To: Jai Medical Providers
From: MC-Rx
Date: October 1, 2025
Subject: Formulary Update – October 2025

Effective Immediately, the following medications have had an update made to their prior authorization criteria. A copy of the updated criteria is provided below the list.

- Releuko (Filgrastim-ayow, a Neupogen biosimilar) – Criteria included below
- Fylnetra (Pegfilgrastim-pbbk, a Neulasta biosimilar) – Criteria included below
- Eligard (leuprolide) – Criteria included below

Medication	**FILGRASTIM-AYOW (RELEUKO 300 MCG/0.5 ML SYRINGE | RELEUKO 480 MCG/0.8 ML SYRINGE | RELEUKO 300 MCG/ML VIAL | RELEUKO 480 MCG/1.6 ML VIAL)**
Covered Uses	All FDA approved indications: • Decrease the incidence of infection, as manifested by febrile neutropenia, in patients with nonmyeloid malignancies receiving myelosuppressive anti- cancer drugs associated with a significant incidence of severe neutropenia with fever. • Reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with acute myeloid leukemia (AML). • Reduce the duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia, in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation (BMT). • Mobilize autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis. • Reduce the incidence and duration of sequelae of severe neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia. • Increase survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome).
Required Medical Information	Document one of the following: (a) Patients with nonmyeloid malignancies receiving myelosuppressive anti- cancer drugs associated with a significant incidence of severe neutropenia with fever; **or** (b) Patient has undergone induction or consolidation chemotherapy treatment for acute myeloid leukemia (AML); **or** (c) Patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation (BMT); **or** (d) Is for mobilizing autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis; **or** (e) Diagnosis of severe neutropenia with an absolute neutrophil count (ANC) < 1,000; **or** (f) ANC nadir of < 1,000 neutrophils to previous chemotherapy. Once this has been documented, approval will be given for prophylaxis for all future chemo cycles; **or**

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	(g) Is for increasing survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome).
Coverage Duration	One (1) year
Other Criteria	• For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary. • Please indicate estimated duration of therapy

Medication	**PEGFILGRASTIM-PBBK (FYLNETRA 6 MG/0.6 ML SYRINGE)**
Covered Uses	All FDA approved indications: • To decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia. • To increase survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome).
Required Medical Information	• To decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies - Document one of the following: (a) Patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever (b) ANC nadir of < 1,000 neutrophils to previous chemotherapy. Once this has been documented, approval will be given for prophylaxis for all future chemo cycles. • For increasing survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome) – Document indication for use.
Coverage Duration	One (1) year
Other Criteria	• For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary. • Please indicate estimated duration of therapy

Medication	**DUPILUMAB (DUPIXENT 100 MG/0.67 ML SYRINGE | DUPIXENT 200 MG/1.14 ML PEN | DUPIXENT 200 MG/1.14 ML SYRINGE | DUPIXENT 300 MG/2 ML PEN | DUPIXENT 300 MG/2 ML SYRINGE)**
Covered Uses	All FDA approved indications: • Indicated for the treatment of adult and pediatric patients aged 6 months and older with moderate-to-severe AD whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable • Indicated as an add-on maintenance treatment of adult and pediatric patients aged 6 years and older with moderate-to-severe asthma characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma

