HealthyPractices™

MVP HEALTH CARE

A Bi-Monthly Publication for MVP-Participating Health Care Providers

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New York

In this Issue:

MVP Provider Directory

You can search the current MVP Provider Network for primary care physicians and specialists. Visit **mvphealthcare.com** and select *Find a Doctor.*

$ Un-Cashed Checks?

Visit **longlostmoney.com** to see if MVP has any un-cashed checks in your name or in the name of your business.

MVP Professional Relations

MVP Corporate Headquarters	**1-888-363-9485**
Southern Tier	**1-800-688-0379**
Central New York	**1-800-888-9635**
Midstate New York	**1-800-568-3668**
Mid-Hudson	**1-800-666-1762**
Buffalo/Rochester	**1-800-684-9286**

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President & CEO
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We welcome your comments.

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Professional Relations Updates

MVP Provider Resource Manual

MVP updates Provider policies and procedures in the Provider Resource Manual on a quarterly basis and posts them on the MVP website. Policy updates are published 30 days in advance of the effective date to allow providers to review these policy changes. All policies are effective on the first day of each quarter unless otherwise stated in the Provider Resource Manual.

MVP's contracts require providers to follow all MVP policies and procedures, so it is imperative that providers continue to review the Provider Resource Manual on a quarterly basis for all policy updates. To view the MVP Provider Resource Manual, visit **mvphealthcare.com** and *Sign In/Register*, and then select *Online Resources*.

Preventive Care Policy

MVP has developed a new Preventive Care Payment policy located in Section 15 of the Provider Resource Manual. The Preventive Care policy houses all services that are covered by MVP as it relates to State and Federal guidelines and MVP benefits. Most of the services listed in this policy are covered in full at no cost-share to the member. MVP will update Providers on new policies as they become effective relating to preventive care; however providers should also be reviewing this policy on a quarterly basis.

CMS Medicare Benefits and Beneficiary Protections

When a member receives items and services through referrals by an MVP-contracted provider to a non-contracted provider, the Centers for Medicare & Medicaid Services (CMS) expects that the contracted provider will coordinate with MVP before making that referral. This important step ensures MVP Medicare members are getting medically necessary services covered by their MVP Medicare Advantage Plan. If a contracted provider is not certain what is covered, they should request a pre-service organization determination prior to referring the member to a non-contracted provider by calling **585-325-3114** or **1-800-999-3920**.

In 2017, MVP Professional Relations Representatives will be working directly with contracted providers on a monthly basis to review data obtained through claims that have been referred to non-contracted providers for on-going education.

NY44 Health Benefits Plan Trust Member Identification Cards

This is a reminder to all providers that NY44/MVP members will need to produce their NY44/MVP Medical ID card as well as their Pharmacy Benefits Dimensions (PBD) RX ID card at the time of service. For NY44/MVP members requiring specialty drugs, providers will need to contact Pharmacy Benefits Dimensions Member Services Department at **1-888-878-9172** or **716-635-7880** before drugs are administered.

MVP Member Identification Cards

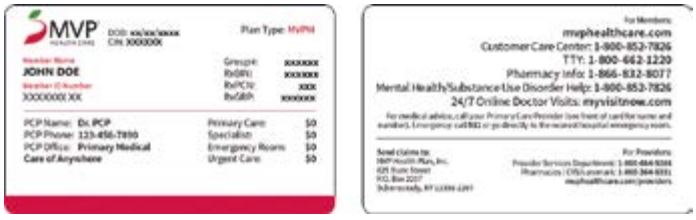
MVP continuously seeks to improve our business processes. We are excited to announce that we will be phasing in new Member ID cards throughout 2017. MVP will launch a newly designed Member ID card for our Commercial, Medicaid, and Medicare members. The 2017 ID cards feature more clearly organized member and provider information and a new design element in an effort to make health care simpler for our members, providers, and employer groups.

