VMC

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

in this issue

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comments

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MVP® HEALTH CARE

www.mvphealthcare.com

MVP launching Care Radius summer 2014

This summer, MVP Health Care® will launch Care Radius, a web-based care management platform that will allow us to connect members, providers and partners for real-time information sharing.

As a part of Care Radius, you will have access to a program called Care Affiliate that will allow you to submit authorizations online. It can be used for inpatient and outpatient medical and pharmacy authorizations. Required information for authorizations will be completed within the program and documentation can be attached before being sent directly to MVP for review. Care Affiliate will be accessible to you through a single sign-on process on MVP's provider portal. It does not require a unique username and password.

MVP will provide regular updates on Care Radius and Care Affiliate features, key dates and how to use the program throughout the year.

Health Insurance Marketplace update

MVP is committed to helping you provide quality care to your patients as they navigate the new Health Insurance Marketplace. Now that coverage for enrolled members in the Marketplace has effectuated, remember to refer to MVP's *Quick Reference Guide* as a resource. It is available at **www.mvphealthcare.com/providers** and highlights key points on member eligibility, ID cards, provider participation, pharmacy and more. Print it out for assistance when you see an MVP Marketplace member.

EFT/ERA live!

MVP is pleased to share that our ability to offer you, our providers, the health care industry's leading solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs) through PaySpan is now live. This service is provided at no cost to you and allows online enrollment, saving you time and ensuring faster payments.

By now you should have received registration information from PaySpan, if you have not, please contact their Provider Services at **1-877-331-7154**, Monday – Friday, 8 am – 8 pm Eastern Time.

A note about Administrative Services Only (ASO) accounts – MVP provides insurance for some ASO employer groups, which means the employer group pays the claims directly from their bank account. There have been some instances where the employer group's bank has not completed set up to allow claims dollars to pull directly from the employer's bank account and transfer to provider offices through the EFT process with PaySpan. If you provide care for one of these members, the claims will not be delivered through EFT but will be sent as a paper check and paper remittance. We anticipate this volume to be low and resolved quickly since PaySpan is working directly with all the banks servicing our self insurance employer groups to get them set up. We appreciate your patience in this matter.

UTILIZATION MANAGEMENT UPDATE

Financial incentives relating to utilization management policy

It is MVP's policy, and that of all of our operating subsidiaries, 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 overutilization 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

CLAIMS UPDATES

ICD-10: Improving clinical documentation

Improving clinical documentation involves a joint effort from both the provider and the coding professional and it includes:

- Well-documented medical records that facilitate communication, coordination and continuity of care and promotes the efficiency and effectiveness of treatment.
- Accurate coding for prompt reimbursement, practice profiling and contract negotiations. It is important for both financial and compliance reasons.
- Documenting chronic conditions to show not only resource utilization, but also severity of illness for statistical purposes.
- Detailed specificity for further research into treatment effectiveness for chronic conditions.
- Showing medical necessity means you are justifying your treatment choice and help support E/M levels.

Focus on these while you work with your staff to prepare for ICD-10, which begins October 1, 2014. For additional resources, visit **www.mvphealthcare.com/provider** and click *ICD-10 Updates and FAQs.*

ICD-10: Take MVP's new readiness survey

As the Centers for Medicare & Medicaid Services (CMS) deadline approaches for ICD-10 compliance on October 1, 2014, MVP invites you to participate in a **new** ICD-10 readiness survey. Participation in this brief survey of 15 questions (which should take you about 10 minutes) will help us gauge how we can best assist you with your ICD-10 preparation readiness plans. Please note, this survey is different from one distributed last spring to some providers.

To take the survey, visit **www.surveymonkey.com/s/MVP_ICD-10**.

We appreciate you sharing your ICD-10 readiness plans with us. Results will be distributed in upcoming *Healthy Practices* articles. For more information on ICD-10, please visit **www.mvphealthcare.com/provider** and click *ICD-10 Updates and FAQs*.

