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| **Number 119—September 7, 2018** |

**MHDL Update**

Below are certain updates to the MassHealth Drug List (MHDL). See the MHDL for a complete listing of updates.

# Additions

Effective September 10, 2018, the following newly marketed drugs have been added to the MassHealth Drug List.

* Cimduo (lamivudine/tenofovir disoproxil fumarate) – **PA**
* Crysvita (burosumab-twza) – **PA**
* Juluca (dolutegravir/rilpivirine) – **PA**
* Kedrab (rabies immune globulin IM, human)
* Lonhala (glycopyrrolate inhalation solution) – **PA**
* Rhopressa (netarsudil) – **PA**
* Symfi (efavirenz/lamivudine/tenofovir disoproxil fumarate) – **PA**
* Symfi Lo (efavirenz/lamivudine/tenofovir disoproxil fumarate) – **PA**

# Change in Prior-Authorization Status

1. Effective September 10, 2018, the following multiple sclerosis agents will require prior authorization.

* Extavia (interferon beta-1b) – **PA**
* Plegridy (peginterferon beta-1a) – **PA**

1. Effective September 10, 2018, the following anticonvulsant agents will no longer require prior authorization for age < 6 years. Pediatric Behavioral Health

Medication Initiative polypharmacy criteria

will still apply. For additional information,

please see the Pediatric Behavioral Health Medication Initiative documents found at www.mass.gov/druglist.

* + Celontin (methsuximide)
  + Dilantin # (phenytoin extended 30 mg and 100 mg capsule)
  + Dilantin-125 # (phenytoin suspension)
  + Dilantin Infatab # (phenytoin chewable tablet)
  + Felbatol # (felbamate)
  + Keppra # (levetiracetam injection, solution, tablet)
  + Mysoline # (primidone)
  + Peganone (ethotoin)
  + phenytoin extended 200 mg and 300 mg capsule
  + Zarontin # (ethosuximide)
  + Zonegran # (zonisamide)

1. Effective September 10, 2018, the following otic antibiotic agents will no longer require prior authorization.
   * acetic acid/hydrocortisone
   * Cipro HC (ciprofloxacin/hydrocortisone)
   * Coly-Mycin S (colistin/neomycin/thonzonium/hydrocortisone)
2. Effective September 10, 2018, the following glaucoma agents will no longer require prior authorization.

* Alphagan P # (brimonidine 0.1%, 0.15% eye drops)
* Betoptic S (betaxolol 0.25%)
* Combigan (brimonidine/timolol, ophthalmic)
* Istalol (timolol) BP
* Travatan Z (travoprost 0.004% eye drop)

# Updated MassHealth Brand Name Preferred Over Generic Drug List

1. Effective September 10, 2018, the following agents will be added to the MassHealth Brand Name Preferred Over Generic Drug List.

* Adcirca (tadalafil) BP – **PA**
* Riomet (metformin solution) BP – **PA ≥ 13 years**
* Zyclara (imiquimod 2.5%, 3.75 % cream) BP – **PA**

b. Effective September 10, 2018, the following

agent will be removed from the MassHealth

Brand Name Preferred Over Generic Drug

List.

* Reyataz # (atazanavir)

**Updated MassHealth Over-the-Counter Drug List**

Effective September 10, 2018, the following nutrient product will be added to the MassHealth Over-the-Counter Drug List.

* glucose products < 19 years

# 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.

**PA** Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment. 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.

**PD** Preferred Drug. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class.