Formulary Impact Tool – WellSense/ACO

- This chart is a tool that highlights MassHealth (MH) pharmacy coverage summaries and prior authorization requirements for drug categories expected to be most impacted on 7/5/2023, at the end of the 90-day transition period for new WellSense ACO members. The categories listed here align with those included in the formulary impact lists.
- For a comprehensive and current guide of all MassHealth pharmacy policies and prior authorization requirements, please visit the online MassHealth Drug List
  - MassHealth Over-the-Counter (OTC) Drug List – lists OTC products covered by MH without PA. All other OTC products require PA, or may be available in Rx formulation.
  - MassHealth Non-Drug Product List – lists non-drug products covered under pharmacy benefit (e.g., diabetes test strips, vaporizer)
- Be sure to send any new prescriptions to patient's preferred WellSense/ACO in-network retail pharmacy. Listing can be found online using the Find a Pharmacy lookup tool.

Category	Drug	MassHealth Coverage Policy	Coverage Summary	MassHealth PA Form

Allergies	**Cetirizine chewable tablets**	Coverage Policy	• Preferred products include:
			  ○ cetirizine **syrup** or **tablet**
			  ○ levocetirizine tablet
			  ○ loratadine tablet or solution
			• Fexofenadine not covered, benefit exclusion; *If **age < 21 years**, eligible for review of medical necessity (submit PA)*	

	Fexofenadine	Benefit Exclusion		
Androgens	**Testosterone products**	Coverage Policy	• PA required for testosterone products and brand name preferred for Androgel® 1.62% gel pump, Fortesta® 2% gel pump, Testim® 1% gel tube	PA Form
Anticonvulsants	**Gabapentin**	Coverage Policy	• PA required if age < 6 years or prescribed >3600mg/day	PA Form
	Epidiolex	Coverage Policy	• PA required	PA Form
	Nayzilam® Nasal Spray	Coverage Policy	• PA required if prescribed >10 units/month	PA Form
	Valtoco® Nasal Spray	Coverage Policy	• PA required if prescribed >10 units/month	PA Form
Antiemetic	**Ondansetron solution**	Coverage Policy	• Ondansetron **tablet** or **ODT** preferred • PA required for ondansetron **solution**, ondansetron 24mg tablet strength, brand name Zofran®	PA Form
Asthma/COPD	**albuterol HFA**	Coverage Policy	• Brand name Proventil® or Ventolin® preferred	*Pharmacy-level change*
	Flovent® HFA (fluticasone propionate)	Coverage Policy	• Brand name Flovent® preferred	
	Symbicort® HFA (budesonide-formoterol)	Coverage Policy	• Brand name Symbicort® preferred	
	budesonide inhalation suspension	Coverage Policy	• PA required for ≥ 13 years	PA Form

	Trelegy® Ellipta (fluticasone furoate-umeclidinium-vilanterol)	Coverage Policy	• PA and Step Therapy Requirements
			• Documentation of inadequate response[1] or adverse reaction to the **separate agents Breo® Ellipta** (fluticasone/vilanterol) and **Incruse® Ellipta** (umeclidinium) once daily
			  ○ Incruse® Ellipta covered without PA
			  ○ PA required for Breo® Ellipta and brand name preferred
			
			[1]Defined as at least 90 days of therapy
				PA Form

Behavioral Health – ADHD	**Adderall XR®** (dextroamphetamine-amphetamine ER) *Brand name Adderall XR preferred®*	Coverage Policy	• PA required if any of the following:
			  ○ Age < 3 years
			  ○ Age ≥ 21 years
			  ○ Prescribed >2 units/day
				PA Form

	Vyvanse®	Coverage Policy		
	Concerta® (methylphenidate ER) *Brand name Concerta® preferred*	Coverage Policy		

