Vermont

# healthy practices™

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www.mvphealthcare.com

## IN THIS ISSUE



## Online authorizations available to providers

MVP has partnered with McKesson to make its software, Advanced Diagnostics Management (ADM), available via the Internet to our providers. The ADM solution connects providers with MVP to obtain imaging authorizations over the Internet in a quick and user-friendly manner. ADM is seamlessly integrated with InterQual® so that providers can enter clinical information and receive real-time authorizations as appropriate.

**The benefits for providers are:**

- ***Self-service*** – Provider offices do not have to call MVP for an authorization and can submit these requests outside of business hours.
- ***Rapid response to authorization requests*** – Requests meeting the online clinical review requirements are given an authorization number immediately.
- ***Centralized location*** – Providers can submit an authorization and check the status of pended requests in one location any time of day without a phone call.
- ***Printable authorizations*** – All authorizations can be downloaded in PDF format and printed out for proof of authorization.

For details regarding participation and availability in your area, contact your Provider Relations representative.

## Advanced imaging focus

In the past, MVP Health Care has shared issues regarding the imaging frequency experience, particularly in the area of MRI and CT scans. Specifically, MVP has concerns regarding the increasing frequency of scans performed in the office setting, as well as the frequency of advanced imaging ordering patterns.

As such, MVP has instituted a plan-wide moratorium on MRI and CT scans performed in the office setting. Offices that have received previous approval are grandfathered in. However, new offices requesting reimbursement of in-office scanning or additional codes beyond those already approved for those offices will not be approved due to this moratorium. Please be advised that this is the policy currently in effect.

## 2010 fee changes

As you may be aware, this year there have been multiple changes to the rates from the Centers for Medicare and Medicaid Services (CMS), and Congress has passed temporary extension acts three times relating to the conversion factor that is part of the fee calculations. As late as May 24, CMS issued material changes to the 2010 RBRVS, including changes to the conversion factor and the CPT code's relative value units (RVUs). These are a direct result of provisions specified in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, signed into law by President Obama in late March.

MVP is in the process of assessing the changes and how the late release of the most recent changes may impact the timeline of our standard July 1 fee schedule updates. We will keep you posted with FastFax communications as soon as we have additional updates to report to you.

## Annual Clinical Editing update

As part of our annual FACETS update, MVP Health Care will be updating its FACETS Clinical Editing software in July 2010 using the national-recognized coding edits. This clinical editing software identifies coding errors and other discrepancies in information submitted on claims.

## QI Manual: Clinical guidelines re-approved

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

**National Comprehensive Cancer Network (NCCN):** The NCCN clinical practice guidelines for oncology are a nationally-recognized reference. The guidelines are available on the NCCN home page at **www.nccn.org**. Follow the *Clinical Recommendations* link and complete the registration progress.

**Acute Otitis Media:** MVP Health Care has adopted recommendations from the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) for the Diagnosis and Management of Acute Otitis Media Clinical Practice Guideline. These recommendations address the management of acute otitis media in children ages two months to 12 years. The guidelines are available on the AAP Web site

MVP HEALTH CARE

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***Healthy Practices*** is a bi-monthly publication of the Corporate Communications Dept.

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**Comments**

Write to:
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at **www.aap.org** under the *AAP Policy* icon, directly beneath the *Home* icon. The guideline also can be located by using the AAP search function. Choose *Policy Statements* and enter the keyword *otitis*.

**Perinatal Care:** MVP's perinatal care guidelines are derived from the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) Guidelines for Perinatal Care, sixth edition. The AAP/ACOG guidelines are available on the ACOG Web site. The guidelines are free to ACOG members. Non-members and members of the public can purchase the guidelines in printed form at the online store. To access any of the ACOG clinical practice guidelines online, go to the ACOG home page at **www.acog.org** and follow the *Publications* link to the guidelines. All clinicians who provide care to MVP's Medicaid patients should be aware of and follow the New York State Medicaid prenatal care guidelines. To access the New York State Medicaid prenatal care guidelines online, go to: **www.nyhealth.gov/health_care/managed_care/docs/nys_medicaid_prenatal_care_standards.pdf.**

**End Stage Renal Disease (ESRD):** MVP continues to endorse the clinical practice guideline from the National Kidney Foundation for Chronic Kidney Disease: Evaluation, Classification, and Stratification. The National Kidney Foundation, Inc., a major voluntary health organization, seeks to prevent kidney and urinary tract disease. The guideline is online at: **www.kidney.org/professionals/kdoqi/guidelines_commentaries.cfm#.**

Paper copies of all of these recommendations are available by calling MVP's Quality Improvement (QI) department at **(800) 777-4793, ext. 2602**. The recommendations also are available in the *MVP Physician Quality Improvement Manual*. The current edition of the manual is located on the provider home page of the MVP Web site at **www.mvphealthcare.com**. To receive a CD-ROM or paper edition of the updated manual, call the QI department at the number above.