PROFESSIONAL RELATIONS UPDATES

Transition update

Over the next few months, MVP will be transitioning Vermont Managed Care's (VMC) provider network into our directly contracted network. There are a number of changes that you should be aware of as we work though this transition. More details will be communicated to you through letters, *FastFax* updates and by your Professional Service Representatives; however there are a few key points to remember:

- First, beginning April 1, 2014 contact MVP directly for all your utilization management, credentialing and other professional service needs. More details regarding these changes will be communicated to you in the next few months, and of course our team will be ready to assist you.
- Additionally, if you have not received a contract from us at this time, please contact MVP Professional Services as soon as possible at **1-800-380-3530, option number 3**. Most agreements were sent out in late December, so if you have not been in contact with us or haven't yet returned your contract, please contact us as soon as possible.
- Finally, please note that MVP uses a different set of medical criteria for medical reviews such as inpatient hospital admissions and certain procedures. MVP uses InterQual rather than Milliman criteria that was utilized by VMC for some medical reviews.

If you have any questions about your transition to MVP, please feel free to contact us. We will do our best to ensure a smooth transition and we look forward to working directly with you.

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 **www.mvphealthcare.com** and click *Privacy and Compliance* at the bottom of the homepage. If you would like to receive a printed copy of this information, please call Professional Relations at the phone number shown on the front page of this newsletter.

Access and availability standards

The Department of Health (DOH) performs regular audits of MVP's network of health care providers. The purpose of the survey is to assess the compliance of PCPs and OB/GYNs participating in the NYS Medicaid Managed Care program with the medical appointment standards delineated in the Medicaid and Family Health Plus contracts. The list of these access standards is available in Section 4 of the MVP *Provider Resource Manual* titled *Provider Responsibilities*.

POPULATION HEALTH MANAGEMENT UPDATES

Quality Assurance Reporting Requirements data collection begins

HEDIS® and New York State Quality Assurance Reporting Requirements (QARR) data collection began in February 2014. The MVP Quality Improvement (QI) department will begin its annual Health Care Effectiveness Data and Information Set (HEDIS); and New York State Department of Health QARR medical record reviews. 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 their 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 (DFR).

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 2014, reviews will include the assessment of the 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 (HPV) for female adolescents
- Adult BMI assessment
- Cholesterol management for patients after an acute cardiovascular event
- Colorectal cancer screening
- Comprehensive diabetes care
- Controlling high blood pressure
- Prenatal and post-partum care

MVP has again contracted with Interim HealthCare® for registered nurses to help our QI staff collect data from medical records. An MVP QI staff or Interim HealthCare 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 allows access to the medical records remotely, and you prefer that the medical record review be conducted remotely to minimize disruption to your office, please let us know.

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 the 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**.

Asthma help

If your patient's asthma is not well controlled, MVP has Case Managers who are registered nurses and registered respiratory therapists to work with

your 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**.

MVP 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 (see the Asthma article above for more information)
- Low back pain
- Cancer (Oncology)
- Cardiac condition (post-event based)
- COPD
- Diabetes
- End stage renal (Dialysis)
- 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, live with hemophilia or HIV 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**.

Smoking cessation

Many people who use tobacco want to quit but need help. There are tools and support available if your patients ask about ways to quit smoking. Quitting smoking medications can double the chances of becoming permanently tobacco-free. Medications along with counseling can improve your patients' chances of quitting successfully.

If your patient wants more information regarding whether they are ready to quit using tobacco, they can visit **www.mvphealthcare.com** and click *Live Healthy* then *Health Tools and Calculators*. For help quitting, the New York State Smokers Quitline is available at **1-866-NY-QUITS** or **www.nysmokefree.com**.

QUALITY UPDATES

Provider Quality Improvement Manual (PQIM) update

Clinical guidelines re-endorsed

The MVP Quality Improvement Committee (QIC) recently re-approved the following enterprise-wide clinical guidelines:

Heart Failure in Adults Guideline – MVP continues to endorse the Institute for Clinical Systems Improvement Heart Failure in Adults guideline. Go to **www.icsi.org**, click *Guidelines and More*, then *Guidelines/Protocols*, select *Cardiovascular* then *Search* and click the article titled *Heart Failure in Adults*. Page one of the guideline contains an algorithm which is supported by the remaining pages of annotations and evidence.

