Mass General Brigham
Health Plan

New to Market
Effective 01/01/2026

Plan	☐ MassHealth UPPL ☒ Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	Coverage for GLP-1s indicated for weight management or obesity may vary depending on the member's plan. Refer to the member's plan documents for additional details or exclusions.		

Overview

New-to-market (NTM) medications have a review process prior to being added to our formulary. Medications will be evaluated by Pharmacy and Therapeutics Committee and Drug Coverage Committee to analyze current literature to determine benefits and risks of these medications.

Coverage Guidelines

Approval of a new-to-market medication may be approved when all of the following criteria are met:

1. Requested medication is being used for an FDA-approved indication that is covered under the member's plan documents OR for a recognized off-label use of an FDA-approved drug used in the treatment of cancer or HIV/AIDS
2. ONE of the following is met:
    a. Documentation from the prescriber the member had an inadequate treatment response or intolerance to ALL formulary alternatives for the given diagnosis (or to at least one agent within each of a given class of agents when more than one class is available for the diagnosis)
    b. Member has a contraindication to all formulary alternatives
    c. Requested agent is the only FDA-approved product for the member's diagnosis and documentation from the prescriber showing that all other available lines of treatment consistent with generally accepted practice and/or guidelines from a nationally recognized entity for the diagnosis being treated have been exhausted.

Limitations

1. The duration of coverage will be limited to 6 months or up to a complete course of therapy if therapy if less than 6 months, as noted in the FDA approved package insert or as deemed medically necessary by the Plan.
2. GLP-1s indicated for the treatment of type 2 diabetes will not be approved for non-FDA approved indications (e.g., weight management, prediabetes, type 1 diabetes).

References

N/A

Review History
06/25/2018 – Reviewed
10/01/2018 – Implemented
01/22/2019 – Reviewed P&T
01/22/2020 – Reviewed at P&T
01/20/2021 – Reviewed and updated for Jan P&T; updated Limitations to include “complete course of therapy if therapy is less than 6 months”. Effective 03/01/21.
08/13/2025 - Reviewed and updated at August P&T. Updated Limitations section to specify that GLP-1s indicated for the treatment of type 2 diabetes will not be approved for any other indications besides type 2 diabetes. Effective 1/1/2026.