MassHealth Unified Pharmacy Product List (UPPL) Coverage Changes

Information may have changed. Please refer to the 2022 Preferred Drug List (PDL) for the most updated coverage information.

Overview

I. AMYLOIDOSIS

a. Amyloidosis Therapies

- Effective January 1, 2022, Tegsedi will be added to the UPPL as a nonpreferred product. Existing utilizers will be grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2022
Preferred Drugs		
Onpattro (patisiran)	MB, PA, Preferred Drug	MB, PA, Preferred Drug
Nonpreferred Drugs		
Tegsedi (inotersen)	PA, QL	PA, QL

CARDIOVASCULAR

a. Anticoagulants

- Effective January 1, 2022, enoxaparin, Fragmin, fondaparinux, and warfarin will be added to the UPPL as covered without prior authorization.

Medication Name	Current Coverage	Coverage effective 1/1/2022
Preferred Drugs		
Eliquis (apixaban) tablet, starter pack	QL	QL
Enoxaparin (generic Lovenox) injection	Covered	Covered
Fragmin (dalteparin) injection	Covered	Covered
Fondaparinux (generic Arixtra) injection	Covered	Covered
Pradaxa (dabigatran)	QL, Brand Preferred	QL, Brand Preferred
Xarelto (rivaroxaban) 10 mg, 15 mg, 20 mg, starter pack	QL	QL
Warfarin tablet	Covered	Covered
Nonpreferred Drugs		
Savaysa (edoxaban) tablet	PA, QL	PA, QL
Xarelto (rivaroxaban) 2.5 mg tablet	PA, QL	PA, QL

ENDOCRINE

a. Biguanides

- Effective January 1, 2022, Glumetza (metformin gastric tablet) will be brand preferred. Members currently approved to take generic Glumetza should switch to the brand on or after January 1, 2022.
- Effective January 1, 2022, generic Glumetza will be removed from the Tufts Health Together voluntary 90-day supply program.

Medication Name	Current Coverage	Coverage Effective 1/1/2022
Preferred Drugs		
Metformin IR tablet (generic Glucophage)	Covered, avail 90-day supply	Covered, avail 90-day supply
Metformin IR solution (generic Riomet)	< 13 y.o.: Covered ≥ 13 y.o.: PA	< 13 y.o.: Covered ≥ 13 y.o.: PA
Metformin ER tablet (generic Glucophage XR tablet)	Covered, avail 90-day supply	Covered, avail 90-day supply
Nonpreferred Drugs		
Glumetza (metformin extended-release osmotic tablet)	Not Covered	PA, Brand Preferred
Metformin ER tablet (generic Glumetza)	PA, avail 90-day supply	Not Covered
Metformin ER tablet (generic Fortamet)	PA, avail 90-day supply	PA, avail 90-day supply
Riomet ER solution (metformin extended-release)	PA	PA

b. <u>Diabetes Combination Products</u>

- Effective January 1, 2022, the DPP-4/SGLT-2 combination products Qtern, Steglujan, and Trijardy XR will be added to the UPPL as nonpreferred agents, requiring PA and QL. Current utilizers will not be grandfathered.
- Additionally, the brand formulations of Kazano and Oseni will be preferred over their generic equivalents. Members currently approved for generic alogliptin/metformin and generic algoliptin/pioglitazone should switch to the brand formulations on or after 1/1/22. Generic Kazano and Oseni will be removed from the Tufts Health Together voluntary 90-day supply program.
- Repaglinide/metformin and brand pioglitazone/glimepiride (Duetact) will require PA and generic pioglitazone/glimepiride will be removed from the Tufts Health Together voluntary 90-day supply program. Additionally, the brand formulation of Duetact will be preferred over the generic. Current utilizers will not be grandfathered.