	Focalin XR® (dexmethylphenidate ER) *Brand name Focalin XR® preferred*	Coverage Policy		
	Adderall® (dextroamphetamine-amphetamine)	Coverage Policy	• PA required if any of the following: ○ Age < 3 years ○ Age ≥ 21 years ○ Prescribed >3 units/day	PA Form
	Methylphenidate	Coverage Policy		
	Clonidine ER	Coverage Policy	• PA required for clonidine ER 0.1mg tabs	PA Form
Behavioral Health – Antidepressants	**Desvenlafaxine succinate ER (Pristiq®)**	Coverage Policy	• Brand name Pristiq® preferred • PA required if any of the following: ○ Age < 6 years ○ Prescribed >1 unit/day	PA Form
	Venlafaxine ER tablets	Coverage Policy	• Venlafaxine ER **capsule** preferred and PA required if age < 6 years	PA Form
Behavioral Health – Antipsychotics	**Latuda®**	Coverage Policy	• PA required	PA Form
	Rexulti®	Coverage Policy	• PA required	PA Form
	Vraylar®	Coverage Policy	• PA required	PA Form
Diabetes – Supplies	**Dexcom**	Coverage Policy	• PA required (for all CGM devices) • Covered products: Dexcom G6, Dexcom G7, Freestyle Libre 2, Freestyle Libre 3, Freestyle Libre 14 Day	PA Form
	Freestyle Libre	Coverage Policy		
	Freestyle Test Strips	Coverage Policy	• Quantity Limit (≤ 100 strips / 30 days)	PA Form
Diabetes – Insulin	**Humalog® 100 units/mL prefilled syringe, vial**	Coverage Policy	• Insulin lispro (generic) preferred • Humalog® (brand) requires PA	PA Form
Diabetes – GLP1a	**Ozempic®**	Coverage Policy	• Trulicity® preferred • PA required for Ozempic®	PA Form
Gastrointestinal	**Famotidine suspension**	Coverage Policy	• Famotidine **tablet** preferred • PA required for famotidine suspension	PA Form
	First-Omeprazole® suspension	Coverage Policy	• Brand name Nexium® 10mg, 20mg, 40mg suspension preferred • First-Omeprazole® suspension compounding kit requires PA	PA Form
	Omeprazole 20mg tablets	Coverage Policy	• Omeprazole 20mg **capsule** preferred and PA required if > 4 units/day	PA Form
Headache/Pain	**Butalbital products**	Coverage Policy	• Preferred products include: ○ butalbital 50mg/acetaminophen 325mg/caffeine 40mg **tablet** ○ butalbital/aspirin/caffeine **tablet** ○ butalbital 50mg/acetaminophen 325mg/caffeine 40mg/codeine 30mg • **Quantity limit** 20 units/month • PA required if **age <18 years** and/or **quantity limit exceeded**	PA Form
	Nurtec®	Coverage Policy	• PA required	PA Form
	Ajovy®	Coverage Policy	• PA required	PA Form
	Lidoderm® patch	Coverage Policy	• Generic lidocaine patch preferred and PA required if prescribed >3 patches/day • Brand name Lidoderm® patch requires PA	PA Form
Infectious Disease (ID)	**Vemlidy®**	Coverage Policy	• Vemlidy® preferred	
Injectables, misc.	**Dupixent®**	Coverage Policy	• PA required	PA Form
	Genotropin®	Coverage Policy	• PA required	PA Form
	Humira®	Coverage Policy	• PA required, brand name Humira® preferred	PA Form
	Taltz®	Coverage Policy	• PA required	PA Form
	Skyrizi®	Coverage Policy	• PA required	PA Form

Topicals	**Azelaic acid gel (Finacea®)**	Coverage Policy	• PA required, brand name Finacea® preferred	PA Form
	Clindamycin-Benzoyl Peroxide	Coverage Policy	• PA required	PA Form
	Drysol®	Coverage Policy	• PA required	PA Form
	Tretinoin (Retin-A®)	Coverage Policy	• Brand name Retin-A® preferred and PA required if age ≥22 years old	PA Form
Vitamins/Supplements	**Fish oil (OTC)**	Coverage Policy	• Rx for omega-3 acid ethyl esters (Lovaza®) covered	
	Melatonin	Coverage Policy	• Melatonin **gummy, solution,** or **tablet** preferred	
Product not covered, misc.	**Dextromethorphan syrup**	Benefit Exclusion	• Not covered, benefit exclusion • *If **age < 21 years**, eligible for review of medical necessity (submit PA)*	
	Guaifenesin			
	Guaifenesin DM syrup			
	Phenazopyridine 200 mg tablets			
	Phentermine			
	Saline Nasal Spray			
	Sildenafil 100mg tablets			