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**Number 60**

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**Page 1 of 2**

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| **MHDL Updates**  Below are certain updates to the MassHealth Drug List (MHDL). See the MHDL for a complete listing of updates.   1. **Additions**    1. The following newly marketed drugs have been added to the MassHealth Drug List.   ActoPlus Met XR (pioglitazone/metformin extended-release) – **PA**  Berinert (C1 inhibitor, human) ^  Exalgo (hydromorphone, extended release)   * **PA**   Hizentra (immune globulin, subcutaneous)   * **PA**   Kalbitor (encallatide) ^  Metvixia (methyl aminolevulinate) ^ Mirapex ER (pramipexole extended-  release) **– PA**  Pennsaid (diclofenac topical solution) **– PA** Qutenza (capsaicin, high dose patch) **– PA** Revatio IV (sildenafil) H  ` Rybix ODT (tramadol, orally disintegrating tablet) **– PA**  Tirosint (levothyroxine) **– PA**  Vibativ (televancin) **– PA**  Vpriv (velaglucerase alfa) **– PA**  Xiaflex (collagenase clostridium histolyticum) **– PA**  Zirgan (ganciclovir) Zyclara (imiquimod) **– 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.  H This drug is available only in an inpatient hospital setting. MassHealth does not pay for this drug to be dispensed through the retail pharmacy or the physician’s office.  **2. New FDA “A”-Rated Generics**  The following FDA “A”-rated generic drugs have been added to the MassHealth Drug List. The brand name is listed with a # symbol, to indicate that PA is required for the brand.  **New FDA “A”-Rated**  **Generic Drug Generic Equivalent**  pramipexole Mirapex # | 1. **Change in Prior-Authorization (PA) Status**    1. The PA requirements for butalbital containing medications are changing. The following will require PA effective August 16, 2010.   Anolor-300 (butalbital/acetaminophen/caffeine) **– PA > 60 units/month**  Ascomp/codeine (butalbital/aspirin/codeine/ caffeine) **– PA > 60 units/month**  butalbital/acetaminophen **– PA > 60 units/month**  butalbital/acetaminophen/caffeine **– PA > 60 units/month**  butalbital/acetaminophen/codeine/caffeine **– PA**  **> 60 units/month**  butalbital/aspirin/caffeine **– PA > 60 units/month**  butalbital/aspirin/codeine/caffeine **– PA > 60 units/month**  Esgic # (butalbital/acetaminophen/caffeine) **– PA > 60 units/month**  Fioricet # (butalbital/acetaminophen/caffeine) **– PA > 60 units/month**  Fioricet/codeine # (butalbital/acetaminophen/codeine/caffeine) **– PA > 60 units/month**  Fiorinal # (butalbital/aspirin/caffeine) **– PA > 60 units/month**  Fiorinal/codeine # (butalbital/aspirin/codeine/ caffeine) **– PA > 60 units/month**  Marten-tab # (butalbital/acetaminophen) **– PA > 60 units/month**  Phrenilin # (butalbital/acetaminophen) **– PA > 60 units/month**  Repan # (butalbital/acetaminophen/caffeine) **– PA > 60 units/month**  Zebutal # (butalbital/acetaminophen/caffeine) **–**  **PA > 60 units/month**   * 1. The following intravenous antibiotics will require PA effective August 16, 2010.   Cubicin (daptomycin) **– PA**  Synercid (dalfopristin/quinpristin) **– PA**  Tygacil (tigecycline) **– PA**  Zyvox (linezolid), injection **– PA**   * 1. The following drugs will require PA effective August 16, 2010.   Lotemax (loteprednol) **– PA** Ontak (denileukin diftitox) **– PA** Zmax (azithromycin) **– PA** |  |

**Pharmacy Facts, Number 60 Page 2 of 2**

1. The following agent previously required prior authorization (PA). Effective August 16, 2010, this agent will be available only through a provider who administers the drug.

Cinryze (C1 inhibitor, human) ^

^ 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.

1. The following agent previously required PA for all quantities. Effective August 4, 2010, the following quantity limits will be effective.

Voltaren Gel (diclofenac) **– PA>100 grams/ month**

1. The following agent previously required PA for quantities greater than one tube/month and three tubes/lifetime. Effective August 16, 2010, this agent will require PA for all quantities.

Regranex (becaplermin) **– PA**

1. The following agent previously required prior authorization for quantities greater than 64 units/month. The following quantity limits will be effective August 16, 2010.

Restasis (cyclosporine, ophthalmic) – **PA > 60 units/month**

1. The following drugs will no longer require prior authorization:

Lialda (mesalamine)

Percocet # (oxycodone/acetaminophen)

Topiramate

1. The following quantity limits for cerebral stimulant solutions are effective August 4, 2010.

Methylin 5mg/5ml (methylphenidate oral solution) **– PA > 1800 ml/month**

Methylin 10mg/5ml (methylphenidate oral solution) **– PA > 900 ml/month**

Procentra (dextroamphetamine oral solution) **– PA > 900 ml/month**

Please direct any questions or comments (or to be taken off of this fax distribution) to

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