Mass Health Partial Unified Formulary: Effective 1/1/21: Miscellaneous Agents

Opioid Dependence and Reversal Agents

- Suboxone Film is **PREFERRED, new prescriptions will need to be written for members on non-preferred products.**
- Sublocade Injection is being moved from PA to Covered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested ACO action
Partial Unified Formulary – Preferred Drugs			
Suboxone* Film (buprenorphine/naloxone)	QL, Brand Preferred, Preferred Drug	QL, Brand Preferred, Preferred Drug	Switch members on non-preferred buprenorphine products to brand Suboxone film
Non-preferred Drugs			
Bunavail Film (buprenorphine/naloxone)	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 SL Tablet (buprenorphine/naloxone)	PA, QL	PA, QL	
Buprenorphine sublingual tablet	PA	PA	Switch members to brand name Suboxone film
Sublocade (buprenorphine extended-release) injection	MB/RX, PA	MB/RX	No action

Evzio (naloxone) Auto-Injector

- Naloxone injection or Narcan nasal spray are **PREFERRED. New prescriptions will need to be written for members on non-preferred products.**
- Patients currently on Evzio will ***not be grandfathered***.

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

CATEGORIES WITH NO ACTIONS REQUIRED FOR CURRENT UTILIZERS

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 ACO action
Partial Unified Formulary – Preferred Drugs			
Adderall XR* Capsule (amphetamine/ dextroamphetamine)	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* Tablet (methylphenidate extended-release)	PA if >/=25 y.o., PBHMI, QL, Brand Preferred, Preferred Drug	PA if >/=25 y.o., PBHMI, QL, Brand Preferred, Preferred Drug	
Focalin XR* Capsule (dexmethylphenidate extended-release)	PA if >/=25 y.o., PBHMI, QL, Brand Preferred, Preferred Drug	PA if >/=25 y.o., PBHMI, QL, Brand Preferred, Preferred Drug	
Vyvanse* Tablet (lisdexamfetamine) chewable	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	

Antiretrovirals

- ***No coverage changes***, all will continue to be covered.

Medication Name	Current Coverage	Coverage effective 1/1/2021	Suggested ACO 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

Blood Glucose Test Strips

- ***No coverage changes*** are being made to blood glucose test strips. ***FreeStyle /Precision continue to be the brand of choice.***

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)	Switch members to preferred FreeStyle or Precision meter and test strips
FreeStyle InsuLinx test strips	QL (300 strips/30 days)	QL (300 strips/30 days)	
FreeStyle Lite test strips	QL (300 strips/30 days)	QL (300 strips/30 days)	
Precision Xtra test strips	QL (300 strips/30 days)	QL (300 strips/30 days)	
Non-preferred Drugs			
FreeStyle Neo test strips	QL (300 strips/30 days)	Not Covered, QL (300 test strips/30 days)	Switch members to preferred FreeStyle or Precision meter and test strips
All other test strips	Not Covered	Not Covered	

Irritable Bowel Syndrome (IBS)-Constipation

- Patients currently on Trulance will ***not be grandfathered***, *except* for those who are male 18 years of age and older who were documented as having a diagnosis of irritable bowel syndrome with constipation (IBS-C) on the Trulance PA request.
- ***Tufts Health Plan has entered authorizations for Amitiza effective 1/1/2021 for any members who are currently on Trulance.***

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

Ophthalmic Prostaglandins

- Bimatoprost 0.03% (generic Lumigan), latanoprost 0.005% (generic Xalatan), or travoprost 0.004%(generic Travatan Z) are **PREFERRED**
- Patients currently taking Zioptan will ***not be grandfathered***.

<table>
<tr><th>Medication Name</th><th>Current Coverage</th><th>Coverage effective 1/1/2021</th><th>Suggested ACO action</th></tr>
<tr><td colspan="4">Preferred Drugs</td></tr>
<tr><td>Bimatoprost 0.03%
(generic Lumigan)</td><td>Prior Authorization</td><td>Covered</td><td rowspan="3">Switch patients from Zioptan to bimatoprost 0.03%, latanoprost 0.005%, or travoprost 0.004%</td></tr>
<tr><td>Latanaprost 0.005%
(generic Xalatan)</td><td>Covered</td><td>Covered</td></tr>
<tr><td>Travoprost 0.004%
(generic Travatan Z)</td><td>Not Covered</td><td>Covered</td></tr>
<tr><td colspan="4">Non-Preferred Drugs</td></tr>
<tr><td>Lumigan 0.01% (bimatoprost)</td><td>Not Covered</td><td>Not Covered</td><td>No action</td></tr>
<tr><td>Zioptan 0.0015% (tafluprost)</td><td>Covered</td><td>Not Covered</td><td>Switch patients to bimatoprost 0.03%, latanoprost 0.005%, or travoprost 0.004%</td></tr>
<tr><td>Vyzulta 0.024%
(latanoprostene bunod)</td><td>Not Covered</td><td>Not Covered</td><td>No action</td></tr>
<tr><td>Xelpros 0.005% (latanoprost)</td><td>Not Covered</td><td>Not Covered</td><td>No action</td></tr>
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Updated 11-2020