Medication Name	Current Coverage	Coverage Effective 1/1/2022
SGLT-2 Inhibitor/Metformin Combination Products		
Preferred Drugs		
Invokamet (canagliflozin/metformin)	QL	QL
Invokamet XR (canagliflozin/metformin ER)		
Synjardy (empagliflozin/metformin)		
Synjardy XR (empagliflozin/metformin ER)		
Xigduo XR (dapagliflozin/metformin ER)		
Nonpreferred Drugs		
Segluromet (ertugliflozin/metformin)	PA, QL	PA, QL
DPP-4/Metformin and Pioglitazone Combination Products		
Preferred Drugs		
Janumet (sitagliptin/metformin)	QL	QL
Janumet XR (sitagliptin/metformin ER)		
Jentadueto (linagliptin/metformin)		
Jentadueto XR (linagliptin/metformin ER)		
Kombiglyze XR (saxagliptin/metformin ER)		
Nonpreferred Drugs		
Kazano (alogliptin/metformin)	Not Covered, QL	PA, QL, Brand Preferred
Alogliptin/metformin (generic Kazano)	PA, QL, avail 90 day	Not Covered, QL
Oseni (alogliptin/pioglitazone)	Not Covered, QL	PA, QL, Brand Preferred
Alogliptin/pioglitazone (generic Oseni)	PA, QL, avail 90 day	Not Covered, QL
DPP-4 Inhibitor/SGLT-2 Inhibitor Combination Product		
Nonpreferred Drugs		
Qtern (dapagliflozin/saxagliptin)	Not Covered	PA, QL
Steglujan (ertugliflozin/sitagliptin)	Not Covered	
Trijardy XR (emapagliflozin/linagliptin/metformin)	Not Covered	
Glyxambi (empagliflozin/linagliptin)	PA, QL	
Other Combination Products		
Nonpreferred Drugs		
Duetact (glimepiride/pioglitazone)	Not Covered	PA, QL, Brand Preferred
Glimepiride/pioglitazone (generic Duetact)	Covered, avail 90 day	Not Covered, QL
Repaglinide/metformin	Covered, avail 90 day supply	PA, QL, avail 90 day supply

Dipeptidyl Peptidase-4 (DPP-4) Inhibitors

- Effective January 1, 2022, brand Nesina will be preferred over generic alogliptin.
- Members currently approved for generic alogliptin should switch to the brand on or after January 1, 2022.
- Also effective January 1, 2022, generic alogliptin will be removed from the Tufts Health Together voluntary 90-day supply program.

Medication Name	Current Coverage	Coverage Effective 1/1/2022
Preferred Drugs		
Januvia (sitagliptin)	Covered	Covered
Onglyza (saxagliptin)		
Tradjenta (linagliptin)		
Nonpreferred Drugs		
Nesina (alogliptin)	Not Covered, QL	PA, QL, Brand Preferred
Alogliptin (generic Nesina)	PA, QL, avail 90-day supply	Not Covered, QL

c. Glucagon-Like Peptide-1 (GLP-1) Agonists

- Effective January 1, 2022, Adlyxin (lixisenatide) will be added to the UPPL as a nonpreferred GLP-1 agonist. It will require prior authorization and have a quantity limit.
- Members currently approved for Adlyxin will not be grandfathered.

Medication Name	Current Coverage	Coverage Effective 1/1/2022
Preferred Drugs		
Bydureon (exenatide ER)	QL	QL
Byetta (exenatide)	QL, Brand Preferred	QL, Brand Preferred
Trulicity (dulaglutide)	QL, Preferred Drug	QL, Preferred Drug
Victoza (liraglutide)	QL	QL
Nonpreferred Drugs		
Adlyxin (lixisenatide)	Not Covered	PA, QL
Bydureon BCise (exenatide ER)	PA, QL	
Ozempic (semaglutide)		
Rybelsus tablet (semaglutide)		
Soliqua (insulin glargine/lixisenatide)		
Xultophy (insulin degludec/ liraglutide)		

d. Rapid-Acting Insulins and Mixes

- Effective February 1, 2022, brand formulations of Humalog, Humalog 75/25, Novolog, and Novolog 70/30 with equivalent authorized generics available will be Not Covered. Effective for fill dates on or after January 1, 2022, the authorized generics will be covered without PA.
- Impacted members will not be grandfathered. The brands do not automatically interchange to the authorized generics at the pharmacy. Therefore, it is recommended that providers specify the generic on the prescription.