MVP Point of Service Member ID Card

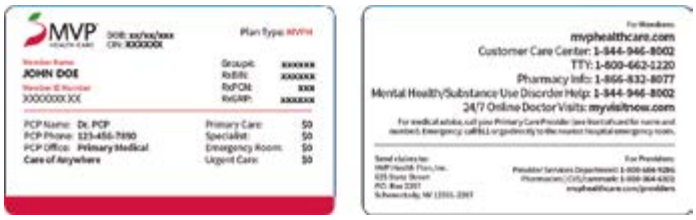
MVP Medicare Member ID Card

MVP HMO Member ID Card

MVP Medicaid Managed Care Member ID Card



MVP Harmonious Health Care Plan Member ID Card



New Office Posters Enlighten Members to the High Cost of Health Care Services

As part of MVP's effort to raise awareness about the importance of having a primary health care provider, we have produced an informative poster available to display within your practice.

The poster provides guidance to your patients about how they should think about health care services—particularly when their primary physician's office is closed.

With the prevalence of high-deductible plans, it is more important than ever for patients to act as consumers when considering their treatment options, it is important for them to understand the cost variations by site-of-service. Non-emergent emergency room services have a significant cost impact on patients when more appropriate options are available. We think this information will help initiate informative dialogue between providers and members when considering cost.

To receive your copies of the poster, please contact your MVP Professional Relations Representative.

Provider Demographic Changes

MVP makes every effort to ensure a provider's demographic information is accurate in our systems. If you or your practice have changes in demographic and/or participation status, it is important to promptly notify MVP.

Examples of status changes are:

- No longer accepting patients
- Changes of address, phone number, or tax ID number

To report demographic changes to MVP, please complete a Provider Demographic Change form. To download the form, visit **mvphealthcare.com** and select *Providers*, then *Forms*, and then the appropriate form under *Provider Demographic Change Forms*. Please return the completed demographic change form on letterhead to the appropriate fax number or email below.

East New York and Massachusetts
518-836-3278 **eastpr@mvphealthcare.com**

Central, Mid-State, or Southern Tier New York
315-736-7002 **centralprdept@mvphealthcare.com**

Rochester
585-327-5747
RocProviderChanges@mvphealthcare.com

Mid-Hudson New York
914-372-2035
MidHudsonprdept@mvphealthcare.com

Vermont
802-264-6555 **vpr@mvphealthcare.com**

For more information, see Section 4 of the MVP Provider Resource Manual.

Quality Improvement Updates

HEDIS® and New York State QARR Data Collection Begins in February 2017

The MVP Quality Improvement (QI) Department will begin its annual Healthcare Effectiveness Data and Information Set (HEDIS); and New York State Department of Health Quality Assurance Reporting Requirements (QARR) medical record reviews in February. HEDIS and QARR are sets of standardized performance measures designed to ensure that consumers and purchasers have the information they need to reliably compare managed health care plans. Managed care organizations are required to report rates to the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), the New York State Department of Health, and the Vermont Department of Financial Regulation.

Every year, the collected HEDIS data is used to guide the design and implementation of our health management activities, measure MVP's health management programs' effectiveness, and measure our performance against other health plans. In 2017, reviews will include the assessment of clinical performance in the following areas:

- Childhood and adolescent immunizations, including meningococcal vaccine, tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), and Human Papillomavirus Vaccine
- BMI assessment
- Colorectal cancer screening
- Comprehensive diabetes care
- Controlling high blood pressure
- Prenatal and postpartum care
- Cervical cancer screening
- Medication reconciliation upon discharge for the Medicare population

MVP has contracted with Interim HealthCare®, JRC Health Care Consulting, and Aerotek for registered nurses to help our QI staff collect data from medical records. A representative may contact your office to schedule the medical record review. We appreciate your cooperation and will make every effort to minimize any impact the review may have on your office operations. If your office will allow access to medical records remotely, and you would prefer that the medical record review be conducted remotely to minimize disruption to your office, please use the contact number below.

