To: **Jai Medical Providers**
From: **MC-Rx**
Date: **September 30, 2024**
Subject: **Formulary Update September 2024**

Effective 10/1/2024, the following products will be added to the formulary:

- Emgality - 120mg/ml pen, 120mg/ml syringe, 300mg dose (100mg/ml) syringe, 100mg/ml syringe - added with PA requirement
- Ajovy - 225mg/1.5ml autoinject, 225mg/1.5ml syringe - added with PA requirement
- Added Generic Vitamin B-6

Effective 10/1/2024, the following changes will be made to medications on the formulary:

- Ropinirole Tablet/Ropinirole ER Tablet – QL updated to 90 for 30 days. PA criteria remains unchanged
- Creon Capsule – QL added – QL=28/day (Approval required for quantities that would exceed $2,000 per claim)
- Budesonide (inhalation) ampul-neb 0.25mg/2ml, 0.5 mg/2ml, 1 mg/2 ml – Age Limit raised to <=8 years

Effective 10/1/2024, the following medications will have updates made to their criteria:

- Fylnetra – 6mg/0.6ml syringe
- Releuko – 300mcg/0.5ml syringe, 480mcg/0.8ml syringe, 300mcg/ml vial, 480 mcg/1.6 ml vial
- Budesonide-Formoterol (Generic Symbicort) – 160mcg-4.5mcg HFA, 80mcg-4.5mcg HFA updated criteria for asthma
- Fluticasone Propionate-Salmeterol (Generic Advair) – Fluticasone-Salmeterol 100-50, Fluticasone-Salmeterol 113-14, Fluticasone-Salmeterol 115-21 | Fluticasone-Salmeterol 230-21, Fluticasone-Salmeterol 232-14, Fluticasone-Salmeterol 250-50, Fluticasone-Salmeterol 45-21, Fluticasone-Salmeterol 500-50, Generic Name Fluticasone Propion/Salmeterol, Fluticasone-Salmeterol 55-14, Wixela 100-50 Inhub, Wixela 250-50 Inhub, Wixela 500-50 Inhub - updated criteria for asthma
- Skyrizi – 150mg/ml pen, 150mg/ml syringe, 180mg/1.2ml on-body, 360 mg/2.4ml on-body, 600mg/10ml vial - Added new indication for Ulcerative Colitis

Prior Authorization Criteria:

PA Description	**Galcanezumab-gnlm (Emgality)**
Covered Uses	All FDA approved indications: • For the preventive treatment of migraine in adults. (ICD-10-CM G43.019, G43.119, G43.719, G43.919) • For the treatment of episodic cluster headache. (ICD-10-CM G44.019)

PA Description	Galcanezumab-gnlm (Emgality)
Required Medical Information	For the first prescription only: (a) Preventive treatment of migraine: 1. Document evidence of 4 or more migraine days per month. AND 2. Document failure or intolerance to 1 prophylactic 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 3. Document no concurrent use of another CGRP indicated for migraine prophylaxis. (b) For the treatment of Episodic Cluster Headache: 1. Physician documentation of at least two cluster periods lasting between 2 weeks and 3 months
Age Restriction	
Coverage Duration	
Other Criteria	(a) Refer to package insert information for dosage and administration.

PA Description	Fremanezumab-vfrm (Ajovy)
Covered Uses	All FDA approved indications: • For the preventive treatment of migraine in adults. (ICD-10-CM G43.019, G43.119, G43.719, G43.919)
Required Medical Information	For the first prescription only: (a) Preventive treatment of migraine: 1. Document evidence of 4 or more migraine days per month. AND 2. Document failure or intolerance to 1 prophylactic 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 3. Document no concurrent use of another CGRP indicated for migraine prophylaxis.
Age Restriction	
Coverage Duration	
Other Criteria	(a) Refer to package insert information for dosage and administration.

PA Description	Filgrastim-ayow (Releuko)
Covered Uses	All FDA approved indications: (a) 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. (b) Reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy of patients with acute myeloid leukemia (AML). (c) 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).

