neutropenia to require a trial with a granulocyte colony-stimulating factor agent.</li> <li>• <b>Updated</b> criteria for prevention of recurrent infections in pediatric HIV to remove CD4 count requirements and require either hypogammaglobulinemia or recurrent infections.</li> <li>• <b>Updated</b> criteria to clarify that selective antibody deficiency includes both specific pneumococcal antibody deficiency and selective antibody deficiency with normal immunoglobulins.</li> <li>• <b>Updated</b> criteria for all immune globulins to require medical necessity for higher or more frequent dosing, except for Guillain-Barré syndrome.</li> <li>• <b>Clarified</b> immune globulin dosing in Guillain-Barré syndrome to permit use in divided doses.</li> </ul> |

| MHDL Therapeutic Class | Additions                                                               | Summary of Change(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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| Immunological Agents   | <b>Avtozma (tocilizumab-anoh auto-injection, prefilled syringe)</b> —PA | <ul style="list-style-type: none"> <li>• <b>Added Avtozma (tocilizumab-anoh) prefilled syringe and autoinjector</b> as a preferred tocilizumab biosimilar managed at parity with <b>Tyenne (tocilizumab-aazg)</b>. Non-preferred tocilizumab products will require trials with preferred biosimilars.</li> <li>• <b>Added Sotyktu (deucravacitinib)</b> criteria to reflect approval in adults with psoriatic arthritis. Required trials include Otezla (apremilast), adalimumab or Enbrel (etanercept), and ustekinumab.</li> <li>• <b>Updated Entyvio (vedolizumab) pen</b> criteria to require a trial with <b>Entyvio (vedolizumab) vials</b>, which are now restricted to medical billing only.</li> <li>• <b>Updated Otezla (apremilast) and Otezla XR (apremilast)</b> criteria for plaque psoriasis to remove age and weight restrictions and remove medical necessity requirements for use of immediate-release tablets.</li> <li>• <b>Updated Sotyktu (deucravacitinib)</b> criteria for plaque psoriasis to require LCA trials of Otezla (apremilast), adalimumab or Enbrel (etanercept), and ustekinumab.</li> <li>• <b>Updated ustekinumab</b> criteria for pediatric irritable bowel disease (IBD) to reflect expanded indications and removal of the anti-TNF agent LCA trial.</li> <li>• <b>Updated Ebglyss (lebrikizumab)</b> recertification criteria for atopic dermatitis to require documentation of medical necessity for continuation of shorter dosing intervals.</li> <li>• <b>Updated</b> hidradenitis suppurativa (HS) criteria for all agents requiring PA to require documentation of baseline disease severity and a trial of conventional therapy.</li> </ul> |

| MHDL Therapeutic Class                                      | Additions                                                               | Summary of Change(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
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| Immunological Agents,<br>(continued)                        | <b>Avtozma (tocilizumab-anoh auto-injection, prefilled syringe)</b> —PA | <ul style="list-style-type: none"> <li>• <b>Updated Bimzelx (bimekizumab)</b> and <b>Cosentyx (secukinumab)</b> criteria to require an LCA trial of adalimumab.</li> <li>• <b>Updated Bimzelx (bimekizumab)</b> criteria to require an LCA trial of Cosentyx (secukinumab).</li> <li>• <b>Updated Bimzelx (bimekizumab)</b> recertification criteria to require documentation of a positive response to therapy.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Lipid-Lowering Agents                                       | --                                                                      | <ul style="list-style-type: none"> <li>• <b>Updated Praluent (alirocumab)</b> and <b>Repatha (evolocumab)</b> criteria to reflect expanded cardiovascular risk reduction indications, including primary prevention in those at high risk of cardiovascular events.</li> <li>• <b>Updated Praluent (alirocumab)</b> and <b>Repatha (evolocumab)</b> criteria to allow monotherapy for treatment of heterozygous familial hypercholesterolemia (HeFH) or homozygous familial hypercholesterolemia (HoFH).</li> <li>• <b>Updated Evkeeza (evinacumab-dgnb)</b> criteria to reflect expanded age indication for use in members one and older.</li> <li>• <b>Updated Leqvio (inclisiran)</b> criteria to reflect expanded age indication for use in members 12 and older with HeFH or HoFH.</li> <li>• <b>Updated Juxtapid (lomitapide)</b> criteria to reflect expanded age indication for use in members two and older with HoFH; clarify LCA trials; and require appropriate dosing within QLs.</li> </ul> |
| Non-refractive and<br>Refractive Error-<br>Modifying Agents | <b>Epioxa (riboflavin 5'-phosphate ophthalmic solution)</b> —PA; MB     | --                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

