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Pharmacy Facts

MassHealth Pharmacy Program

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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

Effective February 8, 2016, the following newly marketed drugs have been added to the MassHealth Drug List.

Aptesio XR (methylphenidate extended-release) –
PA < 3 years and PA > 30 units/month
Asmanex HFA (mometasone inhalation aerosol)
Corlanor (ivabradine) – **PA**
Daklinza (daclatasvir) – **PA**
Duopa (carbidopa/levodopa enteral suspension) – **PA**
Entresto (sacubitril/valsartan) – **PA**
Farydak (panobinostat) – **PA**
Finacea (azelaic acid foam) – **PA**
Invega Trinza (paliperidone extended-release 3-month injection) – **PA < 6 years and PA > 1 unit/3 months**
Namzaric (memantine extended-release/donepezil) –
PA
Natpara (parathyroid hormone) – **PA**
Opdivo (nivolumab) – **PA**
Orkambi (lumacaftor/ivacaftor) – **PA**
phenoxybenzamine – **PA**
Praluent (alirocumab) – **PA**
Proair Respiclick (albuterol inhalation powder) – **PA**
Repatha (evolocumab) – **PA**
Rexulti (brexpiprazole) – **PA**
Stiolto (tiotropium/olodaterol) – **PA**
Synjardy (empagliflozin/metformin) – **PA**
Technivie (ombitasvir/paritaprevir/ritonavir) – **PA**
Tivorbex (indomethacin 20 mg, 40 mg) – **PA**
Zarxio (filgrastim-sndz)
Zecuity (sumatriptan iontophoretic transdermal system) –
PA
Zingo (lidocaine powder intradermal injection system) –
PA

2. Change in Prior Authorization Status

- a. Effective February 8, 2016, the following headache therapy agent will no longer require prior authorization within quantity limits.

Maxalt MLT # (rizatriptan orally disintegrating tablet)
– **PA > 18 units/month**

- b. Effective February 8, 2016, the following leukotriene modifiers will no longer require prior authorization.

Singulair # (montelukast tablet, chewable tablet)

- c. Effective February 8, 2016, the following colony stimulating factor will no longer require prior authorization.

Neupogen (filgrastim)

- d. Effective February 8, 2016, the following opioid dependence agent will no longer require prior authorization within dose and duration of therapy limits.

Suboxone (buprenorphine/naloxone film ≤ 16 mg/day)

Suboxone (buprenorphine/naloxone film) –
PA > 180 days (> 16 mg/day and ≤ 24 mg/day)

Suboxone (buprenorphine/naloxone film) –
PA > 90 days (> 24 mg/day and ≤ 32 mg/day)

Suboxone (buprenorphine/naloxone film) –
PA > 32 mg/day

- e. Effective March 7, 2016, the following nonsteroidal anti-inflammatory agents will require prior authorization.

diflunisal – **PA**

fenoprofen 600 mg – **PA**

salsalate – **PA**

- f. Effective March 7, 2016, the following opioid analgesic will require prior authorization.

Buprenex (buprenorphine injection) – **PA**

- g. Effective March 7, 2016, the following topical antibiotic will require prior authorization.

Evoclin (clindamycin foam) – **PA**

- h. Effective March 7, 2016, the following antimalarial agent will require prior authorization.

Daraprim (pyrimethamine) – **PA**

- i. Effective March 7, 2016, the following opioid dependence agent will require prior authorization for all doses.

buprenorphine/naloxone tablet – **PA**

- j. Effective March 7, 2016, the following opioid analgesic agents will require prior authorization for all doses.

Dolophine (methadone oral) – **PA**

Methadose (methadone oral) – **PA**

- k. Effective March 7, 2016, the opioid analgesic agents will have updated high dose and/or quantity limit restrictions as described in Table 8: Opioids and Analgesics as well as the Pain Initiative. As a result, the following listings will change.

Astramorph-PF (morphine, injection) – **PA** > 120 mg/day

Dilaudid # (hydromorphone) – **PA** > 32 mg/day

Duragesic # (fentanyl 12, 25, 50 mcg/hr transdermal system) – **PA** > 50 mcg/hr and **PA** > 10 patches/month

Duragesic (fentanyl 75, 100 mcg/hr transdermal system) – **PA**

Duramorph (morphine, injection) – **PA** > 120 mg/day

hydrocodone/acetaminophen – **PA** > 80 mg/day

levorphanol tablet – **PA** > 4 mg/day

morphine immediate-release – **PA** > 120 mg/day

MS Contin # (morphine controlled-release tablet) – **PA** > 120 mg/day

oxycodone/acetaminophen – **PA** > 80 mg/day

oxycodone/aspirin – **PA** > 4 grams of aspirin/day

Percocet # (oxycodone/acetaminophen) –

PA > 80 mg/day

Roxicodone # (oxycodone immediate-release) –

PA > 80 mg/day

Vicoprofen # (hydrocodone 7.5 mg/ibuprofen) –

PA > 80 mg/day

PA – Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment. Note: Prior authorization applies to both the brand-name and the FDA “A”-rated generic equivalent of listed product.

– This designates a brand-name drug with FDA “A”-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA “A”-rated generic equivalent.

^ – 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 physician's office.