MassHealth Partial Unified Formulary (PUF)

Note: Information may have changed. Refer to the PDL for the most updated coverage information.

Overview

a. Categories with actions required for current utilizers

I. Cardiovascular
   a. Anticoagulants

II. Central Nervous System
   a. CGRP inhibitors
   b. Injectable Antipsychotics
   c. Opioid Dependence and Reversal Agents
   d. Multiple Sclerosis Agents (Copaxone-injectable)
   e. Multiple Sclerosis Agents (oral)

III. Diabetes
   a. Antidiabetic Agents: Biguanides
   b. Antidiabetic Agents: Biguanides and Combination products
   c. Insulins - Basal Insulins
   d. Insulins – Rapid acting insulins and mixes
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   f. GLP-1 and combination products
   g. SGLT2
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IV. Endocrine
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V. Immunology
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VI. Neutropenia Agents
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VII. Oncology
   a. Kinase Inhibitors: MTOR for Breast Cancer
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VIII. Respiratory
   a. Respiratory Agents – Anticholinergics
   b. Respiratory Agents – Combination Inhaled Corticosteroids/Long-acting Beta-Agonists
   c. Respiratory Agents - Inhaled Glucocorticoids
   d. Respiratory Agents – SABAs

b. Categories with no actions required for current utilizers

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   a. Cerebral Stimulants and ADHD Medications (Long Acting)

II. Immunology
   a. Targeted Immunomodulators – Anti-TNF Agents
   b. Targeted Immunomodulators – Interleukin Antagonists
   c. Targeted Immunomodulators – Janus Kinase Inhibitors

III. Oncology
   a. Kinase Inhibitors

c. Categories with actions required for select categories

I. Antiretrovirals
II. Asthma and Allergy Monoclonal Antibodies
III. Erythropoiesis Stimulating Agents (ESAs)
IV. Glucagon Products
V. Hemophilia Agents
VI. Hepatitis Antiviral Agents
VII. Miscellaneous Oncology Agent
VIII. Multiple Sclerosis Agents (other oral)
IX. Opioid and Alcohol Treatment Agent
X. Spinal Muscular Atrophy
XI. Targeted immunomodulators – Other

d. Tufts Health Plan (Non-PUF) Initiatives Effective January 1, 2021

I. Evzio (naloxone) Auto-Injector
II. Irritable Bowel Syndrome (IBS)-Constipation
III. Ophthalmic Prostaglandins

TUFTS Health Plan

CATEGORIES WITH ACTIONS REQUIRED FOR CURRENT UTILIZERS

I. **Cardiovascular**

a. Anticoagulants

- Existing utilizers of Pradaxa, Savaysa, or Xarelto 2.5 mg will not be grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Eliquis* (apixaban)	QL, Preferred Drug	QL, Preferred Drug	No action
Xarelto (rivaroxaban) 10 mg, 15 mg, 20 mg, starter pack	QL	QL	
Non-preferred Drugs			
Pradaxa (dabigatran) 110 mg ≤ 70 capsules/365 days	Not Covered, QL	QL	Switch to Eliquis or Xarelto 10 mg, 15 mg, or 20 mg
Pradaxa (dabigatran) 110 mg > 70 capsules/365 days		PA, QL	
Pradaxa (dabigatran) 75 mg, 150 mg			
Savaysa (edoxaban) tablet			
Xarelto (rivaroxaban) 2.5 mg	QL		Submit PA

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

II. Central Nervous System

a. CGRP Inhibitors

- Members on Aimovig, Emgality [migraine prophylaxis] and Vyepti will not be grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Ajovy [migraine prophylaxis] (fremanezumab-vfrm)	Not Covered, QL	PA, QL, Preferred Drug	Switch members on Aimovig, Emgality [migraine prophylaxis] or Vyepti to Ajovy
Emgality [cluster headache]			No action
Non-preferred Drugs			
Aimovig (erenumab-aooe)	PA, QL	PA, QL	Switch members to Ajovy for migraine prophylaxis
Emgality [migraine prophylaxis] (galcanezumab-gnlm)	Not Covered, QL	PA, QL	
Vyepti (eptinezumab-jjmr)	MB/RX, PA	MB, PA	

MB = drug is restricted to the medical benefit; MB/RX = drug is available under either the medical benefit for the pharmacy benefit

b. Injectable Antipsychotics

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Aristada* (aripiprazole lauroxil) extended-release injectable suspension	MB/RX, PBHMI, Preferred Drug	MB/RX, QL, PBHMI, Preferred Drug	No action
Aristada Initio* (aripiprazole lauroxil) extended-release injectable suspension	MB/RX, PBHMI, Preferred Drug		
Invega Trinza (paliperidone palmitate) extended-release suspension	MB/RX, PA, PBHMI		
Non-preferred Drugs			
Abilify Maintena (aripiprazole) extended-release suspension	MB/RX, PA, QL, PBHMI	MB/RX, PA, QL, PBHMI	Switch patients to Aristada
Invega Sustenna (paliperidone palmitate) extended-release suspension	MB/RX, PA, PBHMI	MB/RX, QL, PBHMI	Switch patients to Invega Trinza