Please note: HEDIS/QARR are part of "health care operations" and, therefore, the Health Insurance Portability and Accountability Act (HIPAA) does not require authorization from individuals to release their protected health information (PHI) for health care operations activities. MVP has strict standards for the collection and storage of this information. Thank you in advance for your cooperation and support during these important quality activities.

If you have questions, call Michael Farina in the MVP Quality Management Department at **518-388-2463**.

Breast Cancer Screening Mandate Updates

Effective January 1, 2017, New York State has amended the current insurance law to increase access to care for Breast Cancer screening. The mandate indicates that members must have access to Diagnostic Mammograms, Breast Ultrasounds, and/or Breast MRIs. This includes Mammographies provided upon the recommendation of a physician for women of any age who have a prior history of breast cancer or a first degree relative with a prior history of breast cancer, a single baseline mammogram for women age 35–39, and an annual mammogram for women over age 40. Insurers will be prohibited from charging the insured, either in the form of an annual deductible, co-insurance, or a co-payment for these diagnostic services. These services will be covered at no cost to the member when the services are obtained from an MVP participating provider.

In addition, the mandate requires extended hours for mammography screenings to increase access to these services for members. Mammogram providers, specifically hospitals and extension clinics certified as a mammography facility pursuant to the Mammography Qualified Standards Act (MQSA), are required to provide extended hours for mammography services. The legislation requires that these extended hours be offered at least twice a week for two hours in the early morning, evening, or on the weekend.

Breastfeeding Support

MVP recognizes the importance of breastfeeding babies and we are committed to ensuring that breastfeeding support is available for every mother and child we cover. We now offer a comprehensive lactation support program through Corporate Lactation Services that provides the necessary equipment and guidance while breastfeeding.

Through this relationship with Corporate Lactation Services, MVP offers nursing mothers breastfeeding equipment and access to board certified lactation consultants 365 days a year. This support program includes outreach calls placed at specific times to provide mothers with information appropriate to the age of their child. Moms can also call in with questions or concerns until weaning.

All of these services are offered at no additional charge to our members. Benefit limitations may apply. Members may call the MVP Customer Care Center at the phone number on the back of their Member ID card to see if they qualify.

To enroll in this support program, members can visit **corporatelactation.com** and select *Subsidy Login*, then enter the company code, *MVP2229*. Members can contact Corporate Lactation Services by calling **1-888-818-5653**.

Case and Condition Health Management Programs Accepting Referrals

MVP offers dedicated Population Health Management programs to members at a variety of service levels. Drawing on the combined strength of our wellness strategists, registered nurses, social workers, respiratory therapists, physicians, pharmacists, and community health care providers, MVP offers a highly focused, integrated approach to management that promotes quality, cost-effective health care throughout the care continuum. MVP Case Managers utilize key principles within the framework of nursing case management established by the American Nursing Association and the Case Management Society of America.

MVP's Condition Health Management program focuses on members with:

- Asthma
- Low back pain
- Cardiac condition (post-event based)
- COPD
- Diabetes
- Heart failure

MVP's Acute Case Management focuses on high-risk target populations.

Factors considered for identifying eligible members for case management include: diagnosis, cost, utilization (emergency room and inpatient admissions) and qualitative variables (social risk, support network), as well as members' willingness to participate in case management.

Case management activities also include care of members who undergo organ transplant, have cancer, end stage renal disease, HIV/AIDS, or experience a high-risk pregnancy. Additional factors for consideration when determining member eligibility include members who are non-adherent to the plan of care and/or members who require additional guidance in navigating the health care continuum. Members who experience a critical event or diagnosis can be referred for case management services through multiple avenues.

To make a referral to our Population Health Management program, call **1-866-942-7966**, fax **1-866-942-7785**, or email **phmreferrals@mvphealthcare.com**.

Caring for Older Adults

New for 2017: Wellness Rewards for Medicare Members

MVP is encouraging its Medicare Advantage members to stay up-to-date with important preventive screenings by including a Wellness Rewards incentive on most 2017 MVP Medicare Advantage plans.

