

HEALTHY PRACTICES™

VMC

VOLUME 8
NUMBER 2
MARCH/APRIL 2013

THIS NEWSLETTER CONTAINS INFORMATION THAT PERTAINS ONLY TO MVP-PARTICIPATING HEALTH CARE PROVIDERS.

in this issue

| | |
|---|---|
| Improved Asthma Care for MVP Members..... | 2 |
| Raising Antibiotic Awareness..... | 2 |
| Radiation Therapy Management ... | 2 |
| Prior Authorization for Skilled Nursing Stays..... | 2 |
| Annual Notices..... | 2 |
| Updates to Patient Information Accessible Online..... | 3 |
| Financial Incentives Relating to Utilization Management Policy..... | 3 |
| Caring for Older Adults..... | 3 |
| Medical Policy Updates..... | 4 |
| National Drug Codes (NDCs)..... | 5 |
| Pharmacy Updates..... | 5 |

contacting professional relations

| | |
|----------------------------|----------------|
| MVP Corporate Headquarters | 1-888-363-9485 |
| Vermont | 1-800-380-3530 |
| VMC | 1-800-639-3881 |

Denise V. Gonick
President and CEO

Healthy Practices

is a bi-monthly publication of the Corporate Affairs Dept.

comments

Write to:
Healthy Practices
MVP Health Care, Inc.,
Professional Relations Dept.
PO Box 2207, Schenectady, NY 12301



www.mvphealthcare.com

Healthy Practices delivered to your email

To reduce our impact on the environment and minimize the amount of mail that we send to our providers, MVP Health Care® is converting our printed newsletters to email. If you have an MVP online account, you are receiving *Healthy Practices* at the email address associated with that account. To receive communications at a different email address, or if you have not registered for an online account but would like to enroll in MVP e-communications, please complete this form: www.mvphealthcare.com/providerpreferences. If you have any questions or choose to opt out at any time, please email ecomunications@mvphealthcare.com.

RADIOLOGY PROGRAM UPDATE

Advanced imaging member scheduling program changes

MVP Health Care® implemented a member scheduling program in October, 2012. The program was a member advocacy program designed to assist members in scheduling their advanced imaging appointments. It also provided information to our members regarding the accreditation status of advanced imaging facilities and potential variation in out-of-pocket costs under their MVP health benefit plans.

MVP will modify the member scheduling program

- MVP received feedback from providers and members regarding the program. We listened to that feedback and, after careful consideration, have decided to modify the program.
- Effective Friday, January 25, the member scheduling program will be available to members on a voluntary basis only. Members may elect to initiate contact with CareCore National if they desire assistance with scheduling appointments. However, the member scheduling process will no longer be included in the advanced imaging prior authorization process.

Provider site selection

- Effective Friday, January 25, the prior authorization process will be modified so that ordering providers are given information regarding the preferred status of MVP participating providers.
- Ordering providers may select any MVP participating provider to perform advanced imaging services for their patients.
- This change will be incorporated into the existing telephonic and web-based authorization request processes.
- Upon receipt of authorization, ordering providers will now be able to immediately schedule advanced imaging services for their patients.
- CareCore National will no longer make outbound calls to members to schedule appointments.

MVP continues to believe that it is important to engage our members in active participation in their health care choices to ensure that they receive the highest quality, clinically appropriate and cost effective services. We will continue to explore methods of educating our members about their health plan benefits, of promoting transparency as they access health care services and of removing unnecessary costs from the health care system.

We thank you for your feedback regarding this program and for your continued participation with MVP Health Care.

POPULATION HEALTH MANAGEMENT UPDATES

Improving asthma care for MVP members

MVP Health Care analyzed data on members with asthma who visited the emergency room (ER). Our research shows that many members are non-adherent with their asthma medications, or that their asthma is inadequately controlled on their medications. MVP will begin outreach to health care providers in the coming months to address member medication compliance, focusing on members of our Commercial and Medicaid health plans.

If your patient's asthma is not well controlled, MVP has Health Managers (Registered Nurse and Registered Respiratory Therapist) to work with your MVP patients. A Certified Case Manager or Wellness Coach will offer information on lifestyle changes to help your patient minimize triggers, maintain an appropriate medication routine and more. Your patient will receive helpful information by mail about managing asthma with follow-up phone calls to answer questions and offer support. To make a referral, please call **1-866-942-7966**, fax **1-866-942-7785** or email **PHMReferrals@mvphealthcare.com**.

