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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**1. **Change in Prior-Authorization Status**
	1. 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*** 1. The following drugs will no longer require prior authorization.

Aceon # (perindopril) ephedrine injectionSandimmune (cyclosporine) capsules | 1. The following agent will no longer require prior authorization for ≤ 30 units/month.

Wellbutrin XL # (bupropion XL) **– PA > 30 units/month**1. The following drugs will be restricted to inpatient hospital use effective February 28, 2011.

Angiomax (bivalirudin) argatrobanRefludan (lepirudin)1. 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**1. 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 > 2 years and > 30 units/month**Prevacid SoluTab (lansoprazole, orally disintegrating tablet) – **PA > 2 years and > 30 units/month**1. The following drug will require prior authorization effective February 28, 2011.

doxepin 150 mg **– PA**1. The following prior authorization requirement for acetaminophen-containing products are effective February 28, 2011.

acetaminophen **– PA > 4 grams/day** |  |

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

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