# Quality Improvement Updates

## Chlamydia: Educate your female patients about the "silent" STD

You can help prevent pelvic inflammatory disease, infertility, ectopic pregnancies, and other complications for your female patients. Test all sexually active women ages 16 to 25 for Chlamydia. All of these complications and many others can result from having Chlamydia. Teach your patients about the disease, its complications, and how they can be tested.

According to the Centers for Disease Control (CDC), Chlamydia is the most common bacterial sexually transmitted disease in the United States. In a longitudinal study, 4.2 percent of adults ages 18 to 26 had the disease in 2002, and its prevalence is on the rise. Despite this, results from HEDIS 2009 (the Health Plan Employer Data Information Set) indicate that more than 50 percent of women considered at-risk for the disease are not being tested.

Sexually active women ages 16 to 25 are especially at risk for Chlamydia infection. Annual testing is recommended for women in this demographic because the disease frequently has no symptoms. Studies indicate that almost three-quarters of women who are diagnosed had no prior symptoms. Untreated, Chlamydia can lead to pelvic inflammatory disease. In addition, it is a common cause of infertility and can increase a woman's likelihood of contracting HIV.

MVP Health Care and Blue Cross and Blue Shield of Vermont are working together to educate health care providers and our members on the importance of annual Chlamydia screenings for those at risk. To help you educate patients, we sent a letter to our female members ages 20 to 24, encouraging them to talk with their physicians about Chlamydia screening. A copy of the brochure is available to you in the *MVP Physician Quality Improvement Manual*, along with a poster and pamphlet on *Risky Teen Behaviors*.

Please contact the Quality Improvement Department at **(518) 388-2602** if you have any questions, or to request copies of these posters or brochures for your office. These materials also may be downloaded from the *Physician Quality Improvement Manual* posted on the MVP Web site at **www.mvphealthcare.com\provider.**

# Medical Policy Updates

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the May and June meetings. Some of the benefit interpretation policies may reflect new technology while others clarify existing benefits. All policy updates are listed online in the *Benefits Interpretation Manual* (BIM). Visit MVP online at **www.mvphealthcare.com**. Providers can directly access the online BIM through the *Reference* section of the provider portal. The *Current Updates* page of the BIM lists all policy updates. If you have questions regarding the policies or wish to obtain a paper copy of a policy, contact your Professional Relations representative.

*Healthy Practices* and/or *FastFax* will continue to inform your office about new and updated 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** in the *Reference* section.

## Medical policy updates effective August 1, 2010

### Artificial Heart – NEW Policy

- The policy supports the CardioWest™ Total Artificial Heart as a bridge-to-heart transplantation.
- Medicare allows coverage.
- The AbioCor® Implantable Replacement Heart was FDA approved only as a humanitarian exceptions device and is not considered medically necessary as published evidence has not proven a beneficial impact on health outcomes and, therefore, is not covered.

### Cold Therapy Devices

- This policy follows *Medicare Criteria*.
- There were no changes made to the *Criteria*.
- The policy *Description* section was updated to include a definition of non-covered therapy devices.

### Emergency Services

- The policy supports the prudent lay person language for members seeking emergency services.
- A statement that *Notification to MVP is required within 48 hours of all inpatient emergent admissions* was added to the policy.

**External Breast Prosthesis**

- This policy follows Medicare criteria.
- The second bullet under *Indications/Criteria* was clarified to read *up to four (4) mastectomy bras will be considered medically necessary per year.*

**FluMist – Archived Policy**

- This policy was approved for *Archive*.
- FluMist® remains covered and is mentioned in the *Immunizations* policy.

