JAI MEDICAL SYSTEMS

ProCare Rx

**To:** **Jai Medical Providers**
**From:** **MC-Rx**
**Date:** **December 31, 2025**
**Subject:** **Formulary Update – December 2025 – Updated PA Criteria**

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**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.**

- Antihemophilic Clotting Factor – Criteria included below
- Ajovy – Criteria included below
- Somatropin – Criteria included below

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| **Medication** | Antihemophilic Clotting Factor (FEIBA NF 1,000 UNIT (NOMINAL) \| FEIBA NF 2,500 UNIT (NOMINAL) \| FEIBA NF 500 UNIT (NOMINAL) \| RECOMBINATE 1,241-1,800 UNIT V \| RECOMBINATE 1,801-2,400 UNIT V \| RECOMBINATE 220-400 UNIT VIAL \| RECOMBINATE 401-800 UNIT VIAL \| RECOMBINATE 801-1,240 UNIT VL \| HEMOFIL M 1,000 UNIT NOMINAL \| HEMOFIL M 1,700 UNIT NOMINAL \| HEMOFIL M 250 UNIT NOMINAL \| HEMOFIL M 500 UNIT NOMINAL \| KOATE 1,000 UNIT VIAL \| KOATE 250 UNIT VIAL \| KOATE 500 UNIT VIAL \| HUMATE-P 1,200 UNIT VWF:RCO \| HUMATE-P 2,400 UNIT VWF:RCO \| HUMATE-P 600 UNIT VWF:RCO \| THROMBATE III 500 UNIT VIAL) |
| **Covered Uses** | All FDA approved indications:<br>• Indicated for use in hemophilia A and B patients with inhibitors for control and prevention of bleeding episodes, perioperative management, routine prophylaxis to prevent or reduce the frequency of bleeding episodes |
| **Required Medical Information** | • Indicated for use in hemophilia A and B patients with inhibitors for control and prevention of bleeding episodes, perioperative management, routine prophylaxis to prevent or reduce the frequency of bleeding episodes<br>○ Diagnosis of Hemophilia A with inhibitors, OR<br>○ Diagnosis of Hemophilia B with inhibitors |
| **Max Quantity Per Month** | N/A 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 |

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| **Medication** | FREMANEZUMAB-VFRM (AJOVY 225 MG/1.5 ML AUTOINJECT, AJOVY 225 MG/1.5 ML SYRINGE) |
| **Covered Uses** | All FDA approved indications:<br>• For the preventive treatment of migraine in adults. (ICD-10-CM G43.019, G43.119, G43.719, G43.919) |

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| **Medication** | FREMANEZUMAB-VFRM (AJOVY 225 MG/1.5 ML AUTOINJECT, AJOVY 225 MG/1.5 ML SYRINGE) |
| | • For the preventive treatment of episodic migraine in pediatric patients who are 6 to 17 years of age and who weigh 45 kg or more. (ICD-10-CM G43.019, G43.119, G43.719, G43.919) |
| **Required Medical Information** | For the first prescription only:<br>• Preventive treatment of migraine in adults:<br>○ Document evidence of 4 or more migraine days per month AND<br>○ Document failure or intolerance to at least one (1) medication used for migraine prophylaxis, after at least 3 months of use (e.g., beta blocker [propranolol, metoprolol or atenolol], previous use of a CGRP), AND<br>○ Document no concurrent use of another CGRP indicated for migraine prophylaxis.<br>• Preventive treatment of episodic migraine in pediatric patients<br>○ Document evidence of patient's weight<br>○ Document evidence of 4 or more migraine days per month AND<br>○ Document failure or intolerance to at least one (1) medication used for migraine prophylaxis, after at least 3 months of use (e.g., beta blocker [propranolol, metoprolol or atenolol], previous use of a CGRP), AND<br>○ Document no concurrent use of another CGRP indicated for migraine prophylaxis. |
| **Age Restriction** | Age 6 years and older |
| **Other Criteria** | Refer to the package insert for dosage and administration. |