Medication Name	Current Coverage	Coverage Effective 2/1/2022
Preferred Drugs		
Humalog (insulin lispro) cartridge	Covered	Covered
Humalog (insulin lispro) U-200 KwikPen		
Humalog 50/50 (insulin lispro protamine/insulin lispro) vial		

Medication Name	Current Coverage	Coverage Effective 2/1/2022
Humalog 50/50 (insulin lispro protamine/insulin lispro) KwikPen		
Humalog 75/25 (insulin lispro protamine/insulin lispro) vial		
Insulin aspart FlexPen (generic Novolog FlexPen)	Not Covered	Covered
Insulin aspart vial (generic Novolog vial)		
Insulin aspart PenFill cartridge (generic Novolog PenFill cartridge)		
Insulin lispro vial (generic Humalog vial)		
Insulin lispro U-100 KwikPen (generic Humalog -100 KwikPen)		
Insulin lispro Junior KwikPen (generic Humalog Junior KwikPen)		
Insulin aspart protamine/insulin aspart 70/30 vial (generic Novolog Mix 70/30 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)		
Nonpreferred Drugs		
Admelog (insulin lispro) SoloStar	PA	PA
Admelog (insulin lispro) vial		
Apidra (insulin glulisine) vial		
Apidra (insulin glulisine) SoloStar		
Fiasp (insulin aspart) vial		
Fiasp (insulin aspart) FlexTouch		
Fiasp (insulin aspart) PenFill cartridge		
Humalog (insulin lispro) vial	Covered	Not Covered
Humalog (insulin lispro) U-100 KwikPen		
Humalog (insulin lispro) Junior KwikPen		
Novolog (insulin aspart) FlexPen		
Novolog (insulin aspart) vial		
Novolog (insulin aspart) PenFill cartridge		
Humalog Mix 75/25 (insulin lispro protamine and insulin lispro) KwikPen		
Novolog Mix 70/30 (insulin aspart protamine and insulin aspart) vial		
Novolog Mix 70/30 (insulin aspart protamine and insulin aspart) FlexPen		

IMMUNOLOGY

b. Targeted Immunomodulators: Anti-TNF Agents

- Effective January 1, 2022, Avsola, Inflectra, Remicade, and Renflexis will be added to the UPPL as nonpreferred agents. Enbrel and Humira will remain the preferred anti-TNF agents.

- Also effective January 1, 2022, Inflectra, Remicade, Renflxis, and Simponi Aria will be locked to the medical benefit.

Medication Name	Current Coverage	Coverage Effective 1/1/2022
Preferred Drugs		
Enbrel (etanercept)	PA, SP, QL, Preferred Drug	PA, SP, QL, Preferred Drug
Humira (adalimumab)		
Nonpreferred Drugs		
Cimzia (certolizumab pegol)	PA, SP, QL	PA, SP, QL
Avsola (infliximab-axxq)	MB, PA	MB, PA
Inflectra (infliximab-dyyb)	MB/RX, PA	
Remicade (infliximab)	MB/RX, PA, SP	
Renflexis (infliximab-abda)	MB/RX, PA, SP	
Simponi Aria (golimumab)	MB/RX, PA, SP, QL	
Simponi (golimumab)	PA, SP, QL	PA, SP, QL

INFECTIOUS DISEASE

a. HIV

- Effective January 1, 2022, Norvir powder and solution and generic Truvada are being added to the UPPL. There will be no changes in coverage.