**Foot Care**

- A statement has been added that for Commercial members, treatment of mycotic nails requires that the member meets the criteria for routine foot care under the *Indications/Criteria* including the Class Findings.
- A *Medicare Variation* addresses treatment of mycotic nails.

**Hyperbaric Oxygen Therapy**

- The *Exclusions/Limitations* section was revised to include an exclusion stating that local or topical oxygen therapy is not covered for any indication.
- There is a *Variation* for MVP Option products that allows coverage for topical oxygen therapy.
- This policy follows Medicare and the Undersea and Hyperbaric Medical Society criteria.

**Immunization/Childhood/Adolescent/Adult**

- The policy follows the official recommendations of the American Academy of Pediatrics (AAP) and the United States Preventative Services Task Force (USPSTF) Guide to Clinical Preventive Services and the Centers for Disease Control and Prevention (CDC).
- Language was clarified under the *Indications/Criteria* section that permissive recommendations of the Advisory Committee on Immunization Practices (ACIP) are not considered medically necessary and, therefore, are not covered.
- Reference added to the FluMist® Influenza Virus Vaccine.

**Light Therapy for Seasonal Affective Disorder (SAD)**

- The *Indications/Criteria* section was updated to clarify that the device does not conform to the definition of devices that are covered as Durable Medical Equipment.
- The FDA has not approved light emitting devices for treatment of Seasonal Affective Disorder.

**Mechanized Spinal Distraction Therapy**

- A statement was added: *this is a non-inclusive list of FDA approved devices.*

**MRA Brain, Carotid, Kidney, Lower Extremity**

- These policies follow *InterQual Criteria* and there have been no changes to the *Criteria*.

**MRI Brain, Cervical/Thoracic Spine, Extremity, Hip/Knee, Lumbar Spine, Neck, Pituitary, Shoulder/Wrist, TMJ**

- These policies follow *InterQual Criteria* and there have been no changes to the criteria.

**MRI Abdomen**

- Under *Indications/Criteria* section, verbiage in the third bullet was revised. Now reads: *abdominal mass by physical exam/ kidney, ureter, bladder (KUB)/ultrasonography (US), and CT non-diagnostic for etiology of mass.*

**MRI Breast**

- A statement was added to the policy indicating that MVP provides coverage of MRI of the breast that meets the policy criteria. However, MVP does not provide additional professional or technical reimbursement for use of computer aided detection with breast MRI. The use of computer aided detection with breast MRI is left to the discretion of the physician.

**MRI Chest**

- The policy follows *InterQual Criteria*.
- An indication for assessment of myocardial viability has been added to this policy.
- There no longer is a *Medicare Variation* in this policy.

**Neuropsychological Testing**

- CPT Code 96116 was added to the policy. This code requires prior authorization.

**Orthognathic Surgery**

- For consistency and to eliminate confusion, the policy criteria regarding general conditions of the jaw related to malocclusion has been updated to reflect the criteria listed in the TMJ policy.

**Orthotic Devices**

- The *Description* section language was clarified regarding the differences between a pre-fabricated or custom fabricated orthosis.
- The policy follows Medicare criteria.
- Under the *Indications/Criteria* section, the link to the Medicare DME policy for each type of orthosis has been added.

**Oxygen & Oxygen Equipment**

- Language was added regarding Oximeters allowing coverage of Oximeter use in the home for infants and children with chronic lung disease, e.g. bronchopulmonary dysplasia.

**Pectus Excavatum**

- No changes have been made to this policy since the last review.

**PET Scan Brain**

- This policy follows *InterQual Criteria*.
- Under the *Indications/Criteria* section of the policy the bullet stating *non-acute onset mental status changes* was expanded to include *MRI non-diagnostic for etiology of symptoms/findings.*
- In the *Medicare Variation* section of the policy, a statement was added referring to the PET Whole Body policy for evaluation of metastatic disease.
- All references were reviewed and updated.

**PET Scan Chest/Cardiac**

- This policy follows *InterQual Criteria*.
- CPT code 78990 was deleted from the policy as it is an obsolete code.
- All references were reviewed and updated.

**Photodynamic Therapy for Cancer**

- No changes to the policy have been made since the last policy review.
- References were reviewed and updated.

**Rhinoplasty**

- The *Indications/Criteria* section of the policy was revised to provide more clarity regarding the requirement of documentation in cases of trauma and that the member has failed conservative therapy.

