



THE PRESCRIBER e-LETTER

Brand Name Preferred over Generic Drug List

In general, the MassHealth Pharmacy program requires prior authorization (PA) for any brand-name drug for which there is a U.S. Food and Drug Administration (FDA) A-rated generic equivalent. However, there are some agents for which MassHealth has determined cost-effectiveness in the use of brand-name formulation for some agents. This is the list of brand-name drugs that MassHealth prefers over their generic equivalents because the net cost of the brand-name drugs, when adjusted for rebates, is lower than the net cost of the generic equivalents.

The PA process for Brand Name and Non-Preferred Generic Drugs was updated to include Brand Name Preferred formulations on **August 29, 2016**. For the most up-to-date list of medications where the brand-name formulation is preferred, see the [MassHealth Brand Name Preferred Over Generic Drug List](#).

Brand Name Preferred Over Generic Drug List	
Drug	PA Status
Asacol HD® (mesalamine high dose delayed-release) ^{BP}	
Baraclude® (entecavir tablet) ^{BP}	PA > 30 units/month
Copaxone® (glatiramer 20 mg) ^{BP}	
Diastat® (diazepam rectal gel) ^{BP}	PA > 5 kits*/month
Focalin XR® (dexmethylphenidate extended-release) ^{BP}	PA < 3 years PA > 60 units/month
Gleevec® (imatinib) ^{BP}	
Mepron® (atovaquone) ^{BP}	
Pulmicort® (budesonide inhalation suspension) ^{BP}	
Valcyte® (valganciclovir tablet) ^{BP}	
Xeloda® (capecitabine) ^{BP}	
Xenazine® (tetrabenazine) ^{BP}	PA

BP=brand preferred

*10 syringes

Hepatitis C Antiviral Agents

Hepatitis C virus (HCV) infections are the most common chronic blood-borne infections in the United States and the leading cause of liver transplantation. The American Association for the Study of Liver Disease (AASLD) and the Infectious Disease Society of America (IDSA) recommend treatment with direct-acting antivirals for most patients. Treatment is primarily determined by HCV genotype, treatment history, stage of liver disease, and treatment tolerance and adherence.^{1,2}

MassHealth requires PA for the HCV antiviral agents to ensure appropriate utilization and optimal duration of therapy. The PA process for Hepatitis C Antiviral Agents was updated on **August 29, 2016**. This update included the addition of the new antiviral agent Epclusa® (sofosbuvir/velpatasvir). In addition, both Daklinza® (daclatasvir) and Sovaldi® (sofosbuvir) were added to the Supplemental Rebate/Preferred Drug List. Viekira Pak® (ombitasvir/paritaprevir/ritonavir/dasabuvir) was removed from the Supplemental Rebate/Preferred Drug List. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class.

Drugs That Require PA	No PA
Direct-Acting Antiviral Agents	
Olysio® (simeprevir)	
Daklinza® (daclatasvir) ^{PD}	
Sovaldi® (sofosbuvir) ^{PD}	
Harvoni® (ledipasvir/sofosbuvir) ^{PD}	
Epclusa® (sofosbuvir/velpatasvir) ^{PD}	
Zepatier® (elbasvir/grazoprevir)	
Technivie® (ombitasvir/paritaprevir/ritonavir)	
Viekira Pak® (ombitasvir/paritaprevir/ritonavir/dasabuvir)	N/A
Viekira XR® (dasabuvir/ombitasvir/paritaprevir/ritonavir extended-release)	

PD=Preferred Drug

1. Viral Hepatitis - Hepatitis C Information - [Hepatitis C FAQs for Health Professionals](#). Centers for Disease Control and Prevention. Atlanta (GA): Centers for Disease Control and Prevention; 2016 Jul 21 [cited 2016 Oct 17]. Available at <http://www.cdc.gov/hepatitis/hcv/hcvfaq.htm>.
2. American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA). HCV Guidance: Recommendations for testing, managing, and treating hepatitis C [guideline on the Internet]. Alexandria and Arlington (VA): AASLD/IDSA 2016 Jul [cited 2016 Oct 17]. Available at <http://www.hcvguidelines.org>.