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List
PBHMI = Pediatric Behavioral Health Medication Initiative

c. Opioid Dependence and Reversal Agents

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Suboxone* (buprenorphine/naloxone) film	QL, Brand Preferred, Preferred Drug	QL, Brand Preferred, Preferred Drug	Switch members on nonpreferred buprenorphine products to brand Suboxone film
Non-preferred Drugs			
Bunavail (buprenorphine/naloxone) film	PA, QL	PA, QL	Switch members to brand name Suboxone film
Buprenorphine/naloxone film (generic Suboxone)	Not Covered, QL	Not Covered, QL	
Buprenorphine/naloxone sublingual tablet	PA, QL	PA, QL	
Zubsolv (buprenorphine/naloxone) sublingual tablet	PA, QL	PA, QL	
Buprenorphine sublingual tablet	PA	PA	Switch members to brand name Suboxone film as clinical appropriately

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

d. Multiple Sclerosis Agents (copaxone-injectable)

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Copaxone	Not Covered, SP	SP Brand Preferred	No action
Non-preferred Drugs			
glatiramer	SP	Not Covered, SP	Switch patients to brand Copaxone
Glatopa	SP	PA*, SP	

*Glatopa is technically is not an AB-rated generic for Copaxone. MassHealth lists Glatopa as requiring PA but does not include Glatopa in the multiple sclerosis policies provided to the MCOs as part of the PUF project. Per verbal discussions with MassHealth, the coverage criteria would be a trial and failure of brand Copaxone.

e. Multiple Sclerosis Agents (oral)

- Existing utilizers of brand Gilenya and Tecfidera will be grandfathered.

Medication Name^*	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drug			
Gilenya	SP, QL	PA, SP, QL Brand Preferred	No action
Tecfidera			
Non-preferred Drugs			
dimethyl fumarate	NTM	Not Covered, SP, QL	Switch patients to Brand Tecfidera or Gilenya. Consider Brand Tecfidera or Gilenya for new starts
Zeposia	SP	PA, SP	

^Vumerity and Bafiertam are not currently included in the MassHealth PUF; therefore, these medications will be Non-covered to encourage the use of preferred drugs.
*See Multiple Sclerosis Agents (other oral) for coverage of non-preferred Aubagio and Mayzent.

III. Diabetes

a. Antidiabetic Agents: Biguanides

- Members on nonpreferred biguanides will not be grandfathered.
- Members ≥ 13 y.o. on Riomet solution will also not be grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Metformin tablet (generic Glucophage)	Covered	Covered	Switch members on generic metformin solution to metformin (generic Glucophage) tablet or brand Riomet solution (if age appropriate)
Riomet solution (metformin)	Not Covered	< 13 y.o.: Brand Preferred ≥ 13 y.o.: PA, Brand Preferred	Switch members on generic metformin solution or Riomet ER to brand Riomet (if age appropriate)
Metformin ER tablet (generic Glucophage XR)	Covered	Covered	Switch members from generic Glumetza or generic Fortamet to generic Glucophage XR
Non-preferred Drugs			
Metformin ER tablet (generic Fortamet)	PA	PA	Switch members to generic Glucophage XR
Metformin ER tablet (generic Glumetza)	PA	PA	
Metformin solution (generic Riomet)	Covered	Not Covered	Switch members to metformin (generic Glucophage) tablet or brand Riomet (if age appropriate)
Riomet ER solution (metformin ER)	Not Covered	PA	Switch members to generic Glucophage XR or brand Riomet (if age appropriate)

ER = extended-release; IR = immediate release

b. Antidiabetic Agents: Biguanides and Combination Products

- SGLT-2 Inhibitor/Metformin Combination Products: Current Segluromet utilizers will not be grandfathered.
- DPP-4 Inhibitor/Metformin Combination Products: Current alogliptin/metformin utilizers will not be grandfathered.
- DPP-4 Inhibitor/SGLT-2 Inhibitor Combination Product: Current Glyxambi utilizers will not be grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
SGLT-2 Inhibitor/Metformin Combination Products			
Partial Unified Formulary – Preferred Drugs			
Invokamet (canagliflozin/metformin)	Not Covered, QL	QL	Switch members on Segluromet to Invokamet, Invokamet XR, Synjardy, Synjardy XR, or Xigduo XR
Invokamet XR (canagliflozin/metformin ER)			
Synjardy (empagliflozin/metformin)			
Synjardy XR (empagliflozin/metformin ER)			
Xigduo XR (dapagliflozin/metformin ER)			
Non-preferred Drugs			
Segluromet (ertugliflozin/metformin)	STPA	PA, QL	Switch members to Invokamet, Invokamet XR, Synjardy, Synardy XR, or Xigduo XR
DPP-4 Inhibitor/Metformin Combination Products			
Partial Unified Formulary – Preferred Drugs			
Janumet (sitagliptin/metformin)	Not Covered, QL	QL	Switch members on alogliptin/metformin to Janumet, Janumet XR, Jentadueto, Jentadueto XR, or Kombiglyze XR
Janumet XR (sitagliptin/metformin ER)			
Jentadueto (linagliptin/metformin)			
Jentadueto XR (linagliptin/metformin ER)			
Kombiglyze XR (saxagliptin/metformin ER)			
Non-preferred Drugs			
Alogliptin/metformin (generic Kazano)	PA, QL	PA, QL	Switch members to Janumet, Janumet XR, Jentadueto, Jentadueto XR, or Kombiglyze XR
DPP-4 Inhibitor/SGLT-2 Inhibitor Combination Product			
Non-preferred Drugs			
Glyxambi (empagliflozin/linagliptin)	Not Covered, QL	PA, QL	Switch members to Jardiance and Tradjenta