Medication	DUPILUMAB (DUPIXENT 100 MG/0.67 ML SYRINGE | DUPIXENT 200 MG/1.14 ML PEN | DUPIXENT 200 MG/1.14 ML SYRINGE | DUPIXENT 300 MG/2 ML PEN | DUPIXENT 300 MG/2 ML SYRINGE)
	• Indicated as an add-on maintenance treatment in adult patients and pediatric patients aged 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) • Indicated for the treatment of adult and pediatric patients aged one (1) year and older, weighing at least 15 kg, with eosinophilic esophagitis (EoE) • Indicated for the treatment of adult patients with prurigo nodularis (PN) • Indicated as an add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype • Indicated for the treatment of adult and pediatric patients aged 12 years and older with chronic spontaneous urticaria (CSU) who remain symptomatic despite H1 antihistamine treatment. • Indicated for the treatment of adult patients with bullous pemphigoid (BP).
Required Medical Information	• Indicated for the treatment of adult and pediatric patients aged 6 months and older with moderate-to-severe AD whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable o Previous treatment, or intolerance of, TCS; and o Previous treatment, or intolerance of, TCI • Indicated for an add-on maintenance treatment of adult and pediatric patients aged 6 years and older with moderate-to-severe asthma characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma o Previous treatment, or intolerance, with Xolair; and o Patients must be reevaluated after 6 months • Indicated for an add-on maintenance treatment in adult and pediatric patients aged 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) o Previous treatment, or intolerance, with Xolair; and o Previous treatment, or intolerance, with oral corticosteroid • Indicated for the treatment of adult and pediatric patients aged one (1) year and older, weighing at least 15 kg, with eosinophilic esophagitis (EoE) o Confirmed diagnosis with endoscopic esophageal biopsy showing the presence of eosinophils (≥15 eosinophils per high-power field); and o Previous treatment with proton-pump inhibitor (PPI); and o Previous treatment with oral corticosteroid; and o Attestation of dietary modifications (e.g., avoidance of food allergen triggers) • Indicated for the treatment of adult patients with prurigo nodularis (PN) o Previous treatment, or intolerance of TCS; and o Previous treatment, or intolerance of TCI • Indicated as an add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype

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	○ Document diagnosis of severe COPD with exacerbations (requiring treatment with either systemic corticosteroids and/or antibiotics) within the last year ○ Document concurrent use of standard of care therapy (e.g., LABA+LAMA+ICS triple therapy) ○ Document blood eosinophil count (BEC) ≥300 cells/µL within the past 6 months ● For Chronic Spontaneous Urticaria (CSU) ○ For the first prescription only: ▪ Diagnosis of Chronic Spontaneous Urticaria (ICD-10-CM L50.1) ▪ Failure, inadequate response, intolerance, or contraindication to H1 antihistamines (e.g., cetirizine, loratadine, fexofenadine, levocetirizine) ● For Bullous Pemphigoid (BP) ○ For the first prescription only: ▪ Diagnosis of Bullous Pemphigoid (ICD-10-CM L12.0) ▪ Previous inadequate response, intolerance, or contraindication to standard treatments, such as Systemic corticosteroids (e.g., prednisone), Topical corticosteroids (e.g., clobetasol), OR immunosuppressive agents (e.g., azathioprine, mycophenolate).
Required Medical Information – Renewal Requests	Renewal Criteria: • For moderate-to-severe Atopic Dermatitis, Chronic Spontaneous Urticaria, Bullous Pemphigoid renewal also requires: o Documented improvement while on therapy • For moderate-to-severe Asthma, renewal also requires documentation of clinical response as evidenced by ONE of the following: o Reduction in asthma exacerbation (worsening of symptoms) from baseline o Decreased use of rescue medications o Increase in percent predicted FEV1 (amount of air you can forcefully exhale) from pretreatment baseline o Reduction in severity or frequency of asthma-related symptoms such as less wheezing, shortness of breath, coughing, etc. • For Chronic Rhinosinusitis with Nasal Polyposis, renewal also requires: o Document clinical benefit compared to baseline (such as improvements in nasal congestion, sense of smell, or size of polyps)
Max Quantity Per Day/Month	8.85ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	• All FDA approved indications: • Indicated for the treatment of adult and pediatric patients aged 6 months and older with moderate-to-severe AD whose disease is not

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	adequately controlled with topical prescription therapies or when those therapies are not advisable • Indicated as an add-on maintenance treatment of adult and pediatric patients aged 6 years and older with moderate-to-severe asthma characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma • Indicated as an add-on maintenance treatment in adult patients and pediatric patients aged 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) • Indicated for the treatment of adult and pediatric patients aged one (1) year and older, weighing at least 15 kg, with eosinophilic esophagitis (EoE) • Indicated for the treatment of adult patients with prurigo nodularis (PN) • Indicated as an add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype • Indicated for the treatment of adult and pediatric patients aged 12 years and older with chronic spontaneous urticaria (CSU) who remain symptomatic despite H1 antihistamine treatment. • Indicated for the treatment of adult patients with bullous pemphigoid (BP).

All changes in this notice supercede any previous edits to the formulary.

Providers can contact MC-Rx's Prior-Authorization Department at 800-555-8513 for assistance with PA requests or questions regarding clinical guidelines. Our PA Department is available Monday through Friday from 8:30 am-5:30 pm EST. For assistance with PA requests during non-business hours please contact our 24-hour customer service department at 800-213-5640.