With Wellness Rewards, Medicare Advantage members can earn a $75 gift card by:

- Scheduling a Welcome to Medicare or Annual Wellness Visit (see next article).
- Asking the provider to complete a simple form confirming the member has received select preventive services, including a colorectal cancer screening within the recommended Medicare guidelines and a flu shot for the current flu season.
- Submitting the completed form to MVP to receive the reward.

Wellness Rewards are not available to SmartFund™ (MSA) plan members.

The Wellness Rewards Screening form can be downloaded by visiting **mvphealthcare.com** and selecting *Members*, then *Medicare member?-Get Started*, then *Live Well*, then *Learn more about Wellness Rewards*.

Welcome to Medicare and Annual Wellness Visits

The Welcome to Medicare or Annual Wellness Visit (as defined by Medicare) are an important part of a Medicare member's overall preventive care. The visit is a good time to talk about the member's overall health, medications taken, and any preventive screenings needed, as well as wellness topics like the importance of physical activity, fall risk, home safety, nutrition, bladder control issues, hearing loss, and quitting tobacco. You and the member can also develop or update a personal health plan or "Health Risk Assessment" to prevent disease and disability based on current health and risk factors.

There are specific codes to bill for these visits:

- G0402 (Welcome to Medicare initial preventive physical exam or IPPE)
- G0438 (Initial Wellness Visit)
- G0439 (Subsequent Annual Wellness Visit)

For more information, visit **cms.gov** and search for *The ABCs of the Initial Preventive Physical Examination (IPPE)* and *The ABCs of the Annual Wellness Visit (AWV)* education materials.

Participating in the Welcome to Medicare or Annual Wellness Visit is the first step for MVP Medicare members to earn their $75 Wellness Reward.

Medical Policy Updates

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during November and December. Some of the medical policies may reflect new technology while others clarify existing benefits. *Healthy Practices* and/or *FastFax* will continue to inform your office about new and updated medical policies. MVP encourages your office to look at all of the revisions and updates on a regular basis in the *Benefits Interpretation Manual (BIM)*. To access the *Benefits Interpretation Manual*, visit **mvphealthcare.com** and *Sign In/Register,* then select *Resources*. The Current Updates page of the BIM lists all medical policy updates. If you have questions regarding the medical policies or wish to obtain a paper copy of a policy, contact your MVP Professional Relations Representative.

Medical Policy Updates Effective February 1, 2017

Habilitation Services for Individual and Small Group Products (New): Habilitation Services is a new policy for individual and small group products effective January 1, 2017. The policy outlines criteria for both inpatient and outpatient settings. Criteria for inpatient habilitation services follow the same criteria that are used for acute inpatient rehabilitation admission in regard to requirements and number of days. The second set of criteria is for services in a Skilled Nursing Facility and must also meet Skilled Nursing Facility admission criteria. Outpatient section must meet requirements documented in both the medical records requirement section and habilitation services section of the medical policy.

Acute Inpatient Rehabilitation: There are no changes to the medical policy criteria.

Allergy Testing: The medical policy was updated with a Medicaid Variation for In vivo/In vitro testing and oral ingestion challenge testing.

Chiropractic Care: There are no changes to the medical policy criteria.

Continuous Passive Motion Devices: There are no changes to the medical policy criteria.

Colorectal Cancer Susceptibility Genetic Testing (New): This medical policy, Familial Adenomatous Polyposis (FAP) and Attenuated Adenomatosis Polyposis (APAP), addresses MUTYH-Associated Polyposis testing Lynch Syndrome (LS) or hereditary nonpolyposis colorectal cancer (HNPCC), microsatellite instability (MSI) testing or immunohistochemical (IHC) of tumor tissue and Cologuard. All the aforementioned tests are covered when medical policy criteria is met. There is a Medicaid Variation for Lynch Syndrome genetic testing.