c. Insulins: Basal Insulins

- Patients currently using Basaglar or Semglee will need to switch to Lantus SoloStar or vial. Basaglar and Semglee utilizers will not be grandfathered.
- Providers will need to write a new prescription for Lantus.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drug			
Lantus SoloStar (insulin glargine)	Not Covered	Covered	Switch members from Basaglar or Semglee to Lantus vial or SoloStar
Lantus vial (insulin glargine)	Not Covered	Covered	
Non-preferred Drugs			
Basaglar KwikPen (insulin glargine)	Covered	PA	Switch members to Lantus vial or Lantus SoloStar
Semglee pen (insulin glargine)	Not Covered	PA	
Semglee vial (insulin glargine)	Not Covered	PA	

d. Insulins: Rapid-Acting Insulins and Mixes

- Brand Humalog and brand Novolog formulations are going to be preferred over their authorized generics. Prescriptions for Humalog and Novolog should specify the brand.
- Additionally, Admelog SoloStar and vial will be nonpreferred and require PA.
- Members on nonpreferred rapid-acting insulins and mixes will not be grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Humalog vial (insulin lispro)	Not Covered	Brand Preferred	Switch members on Admelog, insulin aspart, or insulin lispro to brand Humalog KwikPen/vial/cartridge or brand Novolog FlexPen/vial/cartridge
Humalog KwikPen (insulin lispro)			
Humalog Junior KwikPen (insulin lispro)			
Humalog cartridge (insulin lispro)			
Novolog vial (insulin aspart)			
Novolog FlexPen (insulin aspart)			
Novolog penfill cartridge (insulin aspart)			
Humalog Mix 75/25 vial (insulin lispro protamine and insulin lispro)	Covered		Switch members on generic insulin lispro protamine/insulin lispro 75/25 to brand Humalog Mix 75/25 KwikPen or vial
Humalog Mix 75/25 KwikPen (insulin lispro protamine and insulin lispro)			
Novolog Mix 70/30 vial (insulin aspart protamine and insulin aspart)			Switch members on generic insulin aspart protamine/insulin aspart 70/30 to brand Novolog Mix 70/30 FlexPen or vial
Novolog Mix 70/30 FlexPen (insulin aspart protamine and insulin aspart)			

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Non-preferred Drugs			
Admelog SoloStar (insulin lispro)	Covered	PA	Switch members to brand Humalog KwikPen/vial/cartridge or Novolog FlexPen/vial/cartridge
Admelog vial (insulin lispro)			
Apidra (insulin glulisine) vial	Not Covered	PA	
Apidra SoloStar (insulin glulisine)			
Fiasp (insulin aspart) vial			
Fiasp (insulin aspart) FlexTouch			
Fiasp (insulin aspart) PenFill cartridge			
Insulin aspart FlexPen (generic Novolog FlexPen)	Not Covered	Not Covered	
Insulin aspart vial (generic Novolog vial)			
Insulin aspart penfill cartridge (generic Novolog cartridge)			
Insulin lispro vial (generic Humalog)			
Insulin lispro Junior KwikPen (generic Humalog Junior KwikPen)			
Insulin lispro KwikPen (generic Humalog KwikPen)			
Insulin aspart protamine/ insulin aspart 70/30 vial (generic Novolog Mix 70/30)	Covered		Switch patients from generic insulin aspart protamine/insulin aspart 70/30 to brand Novolog 70/30 FlexPen or vial
Insulin aspart protamine/ insulin aspart 70/30 FlexPen (generic Novolog Mix 70/30 FlexPen)			
Insulin lispro protamine/ insulin lispro 75/25 KwikPen (generic Humalog Mix 75/25 KwikPen)			Switch patients from generic insulin lispro protamine/insulin lispro 75/25 KwikPen to brand Humalog Mix 75/25 KwikPen or vial