Medication Name	Current Coverage	Coverage effective 1/1/2022
Preferred Drugs		
Biktarvy (bictegravir/emtricitabine/ tenofovir alafenamide)	Preferred Drug	Preferred Drug
Delstrigo (doravirine/lamivudine/ tenofovir disoproxil)		
Descovy (emtricitabine/ tenofovir alafenamide)		
Dovato (dolutegravir/lamivudine)		
Genvoya (elvitegravir/ cobicistat/emtricitabine/ tenofovir alafenamide)		
Juluca (dolutegravir/rilpivirine)		
Odefsey (emtricitabine/rilpivirine/ tenofovir alafenamide)		
Pifeltro (doravirine)		
Prezcobix (darunavir/cobicistat)		
Rukobia (fostemsavir)		
Symtuza (darunavir/cobicistat/ emtricitabine/tenofovir alafenamide)		
Triumeq (abacavir/dolutegravir/lamivudine)		
Cabenuva (cabotegravir/rilpivirine)	MB, Preferred drug	MB, Preferred Drug
Emtricitabine/tenofovir disoproxil fumarate (generic Truvada)	Covered	Covered
Prezista (darunavir)	Preferred Drug, Brand Preferred	Preferred Drug, Brand Preferred
Norvir (ritonavir) tablet	Preferred Drug, Brand Preferred	Preferred Drug, Brand Preferred

Medication Name	Current Coverage	Coverage effective 1/1/2022
Nonpreferred Drugs		
Norvir (ritonavir) powder	Covered	Covered
Norvir (ritonavir) solution	Covered	Covered

II. NEUROLOGY/PSYCHIATRY

a. ADHD CNS Stimulants

- Effective January 1, 2022, Daytrana (methylphenidate transdermal) will be preferred on the UPPL. Approval criteria for nonpreferred long-acting methylphenidate agents (denoted with an "*" in the table below) will require a clinical rationale why the member cannot take Daytrana.
  - Effective February 1, 2022, any members currently taking a brand or generic formulation of one of the nonpreferred long-acting methylphenidate products will require prior authorization in order to continue filling their medications; members with existing authorizations will not be grandfathered and will require a new authorization to continue filling their medication on or after February 1, 2022.
- Effective January 1, 2022, a quantity limit will be added to Jornay PM. Any members exceeding the new quantity limit will require prior authorization on or after January 1, 2022.
- Effective January 1, 2022, Azstarys is moving from Not Covered to PA and a quantity limit is being implemented. Current utilizers will not be grandfathered.
- **Note:** PBHMI age and polypharmacy restrictions apply to all agents in this class. Additionally, THP requires prior authorization for all stimulants for members 25 years of age and older.

Medication Name	Current Coverage	Coverage Effective 1/1/2022
Preferred Drugs		
Daytrana (methylphenidate transdermal)	PA, QL	QL
Adderall XR (amphetamine extended-release)	Brand Preferred, Preferred Drug, QL	Brand Preferred, Preferred Drug, QL
Concerta (methylphenidate extended-release)	Brand Preferred, QL	Brand Preferred, QL
Focalin XR (dexmethylphenidate extended-release)	Brand Preferred, Preferred Drug, QL	Brand Preferred, Preferred Drug, QL
Vyvanse (lisdexamfetamine)	Preferred Drug, QL	Preferred Drug, QL
Nonpreferred Drugs		
Adhansia XR (methylphenidate extended-release capsule)*	PA, QL	PA, QL
Adzenys ER (amphetamine extended-release oral suspension)	PA, QL	PA
Adzenys XR-ODT (amphetamine extended-release orally disintegrating tablet)	PA, QL	PA, QL
Azstarys (serdexmethylphenidate/ dexmethylphenidate capsule)	Not Covered	PA, QL
Cotempla XR-ODT (methylphenidate extended-release orally disintegrating tablet)*	PA, QL	PA, QL
Dyanavel XR (amphetamine extended-release oral suspension)	PA, QL	PA
Jornay PM (methylphenidate extended-release capsule)*	PA	PA, QL