Raising antibiotics awareness

Antibiotics are not always the easy answer to being well. MVP recently partnered with the Vermont Department of Health and Vermont-area insurers to promote the *Get Smart About Antibiotics* campaign created by the Centers for Disease Control and Prevention (CDC).

MVP's focus is on urging all of our members (regardless of whether they live in Vermont) to talk with their doctors about when an antibiotic will help their condition, or if their condition is most likely caused by a virus that cannot be treated by an antibiotic. In addition to educational articles in all of MVP's spring 2013 member newsletters, we created a new web page to promote the campaign and link members to helpful information on the CDC website. To visit this web page, go to **www.mvphealthcare.com**, click *Live Healthy* at the top of the home page, then click the *Antibiotics* link on the left side of that page.

PROFESSIONAL RELATIONS UPDATES

MVP requests your feedback: ICD-10 readiness

MVP Health Care is preparing for the transition to ICD-10 in 2014. We are interested in our participating health care providers' progress toward ICD-10, also.

Please complete our short online survey about your ICD-10 readiness. Simply go to **www.mvphealthcare.com/provider** and click the ICD-10 readiness survey link on the right side of the page. Your feedback will help us implement education and outreach to help our participating providers as we all get ready for the October 2014 adoption deadline set by CMS. We appreciate your time!

OrthoNet professional service claims audit

As communicated in the July/August 2012 issue of *Healthy Practices*, MVP engaged OrthoNet to review the coding accuracy of certain surgical claims. That review program was effective as of October 1, 2012. Claims with dates of service occurring on or after October 1, 2012, may be subject to this review. OrthoNet will contact your office to request additional information, if needed, to complete this review of selected claims.

Radiation therapy management

As communicated in the July/August 2012 issue of *Healthy Practices*, MVP engaged CareCore National ("CareCore") to perform pre-service medical necessity reviews of radiation therapy treatment plans.

Prior Authorization: therapy plans initiated for services rendered on or after 10/29/12

Radiation therapy treatment plans initiated on or after October 29, 2012 require prior authorization from CareCore. Prior authorization requests can be initiated by calling CareCore at **1-866-665-8341**. Radiation therapy prior authorization history and status may be viewed at **www.carecorenational.com**. Claims for radiation therapy initiated and rendered on or after October 29, 2012 will be denied if prior authorization was not obtained.

Registration: treatment plans initiated prior to 10/29/12

Radiation therapy treatment plans that were initiated prior to October 29, 2012 are required to be **registered** with CareCore to ensure claim payment. Claims for radiation therapy services initiated prior to October 29 (with continuation of services rendered beyond that date) will not be paid unless those cases are registered with CareCore. Registration of radiation therapy plans for services that began before October 29 may be obtained by calling CareCore at **1-866-665-8341**. When registering such cases be certain to advise CareCore that the treatment plan was initiated prior to October 29, 2012.

Prior authorization for skilled nursing stays

As a reminder, all skilled nursing facility (SNF) stays require prior authorization from MVP. Please complete a Prior Authorization Request form, available on our website at **www.mvphealthcare.com/provider/ny/forms.html** in the *Prior Authorization, Referral and Admissions* section of the page. Forms may be submitted by fax to **1-866-942-7826** or by mail to MVP Health Care, Utilization Management, 625 State Street, Schenectady, NY 12305. To submit a prior authorization request by phone, please call **1-800-639-3881** or **802-847-8369**.

MVP annual notices

As part of our commitment to the accreditation standards of the National Committee for Quality Assurance (NCQA), and to comply with state and federal government regulations, MVP publishes an annual summary of important information for practitioners and providers. This notice includes the following topics:

- MVP's recognition of members' rights and responsibilities
- Complaints and appeals processes

- Confidentiality and privacy policies, including measures taken by MVP to protect oral, written and electronic PHI
- Medical management decisions
- Pharmacy benefit management
- Transition of patient care
- Emergency services
- Assessment of technology
- Medical record standards and guidelines
- Information about MVP's Quality Improvement Program
- Reporting suspected insurance fraud and abuse
- MVP's stance on physician self-treatment and treatment of immediate family members
- MVP's efforts to meet members' special, cultural and linguistic needs

To access MVP's annual notices for health care providers, visit the MVP website at www.mvphealthcare.com and click the *Privacy and Compliance* link in the green bar at the bottom of the home page. If you would like to receive a printed copy of this information, please call Professional Relations at the phone number shown on the left side of the this newsletter's front page.

