

# Pharmacy Communications

Massachusetts



Date: April 24, 2026

To: All WellSense MassHealth Providers

From: WellSense Health Plan

Subject: **Pharmacy benefit updates**

Product:  MassHealth  MA Clarity plans

## Pharmacy benefit updates

MassHealth evaluates drug coverage on an ongoing basis and updates [its drug list](#) accordingly. The attached drug list summary update identifies changes to the MassHealth drug list effective July 1, 2026. MassHealth will add any additional information about this change to the list on the effective date.

### Questions?

Please reach out Provider Service at 888-566-0008 or [provider.info@wellsense.org](mailto:provider.info@wellsense.org) with any questions. For secure communication, please register or login to the [provider portal](#).



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
P.O. Box 2586, Worcester, MA 01613-2586  
Fax: (877) 208-7428 Phone: (800) 745-7318

## July 2026 MassHealth Drug List Summary Update

MassHealth evaluates the prior authorization (PA) status for drugs on an ongoing basis and updates the MassHealth Drug List accordingly. This Summary Update document identifies changes to the MassHealth Drug List for the rollout effective July 1, 2026

Additional information about these agents may be available within the MassHealth Drug List at [www.mass.gov/druglist](http://www.mass.gov/druglist).

---

### Additions

- a. Effective July 1, 2026, the following newly marketed drugs have been added to the MassHealth Drug List.
  - buspirone capsule – **PA**; A90
  - Enbumyst (bumetanide nasal spray) – **PA**
  - escitalopram capsule – **PA**
  - Exdensur (depemokimab-ulaa) – **PA**; MB
  - Exxua (gepirone) – **PA**
  - Forzinity (elamipretide) – **PA**
  - Hyrnuo (sevabertinib) – **PA**
  - Inluriyo (imlunestrant) – **PA**
  - Javadin (clonidine oral solution) – **PA**
  - Komzifti (ziftomenib) – **PA**
  - Lasix Onyu (furosemide on-body infusor) – **PA**
  - Lopressor (metoprolol immediate-release 12.5 mg tablet) – **PA**
  - Lopressor (metoprolol immediate-release oral solution) – **PA**
  - Pokonza (potassium chloride oral solution) – **PA**
  - potassium chloride 40 mEq powder packet – **PA**; A90
  - Rybrevant Faspro (amivantamab/hyaluronidase-lpuj) – **PA**; MB
  - Unloxcyt (cosibelimab-ipdl) – **PA**; MB
  - Veltassa (patiomer 1 g packet) – **PA ≥ 18 years and PA > 4 unit/day**
  - Voyxact (sibeprenlimab-szsi) – **PA**

---

### Change in Prior Authorization Status

- a. Effective July 1, 2026, the following antitubercular agent will require PA.
  - cycloserine – **PA**; A90
- b. Effective July 1, 2026, the following hematinic agent will require PA.
  - Velforo (sucroferric oxyhydroxide) – **PA**
- c. Effective July 1, 2026, the following hormone agent will require PA.
  - desmopressin acetate 1.5 mg/mL nasal spray – **PA**
- d. Effective July 1, 2026, the following hereditary cardiovascular agent will no longer require PA within newly established quantity limits.
  - Entresto (sacubitril/valsartan tablet) – **PA > 2 units/day**
- e. Effective July 1, 2026, the following cardiovascular agent will no longer require PA.
  - clonidine patch; A90

- f. Effective July 1, 2026, the following cardiovascular agent will no longer require PA within updated age limits.
  - Inzirgo (hydrochlorothiazide suspension) – **PA ≥ 13 years**
- g. Effective July 1, 2026, the following cardiovascular agents will require PA.
  - Exforge HCT (amlodipine/valsartan/hydrochlorothiazide) – **PA**; M90
  - Inspra (eplerenone) – **PA**; M90
  - quinidine sulfate – **PA**; M90
- h. Effective July 1, 2026, the following insulin agent will no longer require PA.
  - Humulin N (insulin NPH)
- i. Effective July 1, 2026, the following insulin agent will require PA.
  - Novolin N (insulin NPH) – **PA**

---

## **New or Revised Therapeutic Tables**

Table 5 – Immunological Agents

Table 6 – Nutrients, Vitamins, and Vitamin Analogs

Table 8 – Opioids and Analgesics

Table 10 – Dermatologic Agents - Acne and Rosacea

Table 14 – Headache Therapy

Table 17 – Antidepressants

Table 18 – Cardiovascular Agents

Table 23 – Respiratory Agents - Inhaled

Table 26 – Antidiabetic Agents

Table 35 – Antibiotics and Anti-Infectives - Oral and Inhaled

Table 42 – Immune Suppressants - Topical

Table 45 – Beta Thalassemia, Myelodysplastic Syndrome, and Sickle Cell Disease Agents