- In addition, *Criteria* language was clarified regarding the fact that airway obstruction will not be resolved by septoplasty or turbinectomy alone or to correct a nasal deformity secondary to a cleft lip/palate that has resulted in a functional impairment.

**Sacral Nerve Stimulation**

- The policy title was changed from *Sacral Nerve Stimulation with Implantable Neuroprosthesis (InterStim) for the Management of Urinary Incontinence and Urinary Retention.* Originally, the policy was specific to urinary incontinence; however, requests have been received for other indications.
- The criteria follow Medicare and the most recent literature available.
- Exclusions have been added for interstitial cystitis and electrical percutaneous tibial nerve stimulation for urinary voiding dysfunction.

**Sclerotherapy for Varicose Veins of the Lower Extremities**

- The *Medicare Variation* section was clarified to read that the medical record must document that the member remains symptomatic after a six-week trial of conservative therapy.

**Skin Endpoint Titration**

- CPT Code 95024 was added to the code section.
- Criteria have been added regarding allergic reactions to egg protein or drugs.
- Members must meet medical necessity criteria for the immunization and that documentation must state that there are no appropriate drug alternatives.
- Allergens must be FDA approved.

**Stereotactic Body Radiation Therapy – NEW Policy**

- This policy covers indications for stereotactic treatment given to body sites other than the brain.
- The policy criteria are based on the indications and criteria of the American College of Radiology and the American Society for Therapeutic Radiology Oncology.

**Therapeutic Footwear for Diabetics**

- No changes have been made to this policy since the last policy review.

**Transplants**

- The *Exclusion* for *cochleostomy with neurovascular transplant for treatment of Meniere's disease* was deleted from the policy as these are considered implants not transplants.
- Direct links to each of the respective *Medicare Transplant* policies were added to the policy.

**Ventricular Assist Device (Left)**

- Coverage is allowed as a bridge to transplantation, post cardiotomy and destination therapy.
- An exclusion was added that the Impella Recover® LP 2.5 Percutaneous Ventricular Assist Device (Abiomed) is not considered medically necessary as the published evidence has not proven a beneficial impact on health outcomes and, therefore, is not covered.

**Vertebroplasty/Kyphoplasty**

- No changes have been made to the policy criteria.
- The *References* were reviewed and updated.

**Video EEG Monitoring**

- No changes have been made to the policy criteria.

**Wheelchairs (Electric) & Power Scooters**

- This policy follows *Medicare* criteria.
- No changes have been made to the policy criteria.
- *References* were reviewed and updated.

**Wheelchair (Manual)**

- This policy follows *Medicare* criteria.
- No changes have been made since the policy was last reviewed.
- *References* were reviewed and updated.

**The policies listed below were presented to the QIC at the May and June meetings.**

The policies were recommended for approval without changes. These policies were comprehensively reviewed during 2009. QIC approved the recommendation.

- Benign Skin Lesions
- Capsule Endoscopy
- Dental Care Services
- Ground Ambulance Services/Ambulette Services
- Hearing Aid Services
- Immunotherapy for Recurrent Spontaneous Abortion
- Thermal Intradiscal Procedures (TIPS)

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.

# UM Updates

## Lipid Profile/Cholesterol Testing coding change (83721 and 80061)

Effective August 9, 2010, MVP Health Care will implement a Medicare guideline regarding the billing of processing of claims with current procedural terminology (CPT) codes 83721 and 80061.

Presently, MVP uses a triglyceride level of less than 250 mg/dl to determine if 83721 is global to 80061.

As of Aug. 9, claims billed to National Government Services with CPT 83721 and 80061 on the same day with triglycerides less than 400 mg/dl will be denied as not medically necessary. This coding change aligns MVP with the following Medicare edit:

National Government Services recently conducted a post-pay probe for CPT code 83721, *Lipoprotein, direct measurement;* LDL cholesterol.

CPT code 83721 was often billed with CPT code 80061 (Lipid panel) on the same day with modifier 59 and the patient's triglyceride level was under 400 mg/dl. According to the Local Coverage Determination (LCD) (L27352) for Lipid Profile/ Cholesterol Testing, it is usually not necessary to perform these tests on the same day unless the triglycerides exceed 400 mg/dl.

