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**Number 60**

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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** |  |

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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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