Hypertension – MVP continues to endorse the recommendations from the National Heart, Lung, Blood Institute for hypertension, *The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure* (JNC7). The recommendations can be found at **www.nhlbi.nih.gov/guidelines/hypertension**.

MVP Health Care updates its clinical guidelines at least every two years. The review process is also initiated when new scientific evidence or national standards are published. Paper copies of these recommendations are available by calling MVP's Quality Improvement (QI) department at **1-800-777-4793, ext. 12247**. The recommendations will also be available in an update to the MVP *Provider Quality Improvement Manual*.

The current edition of the manual is located at **www.mvphealthcare.com/provider** and click *Provider Quality Improvement Manual*.

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

*Scores are rated one to five stars with five stars being the highest or best rating.

CARING FOR OLDER ADULTS

Ask your Medicare patient to see their health tracker!

MVP Medicare members will receive a Personal Health Tracker from MVP. We ask that you review it with your patient. The Personal Health Tracker can also be found in the MVP *PQIM* on our website. Go to **www.mvphealthcare.com/provider** and click *Provider Quality Improvement Manual*, then *MVP Health Tracker*.

The purpose of the tracker is to help our members keep a record of Primary Care Physician (PCP) and specialist visits, answering questions such as:

- What was the reason for the visit?
- What did the member find out at the visit?
- What does the member need to do?

The tracker assists in keeping a record of other health care services. Members can list their medications and why they take them, recommended tests and screenings with results. Members will be encouraged to work with their doctor to take the best care of themselves. The tracker also includes information about free programs offered by MVP to help them live well.

How your patients respond to the CMS Health Outcome Surveys: what is the physician's role?

The Centers for Medicare & Medicaid Services (CMS) requires health plans to monitor the care our members receive from their health care providers. The CMS Star Ratings include many measures associated with care given by physicians who care for 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 and how the physicians work together with their patients to achieve their goals.

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 expects that an assessment of these issues is completed and a treatment plan is in place to improve the quality of life for your patients if any issues are identified.**

Assessment of a patient's physical and mental health is a critical part of any office visit. The MVP CMS star rating of our three Medicare contracts on these measures for the last reporting period are noted in the chart above.

MVP developed tools to assist physicians and their office staff that can be utilized for the above assessments. They are found in the MVP *PQIM* on our website. Go to **www.mvphealthcare.com/provider** and click *Provider Quality Improvement Manual.* The *MVP Adult Preventive Care Guideline* includes a matrix of preventive services recommended for care of the elderly.

Talk to patients about avoiding hospital readmission

In an effort to decrease readmission rates after a hospital stay, MVP is educating its Medicare Advantage plan members on how to be prepared for a smooth transition from hospital to home. We need the help of our physicians and your office staff in this effort. Members who are better prepared before their visit will have a lower chance of re-admissions back into the hospital because of a problem. Providing continuity and coordination of care for a patient as they transition from the hospital setting to outpatient is also crucial in reducing hospital readmission rates.

Health care providers can help by obtaining hospital discharge summaries in a timely manner and documenting any changes in medical/surgical history and medications. Often, after a hospital stay, a patient may have additional specialists involved in their care. It is important for primary care providers (PCPs) and specialists to communicate relevant information to ensure a coordinated approach to the patient's care.

We encourage physicians to speak with MVP Medicare plan members about this important topic.

Some helpful tips that members should follow include:

- Bring a complete list of medications to the hospital on the day of admission.
- Work with the discharge planning staff to make a hospital follow-up plan.
- Take an active role in discharge and treatment planning.
- Learn any important details about the condition and how they can take care of themselves.
- Schedule a follow-up appointment within seven days after leaving the hospital.
- Bring the hospital discharge plan along with a list of medications to follow-up appointment(s).
- Carry important information at all times about the condition, medications, doctor and pharmacy contact information.

To help members keep important information with them at all times, MVP created the *My Hospital Discharge Checklist* wallet card. It is available at **www.mvphealthcare.com**, click *Medicare Members*, select the county in which your patient lives, then click *Live Well* and *Useful Tips After a Hospital Stay*.

