To: **Jai Medical Providers**
From: **ProCare Rx**
Date: **October 2, 2023**
Subject: **Formulary Update October 2023**

Effective 10/2/2023, the following products will be added to the formulary (some agents are biosimilars replacing the reference brand product):

- Arexvy – Added to vaccine coverage with Age Limit of 60+
- Abrysvo – Added to vaccine coverage
- Rezvoglar (Interchangeable Lantus biosimilar)
- Insulin Glargine-YFGN (Unbranded Semglee, an interchangeable Lantus biosimilar)
- Fylnetra (Neulasta biosimilar) – Added with PA Criteria
- Releuko (Biosimilar replacing reference brand Neupogen) – PA Criteria remains

Effective 10/2/2023, the following products will have their PA restriction removed (a Quantity Limit may be added for some products with the PA restriction removed):

- Ondansetron Solution - Added QL of 50mL per fill; PA removed
- Dabigatran (Generic Pradaxa) – PA removed
- Azelastine Ophthalmic - Added QL 12mL per month; PA removed
- Brimonidine Ophthalmic - Added QL 10mL per month; PA removed
- Lodoxamide Ophthalmic - Added QL 20mL per month; PA removed
- Olopatadine Ophthalmic - Added QL 10mL per month; PA removed

Effective 11/1/2023, the following products will be removed from the formulary:

- Synagis (Beyfortus is now available through the medical benefit)
- Osmoprep and any generic versions
- Sucralfate Suspension
- Rabeprazole
- All Digestive Enzymes EXCEPT Creon, including Zenpep, Viokace, Ultresa, Pancreaze, Pancrelipase, and Pertzye (current members utilizing other brands will be grandfathered to allow continuation of therapy) – Creon will become the only preferred product

Effective 11/1/2023, the following products will be replaced by a biosimilar:

- Neupogen (replaced by Releuko)
- Lantus (replaced by Rezvoglar and Insulin Glargine-YFGN)
- Semglee (replaced by Rezvoglar and Insulin Glargine-YFGN)

- Pegfilgrastim - Any members already approved under medical necessity for a non-formulary pegfilgrastim product will be contacted about switching their prescription to Fylnetra or establishing medical necessity of their current treatment.

Prior Authorization Criteria:

Fylnetra PA Criteria:

INDICATIONS:

(1) Prevention of neutropenia in patients receiving myelosuppressive chemotherapy for nonmyeloid malignancies
(2) Patients undergoing peripheral blood progenitor cell collection and therapy
(3) Patients with severe chronic neutropenia

Criteria:

(a) The patient is undergoing peripheral blood progenitor cell collection and therapy; or
(b) Diagnosis of severe chronic neutropenia with an absolute neutrophil count (ANC) < 1,000; or
(c) 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.

Updated Indication in Symbicort PA Criteria:

Maintenance treatment of asthma in patients 6 years of age and older

Providers can contact ProCare'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.