	(d) 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.
Exclusion Criteria	None
Required Medical Information	Document one of the following: (a) Patient 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 for acute myeloid leukemia (AML); or (c) Patient with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation (BMT); or (d) Diagnosis of severe neutropenia with an absolute neutrophil count (ANC) <1,000; or (e) 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.
Coverage Duration	One (1) Year
Max Refills Per Year	Twelve (12) Refills
Other Criteria	(a) For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary. (b) Please indicate estimated duration of therapy

PA Description	**Pegfilgrastim-pbbk (Fylnetra)**
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 febrile neutropenia.
Exclusion Criteria	None
Required Medical Information	Document one of the following: (a) Patient with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever; or (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.
Coverage Duration	One (1) Year
Max Refills Per Year	Twelve (12) Refills
Other Criteria	(a) For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary. (b) Please indicate estimated duration of therapy

PA Description	Budesonide/Formoterol Fumarate
Covered Uses	All FDA approved indications: • Indicated for the treatment of asthma in patients 6 years of age and older • Indicated for the maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD) including chronic bronchitis and/or emphysema
Required Medical Information	• Indicated for the treatment of asthma in patients 6 years of age and older ○ The patient must be reevaluated after 6 months • Indicated for the maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD) including chronic bronchitis and/or emphysema ○ Currently on, but not controlled by a LAMA ○ The patient must be reevaluated after 6 months
Max Quantity Per Month	41.4g per 30 days
Max Refills Per Year	Twelve (12) Refills
Required Informaiton 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 to that medication
Other Criteria	For members currently with an approved prior authorization for Budesonide/Formoterol Fumarate, claims will process as long as the member has filled Budesonide/Formoterol Fumarate within the last 4 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to Budesonide/Formoterol Fumarate therapy or with no claims history of Budesonide/Formoterol Fumarate within the last 4 months. Once approved, 90- day supplies are allowed

PA Description	Fluticasone Propionate/Salmeterol
Covered Uses	All FDA approved indications: • Indicated for the twice-daily treatment of asthma in patients aged 4 years and older • Indicated for the twice-daily maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD) including chronic bronchitis and/or emphysema
Required Medical Information	• Indicated for the twice-daily treatment of asthma in patients 4 years of age and older ○ The patient must be reevaluated after 6 months • Indicated for the twice-daily maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD) including chronic bronchitis and/or emphysema ○ Currently on, but not controlled by a LAMA ○ The patient must be reevaluated after 6 months
Max Quantity Per Month	60EA per 30 days
Max Refills Per Year	Twelve (12) Refills

PA Description	Fluticasone Propionate/Salmeterol
Required Informaiton 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 to that medication
Other Criteria	For members currently with an approved prior authorization for Fluticasone Propionate/Salmeterol, claims will process as long as the member has filled Fluticasone Propionate/Salmeterol within the last 4 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to Fluticasone Propionate/Salmeterol therapy or with no claims history of Fluticasone Propionate/Salmeterol within the last 4 months. Once approved, 90- day supplies are allowed.

PA Description	Risankizumab-rzaa (Skyrizi®)
Covered Uses	All FDA approved indications: • Indicated for the treatment of moderate-to-severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy • Indicated for the treatment of active psoriatic arthritis in adults • Indicated for the treatment of moderately to severely active Crohn's disease in adults • Indicated for the treatment of moderately to severely active ulcerative colitis in adults
Required Medical Information	**(a) For the first prescription and every 12 months for all diagnoses:** • NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to treatment **(b) Indicated for the treatment of moderate-to-severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy:** • Previous treatment with, or intolerance of, Taltz **(c) Indicated for the treatment of active psoriatic arthritis in adults:** • Previous treatment with, or intolerance of, Taltz **(d) Indicated for the treatment of moderately to severely active Crohn's disease or ulcerative colitis in adults:** • Previous treatment with, or intolerance of, adalimumab
Max Quantity Per Month	12.6ml per 30 days
Max Refills Per Year	Twelve (12) Refills
Required Informaiton 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 to that medication
Other Criteria	

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.