e. Dipeptidyl Peptidase-4 (DPP-4) Inhibitor

- Current alogliptin utilizers will not be grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Januvia (sitagliptin)	Not Covered	Covered	Switch members from alogliptin to Januvia, Onglyza, or Tradjenta
Onglyza (saxagliptin)			
Tradjenta (linagliptin)			
Non-preferred Drugs			
Alogliptin (generic Nesina)	PA, QL	PA, QL	Switch members to Januvia, Onglyza, or Tradjenta

f. Glucagon-Like Peptide-1 (GLP-1) Agonists and Combination Products

- Current utilizers of Bydureon BCise, Ozempic, Rybelsus, Soliqua, or Xultophy will not be grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Bydureon (exenatide ER)	Not Covered, QL	QL	Switch members on Bydureon BCise, Ozempic, or Rybelsus to Bydureon, Byetta Trulicity, or Victoza
Byetta (exenatide)	Not Covered, QL	QL, Brand Preferred	
Trulicity* (dulaglutide)	QL, Preferred Drug	QL, Preferred Drug	
Victoza (liraglutide)	QL	QL	
Non-preferred Drugs			
Bydureon BCise (exenatide ER)	Not Covered, QL	PA, QL	Switch members to Byudreon BCise, Byetta, Trulicity, or Victoza
Ozempic (semaglutide)	QL		
Rybelsus tablet (semaglutide)	Not Covered, QL		
Soliqua (insulin glargine/ lixisenatide)	Not Covered		Switch members to Byudreon BCise, Byetta, Trulicity, or Victoza and Lantus vial/SoloStar
Xultophy (insulin degludec/ liraglutide)	Not Covered		

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

g. Sodium Glucose Co-Transporters-2 (SGLT-2) Inhibitors

- Existing Steglatro utilizers will not be grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Farxiga (dapagliflozin)	Not Covered, QL	QL	Switch members from Steglatro to Farxiga, Invokana, or Jardiance
Invokana (canagliflozin)			
Jardiance (empagliflozin)			
Non-preferred Drugs			
Steglatro (ertugliflozin)	STPA	PA, QL	Switch members to Farxiga, Invokana, or Jardiance

h. Blood Glucose Test Strips

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested ACO action
Partial Unified Formulary – Preferred Drugs			
FreeStyle test strips*	QL (300 strips/30 days)	QL (300 strips/30 days), Preferred Product	Switch members from nonpreferred meter and test strips to preferred FreeStyle or Precision meter and test strips
FreeStyle InsuLinx test strips*	QL (300 strips/30 days)	QL (300 strips/30 days), Preferred Product	
FreeStyle Lite test strips*	QL (300 strips/30 days)	QL (300 strips/30 days), Preferred Product	
Precision Xtra test strips*	QL (300 strips/30 days)	QL (300 strips/30 days), Preferred Product	
Non-preferred Drugs			
FreeStyle Neo test strips	QL (300 strips/30 days)	Not Covered, QL (300 test strips/30 days)	Switch members from nonpreferred meter and test strips to preferred FreeStyle or Precision meter and test strips
All other test strips	Not Covered	Not Covered	

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

IV. Endocrine

a. Growth Hormones

- No coverage changes

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Genotropin*	PA, SP Preferred Drug	PA, SP Preferred Drug	No action
Non-preferred Drugs			
Humatrope	PA, SP	PA, SP	Switch patients to Genotropin. Consider Genotropin for new starts
Norditropin			
Nutropin			
Omnitrope			
Serostim			

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

V. Immunology

a. Topical Immune Suppressants

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Eucrisa* ointment	PA, Preferred Drug	PA, QL, Preferred Drug	Ensure patients are being prescribed within the new QL
Elidel (pimecrolimus) cream	Not Covered	Brand Preferred	Switch patients from generic pimecrolimus cream to brand Elidel
Protopic (tacrolimus) ointment			Switch patients from generic tacrolimus ointment to brand Protopic
Non-preferred Drugs			
Pimecrolimus cream (generic Elidel)	PA	Not Covered	Switch patients from generic pimecrolimus cream to brand Elidel
Tacrolimus ointment (generic Protopic)			Switch patients from generic tacrolimus ointment to brand Protopic

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

VI. Neutropenia Agents

a. Colony Stimulating Factors

- Drugs in this category are intentionally covered on both the pharmacy and medical benefit. January 1, 2021 PA rules outlined below will also be applied to the medical benefit.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Leukine	MB/RX, SP	MB/RX, SP	No action
Neulasta	PA, SP, QL	SP, QL	
Fulphila			
Udenyca			
Ziextenzo			
Neupogen	PA, SP, QL	SP, QL	
Non-preferred Drugs			
Zarxio	SP, QL	PA, SP, QL	Switch patients to Neupogen
Granix	PA, SP, QL		
Nivestym			

VII. Oncology

a. Kinase Inhibitors: MTOR for Breast Cancer

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drug			
Afinitor (everolimus) 2.5, 5, 7.5, 10 mg	Not Covered, SP, QL	PA, SP, QL Brand Preferred	Switch patients to Brand Afinitor
Non-preferred Drugs			
everolimus 2.5, 5, 7.5 mg*	PA, SP, QL	Not Covered, SP, QL	Switch patients to Brand Afinitor
Afinitor Disperz	PA, SP, QL	PA, SP, QL	No action