Custodial Care: There are no changes to the medical policy criteria.

Electrical Stimulation Devices and Therapies: Previously, Electrical Tumor Treatment Field Therapy was considered investigational and therefore not covered. Electrical Tumor Treatment Field Therapy is covered when medical policy criteria are met when used with adjuvant temozolomide or as montherapy for recurrent supratentorial glioblastoma

Epidermal Nerve Fiber Testing: There are no changes to the medical policy criteria.

Genetic Counseling and Testing: The colorectal cancer genetic testing section has been removed from the policy. Please refer to the MVP Colorectal Cancer Susceptibility Genetic Testing medical policy. There is a Medicare Variation for coverage for the following tests when medical policy criteria are met: Prolaris™, Decipher®, ConfirmMDx, Genomic Sequence Analysis Panel in the Treatment of Non-Small Cell Lung Cancer. Progenza® PCA3 Assay (Prostate Cancer Antigen 3) and ThyroSeq® v.2. have been added to the policy as investigational and therefore not covered for all products.

Investigational Procedures: Sacroiliac Joint Fusion for treatment of low back pain (Ifuse system) and Percutaneous Sacroplasty for sacral insufficiency were added to the policy. The policy was updated to list percutaneous sacroplasty for treatment of sacral insufficiency fractures as investigational.

Hospital Inpatient Level of Care (NEW): This medical policy addresses determinations for inpatient level of care. The purpose of the policy is to assist with the complex considerations such as severity of illness, intensity of care needed, and individual member circumstances for determining inpatient level of care.

Obstructive Sleep Apnea, Surgical Treatment: There are no changes to the medical policy criteria.

Oncotype DX Test: The following changes were made to the medical policy: Prosigna Breast Cancer Prognostic Gene Signature Assay for the assessment of risk recurrence in individuals with breast cancer is considered investigational and therefore not covered. A Medicare Variation for Oncotype DX Breast Cancer Assay, Oncotype DX Prostate Cancer Assay, and Oncotype DX Colon Cancer Assay was added to the policy. These tests are covered for Medicare products only.

Speech Generating Devices: The medical policy was updated with language to clarify that devices such as tablets or smartphones must be designed by the manufacturer to function solely as a speech generating device. The policy lists separately payable accessories for speech generating devices.

Ventricular Assist Devices (Left): There are no changes to the medical policy criteria.

Vertebroplasty and Vertebral Augmentation: Previously, the medical policy name was Vertebroplasty and Kyphoplasty. The policy is now called Vertebrolplasty and Vertebral Augmentation. Percutaneous sacroplasty for treatment of sacral insufficiency fractures has been added to the policy as investigational and therefore not covered.

Medical Policies for Approval Without Changes in November 2016:

- Audiologic Screening (OAE)
- Compression Stockings
- Intraoperative Neurophysiologic Monitoring
- Interspinous Process Decompression System (IPD)
- Lymphedema Pumps, Compression, Garments, Appliances
- Neuropsychological Testing
- Radiofrequency Neuroblation Procedures for Chronic Pain

Clinical Guideline Updates

Careful Antibiotic Usage–Adult Treatment: MVP continues to endorse the guideline recommendations of the Centers for Disease Control and Prevention (CDC). The recommendations focus on preventing antibiotic resistance in adults. There have been no updates to the current guideline.

Careful Antibiotic Usage–Pediatric Treatment: The guideline addresses the growing problem of antibiotic resistance in children and follows the guideline recommendations of the CDC. There have been no updates to the current guideline.

Childhood Preventive Care

MVP endorses the American Academy of Pediatrics' recommendations as well as the CDC's for immunization. There are few new updates/changes to the 2015 recommendations:

Vision Screening: Routine screening at age 18 has been changed to a risk assessment.

Oral Health: Fluoride varnish is recommended from six months through five years.

Adult Preventive Care

MVP has adopted Adult Preventive Care Guidelines.

