JAI MEDICAL SYSTEMS

ProCare Rx

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

The following changes have recently been made based on updates from Maryland Medicaid:

- **Hepatitis C Criteria** (see separate Hepatitis C Criteria document on the pharmacy page https://jaimedicalsystems.com/providers/pharmacy/) – A copy is also attached to this notice - Update includes criteria for Mavyret for new indication for Acute Hepatitis C
- **Universal Opioid Prior Authorization Form** (see document on the pharmacy page https://jaimedicalsystems.com/providers/pharmacy/) – a copy is also attached to this notice
- **CGM Criteria** – For Formulary Freestyle Libre CGM Products see criteria further down in document or in the Prior Authorization Guidelines Document. For non-formulary CGM products the same criteria applies with the additional requirement to explain why formulary CGM alternative is not appropriate. For requests to access CGM through DME please follow separate process rather than using the Pharmacy PA Form.

GENERIC NAME	BLOOD-GLUCOSE SENSOR [CONTINUOUS GLUCOSE MONITOR (CGM)]
LABEL NAME(S)	**(FREESTYLE LIBRE 3 SENSOR | FREESTYLE LIBRE 10 DAY READER | FREESTYLE LIBRE 14 DAY READER | FREESTYLE LIBRE 2 READER | FREESTYLE LIBRE 10 DAY SENSOR | FREESTYLE LIBRE 14 DAY SENSOR | FREESTYLE LIBRE 2 SENSOR)**
Formulary	
Covered Uses	• For the management of diabetes in members aged 4 years and older with Type 1 and Type 2 diabetes who are using insulin, members with gestational diabetes mellitus, or diabetic members who have problematic hypoglycemic events
Required Medical Information	For the treatment of patients indicated for the management of diabetes in persons aged 4 years and older who meet all of the following initial coverage criteria: 1. The member meets one of the following: a. Diagnosed with Diabetes mellitus (Type I or Type II) and is currently receiving insulin treatment; b. Member has a diagnosis of Gestational Diabetes Mellitus; or c. Member has a history of problematic hypoglycemia with documentation of at least one of the following [as specified in the Policy Specific Documentation Requirements of the LCD-related Policy Article (A52464) from CMS https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52464]: ○ More than one level 2 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple attempts to adjust medications or modify the diabetes treatment plan; or

	○ A history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental or physical state requiring third-party assistance for treatment of hypoglycemia; and 2. The treating practitioner has concluded that the member or their caregiver has sufficient training to use the CGM as shown by writing the prescription; and 3. The CGM is prescribed in accordance with its FDA indications for use
Max Quantity Per Month	2 SENSORS PER MONTH SUPPLY (3 SENSORS FOR 10 DAY READER)
Max Refills Per Year	Twelve (12) Refills
Other Criteria	• Renewal request must include information from the practitioner that the member is utilizing the system successfully. • If product is to be used in conjunction with a compatible insulin pump that has already been approved, please include that information with the request. • Approval requested with a Pharmacy PA Form is for pharmacy benefit and is not transferable between pharmacy and DME benefit without a new request. For requests under the DME benefit, please utilize PCP referral and standard authorization form. • Requests for any other brands of CGM through the pharmacy benefit must include rationale of why Freestyle CGMs are not appropriate. • Criteria based on instructions from Maryland Medicaid (PT 71-26). Criteria will be updated to align with future updates from Maryland Medicaid.

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.

Clinical Criteria for Medication Management of Hepatitis C Virus (HCV)

All HCV medications **require Prior Authorization** and will be considered for coverage when all the criteria below are met, confirmed with supporting medical documentation. A multidisciplinary approach involving specialists, such as hepatologists, gastroenterologists, infectious disease specialists, and potentially others like nephrologists, cardiologists, and mental health professionals, can optimize treatment and management for individuals with HCV and comorbid conditions.