Medication Name	Current Coverage	Coverage Effective 1/1/2022
methylphenidate extended-release (XR) (generic Aptensio XR capsule)*	PA, QL	PA, QL
Methylphenidate extended-release (CD) (generic Metadate CD capsule)*	PA, QL	PA, QL
Methylphenidate extended-release 72 mg tablet*	PA, QL	PA, QL
Methylphenidate extended-release (LA) (generic Ritalin LA capsule)*	PA, QL	PA, QL
Mydayis (amphetamine extended-release capsule)	PA, QL	PA, QL
QuilliChew ER (methylphenidate extended-release chewable tablet)*	PA, QL	PA
Quillivant XR (methylphenidate extended-release oral suspension)*	PA, QL	PA

b. <u>Long-Acting Injectable Antipsychotics</u>

- Effective January 1, 2022, Perseris, Risperdal Consta, and Zyprexa Relprevv are being added to the UPPL. Zyprexa Relprevv and Risperdal Consta will be preferred on the UPPL and will not require prior authorization. Perseris will be nonpreferred will continue to require prior authorization.
- Pediatric Behavioral Health Medication Initiative (PBHMI) age and polypharmacy limits will continue to apply for all agents.

Medication Name	Current Coverage	Coverage effective 1/1/2022
Preferred Drugs		
Aristada (aripiprazole lauroxil) extended-release injectable suspension	MB/RX, QL, Preferred Drug	MB/RX, QL, Preferred Drug
Aristada Initio (aripiprazole lauroxil) extended-release injectable suspension		
Invega Sustenna (paliperidone) extended-release suspension		
Invega Trinza (paliperidone) extended-release suspension		
Risperdal Consta (risperidone) extended-release injection	MB/RX, QL	MB/RX, QL
Zyprexa Relprevv (olanzapine) extended-release injection		
Nonpreferred Drugs		
Abilify Maintena (aripiprazole) extended-release suspension	MB/RX, PA, QL	MB/RX, PA QL
Perseris (risperidone) extended-release injection		

MB/RX = Medication can be accessed though both the pharmacy and medical benefits

<u>Multiple Sclerosis Agents</u>

- Effective January 1, 2022, Aubagio, Mavenclad, and Ponvory will be added to the UPPL. Aubagio will be preferred while Mavenclad and Povory will be nonpreferred.
- As a result of this update, Ponvory will be moved from Not Covered to PA. Quantity limitations and specialty pharmacy lock will still apply.

Medication Name	Current Coverage	Coverage effective 1/1/2022
Preferred Drugs		
Aubagio (teriflunomide) tablet	PA, QL, SP	PA, QL, SP
Copaxone (glatiramer acetate) injection	SP, QL, Brand Preferred	SP, QL, Brand Preferred
Gilenya (fingolimod) capsule	PA, SP, QL, Brand Preferred	PA, SP, QL, Brand Preferred
Tecfidera (dimethyl fumarate) capsule		
Nonpreferred Drugs		
Mavenclad (cladribine) tablet	PA, SP, QL	PA, SP, QL
Ponvory (ponesimod) tablet	NC	
Bafiertam (monomethyl fumarate) tablet	PA, SP, QL	
Glatopa (glatiramer acetate) injection		
Mayzent (siponimod) tablet		
Vumerity (diroximel fumarate) capsule		
Zeposia (ozanimod) capsule		

III. ONCOLOGY

a. Kinase Inhibitors

- Effective January 1, 2022, Cosela, Koselugo, Retevmo, Tepmetko, and Zelboraf will be added to the UPPL as nonpreferred. As part of this update, Tepmetko will be moved from Not Covered to PA.
- Existing utilizers will be grandfathered**.**

Medication Name	Current Coverage	Coverage effective 1/1/2022
Preferred Drugs		
Ibrance	PA, SP, Preferred Drug	PA, SP, Preferred Drug
Jakafi	PA, SP	PA, SP
Nonpreferred Drugs		
Tepmetko	Not Covered	PA
Aliqopa	MB, PA	MB, PA
Cosela		
Balversa	PA	PA
Braftovi		
Copiktra		
Kisqali		
Kisqali Femara Co-Pack		
Koselugo		
Mektovi		
Retevmo		
Tagrisso		
Cotellic	PA, SP	PA, SP
Inrebic		
Lorbrena		
Mekinist		
Nerlynx		
Piqray		
Rozlytrek		
Stivarga		