| MHDL Therapeutic Class | Additions                                                                                                                          | Summary of Change(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
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| Oncology Agents        | <p><b>Beizray (docetaxel)</b>—PA; MB</p> <p><b>Jobevne (bevacizumab-nwgd)</b>—PA; MB</p> <p><b>Kyxata (carboplatin)</b>—PA; MB</p> | <ul style="list-style-type: none"> <li>• <b>Added Avgemsi (gemcitabine vial), Beizray (docetaxel), and Kyxata (carboplatin)</b> criteria requiring a trial of a generic formulation available without PA.</li> <li>• <b>Updated Cyramza (ramucirumab)</b> criteria for hepatocellular carcinoma to add Yervoy (ipilimumab) and Tevimbra (tislelizumab) as LCA options.</li> <li>• <b>Updated Cyramza (ramucirumab)</b> criteria for metastatic colorectal cancer to require LCA trials with bevacizumab, oxaliplatin, and a fluoropyrimidine.</li> <li>• <b>Updated</b> criteria for bevacizumab agents used in metastatic colorectal cancer to allow concomitant Lonsurf (trifluridine/tipiracil) use and allow clinical rationale for use with other NCCN-supported category 1 or 2A recommended regimens.</li> <li>• <b>Updated</b> criteria for bevacizumab agents used in cervical cancer to allow monotherapy and allow clinical rationale for use with other NCCN-supported category 1 or 2A recommended regimens.</li> <li>• <b>Updated Darzalex (daratumumab) and Darzalex Faspro (daratumumab/hyaluronidase-fihj)</b> criteria to reflect use with Tecvayli (teclistamab-cqyv) for relapsed or refractory multiple myeloma (RRMM) after at least one prior line of therapy.</li> <li>• <b>Updated Rezlidhia (olutasidenib) and Tibsovo (ivosidenib)</b> criteria for IDH1-mutated AML to align prior therapy requirements with NCCN recommendations for intensive induction chemotherapy.</li> </ul> |

| MHDL Therapeutic Class                  | Additions                                                                                                                          | Summary of Change(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
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| Oncology Agents<br>(continued)          | <p><b>Beizray (docetaxel)</b>—PA; MB</p> <p><b>Jobevne (bevacizumab-nwgd)</b>—PA; MB</p> <p><b>Kyxata (carboplatin)</b>—PA; MB</p> | <ul style="list-style-type: none"> <li>• <b>Updated Tibsovo (ivosidenib)</b> criteria for IDH1-mutated cholangiocarcinoma to clarify LCA trial requirements.</li> <li>• <b>Updated Rubraca (rucaparib)</b> criteria for BRCA-mutated metastatic castration-resistant prostate cancer (mCRPC) to add Erleada (apalutamide) and Nubeqa (darolutamide) as LCA options and remove the taxane-based chemotherapy trial requirement.</li> <li>• <b>Updated Lynparza (olaparib)</b> criteria for BRCA-mutated mCRPC to require a past trial with an androgen receptor pathway inhibitor when used as monotherapy.</li> <li>• <b>Updated Rubraca (rucaparib)</b> criteria for criteria for HRR gene-mutated mCRPC to add Erleada (apalutamide) and Nubeqa (darolutamide) as LCA options.</li> <li>• <b>Clarified Vyxeos (daunorubicin/cytarabine liposome)</b> criteria to reflect age-based recommendations for acute myeloid leukemia (AML), including use as the preferred induction option for members 60 and older.</li> </ul> |
| Osteoporosis and Bone Metabolism Agents | <p><b>Aukelso (denosumab-kyqq)</b>—PA</p> <p><b>Bosaya (denosumab-kyqq)</b>—PA</p>                                                 | <ul style="list-style-type: none"> <li>• <b>Added Bildyos (denosumab-nxxp)</b> and <b>Bilprevda (denosumab-nxxp)</b> as preferred denosumab biosimilars.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Serums, Toxoids, and Vaccines           | <p><b>mFLUSIVA (influenza virus vaccine, mRNA)</b>—PA</p>                                                                          | <ul style="list-style-type: none"> <li>• <b>Added mFLUSIVA (influenza virus vaccine, mRNA)</b> criteria for members &lt;50 years of age. Pharmacy claims will pay without PA for members 50 and older within QLs.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

