JAI MEDICAL SYSTEMS

ProCare Rx

To: **Jai Medical Providers**
From: **MC-Rx**
Date: **July 1, 2026**
Subject: **Formulary Update – July 2026 –**

Effective immediately, the following products have been added to the formulary:

- Chocolated Sennosides (generic Chocolated Ex-lax)

Effective immediately, the following products have updated Prior Authorization rules:

- **Azelastine nasal spray –** Updated to reflect updated in approved diagnoses in the package insert
- **Repatha –** updated wording of indications to better align with packet insert language
- **fluticasone-salmeterol –** wording of criteria and indication updated to clarify differences for different strengths
- **simvastatin 80mg –** update to wording of indication and criteria for Indicated for the adjunct to diet to reduce low-density lipoprotein cholesterol (LDL-C) in adults with primary hyperlipidemia and/or adults and pediatric patients aged 10 years and older with heterozygous familial hypercholesterolemia (HeFH**)**
- **Valsartan-hydrochlorothiazide -** Max dose updated to match QL on drug list
- **Thrombate III –** Updated criteria

GENERIC NAME	AZELASTINE HCL NASAL SPRAY
LABEL NAME(S)	**(AZELASTINE 0.1% (137 MCG) SPRY)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the relief of the symptoms of seasonal allergic rhinitis in patients 5 years of age and older for the treatment of the symptoms of vasomotor rhinitis in adults and adolescent patients 12 years and older
Required Medical Information	○ Patient is ≥ 5 years of age for the relief of the symptoms of seasonal allergic rhinitis; OR ○ Patient is ≥ 12 years of age for treatment of the symptoms of vasomotor rhinitis; AND ○ Failure of at least one formulary nasal steroid after a period of at least two months on the maximum dose appropriate and tolerated by the patient
Max Quantity Per Month	40.8ML 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

GENERIC NAME	EVOLOCUMAB
LABEL NAME(S)	**(REPATHA 140 MG/ML SURECLICK | REPATHA 140 MG/ML SYRINGE | REPATHA 420 MG/3.5 ML PUSHTRON)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated to reduce the risk of major adverse cardiovascular (CV) events (CV death, myocardial infarction, unstable angina requiring hospitalization, stroke, and coronary revascularization) in adults at increased risk for these events. ● Indicated for the adjunct to diet and exercise, in adults with primary hypercholesterolemia to reduce LDL-C ● Indicated for the adjunct to diet and exercise in adults and pediatric patients aged 10 years and older with heterozygous familial hypercholesterolemia (HeFH), to reduce LDL-C ● Indicated for the adjunct to diet and exercise in adults and pediatric patients aged 10 years and older with homozygous familial hypercholesterolemia (HoFH), to reduce LDL-C
Required Medical Information	○ positive clinical response ○ Comprehensive counseling regarding diet ○ Not used in combination with another type 9 (PCSK9) INHIBITOR
Max Quantity Per Month	4.41ML 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

GENERIC NAME	FLUTICASONE PROPION/SALMETEROL
LABEL NAME(S)	**(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 | FLUTICASONE-SALMETEROL 55-14 | WIXELA 100-50 INHUB | WIXELA 250-50 INHUB | WIXELA 500-50 INHUB)**
Formulary	

Covered Uses	All FDA approved indications:
	• fluticasone-salmeterol 55-14 mcg, 113-14 mcg, 232-14 mcg
	• fluticasone-salmeterol 45-21 mcg, 115-21mcg, 230-21mcg
	  ○ Indicated for the treatment of asthma in adult and pediatric patients aged 12 years and older
	• fluticasone-salmeterol 100-50 mcg, 250-50 mcg, 500-50 mcg
	  ○ 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	• For the treatment of asthma in adult and adolescent patients aged 12 years and older
	  ○ Documentation of diagnosis
	  ○ The patient must be reevaluated after 6 months
	• For the twice-daily treatment of asthma in patients aged 4 years and older
	  ○ Documentation of diagnosis
	  ○ 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; and
	  ○ The patient must be reevaluated after 6 months

Max Quantity Per Month	60EA 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	For members currently with an approved prior authorization for Fluticasone-Salmeterol, claims will process as long as the member has filled the medication 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 therapy, or with no claim history of the medication within the last 4 months. Once approved, 90-day supplies are allowed.