Table 51 – Antiglaucoma Agents - Ophthalmic

Table 53 – Otic Agents

Table 55 – Androgens

Table 56 – Alzheimer’s Agents

Table 57 – Oncology Agents

Table 64 – Asthma/Allergy Monoclonal Antibodies

Table 65 – Enzyme Replacement and Substrate Reduction Therapies

Table 69 – Barbiturates, Benzodiazepines, and Miscellaneous Antianxiety Agents

Table 70 – Progesterone Agents

Table 71 – Pediatric Behavioral Health

Table 72 – Agents Not Otherwise Classified

Table 73 – Iron Agents and Chelators

Table 75 – T-Cell Immunotherapies

Table 76 – Neuromuscular Agents - Duchenne Muscular Dystrophy and Spinal Muscular Atrophy

Table 79 – Pharmaceutical Compounds

Table 80 – Anti-Hemophilia Agents

Table 81 – Anti-Obesity Agents

Table 83 – Renal Disorder Agents

Table 84 – Complement Inhibitors and Miscellaneous Immunosuppressive Agents

---

## **Updated and New Prior Authorization Request Forms**

- Androgen Therapy Prior Authorization Request
- Antidepressant Prior Authorization Request
- Antidiabetic Agents Prior Authorization Request
- Asthma/Allergy Monoclonal Antibodies Prior Authorization Request

- Benzodiazepines and Other Anti-Anxiety Agents Prior Authorization Request
- Breast Cancer Agents Prior Authorization Request
- Glaucoma Agents Prior Authorization Request
- Headache Therapy (Calcitonin Gene-Related Peptide (CGRP) Inhibitors) Prior Authorization Request
- Heart Failure Agents Prior Authorization Request
- Inhaled Respiratory Agents Prior Authorization Request
- Lung Cancer Agents Prior Authorization Request
- Neuromuscular Agents Prior Authorization Request
- One-Time Cell and Gene Therapies
- Progesterone Agents Prior Authorization Request
- **Renal Disorder Agents Prior Authorization Request**
- T-Cell Immunotherapies Prior Authorization Request
- Targeted Immunomodulators Prior Authorization Request
- **Topical Immune Suppressants Prior Authorization Request**

---

### Updated MassHealth Brand Name Preferred Over Generic Drug List

The MassHealth Brand Name Preferred Over Generic Drug List has been updated to reflect recent changes to the MassHealth Drug List.

- Effective July 1, 2026, the following agents will be added to the MassHealth Brand Name Preferred Over Generic Drug List.
  - Belbuca (buprenorphine buccal film) – **PA**; BP
  - Endometrin (progesterone vaginal insert) – **PA**; BP
  - Humulin N (insulin NPH); BP
  - Incruse (umeclidinium); BP, A90
  - Lumigan (bimatoprost 0.01% ophthalmic solution); BP, M90
  - Qvar Redihaler (beclomethasone inhaler) – **PA**; BP
- Effective July 1, 2026, the following agents will be removed from the MassHealth Brand Name Preferred Over Generic Drug List.
  - Fabior (tazarotene foam) – **PA**

---

### Updated MassHealth 90-day Initiative

The MassHealth 90-day Initiative has been updated to reflect recent changes to the MassHealth Drug List.

- Effective July 1, 2026, the following agents may be allowed or mandated to be dispensed in up to a 90-day supply, as indicated below.
  - Incruse (umeclidinium); BP, A90
  - Lumigan (bimatoprost 0.01% ophthalmic solution); BP, M90
- Effective July 1, 2026, the following agents will no longer be allowed or mandated to be dispensed in up to a 90-day supply, as indicated below.
  - Revlimid (lenalidomide) – **PA**; BP
  - Samsca (tolvaptan) – **PA**

---

### Updated Health Safety Net (HSN) Formulary Page

The Health Safety Net (HSN) Formulary page has been updated to reflect recent changes.

- Health Safety Net Prior Authorization Request
- Patient Assistance Program Resource
- Health Safety Net Reimbursable Pharmacy Services - Highly Utilized Therapeutic Classes

---

### Updated MassHealth Over-the-Counter Drug List

The MassHealth Over-the-Counter Drug List has been updated to reflect recent changes to the MassHealth Drug List.

Effective July 1, 2026, the following agents were removed from the MassHealth Over-the-Counter Drug List.

- cherry syrup; \*
- gelatin capsule, empty; \*
- hydrophilic ointment; \*, A90
- Ora-Plus suspending vehicle; \*
- Ora-Sweet oral syrup; \*
- Ora-Sweet-SF oral syrup; \*
- simple syrup; \*

---

### Updated MassHealth Supplemental Rebate/Preferred Drug List

The MassHealth Supplemental Rebate/Preferred Drug List has been updated to reflect recent changes to the MassHealth Drug List.