MEDICAL POLICY UPDATES

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the February 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 policies updates. If you have questions regarding the medical policies, or wish to obtain a paper copy of a policy, contact your Professional Relations representative.

Medical policy updates effective March 1, 2014

Clinical Guidelines Development, Implementation and Review Process

The medical policy was updated to state that MVP seeks to endorse or develop clinical practice guidelines that support appropriate care of behavioral health services that address adult, children and adolescent populations.

Medical policy updates effective April 1, 2014

Alopecia/Wigs/Scalp Prosthesis

There are no criteria changes to the medical policy. There is wig coverage for New York Marketplace (Standard and Non-Standard) products.

Blepharplasty/Browlift/Ptosis Repair

The visual field testing criteria was updated as follows: visual field testing demonstrates that there is an upper visual field loss of at least 20[2] degrees or 30 percent that is corrected when the upper lid margin is elevated by taping the eyelid.

BRCA Testing (Genetic Testing for Susceptibility to Breast and Ovarian Cancer)

The policy was updated to reflect the current National Comprehensive Cancer Network (NCCN) Genetic/Familial High-Risk Assessment Breast and Ovarian Clinical Practice Guideline.

Breast Implantation

There are no criteria changes to the medical policy.

Breast Reconstruction Surgery

There are no criteria changes to the medical policy.

Dental Care Services Medical Services for Complications of Dental Problems

There are no criteria changes to the medical policy. The policy language has been updated to clarify that any service related to dental care or treatment are not covered.

Erectile Dysfunction

There are no criteria changes to the medical policy.

Penile Implant for Erectile Dysfunction

There are no criteria changes to the medical policy.

Extracorporeal Shock Wave Therapy for Musculoskeletal Indications

There are no criteria changes to the policy. Extracorporeal Shock Wave Therapy is covered for MVP Medicare products when policy criteria are met.

Ground Ambulance/Ambulette Services

There are no criteria changes to the medical policy. The MVP Option Variation was updated as follows: Non-emergency transportation is not covered by MVP for MVP Option members.

Hearing Aid Services

The policy was updated to include that disposable ear molds, In-the-Canal (ITC) and Completely–in-the-Canal (CIC) hearing aids are not covered.

Hip and Shoulder Joint Resurfacing

The policy was updated with coverage criteria for total hip resurfacing for patients requiring primary hip resurfacing arthroplasty utilizing FDA approved metal-on-polyethylene, metal-on-ceramic or ceramic-on-ceramic hip implants who meet policy criteria. Metal-on-metal total hip resurfacing is not covered. Shoulder resurfacing for treatment of arthritis and degenerative joint disease is not covered.

Hyperhidrosis Treatments

The policy was updated to add rimabotulinumtoxin (Myobloc®) as an indication for the treatment of hyperhidrosis when policy criteria are met. The Medicare variation was updated to add rimabotulinumtoxin (Myobloc®) as an indication for the treatment of hyperhidrosis when policy criteria are met.

Lenses for Medical Conditions of the Eye

The policy was updated to state that there will be no additional payment for lenses considered to be not medically necessary including, but not limited to, presbyopia-correcting intraocular lenses, astigmatism-correcting intraocular lenses, monofocal intraocular lenses and multifocal intraocular lenses. The Medicare variation was updated to include coverage criteria for astigmatism-correcting intraocular lenses. Medicare does not cover radial keratotomy or keratoplasty to treat refractive defects.

Oncotype DX™ Test

The medical policy title was changed to Oncotype DX™ Test. Previously the policy name was Oncotype DX™ Test for Breast Cancer Prognosis. Oncotype DX™ colon cancer test and Oncotype DX™ prostate cancer test is not covered. Oncotype DX™ Test for any other condition not listed in the Indications/ Criteria section is not covered.

Orthotic Devices

There are no criteria changes to the medical policy. The MVP Option variation was updated to remove coverage limitations such as age. Coverage is limited to two pair of footwear every calendar year. There is no orthopedic footwear coverage for New York Marketplace (Standard and Non-Standard) products.

Phototherapeutic Keratectomy/Refractive Surgery

There are no criteria changes to the medical policy.