The serum LDL concentration may be calculated using the Friedenwald formula (LDL = total cholesterol – HDL – triglycerides / 5). This formula is valid only for triglyceride levels less than 400mg/dL. The LDL should be measured directly when the triglyceride level exceeds this value. This calculation may not accurately calculate the LDL in alcoholic patients. These patients also may require direct measurement of the serum LDL.

### References

- Local Coverage Determination (LCD) (L27352) for Lipid Profile/Cholesterol Testing
- Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual Publication 100-03, *Medicare National Coverage Determination (NCD) Manual,* Section 190.23

# EDI Updates

## How it works: MVP's EDI Coordination of Benefits (COB) model when MVP is the secondary payer

1. The provider originates the transaction and sends the claim information to the primary payer
2. The *subscriber* loop (Loop ID-2000B) contains information about the person who holds the policy with the primary payer
3. Loop ID-2320 contains information about MVP and the subscriber who holds the policy with MVP
4. The primary payer adjudicates the claim and sends an electronic remittance advice (ERA) transaction (835) back to the provider
5. The 835 contains any claim adjustment reason codes that apply to the specific claim; claim adjustment reason codes detail what was adjusted and why
6. Upon receipt of the 835, the provider sends a second health care claim transaction (837) to MVP, the secondary payer
7. The *subscriber* loop (Loop ID-2000B) now contains information about the subscriber who holds the policy with MVP
8. The *other subscriber information* loop (Loop ID-2320) now contains information about the subscriber for the primary payer
9. Total amounts paid at the claim level go in the *AMT* segment in Loop ID-2320
10. Any claim level adjustment codes are retrieved from the 835 from the primary payer and are applied to the *CAS* (Claims Adjustment) segment in Loop ID-2320
11. Line level adjustment reason codes also are retrieved from the 835 and go in the CAS segment in the 2430 loop
12. MVP adjudicates the claim and sends the provider an electronic remittance advice

## EDI 5010 and Coordination of Benefits (COB)

### 5010 COB Professional Claim Changes

#### Loop 2320

The following data elements were **REMOVED** from the COB Claim Level section of the 837P claim:

- COB Allowed Amount **(AMT)** segment
- COB Patient Responsibility Amount **(AMT)** segment
- COB Discount Amount **(AMT)** segment
- COB Per Day Limit Amount **(AMT)** segment
- COB Patient Paid Amount **(AMT)** segment
- COB Tax Amount **(AMT)** segment
- COB Total Claim Before Taxes Amount **(AMT)** segment

These data elements were **ADDED** to the COB Claim Level section of the 837P claim:

- COB Total Non-Covered Amount **(AMT)** segment
- Remaining Patient Liability **(AMT)** segment

This data element **REMAINS THE SAME** in the COB Claim Level section of the 837P claim

- Coordination of Benefits (COB) Payer Paid Amount

#### Loop 2430

This data element was **REMOVED** from the COB Line Level section of the 837P claim:

- Allowed Amount **(AMT)** segment

This data element was **ADDED** to the COB Line Level section of the 837P claim:

- Remaining Patient Liability **(AMT)** segment

### 5010 COB Institutional Claim Changes

#### Loop 2320

The following data elements were **REMOVED** from the COB Claim Level section of the 837I claim:

- Coordination of Benefits (COB) Total Allowed Amount
- Coordination of Benefits (COB) Total Submitted Charges
- Coordination of Benefits (COB) Total Medicare Paid Amount
- Medicare Paid Amount - 100%
- Medicare Paid Amount - 80%
- Coordination of Benefits (COB) Medicare A Trust Fund Paid Amount
- Coordination of Benefits (COB) Medicare B Trust Fund Paid Amount
- Coordination of Benefits (COB) Total Non-covered Amount
- Coordination of Benefits (COB) Total Denied Amount

These data elements were **ADDED** to the COB Claim Level section of the 837I claim:

- COB Total Non-Covered Amount **(AMT)** segment
- Remaining Patient Liability **(AMT)** segment

This data element **REMAINS THE SAME** in the COB Claim Level section of the 837I claim:

- Coordination of Benefits (COB) Payer Paid Amount

### MVP's 5010 COB Requirements

#### Loop 2300

- Patient Paid Amount **AMT** (F5 for Professional/F3 for Institutional)