Recent MassHealth Drug List Updates

Drug/Drug Class	Addition/Deletion/Change	Rationale
Antibiotics - Otic	Addition: does not require PA Ciprofloxacin otic suspension (Otiprio®)^\n	Otiprio® is indicated in the treatment of pediatric patients with bilateral otitis media with effusion undergoing tympanostomy tube (TT) placement. Since this medication is designed to be administered by a medical professional and will be distributed directly to health care facilities performing these procedures, MassHealth has removed the requirement for PA.
	Change in PA status: does not require PA Ciprofloxacin/dexamethasone (Ciprodex®)	Based on the shortage of less costly alternative ofloxacin solution, MassHealth has removed the requirement for PA.
Anti-hemophilia agents	Addition: does not require PA factor IX recombinant, albumin fusion protein (Idelvion®) antihemophilic factor, recombinant (Kovaltry®)	MassHealth has removed the requirement for PA.
Bowel Prep	Change in PA status: does not require PA polyethylene glycol-electrolyte solution (Golytely® packet)	Based on a reduction in cost, MassHealth has removed the requirement for PA.
	Deletion: no longer on MassHealth Drug List polyethylene glycol-electrolyte solution (Colyte® #) polyethylene glycol-electrolyte solution/bisacodyl (HalfLytely®) polyethylene glycol-electrolyte solution (Suclear® Bowel Prep Kit)	These drugs have been removed from the MassHealth Drug List because the manufacturer has discontinued them.
Cardiovascular Agents	Deletion: no longer on MassHealth Drug List eprosartan (Teveten®) eprosartan/hydrochlorothiazide (Teveten HCT®)	These drugs have been removed from the MassHealth Drug List because the manufacturer has discontinued them.
Cerebral Stimulants and ADHD Medications	Addition: requires PA amphetamine extended-release orally disintegrating tablet (Adzenys XR®-ODT) amphetamine extended-release oral suspension (Dyanavel XR®) methylphenidate extended-release chewable tablet (Quillichew ER®) – PA < 3 years and PA > 60 units/month	Dyanavel XR® is an extended-release, oral suspension indicated treatment of ADHD in children six years of age or older and is the only available once-daily, extended-release, amphetamine-based oral liquid. Adzenys XR ODT® is the first extended-release, orally disintegrating tablet (ODT) indicated for the treatment of ADHD in children six years of age or older. With the availability of less costly alternatives, MassHealth has determined that these agents will require PA. QuilliChew ER® requests that exceed a quantity of 60 units/30 days require a PA.
Chemotherapy	Addition: does not require PA Bendeka® (bendamustine) Evomela® (melphalan injection)	Given that Bendeka® replaces the solution formulation of Treanda®, the availability of Treanda® without PA; multiple FDA-approved and off-label indications; and limited utilization of bendamustine, MassHealth has removed the requirement for PA. MassHealth has removed the requirement for PA.