- Effective July 1, 2026, the following biological agents will be added to the MassHealth Supplemental Rebate/Preferred Drug List.
  - Fasenra (benralizumab) <sup>PD</sup> – **PA**
  - Nemludio (nemolizumab-ilto) <sup>PD</sup> – **PA**
- Effective July 1, 2026, the following topical immunosuppressant agent will be added to the MassHealth Supplemental Rebate/Preferred Drug List.
  - Vtama (tapinarof) <sup>PD</sup> – **PA**

---

### Updated MassHealth Quick Reference Guide

The MassHealth Quick Reference Guide has been updated to reflect recent changes to the MassHealth Drug List.

---

### Updated and New Pharmacy Initiatives

- Pediatric Behavioral Health Medication Initiative

---

### Updated MassHealth Acute Hospital Carve-Out Drugs List

The MassHealth Acute Hospital Carve-Out Drugs list has been updated to reflect recent changes to the MassHealth Drug List.

---

### Drugs Designated for Exclusion from 340B Coverage

This List identifies the current list of “Drugs Designated for Exclusion from 340B Coverage” from being purchased through the 340B Program for applicable MassHealth members. The List of “Drugs Designated for Exclusion from 340B Coverage” may be updated from time-to-time.

---

### Deletions

- The following drugs have been removed from the MassHealth Drug List because they have been discontinued by the manufacturer.
  - Androgel (testosterone 1.62% gel packet) – **PA**
  - Androgel (testosterone 1% gel packet) – **PA**
  - Beqvez (fidanacogene elaparvovec-dzkt) – **PA**; CO
  - Cymbalta (duloxetine 20 mg, 30 mg, 60 mg capsule) – **PA < 6 years**; #, A90
  - Exservan (riluzole film) – **PA**
  - Namenda (memantine titration pack) – **PA < 6 years and PA > 49 units/28 days**; A90
  - Namenda XR (memantine extended-release) – **PA < 6 years and PA > 1 unit/day**; #, A90
  - Prozac (fluoxetine 10 mg, 20 mg, 40 mg capsule, solution) – **PA < 6 years**; #, A90
  - Qtern (dapagliflozin/saxagliptin) – **PA**
  - Rilutek (riluzole tablet); #, A90
  - Roctavian (valoctocogene roxaparvovec-rvox) – **PA**; CO
  - Trecator (ethionamide)

- b. The following drugs have been removed from the MassHealth Drug List. MassHealth does not pay for drugs that are manufactured by companies that have not signed rebate agreements with the U.S. Secretary of Health and Human Services.
- Qlosi (pilocarpine 0.4% ophthalmic solution) – **PA**
  - Vizz (aceclidine ophthalmic solution) – **PA**

---

## Corrections/Clarifications

The following listings have been clarified. These changes do not reflect any change in MassHealth policy.

- buspirone tablet – **PA < 6 years**; A90
- DDAVP (desmopressin injection, 10 mcg/0.1 mL nasal spray, tablet); #, A90
- Klor-Con (potassium chloride 20 mEq powder packet, extended-release tablet); #, A90
- Lopressor (metoprolol immediate-release 25 mg, 37.5 mg, 50 mg, 75 mg, 100 mg tablet); #, M90
- Veltassa (patiromer 8.4 g, 16.8 g) – **PA > 1 packet/day**

---

## Abbreviations, Acronyms, and Symbols

**#** This designates a brand-name drug with FDA “A”-rated generic equivalents. PA is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA “A”-rated generic equivalent.

<sup>MB</sup> This drug is available through the health care professional who administers the drug or in an outpatient or inpatient hospital setting. MassHealth does not pay for this drug to be dispensed through the retail pharmacy. If listed, PA does not apply through the acute hospital inpatient setting, unless on the APAD/APEC carve out drug list, or in the emergency, trauma, or urgent acute hospital outpatient settings. Please refer to 130 CMR 433.408 for PA requirements for other health care professionals. Notwithstanding the above, this drug may be an exception to the unified pharmacy policy; please refer to respective MassHealth Accountable Care Partnership Plans (ACPPs) and Managed Care Organizations (MCOs) for PA status and criteria, if applicable.

\* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without PA.

**PA** Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the provider to receive reimbursement. Note: PA applies to both the brand-name and the FDA “A”-rated generic equivalent of listed product.

<sup>A90</sup> Allowable 90-day supply. Dispensing in up to a 90-day supply is allowed. May not include all strengths or formulations. Quantity limits and other restrictions may apply.

<sup>BP</sup> Brand Preferred over generic equivalents. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.

<sup>M90</sup> Mandatory 90-day supply. After dispensing up to a 30-day supply initial fill, dispensing in a 90-day supply is required. May not include all strengths or formulations. Quantity limits and other restrictions may also apply.

<sup>PD</sup> Preferred Drug. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class.