WEB UPDATE

Updates to patient information accessible online

MVP is updating its online content for health care providers to ensure that the code descriptions we display are consistent with codes that are used in transmitting electronic (5010) transactions. These updates are effective March 22, 2013 and will affect some of the information that you access when you log in to your account at www.mvphealthcare.com.

PCP Specialty/Taxonomy Code Description

PCP Details on the *Patient Information* page will display the HIPAA-compliant Taxonomy Code Description for the provider's specialty.

Benefit Summary

After searching for and selecting a member, the member's benefits on the *Benefit Details* page will display *Service Type* descriptions.

Claim Status

The claims summary status will display a HIPAA-compliant claim status category code.

Examples of revised claim status language:

"Completed" will now read "Finalized"

"Adjusted Complete" will now read

"Finalized/Adjudication Complete"

"In process" will now read "Pending/In Process"

Deductible Amounts

A member's remaining deductibles will reflect HIPAA-compliant language and format changes.

For example:

Family deductible can include a Family Members Required option. In this type of deductible, once the stated number of members has met their deductible,

it is considered to have been met, even if the total dollar amount for the family has not been met.

For example:

- Member Amount 100
- Family Amount 350
- Family Members Required 3

In this example, once three family members have met their \$100 deductible requirement, benefit payment will begin, even though the \$350 entered as being the family amount has not been met. The deductibles will also be considered as satisfied when deductibles for all family members reach \$350. For example, Family Members #1, #2 and #3 have each accumulated \$90 toward the deductible, and Family Member #4 has accumulated \$80, for a total of \$350. No further charges will be applied to deductibles.

UTILIZATION MANAGEMENT UPDATE

Financial incentives relating to utilization management policy

It is the policy of all of the operating subsidiaries of MVP Health Care, Inc. to facilitate the delivery of appropriate health care to our members and to monitor the impact of the Plan's Utilization Management program to detect and correct potential under- and over-utilization of services.

MVP's Utilization Management Program does not provide financial incentives to employees, providers or practitioners who make utilization management decisions that would encourage barriers to care and services.

Utilization management decisions are based only on appropriateness of care and the benefits provisions of the member's coverage. MVP does not specifically reward practitioners, providers, or staff, including Medical Directors and UM staff, for issuing denials of requested care.

Financial incentives, such as annual salary reviews and/or incentive payments do not encourage decisions that result in underutilization.

QUALITY UPDATE

Reports from MVP help enhance patient management

The MVP Quality Improvement Department offers primary care quality reports (produced at the practice site level) that can help you manage your patient population.

- The prospective Gaps in Care report identifies members who have not had preventive screenings, well care visits or immunizations. If a member is lacking services in multiple areas, the information is consolidated on one row to make it easier for you to ensure that all services are provided in a timely fashion. This report is produced three times a year.
- MVP also produces two emergency room (ER) utilization reports. One provides detailed

information on members who have utilized the ER in the past month for care. The other report provides a list of members who have utilized the ER two or more times in the past month for care. These reports are produced monthly and are usually available around the 20th of each month.

- The Inpatient report provides a list of members who were discharged from the hospital during the previous month. The report lists the discharging hospital, the length of stay and diagnosis. This report also is produced monthly and is available around the 20th of each month.

MVP's reports are provided in an electronic format (Excel), allowing you to work with the data based on your particular need or interest. All of the reports that you request will be sent to you via MVP's secure email service (ZixMail) to ensure the protection of PHI.

If you would like to begin receiving these reports or have questions about any of the reports that you currently receive, please email: Michael Farina, Associate Director Clinical Reporting, at mfarina@mvphealthcare.com.

CARING FOR OLDER ADULTS

Your impact on patients' Health Outcome Survey (HOS) responses

The Centers for Medicare & Medicaid Services (CMS) requires health plans to monitor the care our members receive from their health care providers. As we have discussed in previous editions of this newsletter, the CMS Star Ratings include many measures that are associated with care given by physicians who care for MVP Medicare Advantage (MA) members.

Some of the measures are self-reported by your patients through a survey called the Health Outcome Survey (HOS). The HOS assesses each MA plan's ability to maintain or improve the physical and mental health functioning of its beneficiaries over a two-year period. The initial survey is sent to get baseline information on the patient's perception of their health.