Prolotherapy

There are no criteria changes to the medical policy.

Therapeutic Footwear for Diabetics

There are no criteria changes to the medical policy. There is no orthopedic footwear coverage for New York Marketplace (Standard and Non-Standard) products.

Wheelchairs (Manual)

Additional Medicare criteria for specific manual wheelchairs (E1037, E0138, E1039, E1161, K0002-K0008) have been added.

List of Medical Policies recommended for approval without changes in January and February 2014:

- Bone Density Study for Osteoporosis (DEXA)
- Bone Growth Stimulator
- Dermabrasion
- Indirect Handheld Calorimeter
- OVACheck® Proteomic Pattern Analysis of Blood
- Speech Generating Devices
- Spinal Fusion-Lumbar

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.

PHARMACY UPDATES

Policy updates effective March 1, 2014

Epinephrine Auto-Injector NEW

- Policy establishes prior authorization criteria for non-formulary epinephrine products

Overactive Bladder

- Criteria changed to allow coverage of Myrbetriq without prior authorization. Coverage for non-preferred brands will require failure of at least one preferred agent

Male Hypogonadism (previously Androgens and Anabolic Steroids)

- Maximum doses and sampling requirements added
- Target testosterone levels clarified
- Prior authorization required for all non-preferred brands
- Requirement for additional labs (hematocrit and PSA levels) added

Arthritis-Inflammatory Biologic Drug Therapy

- Simponi Aria and Actemra SQ added
- Initial approval time frames were updated
- New indications for Stelara and Cimzia added
- Marketplace formulary variances were added

Gout

- Krystexxa criteria updated to include failure of probenecid in combination with allopurinal/Uloric
- Exclusion for Uloric for asymptomatic hyperuricemia was added

Psoriasis Drug Therapy

- Amevive removed from policy
- Percent BSA changed from 30 percent to 10 percent
- Marketplace formulary variances were added

Hemophilia Factor NEW

- New policy indicating Accredo as the preferred vendor of hemophilia blood factor

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

- Benlysta
- Cosmetic Agents
- Dermatologicals for Inflammation
- Enteral Therapy-New Hampshire
- Enteral Therapy-Vermont

MVP HEALTH CARE
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Simply complete the form at **www.mvphealthcare.com/providerpreferences** to enroll in MVP e-communications.

Formulary updates for Commercial, Option and Marketplace formularies

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

Drug Name	Indication
Astagraf XL	Prevention of organ rejection
Brisdelle	Vasomotor symptoms
Epaned	Hypertension
Fabior	Acne
Khedezla	Major depressive disorder
Marqibo*	ALL
Mirvaso	Rosacea
Trokendi XR	Seizures

Drugs added to Formulary (Tier 1)

diclofenac topical†
tobramycin inhalation†
rabeprazole†

†Tier 2 on Marketplace (Exchange) formulary

Drugs added to Formulary (Tier 3)

Zubsolv[QL]
Onfi

Drugs removed from prior authorization

Ilevro
Uceris
Invokana

*Medical drug
+Must be obtained from Accredo Specialty Pharmacy
QL=Quantity limits apply

Prior authorization update

As a reminder, all pharmacy prior authorization forms can be found online at **www.mvphealthcare.com/provider/ny/forms.html.** Make sure all forms are filled out completely and supporting documentation is sent with the request to avoid any processing delays.

MVP formularies

MVP developed prescription drug formularies that are used for specific products and benefit offerings. A formulary is an extensive list of drugs, both generic and name brand, that are covered by MVP for plans that offer prescription drug coverage. Each formulary is a comprehensive guide that is developed based on sound clinical evidence and is a reflection of current treatment guidelines and community practice standards. All formularies, except the MVP Medicare Part D Formulary can be found at **www.mvphealthcare.com**, click *Manage Prescriptions* under *Members*, then *Drug Coverage*.

The 2014 Comprehensive Medicare Part D Formulary and periodic updates can be found at **www.mvphealthcare.com**, click *Manage Prescriptions* under *Medicare Members*. All formularies are updated several times a year, so be sure to check regularly.