

To: Jai Medical Providers
From: MC-Rx
Date: October 1, 2025
Subject: Formulary Update – October 2025

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.

- Relueko (Filgrastim-ayow, a Neupogen biosimilar) – Criteria included below
- Fylnetra (Pegfilgrastim-pbbk, a Neulasta biosimilar) – Criteria included below
- Eligard (leuprolide) – Criteria included below

Medication	FILGRASTIM-AYOW (RELEUKO 300 MCG/0.5 ML SYRINGE RELEUKO 480 MCG/0.8 ML SYRINGE RELEUKO 300 MCG/ML VIAL RELEUKO 480 MCG/1.6 ML VIAL)
Covered Uses	<p>All FDA approved indications:</p> <ul style="list-style-type: none"> • 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. • Reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with acute myeloid leukemia (AML). • 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). • Mobilize autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis. • 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. • Increase survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome).
Required Medical Information	<p>Document one of the following:</p> <p>(a) Patients with nonmyeloid malignancies receiving myelosuppressive anti- cancer drugs associated with a significant incidence of severe neutropenia with fever; or</p> <p>(b) Patient has undergone induction or consolidation chemotherapy treatment for acute myeloid leukemia (AML); or</p> <p>(c) Patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation (BMT); or</p> <p>(d) Is for mobilizing autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis; or</p> <p>(e) Diagnosis of severe neutropenia with an absolute neutrophil count (ANC) < 1,000; or</p> <p>(f) 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; or</p>

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	(g) Is for increasing survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome).
Coverage Duration	One (1) year
Other Criteria	<ul style="list-style-type: none"> For injectable medications administered by a healthcare professional, please refer to the “Specialty Medication Guidelines” in the beginning of this formulary. Please indicate estimated duration of therapy

Medication	PEGFILGRASTIM-PBBK (FYLNETRA 6 MG/0.6 ML SYRINGE)
Covered Uses	<p>All FDA approved indications:</p> <ul style="list-style-type: none"> To decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia. To increase survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome).
Required Medical Information	<ul style="list-style-type: none"> To decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies - Document one of the following: <ul style="list-style-type: none"> (a) Patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever (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. For increasing survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome) – Document indication for use.
Coverage Duration	One (1) year
Other Criteria	<ul style="list-style-type: none"> For injectable medications administered by a healthcare professional, please refer to the “Specialty Medication Guidelines” in the beginning of this formulary. Please indicate estimated duration of therapy

Medication	DUPILUMAB (DUPIXENT 100 MG/0.67 ML SYRINGE DUPIXENT 200 MG/1.14 ML PEN DUPIXENT 200 MG/1.14 ML SYRINGE DUPIXENT 300 MG/2 ML PEN DUPIXENT 300 MG/2 ML SYRINGE)
Covered Uses	<p>All FDA approved indications:</p> <ul style="list-style-type: none"> Indicated for the treatment of adult and pediatric patients aged 6 months and older with moderate-to-severe AD whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable Indicated as an add-on maintenance treatment of adult and pediatric patients aged 6 years and older with moderate-to-severe asthma characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma

Medication	DUPILUMAB (DUPIXENT 100 MG/0.67 ML SYRINGE DUPIXENT 200 MG/1.14 ML PEN DUPIXENT 200 MG/1.14 ML SYRINGE DUPIXENT 300 MG/2 ML PEN DUPIXENT 300 MG/2 ML SYRINGE)
	<ul style="list-style-type: none"> • Indicated as an add-on maintenance treatment in adult patients and pediatric patients aged 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) • Indicated for the treatment of adult and pediatric patients aged one (1) year and older, weighing at least 15 kg, with eosinophilic esophagitis (EoE) • Indicated for the treatment of adult patients with prurigo nodularis (PN) • Indicated as an add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype • Indicated for the treatment of adult and pediatric patients aged 12 years and older with chronic spontaneous urticaria (CSU) who remain symptomatic despite H1 antihistamine treatment. • Indicated for the treatment of adult patients with bullous pemphigoid (BP).
Required Medical Information	<ul style="list-style-type: none"> • Indicated for the treatment of adult and pediatric patients aged 6 months and older with moderate-to-severe AD whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable <ul style="list-style-type: none"> ○ Previous treatment, or intolerance of, TCS; and ○ Previous treatment, or intolerance of, TCI • Indicated for an add-on maintenance treatment of adult and pediatric patients aged 6 years and older with moderate-to-severe asthma characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma <ul style="list-style-type: none"> ○ Previous treatment, or intolerance, with Xolair; and ○ Patients must be reevaluated after 6 months • Indicated for an add-on maintenance treatment in adult and pediatric patients aged 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) <ul style="list-style-type: none"> ○ Previous treatment, or intolerance, with Xolair; and ○ Previous treatment, or intolerance, with oral corticosteroid • Indicated for the treatment of adult and pediatric patients aged one (1) year and older, weighing at least 15 kg, with eosinophilic esophagitis (EoE) <ul style="list-style-type: none"> ○ Confirmed diagnosis with endoscopic esophageal biopsy showing the presence of eosinophils (≥ 15 eosinophils per high-power field); and ○ Previous treatment with proton-pump inhibitor (PPI); and ○ Previous treatment with oral corticosteroid; and ○ Attestation of dietary modifications (e.g., avoidance of food allergen triggers) • Indicated for the treatment of adult patients with prurigo nodularis (PN) <ul style="list-style-type: none"> ○ Previous treatment, or intolerance of TCS; and ○ Previous treatment, or intolerance of TCI • Indicated as an add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype

