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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 injection  Sandimmune (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) argatroban  Refludan (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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