Medication Name	Current Coverage	Coverage effective 1/1/2022
Tabrecta		
Tafinlar		
Verzenio		
Vitrakvi		
Vizimpro		
Zelboraf		
Zydelig		

b. <u>Kinase Inhibitors: MTOR</u>

- Effective January 1, 2022, everolimus and temsirolimus will be added to the UPPL. There will be no changes in coverage.

Medication Name	Current Coverage	Coverage effective 1/1/2022
Preferred Drugs		
Afinitor (everolimus) 2.5, 5, 7.5, 10 mg	PA, SP, QL Brand Preferred	PA, SP, QL Brand Preferred
Afinitor Disperz		
Everolimus 0.25, 0.5, 0.75, 1 mg	SP	SP
Temsirolimus	MB	MB

c. <u>Kinase Inhibitors: Tyrosine</u>

- Effective January 1, 2022, the following agents will be added to the UPPL as nonpreferred: Ayvakit, Fotivda, Gavreto, Qinlock, and Tukysa.
- Existing utilizers will be grandfathered.

Medication Name	Current Coverage	Coverage effective 1/1/2022
Preferred Drugs		
Bosulif	PA, SP, Preferred Drug	PA, SP, Preferred Drug
Inlyta		
Sutent	PA, SP, Preferred Drug, Brand Preferred	PA, SP, Preferred Drug, Brand Preferred
Tykerb	SP, Brand Preferred	SP, Brand Preferred
Imatinib	SP	SP
Tasigna		
Sprycel	SP, QL	SP, QL
Nonpreferred Drugs		
Fotivda	Not Covered	PA
Ayvakit	PA	PA
Alunbrig		
Brukinsa		
Calquence		
Caprelsa		
Gilotrif		
Iclusig		
Imbruvica		
Iressa		
Qinlock		

Medication Name	Current Coverage	Coverage effective 1/1/2022
Tukysa		
Turalio		
Xospata		
Alecensa	PA, SP	PA, SP
Cabometyx		
Cometriq		
Erlotinib		
Gavreto		
Lenvima		
Nexavar		
Rydapt		
Votrient		
Xalkori		
Zykadia		

IV. RESPIRATORY

a. Combination Inhaled Corticosteroids/Long-Acting Beta-Agonists

- Effective January 1, 2022, AirDuo Digihaler will be moved from Not Covered to PA and a quantity limit will be implemented. Current utilizers will not be grandfathered.

Medication Name	Current Coverage	Coverage Effective 1/1/2022
Preferred Drugs		
Advair Diskus (fluticasone/salmeterol inhalation powder)	Brand Preferred	Brand Preferred
Advair HFA (fluticasone/salmeterol inhalation aerosol)	Covered	Covered
Dulera (mometasone/formoterol)	Brand Preferred	Brand Preferred
Symbicort (budesonide/formoterol)	Brand Preferred	Brand Preferred
Nonpreferred Drugs		
AirDuo Digihaler (fluticasone/salmeterol inhalation powder)	Not Covered	PA, QL
Fluticasone/salmeterol inhalation powder (generic Advair Diskus)	Not Covered	Not Covered
Wixela (generic Advair Diskus)		
Fluticasone/salmeterol inhalation powder (generic AirDuo Respiclick)	PA, QL	PA, QL
AirDuo Respiclick (fluticasone/salmeterol inhalation powder)	Not Covered, QL	Not Covered, QL
Breo Ellipta (fluticasone/vilanterol)	PA, QL	PA, QL
Budesonide/formoterol (generic Symbicort)	Not Covered	Not Covered

Inhaled Corticosteroids

- Effective January 1, 2022, Armonair Digihaler will be moved from Not Covered to PA. Current utilizers will not be grandfathered.