Acute Hepatitis C Treatment:

I. Criteria for Approval

- Direct-acting antiviral (DAA) Medication(s) are FDA-approved for age range,
- Baseline lab values should include an HCV RNA quantitative and the absence of HCV antibodies within 6 months of initial diagnosis,
- Confirmation that the patient has not been exposed to DAA therapy previously,
- HBV status and, if active HBV disease, current antiretroviral regimen and degree of viral suppression within 6 months of application for therapy,
- HIV status and, if HIV positive, current antiretroviral regimen and degree of viral suppression within 6 months of application for therapy,

II. Dosing/Administration/Duration

All DAA medication must be administered according to the current FDA labeling guidelines for dosage and timing

Maryland
DEPARTMENT OF HEALTH

Chronic Hepatitis C Treatment

I. Criteria for Approval

- Direct-acting antivirals (DAA) medications are FDA-approved for age ranges,
- Chronic hepatitis C and HCV genotype and sub-genotype documented*,
- Patients who have prior exposure to DAA therapy must have a pre-DAA genotype and post-DAA genotype documented (Appendix A), including previous HCV treatment history and outcome,
- HCV RNA quantitative within 180 days of application for therapy, unless the patient is cirrhotic, then the baseline lab values must be within 90 days of the prior authorization request and should include a total bilirubin, albumin, and INR,
- Accepted fibrosis test (ex. fibrosure, hepascore/fibroscore, liver-biopsy, fibroscan, point shear wave elastography (PSWE), acoustic radiation force impulse imaging (AFRI)*^,
- HBV status and, if active HBV disease, current antiretroviral regimen and degree of viral suppression within 6 months of application for therapy,
- HIV status and, if HIV positive, current antiretroviral regimen and degree of viral suppression within 6 months of application for therapy,
- Drug resistance testing as indicated,
- If the patient or their partner is of childbearing age, recommend at least two (2) forms of contraception (by the patient or their partner) if an RBV-containing regimen is prescribed throughout therapy and for six (6) months after the regimen is completed.

II. Dosing/Administration/Duration

All DAA medications must be administered according to the current FDA labeling guidelines for dosage and timing

*Not required in the treatment of HCV-Uninfected Recipients of organs from HCV-Viremic Donors

^Fibrosis evaluation for pediatric patients should be done in accordance with the recommendations from the AASLD/IDSA HCV Guidelines

Appendix A:

HCV Treatment Definitions

Retreatment: Previous exposure to an HCV treatment direct-acting antiviral (DAA) regimen, which does NOT result in achievement of SVR, and current need for an additional course of therapy to treat chronic HCV infection.

Conditions required:

- Detectable HCV RNA at 12 weeks post-treatment.
- HCV genotype is the SAME before and after the INITIAL HCV treatment regimen.

Reinfection: Exposure to an HCV treatment regimen, which results in the achievement of SVR.

Conditions required:

- Detectable HCV RNA > 12 weeks post-treatment
- HCV genotype is DIFFERENT after the INITIAL HCV treatment regimen.
- The current infection has been present for ≥ 6 months.

OPIOID PRIOR AUTHORIZATION FORM

Incomplete forms will not be reviewed

Managed care organizations (listed) and Medicaid fee-for-service use this form for opioid prior authorization

Fax completed forms to the number corresponding to the patient's plan.

MCO and Fee-for-Service	Telephone	Fax
Aetna Better Health of Maryland	1-866-827-2710	1-877-270-3298 or www.aetnabetterhealth.com/maryland
CareFirst Blue Cross Blue Shield Community Health Plan Maryland	1-877-418-4133	1-855-762-5205 OR CVS Caremark Prior Authorization Forms | CoverMyMeds
Jai Medical Systems	1-800-555-8513	1-866-999-7736 OR 1-800-583-6010
Kaiser Permanente Health Choice	1-866-331-2103	1-866-331-2104
Maryland Medicaid Fee-for-Service	1-800-932-3918	1-866-440-9345
Maryland Physicians Care	1-888-258-8250	1-833-896-0656
MedStar Family Choice	1-877-772-6505	410-350-7454
Priority Partners	1-888-819-1043	410-424-4607
United Healthcare Community Plan	1-800-310-6826	1-866-940-7328
WellPoint Maryland	1-833-707-0867	1-844-490-4871

For Amerigroup and UnitedHealthcare forms visit:

https://health.maryland.gov/mmcp/pap/Pages/Pharmacy-Program-Forms.aspx

All prescribers must complete SECTION 1, SECTION 2, AND SECTION 3.

Prescribers must complete either SECTION 4 or SECTION 5 as appropriate.

TO AVOID DELAYS in processing this request, please ensure that contact information is accurate in case additional information is required.

Duration of prior authorization is determined by Medicaid fee-for-service of managed care organizations.