*An AB-rated is not available for Afinitor 10 mg.

b. **Kinase Inhibitors: Tyrosine**

- Existing utilizers of erlotinib will be grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Bosulif*	PA, SP, QL Preferred Drug	PA, SP, QL Preferred Drug	No action
Inlyta*	PA, SP Preferred Drug	PA, SP Preferred Drug	
Sutent*			
imatinib	SP	SP	
Sprycel	PA, SP, QL	SP, QL	
Tasigna	PA, SP	SP	
Tykerb (lapatinib)	Not Covered, SP, QL	SP, QL Brand Preferred	
Non-preferred Drugs			
lapatinib	SP, QL	Not Covered, SP, QL	Switch patients to Brand Tykerb
erlotinib	SP, QL	PA, SP, QL	No action
Alecensa	PA, SP	PA, SP	
Alunbrig			
Cabometyx			
Inrebic			
Rydapt			
Tabrecta			
Xalkori			
Zykadia			
Brukinsa	PA	PA	
Calquence			
Cometriq			
Iclusig			
Imbruvica			
Iressa			
Turalio			
Xospata			
Venclexta			
Caprelsa	PA, QL	PA, QL	
Nexavar			
Votrient			
Gleevec (imatinib)	Not Covered	Not Covered	
Tarceva (erlotinib)	Not Covered, SP, QL	Not Covered, SP, QL	

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

VIII. Respiratory

a. Anticholinergics

- Existing Lonhala and Yupelri utilizers will not be grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drug			
Atrovent HFA (ipratropium inhalation aerosol)	Covered	Covered	No action
Ipratropium inhalation solution			Switch patients from Lonhala or Yupelri to ipratropium inhalation solution
Incruse Ellipta (umeclidinium)	Covered	QL	Ensure patients are being prescribed within the new QL
Seebri (glycopyrrolate inhalation powder)	Not Covered		
Spiriva HandiHaler (tioptropium inhalation powder)	Not Covered		
Spiriva Respimat (tiotropium inhalation solution)	1.25 mcg: Covered		
	2.5 mcg: Not Covered		
Tudorza Pressair (aclidinium)	Not Covered		
Non-preferred Drugs			
Lonhala (glycopyrrolate inhalation solution)	Not Covered	PA, QL	Switch patients to ipratropium inhalation solution
Yupelri (revefenacin)			

b. **Combination Inhaled Corticosteroids/Long-Acting Beta-Agonists**

- Patients who are currently using generic Advair Diskus (fluticasone/salmeterol, Wixela) and generic Symbicort (budesonide/formoterol) should switch to the brands. It is recommended that prescriptions be written for brand Advair Diskus and brand Symbicort.
- Utilizers of generic Advair Diskus, generic AirDuo Respiclick, Breo Ellipta, and generic Symbicort will not be grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Advair Diskus (fluticasone/salmeterol inhalation powder)	Not Covered	QL, Brand Preferred	Switch patients on generic Advair Diskus (including Wixela), generic AirDuo Respiclick, or Breo Ellipta to brand Advair Diskus within the new QL
Advair HFA (fluticasone/salmeterol inhalation aerosol)	PA	QL	Switch patients on generic AirDuo Respiclick or Breo Ellipta to Advair HFA or Dulera within the new QLs
Dulera (mometasone/formoterol)	PA	QL	
Symbicort (budesonide/formoterol)	Not Covered	QL, Brand Preferred	Switch patients on generic budesonide/ formoterol or Breo Ellipta to brand Symbicort within the new QL
Non-preferred Drugs			
Fluticasone/salmeterol inhalation powder (generic Advair Diskus)	Covered	Not Covered, QL	Switch patients to brand Advair Diskus within the new QL
Wixela (generic Advair Diskus)			
Fluticasone/salmeterol inhalation powder (generic AirDuo Respiclick)	Covered	PA, QL	Switch patients to brand Advair Diskus, Advair HFA, Dulera, or brand Symbicort within the new QLs
AirDuo Respiclick (fluticasone/salmeterol inhalation powder)	Not Covered	Not Covered, QL	
Breo Ellipta (fluticasone/vilanterol)	PA	PA, QL	
Budesonide/formoterol (generic Symbicort)	80/4.5: PA (covered without PA for members 6 through 11 years of age)	Not Covered, QL	Switch patients to brand Symbicort within the new QL
	160/4.5: PA		