Recent MassHealth Drug List Updates

Drug/Drug Class	Addition/Deletion/Change	Rationale
Fibric Acid Derivatives	Change in PA status: does not require PA fenofibrate capsule 43 mg fenofibrate capsule 50 mg (Lipofen®) fenofibric acid capsule 45 mg and 135 mg (Trilipix®#)	Based on a decrease in cost, MassHealth has removed the requirement for PA.
Hepatitis Antiviral Agents	Addition: requires PA sofosbuvir/velpatasvir (Epclusa®)	Given high cost; opportunities to manage the duration of therapy and off-label use; and to promote utilization of the preferred products, MassHealth has determined this agent will require a PA.
	Addition: added to the MassHealth Supplemental Rebate/Preferred Drug List daclatasvir (Daklinza®) PD sofosbuvir (Sovaldi®) PD	MassHealth has either entered into a supplemental rebate agreement with drug manufacturers or designated a particular drug as preferred based on net costs to MassHealth, allowing MassHealth to provide coverage of medications at the lowest possible costs.
	Deletion: removed from the MassHealth Supplemental Rebate/Preferred Drug List ombitasvir/paritaprevir/ritonavir/dasabuvir (Viekira Pak®)	MassHealth requires a trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class.
HIV Antiviral Agents	Addition: does not require PA Descovy® (emtricitabine/tenofovir alafenamide) Odefsey® (emtricitabine/rilpivirine/tenofovir alafenamide)	Descovy® and Odefsey® are fixed-dose combination tablets indicated in the treatment of human immunodeficiency virus type 1 (HIV-1) infection in adults and pediatric patients 12 years of age and older. Based on clinical guideline recommendations listing these agents as alternative antiretroviral treatment options, and the decrease in kidney and bone toxicity, MassHealth has removed the requirement for PA.
Intranasal Corticosteroids	Change in PA status: requires PA flunisolide nasal spray	Based on an increase in cost and the availability of less costly alternatives, MassHealth has determined that this agent will require a PA.
	Addition: added to MassHealth Over-the-Counter Drug List budesonide nasal spray ≤ 1 inhaler/month	Based on the availability of an over-the-counter formulation of budesonide nasal spray, MassHealth has removed the PA requirement within quantity limits.
	Deletion: no longer on MassHealth Drug List fluticasone propionate nasal spray (Flonase®) triamcinolone nasal spray (Nasacort AQ®)	These drugs have been removed from the MassHealth Drug List because the manufacturer has discontinued them.
NSAIDs	Addition: requires PA diclofenac injection (Dyloject®) meloxicam capsule (Vivlodex®)	Dyloject® is a new injectable NSAID indicated in adults for the short-term management of mild-to-moderate pain and management of moderate-to-severe pain alone or in combination with opioids. Due to its high cost compared to ketorolac injection, MassHealth has determined that this agent will require a PA. Based on limited clinical evidence supporting the use of Vivlodex® over traditional formulations as well as other generically available NSAIDs, MassHealth has determined

Recent MassHealth Drug List Updates

Drug/Drug Class	Addition/Deletion/Change	Rationale
		that this agent will require a PA.
	Deletion: no longer on MassHealth Drug List diclofenac potassium (Cataflam®#)	This drug has been removed from the MassHealth Drug List because the manufacturer has discontinued it.
Respiratory Agents - Inhaled	Addition: requires PA glycopyrrolate inhalation powder (Seebri®) indacaterol/glycopyrrolate (Utibron®)	Seebri® and Utibron® Neohalers are indicated for the long-term maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema. Based on the availability of multiple less costly alternatives, MassHealth has determined that these agents will require a PA.
Topical corticosteroids	Addition: requires PA betamethasone dipropionate spray (Sernivo®) halobetasol lotion (Ultravate®)	Based on the availability of less costly alternatives, MassHealth has determined that these agents will require a PA.
Urinary Antispasmodics	Change in PA status: does not require PA darifenacin 15 mg (Enablex®#) Change in PA status: requires PA darifenacin 7.5 mg (Enablex®#) – PA > 30 units/month	Based on the availability of a new FDA “A”-rated generic for Enablex®, MassHealth has removed the PA requirement for generic darifenacin within quantity limits.
Vaccines	Change in PA status: requires PA human papillomavirus 9-valent vaccine (Gardasil 9®) - PA < 9 years and ≥ 27 years Addition: requires PA Influenza virus vaccine, (adjuvanted) (Fluad®) – PA < 65 years	Based on new guideline recommendations for the dosing of the human papillomavirus 9-valent vaccine, MassHealth has modified PA criteria to include updated recommendations. Based on the specific indication and age criteria of Fluad®, MassHealth has determined that this agent will require a PA.
acamprosate (Campral®#)	Deletion: no longer on MassHealth Drug List	This drug has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
buprenorphine buccal film (Belbuca®)	Addition: requires PA	Buprenorphine buccal film is indicated in the treatment of pain severe enough to require daily, around-the-clock, long-term opioid treatment, for which alternative treatment options are inadequate. Based on the availability of less costly alternatives, MassHealth has determined that this agent will require a PA.
cariprazine (Vraylar®)	Addition: requires PA	Cariprazine is an atypical antipsychotic indicated for the treatment of schizophrenia and acute treatment of manic or mixed episodes associated with bipolar I disorder. Based on the availability of less costly generic antipsychotics, MassHealth has determined that this agent will require PA.