The adult guidelines reflect recommendations by the US Preventive Services Task Force. There are a few new recommendations for 2016/2017:

Obesity Screening and Counseling for Adults: Screening of all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions.

Statin Preventive Medication: For adults ages 40–75 years with no history of CVD, one or more CVD risk factors, and a calculated 10-year CVD event risk of 10 percent or greater.

Tuberculosis Screening for Adults: Screening for latent tuberculosis infection in populations at increased risk.

Syphilis Screening for Non-pregnant Persons: Screening for syphilis infection in persons who are at increased risk for infection.

Colorectal Cancer Screening: Screening for colorectal cancer starting at age 50 and continuing until age 75. See the USPSTF Clinical Considerations section for the various screening tests and the potential frequency of use.

Aspirin Preventive Medication: Adults age 50–59 with a ≥10 percent 10-year cardiovascular risk.

Pharmacy Updates

2017 Formulary Changes for Commercial and Marketplace Members

Formulary Exclusions: These medications will require medical exception approval.

2017 Commercial/Exchange Formulary Changes

Drug Class/Category	Excluded Drug	Preferred Drugs*
Anticoagulants	Pradaxa, Savaysa	Eliquis, Zarelto, warfarin
Antidepressants	Aplenzin	bupropion ER/XL/SR
	Parnate	tranylcypromine, phenelzine
Anxiety	Ativan	lorazepam, alprazolam, diazepam
Diabetes	Kombiglyze XR, Onglyza, Oseni, Kazano, alogliptan, alogliptan/metformin, alogliptan/pioglitazone	Tradjenta, Januvia, Janumet, Janumet XR, Jentadueto, Jentadueto XR
Erectile Dysfunction (Quantity limits still apply)	Cialis 10mg, 20mg (2.5mg and 5mg require prior authorization) Levitra, Staxyn, Stendra	Viagra

2017 Commercial/Exchange Formulary Changes continued from page 7.

Drug Class/Category	Excluded Drug	Preferred Drugs*
Gastrointestinal	gavilyte-H	gavilyte-C, gavilyte-G, gavilyte-N
	Metozolv ODT	metoclopramide
	Zuplenz	ondansetron, ondansetron ODT
	Lotronex	alosetron
Muscle Spasm	Amrix	cyclobenzaprine, tizanidine
Respiratory	Incruse Ellipta, Tudorza, Alvesco, Aerospan	Spiriva Respimat/Handihaler, Combivent, Atrovent, Advair HFA/Diskus, Asmanex/HFA, Qvar, Symbicort
Seizure	Felbatol	felbamate
	Mysoline	primidone
Vitamins	Revesta	folic acid and Vitamin D 50,000U

** No prior authorization required.*

New Clinical Edits

Drug	Clinical Edits
Xifaxan 550mg	Prior authorization required
Syprine	Prior authorization required
Long acting oral stimulants (i.e., Adderall XR, Concerta, Ritalin LA, Vyvanse)	Quantity limit of one capsule per day

Positive Change

Drug Class	Drug Name	Change
Diabetes	Toujeo Solostar	Tier 3 to Tier 2
	Tresiba FlexTouch	Tier 3 to Tier 2
Respiratory	Anoro Ellipta	Tier 3 to Tier 2
	Breo Ellipta	Tier 3 to Tier 2
	Flovent	Tier 3 PA to Tier 2 (no PA)

2017 Formulary Changes for Medicare Part D Members

This is not a complete list of changes. Please refer to 2017 formulary document. For more information about the 2017 MVP Medicare Part D Formulary, visit **mvphealthcare.com** and select *Members* , then *Prescription Benefits*, and then *2017 Formularies*.