For additional information about individual managed care organizations' opioid-prescribing requirements, visit:

https://health.maryland.gov/mmcp/pap/Pages/Pharmacy-Program-Forms.aspx

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SECTION 1: DEMOGRAPHICS

Date (mm/dd/yyyy): _____

Patient name: _____

MCO Plan ID: _____

MD Medicaid ID: _____

Date of Birth (mm/dd/yyyy): _____ Gender as listed by the patient: ☐ Male ☐ Female

Name of MCO: _____ Other Insurance? : _____

Prescriber Name: _____ Prescriber NPI#: _____

Prescriber DEA#: _____ Phone for Prescriber: _____

Office Contact Name / Fax Attention to: _____

Office Contact Direct Phone#: _____ Office / Prescriber Fax #: _____

Facility / Clinic Name (if applicable):

SECTION 2: CHECK ALL THE BOXES THAT APPLY

❑ Non-Urgent Review

❑ Urgent Review: By checking this box, I certify that applying non-urgent review timeframe may lead to patient harm.

❑ Yes ❑ No This patient is currently an inpatient at an acute care hospital.

❑ Yes ❑ No Is this patient being discharged from the hospital or ED?

❑ Yes ❑ No Is the patient pregnant? (See references below.)

1. http://www.medscape.com/viewarticle/867512
2. https://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm
3. https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm118113.htm

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SECTION 3: USE A SEPARATE FORM FOR EACH MEDICATION BEING REQUESTED

Select One: ❑ New Prescription ❑ Refill (i.e., patient has been taking medication)

Diagnosis: _____

Select All That Apply: ❑ Immediate-Release Opioid ❑ Extended-Release Opioid ❑ Fentanyl

❑ Methadone (for pain) ❑ Exceeds 90 MME/day ❑ Exceeds Tablet Quantity Limit (Maximum Daily Limit)

If 90 MME/day or Quantity Limit is exceeded, provide rationale: _____

Previous Formulary Trial(s)

Drug Name/Strength/Dose	Date(s) & Duration of Trial	Treatment Outcome

Requested Drug Name: _____ **Strength: _____**

Quantity: _____ Length of Treatment: Day(s) _____ Month(s): _____

SIG: _____

SECTION 4: FOR EXEMPT PATIENTS ONLY

❑ Yes ❑ No Active Cancer Treatment Cancer Type: _____

❑ Yes ❑ No Sickle Cell Disease

❑ Yes ❑ No Hospice Care Diagnosis: _____

❑ Yes ❑ No Palliative Care [Diagnosis Code (Z51.5)] Diagnosis: _____

❑ Yes ❑ No Long-Term Care / Skilled Nursing Facility

Important: The remainder of this PA form does not need to be completed for patients who meet at least one of the above exceptions

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SECTION 5: ATTESTATION REQUIRED OF ALL PRESCRIBERS FOR NON-EXEMPT PATIENTS

Choose the section (A or B) that applies

A. For Outpatient Prescribers providing ongoing care: *EACH Question Must be Answered*

❑ Yes ❑ No Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).

❑ Yes ❑ No Patient has/will have random Urine Drug Screens (UDS).

❑ Yes ❑ No Naloxone prescription was provided or offered to patient/patient's household.

❑ Yes ❑ No Patient-Prescriber Pain Management/Opioid Treatment Agreement signed and in medical record

B. For Inpatient Hospital (Hospital), Ambulatory Surgery Center (ASC), and Emergency Room (ER) Prescribers: *EACH Question Must be Answered*

❑ Yes ❑ No Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).

❑ Yes ❑ No Naloxone prescription was provided or offered to patient/patient's household.

❑ Yes ❑ No I have discussed the risks/benefits associated with opioid use with patient/patient's house- hold

❑ Yes ❑ No The patient is exempt from need for a Patient-Prescriber Pain Management/Opioid Treatment Agreement and random UDS, because he/she is being discharged from the Hospital/ASC/ER and opioid treatment prescribed by the discharging provider will be for less than 30 days or the need for further opioid use will be re-evaluated by an Outpatient provider within 30 days.

I certify that the benefits of opioid treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Prescriber Signature: _____ Date (mm/dd/yyyy): _____

Important: Incomplete attestations will not be able to be processed by Medicaid Fee-For-Service (FFS) or Managed Care Organization (MCO) and will delay requests.