**Number 140, February 19, 2020**

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# MHDL Update

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

## Additions

Effective February 24, 2020, the following newly marketed drugs have been added to the MassHealth Drug List.

* Adakveo (crizanlizumab-tmca) – **PA**
* Asceniv (immune globulin IV, human-slra) – **PA**
* Asparlas (calaspargase pegol-mknl) ^ – **PA**
* Beovu (brolucizumab-dbll) ^
* Duaklir (aclidinium/formoterol) – **PA**
* Gloperba (colchicine solution) – **PA**
* Inrebic (fedratinib) – **PA**
* Reblozyl (luspatercept-aamt) – **PA**
* Tosymra (sumatriptan 10 mg nasal spray) – **PA**
* Xembify (immune globulin subcutaneous injection, human-klhw) – **PA**
* Ziextenzo (pegfilgrastim-bmez)

## Change in Prior Authorization

1. Effective February 24, 2020, the following antiparasitic will no longer require prior authorization (PA).
	* Eurax (crotamiton cream)
2. Effective February 24, 2020, the following antiplatelet agents will no longer require PA.
	* Brilinta (ticagrelor)
	* Effient # (prasugrel)

c. Effective February 24, 2020, the following hematinic agents will no longer require PA.

* Fulphila (pegfilgrastim-jmdb)
	+ Udenyca (pegfilgrastim-cbqv)

## Updated MassHealth Brand Name Preferred Over Generic Drug List

The MassHealth Brand Name Preferred Over Generic Drug List has been updated to reflect recent changes to the MassHealth Drug List.

1. Effective February 24, 2020, the following agent will be added to the MassHealth Brand Name Preferred Over Generic Drug List.
* Symbicort (budesonide/formoterol)BP – **PA**
1. Effective February 24, 2020, the following agent will be removed from the MassHealth Brand Name Preferred Over Generic Drug List.
* Zytiga (abiraterone 250 mg, 500 mg) – **PA**

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### Legend

**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.

# 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.

 **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.

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