c. **Respiratory Agents – Inhaled Corticosteroids**

- Existing utilizers of budesonide inhalation suspension, Alvesco, Arnuity Ellipta, and Qvar Redihaler will not be grandfathered. Additionally, members on Asmanex Twisthaler outside of the age appropriate dose will not be grandfathered, either.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drug			
Asmanex HFA (mometasone inhalation aerosol)	Covered	Covered	Switch patients on budesonide inhalation suspension, Alvesco, Arnuity Ellipta, or Qvar Redihaler to Asmanex HFA, Flovent HFA, Flovent Diskus, Pulmicort Flexhaler, or age-appropriate Asmanex Twisthaler dose
Flovent HFA (fluticasone propionate inhalation aerosol)			
Flovent Diskus (fluticasone propionate inhalation powder)			
Pulmicort FlexHaler (budesonide inhalation powder)			
Asmanex Twisthaler 110 mcg (mometasone inhalation powder)	Covered	< 12 y.o.: Covered ≥ 12 y.o.: PA	
Asmanex Twisthaler 220 mcg (mometasone inhalation powder)		< 12 y.o.: PA ≥ 12 y.o.: Covered	
Non-preferred Drugs			
Budesonide inhalation suspension (generic Pulmicort)	Covered	PA, QL	Switch patients to Asmanex HFA, Flovent HFA, Flovent Diskus, Pulmicort Flexhaler, or age-appropriate Asmanex Twisthaler dose
Alvesco (ciclesonide inhaler)	Covered	PA, QL	
Arnuity Ellipta (fluticasone furoate inhalation powder)	Not Covered	PA, QL	
Qvar Redihaler (beclomethasone inhaler)	QL	PA, QL	

d. **Respiratory Agents - Short-Acting Beta Agonists**

- Patients currently filling generic albuterol HFA will need to switch to brand Proair HFA. It is recommended that providers write the prescription for brand Proair HFA.
- Patients currently filling generic levalbuterol HFA will need to switch to brand Xopenex HFA. It is recommended that providers write the prescription for brand Xopenex HFA.
- Patients currently filling levalbuterol nebulization solution will need to switch to albuterol nebulization solution.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Albuterol inhalation solution	Covered	Covered	No action
Proair HFA (albuterol sulfate inhalation aerosol)	Not Covered	Brand Preferred	Switch patients from generic albuterol HFA formulations to brand Proair HFA
Xopenex HFA (levalbuterol inhaler)			Switch patients from generic levalbuterol HFA to brand Xopenex HFA
Proair RespiClick (albuterol sulfate inhalation powder)	PA	Covered	No action
Non-preferred Drugs			
Albuterol sulfate HFA (generic Proair HFA)	Covered	Not Covered	Switch patients to brand Proair HFA
Albuterol sulfate HFA (generic Proventil)		PA	
Albuterol sulfate HFA (generic Ventolin)			
Proventil HFA (albuterol sulfate inhaler)	Not Covered	Not Covered	
Ventolin HFA (albuterol sulfate inhaler)	Not Covered	Not Covered	
Levalbuterol HFA (generic Xopenex)	Covered	Not Covered	Switch patients from generic levalbuterol HFA to brand Xopenex HFA
Levalbuterol nebulization solution (generic Xopenex)	Covered	PA	Switch patients from levalbuterol nebulization solution to albuterol nebulization solution
Proair Digihaler (albuterol sulfate)	PA	PA	Switch patients to brand Proair HFA or Proair Respiclick

CATEGORIES WITH NO ACTIONS REQUIRED FOR CURRENT UTILIZERS

I. Central Nervous System

a. Cerebral Stimulants and ADHD Medications (Long Acting)

- No changes are being made to the long-acting cerebral stimulants/ADHD medication strategy.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Adderall XR* (amphetamine/ dextroamphetamine) capsule	PA if >/=25 y.o., PBHMI, QL, Brand Preferred, Preferred Drug	PA if >/=25 y.o., PBHMI, QL, Brand Preferred, Preferred Drug	No action
Concerta* (methylphenidate extended-release) tablet	PA if >/=25 y.o., PBHMI, QL, Brand Preferred, Preferred Drug	PA if >/=25 y.o., PBHMI, QL, Brand Preferred, Preferred Drug	
Focalin XR* (dexmethylphenidate extended-release) capsule	PA if >/=25 y.o., PBHMI, QL, Brand Preferred, Preferred Drug	PA if >/=25 y.o., PBHMI, QL, Brand Preferred, Preferred Drug	
Vyvanse* (lisdexamfetamine) chewable tablet	PA if >/=25 y.o., PBHMI, QL, Preferred Drug	PA if >/=25 y.o., PBHMI, QL, Preferred Drug	
Vyvanse* (lisdexamfetamine) capsule	PA if >/=25 y.o., PBHMI, QL, Preferred Drug	PA if >/=25 y.o., PBHMI, QL, Preferred Drug	

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

II. Immunology

a. Targeted Immunomodulators: Anti-TNF Agents

- No coverage changes

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drug			
Enbrel*	PA, SP, QL Preferred Drug	PA, SP, QL Preferred Drug	No action
Humira*			
Non-preferred Drugs			
Cimzia	PA, SP, QL	PA, SP, QL	No action
Simponi			
Simponi Aria	MB/RX, PA, SP, QL	MB/RX, PA, SP, QL	