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| **Medication** | SOMATROPIN (HUMATROPE 12 MG CARTRIDGE \| HUMATROPE 24 MG CARTRIDGE \| HUMATROPE 5 MG VIAL \| HUMATROPE 6 MG CARTRIDGE) |
| **Covered Uses** | All FDA approved indications:<br>• Indicated for the growth failure due to inadequate secretion of endogenous growth hormone (GH)<br>• Indicated for the short stature associated with Turner syndrome<br>• Indicated for the Idiopathic Short Stature (ISS), height standard deviation score (SDS) less than or equal to < -2.25, and associated with growth rates unlikely to permit attainment of adult height in the normal range<br>• Indicated for the short stature or growth failure in short stature homeobox-containing gene (SHOX) deficiency<br>• Indicated for the short stature born small for gestational age (SGA) with no catch-up growth by 2 years to 4 years of age<br>• Indicated for the replacement of endogenous GH in adults with GH deficiency. |
| **Required Medical Information** | • Indicated for the growth failure due to inadequate secretion of endogenous growth hormone (GH):<br>○ Patient with open epiphyses (as confirmed by radiograph of wrist and hand) who has not reached final height; and<br>○ Medication prescribed by an endocrinologist; and<br>○ Patient meets one of the following criteria: |

| Medication | SOMATROPIN (HUMATROPE 12 MG CARTRIDGE \| HUMATROPE 24 MG CARTRIDGE \| HUMATROPE 5 MG VIAL \| HUMATROPE 6 MG CARTRIDGE) |
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| | ▪ Growth Hormone Deficiency (GHD) with diagnosis confirmed by one of the following:<br>i. Severe short stature defined as patient's height at > 2 SD below the population mean<br>ii. Patient's height > 1.5 SD below the midparental height (average of mother's and father's heights)<br>iii. Patient's height > 2 SD below the mean and a 1-year height velocity more than 1 SD below the mean for chronologic age or (in children 2 years of age or older) a 1-year decrease of more than 0.5 SD in height<br>iv. In the absence of short stature, a 1-year height velocity more than 2 SD below the mean or a 2-year height velocity more than 1.5 SD below the mean (may occur in GHD manifesting during infancy or in organic, acquired GHD)<br>v. Signs indicative of an intracranial lesion<br>vi. Signs of multiple pituitary hormone deficiencies<br>vii. Neonatal symptoms and signs of GHD<br>• Indicated for the short stature associated with Turner syndrome,<br>○ Document height below the 5th percentile of normal growth curve, and<br>○ Medication prescribed by an endocrinologist<br>• For the Idiopathic Short Stature (ISS),<br>○ Document height standard deviation score (SDS) less than or equal to -2.25, and associated with growth rates unlikely to permit attainment of adult height in the normal range and,<br>○ Medication prescribed by an endocrinologist<br>• Indicated for the short stature or growth failure in short stature homeobox-containing gene (SHOX) deficiency<br>○ Document gene (SHOX) deficiency, and<br>○ Height more than two standard deviations below the mean for age and gender, and<br>○ Medication prescribed by an endocrinologist;<br>• Indicated for the short stature born small for gestational age (SGA) with no catch-up growth by 2 years to 4 years of age<br>○ The patient has a documented birth weight and/or length that is more than two standard deviations (SD) below the mean for gestational age; and,<br>○ At 24 months of age, the patient failed to manifest catch-up growth evidenced by a height more than two standard deviations (SD) below the mean for age and sex, and<br>○ Medication prescribed by an endocrinologist<br>• Indicated for the replacement of endogenous GH in adults with GH deficiency.<br>○ Document irreversible hypothalamic/pituitary structural lesions or ablation (e.g., pituitary tumor, pituitary damage from surgery, hypothalamic disease, radiation, pituitary damage from trauma) OR GH deficiency diagnosed during childhood OR Defect in GH synthesis.<br>○ Medication prescribed by an endocrinologist |

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| **Medication** | SOMATROPIN (HUMATROPE 12 MG CARTRIDGE \| HUMATROPE 24 MG CARTRIDGE \| HUMATROPE 5 MG VIAL \| HUMATROPE 6 MG CARTRIDGE) |
| **Max Quantity Per Day/Month** | N/A PER 30 DAYS |
| **Max Refills Per Year** | Twelve (12) Refills |
| **Other Criteria** | Include copy of any test results done to confirm diagnosis and for ongoing patient monitoring, when applicable<br><br>To continue therapy, requests will be reviewed every six months.<br><br>For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary. |

*All changes in this notice supersede 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.*