| MHDL Therapeutic Class                                                      | Additions                                         | Summary of Change(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
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| T-Cell Immunotherapies                                                      | <b>Lunsumio Velo (mosunetuzumab-axgb)</b> —PA; MB | <ul style="list-style-type: none"> <li>• <b>Added Breyanzi (lisocabtagene maraleucel)</b> criteria for expanded indication of relapsed or refractory marginal zone lymphoma after two or more lines of systemic therapy.</li> <li>• <b>Updated Tecvayli (teclistamab-cqyv)</b> criteria to reflect expanded use with Darzalex Faspro (daratumumab/hyaluronidase-fihj) for RRMM after at least one prior line of therapy.</li> <li>• <b>Clarified Elrexfio (elranatamab-bcmm), Lynozyfic (linvoseltamab-gcpt), Talvey (talquetamab-tgvs), and Tecvayli (teclistamab-cqyv)</b> criteria for RRMM following at least four prior lines of therapy.</li> <li>• <b>Updated Elrexfio (elranatamab-bcmm)</b> criteria to allow every-four-week dosing after 24 weeks of maintained response on biweekly dosing.</li> <li>• <b>Updated</b> criteria to allow stability on a T-cell immunotherapy for an FDA-approved or literature-supported oncology indication as rationale for approval.</li> <li>• <b>Updated</b> criteria for applicable CAR-T therapies to reflect elimination of REMS requirements and standardize qualified treatment center requirements.</li> </ul> |
| Agents Not Otherwise Classified—Cerebral Adrenoleukodystrophy (CALD) Agents | --                                                | <ul style="list-style-type: none"> <li>• <b>Updated Skysona (elivaldogene autotemcel)</b> criteria for CALD to align with revised labeling limiting use to members without an available HLA-matched or when medically necessary in a member with an available HLA-matched donor.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Agents Not Otherwise Classified— Melanocortin Receptor Agonists             | --                                                | <ul style="list-style-type: none"> <li>• <b>Added Imcivree (setmelanotide)</b> criteria for the expanded indication of acquired hypothalamic obesity; allow endocrinology consult notes to satisfy specialist requirements; and allow recertification based on improvement in secondary clinical measures.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

| MHDL Therapeutic Class                                          | Additions | Summary of Change(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
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| Agents Not Otherwise Classified—Purified Collagenase            | --        | <ul style="list-style-type: none"> <li>• <b>Updated Xiaflex (collagenase clostridium histolyticum)</b> criteria for Dupuytren's contracture to align age requirements with FDA labeling.</li> <li>• <b>Updated Xiaflex (collagenase clostridium histolyticum)</b> criteria for Peyronie's disease to remove the requirement that the member is not a candidate for surgery.</li> </ul>                                                                                                                                                                   |
| Agents Not Otherwise Classified—Small Interfering RNA Therapies | --        | <ul style="list-style-type: none"> <li>• <b>Clarified Oxlumo (lumasiran) and Rivfloza (nedosiran)</b> criteria to accept urologists as appropriate specialists.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                               |
| Agents Not Otherwise Classified—Stem Cell Therapies             | --        | <ul style="list-style-type: none"> <li>• <b>Added Omisirge (omidubicel-only)</b> criteria for expanded indication of severe aplastic anemia.</li> <li>• <b>Updated Omisirge (omidubicel-only)</b> criteria to require administration at a qualified treatment facility and documentation of anticipated treatment date.</li> <li>• <b>Updated Ryoncil (remestemcel-L-rknd)</b> criteria to require an additional LCA trial with one NCCN-recommended non-steroid systemic therapy, in addition to Jakafi (ruxolitinib), for members 12 to 17.</li> </ul> |

## Abbreviations, Acronyms, and Definitions

|                            |                                                                                                                                                                                                                                       |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>BP</b>                  | <b>Brand</b> 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.                                       |
| <b>CO</b>                  | <b>Carve-Out.</b> This agent is listed on the Acute Hospital Carve-Out Drugs List and is subject to additional monitoring and billing requirements.                                                                                   |
| <b>M90</b>                 | <b>Mandatory 90-day supply.</b> 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. |
| <b>MB</b>                  | <b>Drug</b> is restricted to medical billing.                                                                                                                                                                                         |
| <b>LCA</b>                 | <b>Lower-cost alternative</b>                                                                                                                                                                                                         |
| <b>PA</b>                  | <b>Prior authorization</b>                                                                                                                                                                                                            |
| <b>PD</b>                  | <b>Preferred Drug.</b> In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class.                                                           |
| <b>QL</b>                  | <b>Quantity limit</b>                                                                                                                                                                                                                 |
| <b>Non-rebate criteria</b> | Please refer to the <a href="#">MassHealth Pharmacy Operational Page</a> for non-rebate drugs and biologics criteria.                                                                                                                 |