

New to Market
Effective 02/20/2026

Plan	<input checked="" type="checkbox"/> MassHealth UPPL <input type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit		
Specialty Limitations	N/A		
Contact Information	Medical Benefit	Phone: 833-895-2611	Fax: 888-656-6671
	Pharmacy Benefit	Phone: 800-711-4555	Fax: 844-403-1029
Exceptions	N/A		

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 the following criteria is met:

1. The requested drug 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 patient 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. Documentation that the patient has a contraindication to all formulary alternatives
 - c. This is the only FDA-approved product for the patient'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

The duration of coverage will be limited to three (3) months UNLESS:

1. If the FDA-approved package insert limits the recommended duration of therapy for the requested diagnosis to be less than 3 months, duration of coverage will be limited to the recommended duration of therapy specified in the FDA-approved package insert, OR
2. If requesting duration of coverage that is more than the recommended duration of therapy specified in the FDA-approved package insert, duration of coverage can exceed the recommended duration of therapy up to a maximum of 3 months as deemed medically necessary by the plan.

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.

09/21/2022 – Reviewed at Sept P&T; Separated Comm/Exch vs MH policy; no clinical updates.

04/12/23 – Reviewed for P&T. Updated approval durations to 3 months. Verbiage updates. Effective 4/1/23

3/11/26 – Reviewed and updated for P&T. Clarified that contraindications will require documentation. Effective 2/20/26