Medication Name	Current Coverage	Coverage Effective 1/1/2022
Preferred Drugs		
Asmanex HFA (mometasone inhalation aerosol)	Covered	Covered
Flovent Diskus (fluticasone propionate inhalation powder)		
Pulmicort FlexHaler (budesonide inhalation powder)		
Flovent HFA (fluticasone propionate inhalation aerosol)	Brand Preferred	Brand Preferred
Asmanex Twisthaler 110 mcg (mometasone inhalation powder)	< 12 y.o.: Covered ≥ 12 y.o.: PA	< 12 y.o.: Covered ≥ 12 y.o.: PA
Asmanex Twisthaler 220 mcg (mometasone inhalation powder)	< 12 y.o.: PA ≥ 12 y.o.: Covered	< 12 y.o.: PA ≥ 12 y.o.: Covered
Budesonide inhalation suspension (generic Pulmicort)	< 13 y.o.: Covered ≥ 13 y.o.: PA	< 13 y.o.: Covered ≥ 13 y.o.: PA
Nonpreferred Drugs		
Armonair Digihaler (fluticasone propionate inhalation powder)	Not Covered	PA
Alvesco (ciclesonide inhaler)	PA	
Arnuity Ellipta (fluticasone furoate inhalation powder)	PA	
Qvar Redihaler (beclomethasone inhaler)	PA	

b. Short-Acting Beta-Agonists

- Effective January 1, 2022, Proair Respiclick will require PA. Members currently on Proair Respiclick will not be grandfathered and will require prior authorization in order to continue filling this product. Brand Proair HFA and brand Xopenex HFA will continue to be the preferred short-acting beta-agonists.
- Generic Proventil, levalbuterol nebulizer solution and levalbuterol concentrate nebulizer are also being added to the UPPL as nonpreferred drugs. These agents currently require PA for Tufts Health Together and will continue to require PA in 2022.

Medication Name	Current Coverage	Coverage Effective 1/1/2022
Preferred Drugs		
Albuterol inhalation solution	Covered	Covered
Proair HFA (albuterol sulfate inhalation aerosol)	Brand Preferred	Brand Preferred
Xopenex HFA (levalbuterol inhaler)		
Nonpreferred Drugs		
Proair Respiclick (albuterol sulfate inhalation powder)	Covered	PA
Albuterol sulfate HFA (generic Proair)	Not Covered	Not Covered
Albuterol sulfate HFA (generic Proventil)	PA	PA
Albuterol sulfate HFA (generic Ventolin)		

Medication Name	Current Coverage	Coverage Effective 1/1/2022
Levalbuterol nebulization solution (generic Xopenex)		
Proair Digihaler (albuterol sulfate)		

V. SUBSTANCE USE DISORDER

a. Opioid Dependence and Reversal Agents

- Brand Suboxone film continues to be the preferred OUD agent.
- Bunavail, buprenorphine/naloxone SL tablet, buprenorphine SL tablet, and Zubsolv are being added to the UPPL effective January 1, 2022 as nonpreferred agents. There are no changes in the overall strategy. Quantity limits will be updated to match that of MassHealth. Anyone exceeding the new quantity limits will require prior authorization.

Medication Name	Current Coverage	Coverage Effective 1/1/2022
Preferred Drugs		
Suboxone (buprenorphine/naloxone) film	Brand Preferred, Preferred Drug, QL	Brand Preferred, Preferred Drug, QL
Sublocade (buprenorphine extended-release) injection	Preferred Drug	Preferred Drug
Nonpreferred Drugs		
Bunavail (buprenorphine/naloxone) film	PA, QL	PA, QL (≤ 12.6/2.1 mg/day)
Buprenorphine/naloxone SL tablet	PA, QL	PA, QL (≤ 24 mg/day)
Buprenorphine SL tablet	PA	PA, QL (≤ 24 mg/day)
Zubsolv (buprenorphine/naloxone) SL tablet	PA, QL	PA, QL (≤ 17.2/4.3 mg/day)