The survey is sent to the same patients (if possible) after two years to assess changes in their physical health status. The survey includes questions that ask

your patients if their PCP has talked to them about physical activity, about their risk of falls and about urinary incontinence. **CMS is expecting that an assessment of these issues is completed and that a treatment plan is in place to improve the quality of life for your patients if any issues are identified.**

The HOS also includes questions about their physical and mental well-being. Several questions are asked about their physical and mental health that compares results to how these patients responded to the survey done two years earlier. Assessment of a patient's physical and mental health is a critical part of any office visit.

The CMS star rating for these measures for the last reporting period are in the chart below.

MVP has developed some tools to assist physicians and their office staff that can be utilized for the above assessments. They can be found in the *Provider QI Manual* on our website.

Go to www.mvphealthcare.com, click *Provider* and then *Provider Quality Improvement Manual* in the *Quality Programs* section of that web page. The direct link is www.mvphealthcare.com/provider/qim/caring_for_older_adults.html. The MVP Adult Preventive Care Guideline includes a matrix of preventive services recommended for care of the elderly.

MEDICAL POLICY UPDATES

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the January meeting. 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 *Benefit Interpretation Manual* (BIM) located on www.mvphealthcare.com. To access the BIM, log in to your account, visit *Online Resources* and click *BIM* under *Policies*. 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 Professional Relations representative.

(Continued on Page 5)

HEALTH OUTCOME SURVEY RATINGS (see above article: *Your impact on patients' Health Outcome Survey (HOS) responses*)

| CMS Measure* | Rochester HMO Members Results | Rochester PPO Members Results | East Region HMO Members Results | East Region PPO Members Results |
|--|-------------------------------|-------------------------------|---------------------------------|---------------------------------|
| Monitoring physical activity (discussed physical activity & PCP advised to start, increase or maintain level of exercise or physical activity) | 2 | 2 | 3 | 3 |
| Reducing Fall Risk (assess patient's risk of falling & development of a plan to reduce risk of falls) | 4 | 3 | 1 | 3 |
| Improving Bladder Control (assess patient for urinary incontinence & received treatment) | 3 | 3 | 3 | 3 |
| Improving or maintaining physical health | 5 | 5 | NA | 4 |
| Improving or maintaining mental health | 2 | 3 | NA | 2 |

*Scores are rated 1 to 5 stars with 5 stars being the highest or best rating.

Medical policy updates effective April 1, 2013

Bone Density Study for Osteoporosis (DEXA)

There are no changes to the medical policy.

Bone Growth Stimulator

The Indications/Criteria for the Ultrasound Bone Growth Stimulator now lists the types of bone fractures that are covered.

Compression Stockings

The following codes are not covered under MVP Option products: surgical stockings (A4495, A4500); gradient compression stockings (A6530, A6533 - A6541, A6544; and A6549; miscellaneous DME supply or accessory, A9999, not otherwise specified).

Speech Generating Devices

Communication boards have been added under accessories covered for speech generating devices.

Please refer to the coding section on the policies to identify any code changes (e.g., new, deleted) or codes no longer requiring prior authorization for a specific policy. Each policy grid defines the prior authorization requirements for a specific product.

Medical policy updates effective June 1, 2013

Electrical Stimulation Devices & Therapies (NEW POLICY)

The policy follows Medicare's National and Local Coverage Determination. Coverage is allowed for TENS for chronic low back pain when criteria in the policy are met. Medicare does not allow coverage of TENS for low back pain.

CLAIMS UPDATE

National Drug Codes (NDCs)

Health care providers have asked how to bill NDC codes. What follows are answers to your most-asked questions.

NDC Formatting

- A valid NDC is submitted as an 11-digit code without any dashes.
- However, you will usually not see just 11 numbers when you look at an NDC on a medication package. This is because the 11 digits of an NDC are broken out into 3 sections:
 - The first 5 digits identify the drug manufacturer.
 - The next 4 digits identify the specific drug and its strength.

- The last 2 digits are indicative of the package size.
- In some cases, you may see a "5 digit-4 digit-2 digit" code (example: 12345-1234-12).
 - In this situation, you will simply remove the dashes and submit the 11 numbers.
- You also may see other formats for NDCs, since many manufacturers omit leading zeros in one or more of the three NDC sections.
- For a claim to be paid, any leading zeros must be added back into the appropriate place within the NDC to create an 11-digit NDC number that matches the Medispan and/or First Databank databases.

Choosing the applicable NDC:

- Drug manufacturers are currently not allowing NDCs found on the inside packaging to be published. This means that the outermost NDC (on a box) should always be used for billing rather than the NDC found on an individual syringe or vial.