#### Loop 2320

- Other Subscriber Information (SBR segment)
  -**SBR01** must equal P
  -**SBR09** must be valued
- Claim Level Adjustments (CAS segment)
  **CAS** must be present with **CAS01** equal to either PR, CO, or OA
- Coordination of Benefits (COB) Payer Paid Amount **AMT** (D)
- Coordination of Benefits (COB) Total Non-Covered Amount **AMT** (A8)
- Remaining Patient Liability **AMT** (EAF)

#### Loop 2430

**Line level COB only (Professional)**

- Claim Level Adjustments (CAS segment)
  **CAS** must be present with either **CAS01** equal to PR, CO, or OA
- Remaining Patient Liability **AMT** (EAF)

In the next issue of *Healthy Practices*, learn more about *Misc. Claim (837) Changes* and EDI 5010.

# Pharmacy Updates

## Gardasil

The Food and Drug Administration has approved Gardasil for use in boys and men ages 9 through 26 for the prevention of genital warts caused by HPV types 6 and 11. The CDC's Advisory Committee on Immunization Practices (ACIP) has recommended against the routine use of quadrivalent human papillomavirus vaccine to prevent genital warts in boys and young men. Instead, the committee voted to support the "permissive use" of Gardasil in this patient population. Therefore, per the MVP policy *Immunizations – Childhood, Adolescent and Adult,* Gardasil use in boys and men is not covered. MVP will continue to monitor and report any changes.

## Provenge

This new agent, sipuleucel-T, is considered the first cancer vaccine used for the treatment of prostate cancer. This novel vaccine is manufactured in several steps, beginning with a patient's own blood components. It is expected that this product will be available in early third quarter 2010 with limited availability. It will not be distributed to retail, mail or specialty pharmacies. MVP will require prior authorization for this drug in all situations.

## Ampyra

Ampyra (dalfampridine) is an oral potassium channel blocker indicated to improve walking in patients with multiple sclerosis (MS), for which MVP requires prior authorization.

**For initiation of therapy, the prescriber must:**

- be a neurologist
- submit neurology chart notes over the past 2 years, including all radiologic reports, with the request
- include results of three timed 25-foot walks — at least one week apart — within the past 60 days with current chart notes (assistive devices must be consistently used across pre-treatment walk tests and identified in chart notes)

**Patient must:**

- have a diagnosis of multiple sclerosis
- be between 18 and 70 years old
- have an EDSS score between 5.0 - 6.0
- currently be receiving a stable dose of disease-modifying therapy for MS for at least 60 days
- show the ability to walk 25 feet in 8 to 45 seconds

Additional criteria are required for continuation of therapy. These include, but are not limited to, a 50 percent improvement from the baseline average as measured by two T25FW tests,. Ampyra must be obtained from CuraScript specialty pharmacy.

## Policy updates effective July 1, 2010

### Pharmacy Programs Administration

- IV vs Oral language was updated.

### Quantity Limits

- Provigil and Nuvigil were added to the policy. Quantity limits are 30 units in 30 days.

### ACE/ARB

- Benicar/HCT were added requiring prior authorization. Losartan/HCTZ also were added and require failure on an ACE inhibitor.

### Proton Pump Inhibitors

- Prevacid capsules (brand only) were added and require prior approval. All other dosage forms of Prevacid are Tier 3.

## Formulary updates for Commercial members

The MVP Formulary is updated after each Pharmacy and Therapeutics Committee meeting. The most current version is available online at **www.mvphealthcare.com**. Simply visit the site's *Provider* section and under *Pharmacy,* click on *Formulary.* The MVP Formulary can be downloaded to a PDA device from **www.epocrates.com**. There is a link to ePocrates® on the MVP Web site. Please update your ePocrates account if your computer or PDA is set up to automatically download the Formulary. Unless otherwise noted, the following Formulary information is effective July 1, 2010.

**New drugs** ***(recently approved by the FDA, prior authorization required, Tier 3)***

Cayston
Exalgo
Hizentra *(medical benefit)*
Oforta *(must be obtained from CuraScript)*
Vpriv *(diabetic benefit)*
Xiaflex *(medical benefit)*

**Drugs added to Formulary (Tier 1)**

diltiazem 24-hour ER tablets *(generic Cardizem LA tablets)*
metaxalone *(generic Skelaxin)*

**Drugs removed from prior authorization** ***(non-formulary, Tier 3)***

Ulesfia

**Drugs determined to be not covered**

Fluzone High Dose