GENERIC NAME	SIMVASTATIN (80MG TABLET ONLY)
LABEL NAME(S)	**(SIMVASTATIN 80 MG TABLET)**
Formulary	

Covered Uses	All FDA approved indications: ● Indicated for the reduce the risk of total mortality by reducing risk of coronary heart disease death, non-fatal myocardial infarction and stroke, and the need for coronary and non-coronary revascularization procedures in adults with established coronary heart disease, cerebrovascular disease, peripheral vascular disease, and/or diabetes, who are at high risk of coronary heart disease events ● Indicated for the adjunct to diet to reduce low-density lipoprotein cholesterol (LDL-C) in adults with primary hyperlipidemia and/or adults and pediatric patients aged 10 years and older with heterozygous familial hypercholesterolemia (HeFH) ● Indicated for the adjunct to other LDL-C-lowering therapies to reduce LDL-C in adults with homozygous familial hypercholesterolemia (HoFH) ● Indicated for the adjunct to diet for the treatment of adults with primary dysbetalipoproteinemia and/or hypertriglyceridemia
Required Medical Information	• For all Adult indications listed above: ○ Age ≤ 65 years ○ Male gender (female gender predisposed to myopathy including rhabdomyolysis) ○ Controlled hypothyroidism ○ Normal renal function ○ All cholesterol lowering agents tried and failed must be provided • For pediatric patients aged 10 years and older with heterozygous familial hypercholesterolemia (HeFH) ○ Age ≥ 10 years ○ Male gender (female gender predisposed to myopathy including rhabdomyolysis) ○ Controlled hypothyroidism ○ Normal renal function ○ All cholesterol lowering agents tried and failed must be provided
Max Quantity Per Month	15EA 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

GENERIC NAME	VALSARTAN/HYDROCHLOROTHIAZIDE
LABEL NAME(S)	**(VALSARTAN-HYDROCHLOROTHIAZIDE TABLET 160-12.5MG, 160-25MG, 320-12.5MG, 320-25MG, 80MG-12.5MG)**
Formulary	

Covered Uses	All FDA approved indications: ● Indicated for the treatment of hypertension, to lower blood pressure in adults and pediatric patients six years of age and older ● Indicated for the reduction of hospitalization for heart failure in adult patients with heart failure (NYHA class II-IV) ● Indicated to reduce the risk of cardiovascular mortality in clinically stable adult patients with left ventricular failure or left ventricular dysfunction following myocardial infarction
Required Medical Information	○ Failure or contraindication of 2 formulary ARB-Hydrochlorothiazide combinations (Irbesartan- Hydrochlorothiazide, Losartan-Hydrochlorothiazide)
Max Quantity Per Month	30EA 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

GENERIC NAME	ANTITHROMBIN III (HUMAN)
LABEL NAME(S)	**(THROMBATE III 500 UNIT VIAL)**
Formulary	
Covered Uses	All FDA approved indications: • Indicated in adult and pediatric patients with hereditary antithrombin deficiency for: ○ Treatment and prevention of thromboembolism ○ Prevention of peri-operative and peri-partum thromboembolism
Required Medical Information	• Documentation supporting hereditary antithrombin deficiency, such as low functional antithrombin activity level and/or genetic/family history documentation • Requested use is for one of the following: ○ Treatment of active thromboembolism ○ Peri-operative thromboembolism prevention ○ Peri-partum thromboembolism prevention
Max Quantity Per Month	N/A PER 30 DAYS
Max Refills Per Year	N/A — authorization should be episode-specific or based on documented ongoing medical necessity
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

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

Providers can contact ProCare 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.