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# Pharmacy Facts

## MassHealth Pharmacy Program

[www.mass.gov/masshealth/pharmacy](http://www.mass.gov/masshealth/pharmacy)

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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.

#### 1. Additions

The following newly marketed drugs have been added to the MassHealth Drug List effective February 14, 2011.

- Atelvia (risedronate) delayed release – **PA**
- Beyaz (drospirenone/ethinyl estradiol/levomefolate)
- Bromday (bromfenac) – **PA**
- Gilenya (fingolimod) – **PA**
- Glassia (alpha 1-proteinase inhibitor, human)
- Kombiglyze XR (saxagliptin/metformin ER) – **PA**
- Lo Loestrin Fe (norethindrone/ethinyl estradiol/ferrous fumarate)
- Natazia (estradiol valerate and estradiol valerate/dienogest)
- Pacnex Cleansing Pads (benzoyl peroxide) – **PA**
- Pradaxa (dabigatran) – **PA**
- Silenor (doxepin) – **PA**
- Suboxone (buprenorphine/naloxone) film – **PA**
- Suprep Bowel Kit (sodium sulfate/potassium sulfate/magnesium sulfate) – **PA**
- Tachosil (fibrinogen/thrombin) patch
- Tekamlo (aliskiren/amlodipine) – **PA**
- Tobradex ST (tobramycin 0.3%/dexamethasone 0.05%) – **PA**
- Xeomin (incobotulinum toxinA) – **PA**

#### 2. Change in Prior-Authorization Status

- a. The prior authorization requirement for the following drug is changing. Please refer to Table 31 and applicable PA request form for PA requirements for this drug.
  - Daytrana (methylphenidate transdermal system) – **PA < 6 years or > 17 years and PA > 30 units/month**
- b. The following drugs will no longer require prior authorization.
  - Aceon # (perindopril)
  - ephedrine injection
  - Sandimmune (cyclosporine) capsules

- c. The following agent will no longer require prior authorization for  $\leq 30$  units/month.
  - Wellbutrin XL # (bupropion XL) – **PA > 30 units/month**

- d. The following drugs will be restricted to inpatient hospital use effective February 28, 2011.
  - Angiomax (bivalirudin)
  - argatroban
  - Refludan (lepirudin)

- e. The following ophthalmic antibiotic/corticosteroid combination drugs will require prior authorization effective February 28, 2011.
  - Blephamide (sulfacetamide/prednisolone) – **PA**
  - Poly-Pred (neomycin/polymyxin B/prednisolone) – **PA**
  - Pred-G (prednisolone/gentamycin) – **PA**
  - Tobradex (tobramycin 0.3%/dexamethasone, ophthalmic ointment 0.1%) – **PA**
  - Zylet (loteprednol/tobramycin) – **PA**

- f. The prior authorization requirements for the following drugs are changing effective February 28, 2011. Please refer to Table 3 and applicable PA request forms for PA requirements for these drugs.
  - Prilosec # (omeprazole) 10 mg – **PA > 30 units/month**
  - Prilosec # (omeprazole) 20 mg – **PA > 120 units/month**
  - Prevacid # (lansoprazole) capsule – **PA  $\geq$  2 years and > 30 units/month**
  - Prevacid SoluTab (lansoprazole, orally disintegrating tablet) – **PA  $\geq$  2 years and > 30 units/month**

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- g. The following drug will require prior authorization effective February 28, 2011.
  - doxepin 150 mg – **PA**

- h. The following prior authorization requirement for acetaminophen-containing products are effective February 28, 2011.
  - acetaminophen – **PA > 4 grams/day**