PHARMACY UPDATES

Therapeutic class changes

Upon review of select therapeutic classes, the Pharmacy & Therapeutics committee approved the following changes. These changes do *not* apply to MVP Medicare, Option or Option Family business. All impacted members and providers will receive a letter if further action is required.

Antidiabetic agents

Janumet XR will be added to the formulary. Onglyza and Kombiglyze XR will be removed from the formulary and require prior authorization effective April 1, 2013.

Inhaled corticosteroids

Qvar will be added to the formulary. Flovent will be removed from the formulary. Prior authorization will be required for non-formulary agents Alvesco and Flovent effective April 1, 2013.

Inhaled corticosteroids/LABA combinations

Dulera will be added to the formulary. Advair will be removed from the formulary and require prior authorization effective April 1, 2013.

Urinary anticholinergics/antispasmodics

Toviaz and Vesicare will be added to the formulary. Prior authorization will be required for non-formulary agents effective April 1, 2013.

(Continued on Page 7)

HERE'S HOW TO CONVERT YOUR NDC INTO THE "5-4-2" FORMAT AND HOW TO KEY IT ONTO THE CLAIM FORM BY ADDING THE N4 QUALIFIER:

| Packaging NDC Format | Add leading zero(s) to the: | Conversion Examples | and is keyed as |
|----------------------|--|---|-----------------|
| 4-4-2 | First segment to make it 5-4-2 | 4-4-2=1234-1234-12 becomes 5-4-2=01234-1234-12 | N401234123412 |
| 5-3-2 | Second segment to make it 5-4-2 | 5-3-2=12345-123-12 becomes 5-4-2=12345-0123-12 | N401234123412 |
| 5-4-1 | Third segment to make it 5-4-2 | 5-4-1=12345-1234-1 becomes 5-4-2=12345-1234-01 | N401234123412 |
| 3-2-1 | First, second, and third segments to make it 5-4-2 | 3-2-1=333-22-1 becomes 5-4-2=00333-0022-01 | N400333002201 |

NDCS ON CMS-1500 CLAIM FORMS

Instructions for filling out a CMS-1500 form

- NDC should be entered in the shaded area of fields 24A - 24G for the corresponding procedure code
- The following should be included in order
 - Report the N4 qualifier (left justified) followed immediately by:
 - 11 digit NDC (no hyphens)
 - One space followed immediately by:
 - Unit of measurement qualifier:
 - F2 - International Unit
 - GR - Gram
 - ML - Milliliter
 - UN - Unit
 - Unit Quantity
 - Quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal.
 - Examples:
 - 1234.56
 - 2
 - 99999999.999

Example : N412345678901 UN1234.567

NDC Code:

| 24. A. DATE(S) OF SERVICE | | | | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | | | E. DIAGNOSIS POINTER | F. \$ CHARGES | G. DAYS OR UNITS | H. SPRT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # | | | |
|---------------------------|----|----|----|---------------------|--------|---|----------|-------|-------------------------|---------------|------------------|------------------------|-----------------|--------------------------------|---|-----|-------------|
| MM | DD | YY | MM | DD | YY | CPT/HCPCS | MODIFIER | | | | | | | | | | |
| N45914801665 UN1 | | | | | | | | | | | | | | | | | |
| 10 | 01 | 05 | 10 | 01 | 05 | 11 | | J0400 | | | 1 | | 250 00 | 40 | N | 1B | 12345678901 |
| | | | | | | | | | | | | | | | N | NPI | 0123456789 |

NDCS ON UB-04 FORMS AND ELECTRONIC CLAIM SUBMISSIONS

Instructions for filling out a UB-04 form

- NDC should be entered into field 43
- The following should be included in order
 - Report the N4 qualifier (left justified) followed immediately by:
 - 11 digit NDC (no hyphens) followed immediately by:
 - Unit of measurement qualifier:
 - F2 - International Unit
 - GR - Gram
 - ML - Milliliter
 - UN - Unit

followed immediately by:

- Unit Quantity (floating decimal, limited to three digits to the right of the decimal)

Example : N412345678901UN1234.567

Instructions for electronic claim submissions

Complete the drug identification and drug pricing segments in Loop 2410 following the instructions below.

| Loop | Segment | Element Name | Information |
|------|---------|------------------------------------|--|
| 2410 | LIN 02 | Product or Service ID Qualifier | Use qualifier N4 to indicate that entry of the 11 digit National Drug Code in 5-4-2 format in LIN03 |
| 2410 | LIN 03 | Product or Service ID | Include the 11-digit NDC (No hyphens) |
| 2410 | CTP 04 | Quantity | Include the quantity for the NDC billed in LIN03 |
| 2410 | CTP 05 | Unit or Basis for Measurement Code | For the NDC billed in LIN03, include the unit or basis for measurement code using the appropriate code qualifier: <ul style="list-style-type: none"> • F2 - International Unit • GR - Gram • ML - Milliliter • UN - Unit |

Policy updates (effective April 1, 2013)

Antipsychotics for Depression

- Step edit requirement language was clarified.