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

b. **Targeted Immunomodulators: Interleukin Antagonists**

- No coverage changes

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drug			
Taltz*	PA, SP, QL Preferred Drug	PA, SP, QL Preferred Drug	No action
Non-preferred Drugs			
Actemra intravenous solution	MB/RX, PA, SP, QL	MB/RX, PA, SP, QL	No action
Stelara intravenous solution*			
Ilumya	MB/RX, PA	MB/RX, PA	
Actemra prefilled syringe	PA, SP, QL	PA, SP, QL	
Cosentyx			
Kevzara			
Siliq			
Skyrizi			
Stelara*			
Tremfya			
Kineret	PA, QL	PA, QL	

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

c. **Targeted Immunomodulators: Janus Kinase Inhibitors**

- No coverage changes

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drug			
Xeljanz/Xeljanz XR*	PA, SP, QL Preferred Drug	PA, SP, QL Preferred Drug	No action
Non-preferred Drugs			
Olumiant	PA, SP	PA, SP	No action
Rinvoq	PA, SP, QL	PA, SP, QL	

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

III. Oncology

a. Kinase Inhibitors

- Existing utilizers of Aliqopa will be grandfathered on the medical benefit

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Ibrance	PA, SP Preferred Drug*	PA, SP Preferred Drug*	No action
Jakafi	PA, SP	PA, SP	
everolimus 0.25, 0.5, 0.75 mg	SP	SP	
Zortress (everolimus) 1 mg			
temsirolimus	MB/RX, SP	MB	
Non-preferred Drugs			
Aliqopa	MB/RX	MB, PA^	No action
Balversa	PA	PA	
Braftovi			
Copiktra			
Gilotrif			
Kisqali			
Mektovi			
Piqray			
Cotellic	PA, SP	PA, SP	
Lenvima			
Lorbrena			
Mekinist			
Nerlynx			
Rozlytrek			
Tafinlar			
Verzenio			
Vitrakvi			
Vizimpro			
Zydelig			
Stivarga	PA, SP, QL	PA, SP, QL	
Tagrisso¥			
Kisqali-Femara Co-Pack	Not Covered	PA	
Zortress (everolimus) 0.25, 0.5, 0.75 mg	Not Covered	Not Covered	

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

^Coverage will be updated to medical benefit only

¥QL on 40 mg tablet only

CATEGORIES WITH ACTIONS REQUIRED FOR SELECT CATEGORIES

I. **Antiretrovirals**

- No coverage changes

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Biktarvy* (bictegravir/emtricitabine/ tenofovir alafenamide)	Preferred Drug	Preferred Drug	No action
Descovy* (emtricitabine/ tenofovir alafenamide)			
Dovato* (dolutegravir/lamivudine)			
Genvoya* (elvitegravir/ cobicistat/emtricitabine/ tenofovir alafenamie)			
Juluca* (dolutegravir/rilpivirine)			
Odefsey* (emtricitabine/rilpivirine/ tenofovir alafenamide)			
Norvir* (ritonavir) tablet	Preferred Drug, Brand Preferred	Preferred Drug, Brand Preferred	
Delstrigo (doravirine/lamivudine/ tenofovir disoproxil)	Covered	Preferred Drug	
Pifeltro (doravirine)			
Prezcobix (darunavir/cobicistat)			
Prezista (darunavir)			
Symtuza (darunavir/cobicistat/ Emtricitabine/tenofovir alafenamide0			
Triumeq (abacavir/dolutegravir/ lamivudine)			

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

II. Asthma and Allergy Monoclonal Antibodies

- No coverage changes

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Cinqair	MB/RX, PA, SP	MB/RX, PA, SP	No action
Fasenra prefilled syringe			
Xolair	MB/RX, PA, SP, QL	MB/RX, PA, SP, QL	
Nucala reconstituted solution	MB, PA	MB, PA	
Dupixent	PA, SP, QL	PA, SP, QL	
Fasenra auto-injector	PA, SP	PA, SP	
Nucala auto-injector, prefilled syringe			
Non-preferred Drugs			
N/A	N/A	N/A	N/A

III. Erythropoiesis Stimulating Agents (ESAs)

- Drugs in this category are intentionally covered on both the pharmacy and medical benefit. January 1, 2021 PA rules outlined below will also be applied to the medical benefit.
    - Of note, on the medical benefit only non-ESRD HCPCS codes will require PA. ESRD HCPCS codes will not require PA based on the intent of MassHealth coverage criteria for the ESA agents.
- Existing utilizers of all ESA agents will be grandfathered as all agents are preferred.