Medication	DUPILUMAB (DUPIXENT 100 MG/0.67 ML SYRINGE DUPIXENT 200 MG/1.14 ML PEN DUPIXENT 200 MG/1.14 ML SYRINGE DUPIXENT 300 MG/2 ML PEN DUPIXENT 300 MG/2 ML SYRINGE)
	<ul style="list-style-type: none"> ○ Document diagnosis of severe COPD with exacerbations (requiring treatment with either systemic corticosteroids and/or antibiotics) within the last year ○ Document concurrent use of standard of care therapy (e.g., LABA+LAMA+ICS triple therapy) ○ Document blood eosinophil count (BEC) ≥ 300 cells/μL within the past 6 months ● For Chronic Spontaneous Urticaria (CSU) <ul style="list-style-type: none"> ○ For the first prescription only: <ul style="list-style-type: none"> ▪ Diagnosis of Chronic Spontaneous Urticaria (ICD-10-CM L50.1) ▪ Failure, inadequate response, intolerance, or contraindication to H1 antihistamines (e.g., cetirizine, loratadine, fexofenadine, levocetirizine) ● For Bullous Pemphigoid (BP) <ul style="list-style-type: none"> ○ For the first prescription only: <ul style="list-style-type: none"> ▪ Diagnosis of Bullous Pemphigoid (ICD-10-CM L12.0) ▪ Previous inadequate response, intolerance, or contraindication to standard treatments, such as Systemic corticosteroids (e.g., prednisone), Topical corticosteroids (e.g., clobetasol), OR immunosuppressive agents (e.g., azathioprine, mycophenolate).
Required Medical Information – Renewal Requests	<p>Renewal Criteria:</p> <ul style="list-style-type: none"> ● For moderate-to-severe Atopic Dermatitis, Chronic Spontaneous Urticaria, Bullous Pemphigoid renewal also requires: <ul style="list-style-type: none"> ○ Documented improvement while on therapy ● For moderate-to-severe Asthma, renewal also requires documentation of clinical response as evidenced by ONE of the following: <ul style="list-style-type: none"> ○ Reduction in asthma exacerbation (worsening of symptoms) from baseline ○ Decreased use of rescue medications ○ Increase in percent predicted FEV1 (amount of air you can forcefully exhale) from pretreatment baseline ○ Reduction in severity or frequency of asthma-related symptoms such as less wheezing, shortness of breath, coughing, etc. ● For Chronic Rhinosinusitis with Nasal Polyposis, renewal also requires: <ul style="list-style-type: none"> ○ Document clinical benefit compared to baseline (such as improvements in nasal congestion, sense of smell, or size of polyps)
Max Quantity Per Day/Month	8.85ML 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	<ul style="list-style-type: none"> ● All FDA approved indications: ● Indicated for the treatment of adult and pediatric patients aged 6 months and older with moderate-to-severe AD whose disease is not

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	<p>adequately controlled with topical prescription therapies or when those therapies are not advisable</p> <ul style="list-style-type: none"> • Indicated as an add-on maintenance treatment of adult and pediatric patients aged 6 years and older with moderate-to-severe asthma characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma • Indicated as an add-on maintenance treatment in adult patients and pediatric patients aged 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) • Indicated for the treatment of adult and pediatric patients aged one (1) year and older, weighing at least 15 kg, with eosinophilic esophagitis (EoE) • Indicated for the treatment of adult patients with prurigo nodularis (PN) • Indicated as an add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype • Indicated for the treatment of adult and pediatric patients aged 12 years and older with chronic spontaneous urticaria (CSU) who remain symptomatic despite H1 antihistamine treatment. • Indicated for the treatment of adult patients with bullous pemphigoid (BP).

All changes in this notice supercede 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.