Non-Formulary Medications Requiring a Formulary Exception Request

Non-Formulary Medication	Formulary Alternatives
Nexium 20mg and 40mg capsules	Esomeprazole 20mg and 40mg capsules
Omeprazole/sodium bicarb capsules (generic Zegerid)	Esomeprazole, pantoprazole, lansoprazole, rabeprazole
Beconase, Omnaris, and Vermyst nasal sprays	Fluticasone, mometasone, and budesonide nasal sprays
Asacol HD, Uceris, Pentasa	Apriso, Delzicol, Lialda, balsalazide, mesalamine
Zioptan	Lumigan, Travatan Z

The following medications will now require prior authorization for Medicare Part D members for 2017:

- Lidocaine 5% ointment
- Xifaxan 550mg tablets

Office Administered Drugs for Medicare Members

For dates of service on or after January 1, 2017, medications ordered from the CVS Specialty Pharmacy and administered in the office for Medicare Advantage plan members will no longer be billed to the member's Part B benefit. If the drug is on the Medicare Part D formulary and you continue to obtain it through CVS Specialty Pharmacy, it will follow the utilization management requirements identified on the Medicare Part D formulary. Under the Part D benefit, the amount the member pays for the drug will change and drug cost will count toward the coverage gap. Please keep in mind that the amount the member pays for the medication may be more when billed under the Part D benefit.

Policy Updates Effective January 1, 2017

Crohn's Disease & Ulcerative Colitis, Select Agents: No changes to this policy.

Proton Pump Inhibitor Therapy: Omeprazole-sodium bicarb packets will require prior authorization. Brand Nexium and generic Zegerid removed from requirements for doses greater than allowed quantity.

Viberzi: New policy.

Enteral Therapy New York and Vermont: Promactin AA Plus added to list of products not requiring prior authorization. Clarified that medical foods are not covered.

Enteral Therapy New Hampshire: Policy archived.

Gaucher Disease Type 1 Treatment: Exclusions updated.

Pradaxa: Policy archived.

Hereditary Angioedema: Updated dosing of Ruconest.

Cuprimine: Policy achieved.

Chelating Agents: **New Policy** Cuprimine and Syprine will require prior authorization.

Hemophilia Factor: Coagadex, Adynovate, and Kovaltry added to policy.

Xifaxan: 550mg tablets will not require prior authorization.

Benlysta: No changes to this policy.

Select Hypnotics: Generic Intermezzo must meet step edit requirements.

Gralise: No changes to this policy.

Multiple Sclerosis Agents: EDSS criteria removed from policy.

Oral Allergen Immunotherapy Medications: No changes to this policy.

Weight Loss Agents: Saxenda will require failure of Belviq and Contrave.

Xyrem: Failure of methylphenidate added to excessive daytime sleepiness criteria.

Respiratory Syncytial Virus/Synagis: Medicaid variation updated.

Immunoglobulin Therapy: Hemolytic uremic syndrome removed from criteria.

Addyi: New policy.

Pain Medications: Criteria for opioid point-of-sale edits added to policy.

Formulary Updated for Commercial, Marketplace, and Medicaid Formularies

New drugs–recently FDA approved, prior authorization required, Tier 3, non-formulary for MVP Medicaid plans.

Drug Name	Indication
Afstyla	Hemophilia A
Epclusa	Hepatitis C
Zinbryta	MS
Vonvendi	Von Willebrand disease
Xiidra	Dry eyes
Bevespi Aerosphere	COPD
Byvalson	Hypertension
Qbrelis	MI
Zurampic	Gout
Sustol	N/V due to chemotherapy
Otovel	Otitis media
Exondys 51	DMD
Cuvitru	Immunodeficiency
Taytulla	Acne vulgaris
Kyleena	Contraception

Drugs Added to Formulary
Tier 1 for Commercial/Medicaid and Tier 2 for Marketplace

Aripiprazole ODT
Nilutamide
Olmesartan/HCT
Ethacrynic acid
Olmesartan-amlodipine
Yuvafem

Drugs Removed from Prior Authorization

Alecensa	Bendeka
Darzalex	Descovy
Iressa	Odefsey
Otiprio	Portazza
Propel Implant	Seebri Neohaler
Utibron Neohaler	Vistogard