Compounded (Extemporaneous) Meds

- Language clarified that self-administered compounds must process through the PBM.
- All compounds, medical or pharmacy, over \$250 require prior authorization.

Cox-2 Inhibitors

- Formulary language updated for Option/Option Family.

DPP4 Inhibitors (NEW)

- New policy requiring prior authorization for non-formulary Onglyza and Kombiglyze XR.
- Criteria includes failure on formulary DPP4 agents.

Erivedge (NEW)

- New policy establishing prior authorization criteria that includes but is not limited to diagnosis of locally advanced or metastatic basal cell carcinoma, prescribed by an oncologist or dermatologist and age 18 or older.

Horizant

- New indication and criteria for the use in post-herpetic neuralgia was added. Criteria is the same as Gralise.

Hypnotics (select)

- Intermezzo was added to the policy with quantity limits.
- Select Medicare language was removed as new CMS guidelines allow coverage for select benzodiazepines.

Inhaled Corticosteroids and Combinations (NEW)

- New policy requiring prior authorization for non-formulary Alvesco, Flovent and Advair.
- Criteria includes FDA approved dosing and age requirements as well as failure on all other formulary covered drugs.

Mepron (NEW)

- New policy establishing prior authorization to ensure appropriate utilization.

Migraine Agents

- Clarified prior authorization requirements on drug table.

Overactive Bladder (Oral) Treatment (NEW)

- New policy requiring prior authorization for non-formulary Sancture/XR and Enablex.
- Criteria include failure on formulary agents.

Pain Medication

- Subsys was added to policy.
- Language referring to the new REMS Program for Tansmucosal Immediate Release Fentanyl was added.
- Use of buprenorphine in combination with opioids was excluded.

Pharmacy Programs Administration

- Prescriber prevails provision added for atypical antipsychotics, for Option and Option Family business only.

Prescribers Treating Self and Family Members

- Contract language was updated.

Provenge

- Prostate cancer stats were updated. No changes to criteria.

Xyrem

- Use with alcohol added as an exclusion.

The following policies were reviewed and approved without any changes to criteria:

- Gralise
- Mail Order
- Physician Prescriptions Eligibility
- Qutenza
- Sabril
- Vimovo

Formulary updates for Commercial and Option members

New drugs (recently FDA approved, prior authorization required, Tier 3, non-formulary for MVP Option/MVP Option Family)

| <u>Drug Name</u> | <u>Indication</u> |
|------------------|-----------------------------------|
| Aubagio | Multiple sclerosis |
| Linzess | IBS-C and CIC |
| Synribo* | Chronic myeloid leukemia |
| Ultresa | Exocrine pancreatic insufficiency |
| Viokace | Exocrine pancreatic insufficiency |
| Xeljanz | Rheumatoid arthritis |

*Medical drug

Generic drugs added to Formulary (Tier 1)

betamethasone foam (Luxiq)
candesartan-HCTZ (Atacand HCT)
fenofibrate (Tricor)
glimepiride-metformin (Duetact)
griseofulvin ultra (Gris-Peg)
Lamictal XR (lamotrigine XR)
oxymorphone (Opana ER –old formulation)
phenytoin (Dilantin Chewable)
rizatriptan (Maxalt/MLT)
tranexamic acid (Lysteda)

Drugs removed from the Formulary

(effective April 1, 2013)*

| | |
|------------|----------|
| Celontin | Peganone |
| Duetact | Tricor |
| Maxalt/MLT | |

*Affected members will receive a letter if further action is required (i.e. contacting the prescriber for a formulary alternative)

Drugs removed from prior authorization

(all medications are non-formulary, Tier 3 unless otherwise noted)

| | | |
|---------|---------|-----------|
| Pertzye | Sorilux | Voraxaze* |
|---------|---------|-----------|

*Medical drug



P.O. Box 2207
Schenectady, NY 12301

your
healthy **practices**
newsletter is here!