Medication Name	Current Coverage	Coverage effective 1/1/2021*	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Aranesp	SP, QL	PA, SP, QL	Submit PA for new starts
Epogen			
Procrit			
Retacrit			
Non-preferred Drugs			
N/A	N/A	N/A	N/A

*Use for patients with end stage renal disease on dialysis use does not require prior authorization (HCPCS Codes: J0882, Q4081, Q5105)

IV. Glucagon Products

- Patients currently on Gvoke will not be grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drug			
Baqsimi* (glucagon nasal powder)	Covered, Preferred Drug	Covered, Preferred Drug	Switch patients currently on Gvoke to Baqsimi
Non-preferred Drug			
Gvoke (glucagon auto-injection, prefilled syringe)	Not Covered	PA	Switch patients currently on Gvoke to Baqsimi

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

V. Hemophilia Agents

- No coverage changes

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
Benefix*	MB/RX, PA, SP Preferred Drug	MB/RX, PA, SP Preferred Drug	No action
Xyntha*			
Non-preferred Drugs			
N/A	N/A	N/A	No action

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

VI. Hepatitis Antiviral Agents

- No coverage changes

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
ledipasvir/sofosbuvir*	PA, SP Preferred Drug	PA, SP Preferred Drug	No action
sofosbuvir/velpatasvir*			
Mavyret*			
Non-preferred Drugs			
Epclusa	Not Covered, SP	Not Covered, SP	No action
Harvoni			
Vosevi	PA, SP	PA, SP	
Zepatier			

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

VII. Miscellaneous Oncology Agent

- No coverage changes

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
N/A	N/A	N/A	No action
Non-preferred Drugs			
Venclexta	PA	PA	No action

VIII. Multiple Sclerosis Agents (other oral)

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drug			
N/A*			
Non-preferred Drugs			
Aubagio	SP, QL	PA, SP, QL	No action
Mayzent			

*See Category Multiple Sclerosis Agents (oral) for preferred drugs.

IX. Opioid and Alcohol Treatment Agent

- No coverage changes

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drugs			
N/A	N/A	N/A	No action
Non-preferred Drugs			
Vivitrol (naltrexone extended-release)	Covered	Covered	No action

X. Spinal Muscular Atrophy Agents

- No coverage changes

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drug			
Zolgensma*	MB, PA	MB, PA	No action
Non-preferred Drugs			
N/A	N/A	N/A	No action

*Medication on the MassHealth ACPP/MCO Uniform Preferred Drug List

XI. Targeted Immunomodulators: Other

- No coverage changes

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Partial Unified Formulary – Preferred Drug			
Orencia reconstituted solution	MB/RX, PA, SP, QL	MB/RX, PA, SP, QL	No action
Orencia auto-injector	PA, SP, QL	PA, SP, QL	
Otelza			
Non-preferred Drugs			
N/A	N/A	N/A	No action

TUFTS HEALTH PLAN NON-PUF INITIATIVES EFFECTIVE JANUARY 1, 2021

I. Evzio (naloxone) Auto-Injector

- Patients currently on Evzio will not be grandfathered.
- As with other Not Covered drugs, Evzio will be reviewed against the Non-Covered Pharmacy Products criteria and approved if criteria are met.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Preferred Drugs			
Naloxone injection	Covered	Covered	Switch patients currently on Evzio to naloxone injection or Narcan nasal spray
Narcan (naloxone) nasal spray	QL	QL	
Non-Preferred Drugs			
Evzio (naloxone) auto-injector	PA	Not Covered	Switch patients from Evzio to naloxone injection or Narcan nasal spray

II. **Irritable Bowel Syndrome (IBS)-Constipation**

- Patients currently on Trulance will not be grandfathered, *except* for those who are adult males with a documented diagnosis of irritable bowel syndrome with constipation (IBS-C) on the previous submitted Trulance PA request.
- Tufts Health Plan has entered authorizations for Amitiza effective 1/1/2021 for any members who are currently on Trulance who are not being grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Preferred Drugs			
Amitiza (lubiprostone)	Not Covered	PA, QL	Switch patients from Trulance to Amitiza
Non-Preferred Drugs			
Linzess (linaclotide)	Not Covered	Not Covered	No action
Trulance (plecanatide)	PA	Not Covered	Switch patients from Trulance to Amitiza

III. **Ophthalmic Prostaglandins**

- Patients currently taking Zioptan will not be grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested prescriber action
Preferred Drugs			
Bimatoprost 0.03% (generic Lumigan)	PA	Covered	Switch patients from Zioptan to bimatoprost 0.03%, latanoprost 0.005%, or travoprost 0.004%
Latanaprost 0.005% (generic Xalatan)	Covered	Covered	
Travoprost 0.004% (generic Travatan Z)	Not Covered	Covered	
Non-Preferred Drugs			
Lumigan 0.01% (bimatoprost)	Not Covered	Not Covered	No action
Zioptan 0.0015% (tafluprost)	Covered	Not Covered	Switch patients from Zioptan to bimatoprost 0.03%, latanoprost 0.005%, or travoprost 0.004%
Vyzulta 0.024% (latanoprostene bunod)	Not Covered	Not Covered	No action
Xelpros 0.005% (latanoprost)	Not Covered	Not Covered	No action