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| **banner**  **Number 122, December 6, 2018** |

**MHDL Update**

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

Additions

Effective December 10, 2018, the following newly marketed drugs have been added to the MHDL.

* Altreno (tretinoin 0.05% lotion) – **PA**
* Epidiolex (cannabidiol) – **PA**
* Fulphila (pegfilgrastim-jmdb) – **PA**
* Jivi (antihemophilic factor, recombinant pegylated-aucl)
* Lokelma (sodium zirconium cyclosilicate) – **PA > 30 units/month**
* Lucemyra (lofexidine) – **PA**
* Macrilen (macimorelin) ^
* Nivestym (filgrastim-aafi) – **PA**
* Orilissa (elagolix) – **PA**
* Palynziq (pegvaliase-pqpz) – **PA**
* Poteligeo (mogamulizumab-kpkc) – **PA**
* Tibsovo (ivosidenib) – **PA**
* Trivisc (hyaluronate) – **PA**

**Change in Prior-Authorization Status**

1. Effective December 10, 2018, the following antidiabetic agents will no longer require prior authorization.

* Bydureon (exenatide extended-release pen, vial)
* Byetta (exenatide)
* Farxiga (dapagliflozin)

**Change in Prior-Authorization Status** (cont.)

* Invokamet (canagliflozin/metformin)
* Invokana (canagliflozin)
* Janumet (sitagliptin/metformin)
* Janumet XR (sitagliptin/metformin extended-release)
* Januvia (sitagliptin)
* Jardiance (empagliflozin)
* Jentadueto (linagliptin/metformin)
* Kombiglyze XR (saxagliptin/metformin extended-release)
* Onglyza (saxagliptin)
* Tradjenta (linagliptin)
* Xigduo XR (dapagliflozin/metformin extended-release)

1. Effective December 10, 2018, the following hematopoietic agents will require prior authorization.

Granix (TBO-filgrastim) – **PA**

Zarxio (filgrastim-sndz) – **PA**

1. Effective December 10, 2018, the following enzyme cofactor agent will require prior authorization.

Kuvan (sapropterin) – **PA**

(cont.)

# Updated MassHealth Brand Name Preferred Over Generic Drug List

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

* Androgel (testosterone 1.62% gel packet, pump) BP – **PA**
* Androgel (testosterone 1% gel packet) BP – **PA**
* Byetta (exenatide) BP
* Canasa (mesalamine suppository) BP
* Epclusa (sofosbuvir/velpatasvir) BP – **PA**
* Finacea (azelaic acid gel) BP – **PA**
* Harvoni (ledipasvir/sofosbuvir) BP – **PA**
* Latuda (lurasidone) BP – **PA**
* Rapaflo (silodosin) BP – **PA**
* Zytiga (abiraterone) BP – **PA**

1. Effective December 10, 2018, the following agents will be removed from the MassHealth Brand Name Preferred Over Generic Drug List.

* Renvela # (sevelamer carbonate)
* Tazorac (tazarotene) – **PA**

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**Legend**

# 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: PA 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 nonpreferred drug generic equivalent.

**PD** Preferred drug. In general, MassHealth requires a trial of the preferred drug (PD) or a clinical rationale for prescribing a nonpreferred drug within a therapeutic class.

**^** Drug available through the health care professional who administers the drug. MassHealth does not pay for this drug to be dispensed through a retail pharmacy.

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