The Inside Story

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As 2014 draws to a close, Scott & White Health Plan (SWHP) can once again look back on a very busy year. We continue to expand our service area and offer a wide variety of benefit packages to our members (your patients) in order to provide the best possible service.

The Medical Delivery Strategy Division has been working diligently throughout the year to ensure any issues you may have had were addressed and resolved. Over the last several months, many of you met our new Provider Relations Representatives, Davette, Louis, and Sandi, as they visited your offices. In this issue of *The Inside Story,* you will learn a little more about them and Zach, our new Provider Contracting Manager.

We continue improving our website, www.swhp.org, to better serve your needs, and we have more improvements planned for 2015! We have enjoyed working with you this past year and appreciate the opportunity to continue to do so next year.

In This Issue

New Scott & White Health Plan (SWHP) Provider Relations Representatives

Central Texas Region

Davette Quinones

Davette Quinones – Davette joined SWHP in March of 2014. She graduated from Baker College in Flint, Michigan, with a degree in Business Administration. Prior to joining the Health Plan, Davette worked as a Senior Executive Assistant for Baylor Scott & White Health – Temple in Health Information Management, where she was the Texas Electronic Registrar (TER) Administrator responsible for physician's certification of death certificates in a timely manner and stayed abreast of new policies and procedures. She enjoys being the face of SWHP Provider Relations and letting the providers know that we are here to help in any way that we can. She is married to Bernabe Quinones and they have two adult children, Breana a graduate of the University of Texas at Austin and Devin who is in the process of enlisting in the United States Air Force.

North Texas Region

Louis Limas – Louis joined SWHP in February of 2014. He has worked in the healthcare industry for 14 years and enjoys his daily interactions with the Health Plan's contracted physicians and their support staff. Louis attended West Texas A&M University. He is married to Jennifer Limas and has two sons, Gabriel and Landry.

Louis Limas

Sandi Janacek

Sandi Janacek – Sandi joined SWHP in October of 2013 as the first Provider Relations Representative in the Dallas-Fort Worth area. She graduated from Texas A&M University with a degree in Community Health. She has worked in physician offices and healthcare delivery for the past 12 years. She will be educating and maintaining relationships with our providers for the Medicare Advantage and Commercial plans. Her goal is to provide the most up-to-date information, while building successful networks for SWHP.

New Scott & White Health Plan (SWHP) Provider Contract Manager – North Texas Region

Zach Alexander

Zach Alexander – Zach is the newest recruit to the North Texas team and joined SWHP in September of 2014. He has been in the healthcare industry since graduating from USC with a degree in Finance. His experience includes building and managing provider networks for United Healthcare, WellPoint, Amerigroup and Humana in the Commercial, Medicare, and Medicaid arenas. In addition to being an avid USC football fan, Zach is currently pursuing his fellowship with the American College of Healthcare Executives. USC Trojans, fight on!

MEMORANDUM

TO: **Scott & White Health Plan Participating Providers**

FROM: **Scott & White Health Plan**

SUBJECT: **Vital Traditions (HMO SNP) – Medicare Advantage Plan**

DATE: **November 26, 2014**

Scott & White Health Plan (SWHP) would like to say thank you to all of our participating providers who provide high-quality and affordable care to our Vital Traditions (HMO SNP) – Medicare Advantage Plan members. Your service is greatly appreciated.

SWHP will no longer offer the Vital Traditions (HMO SNP) – Medicare Advantage Plan in the Central Texas region after December 31, 2014. This includes the following counties: Bell, Bosque, Brazos, Burleson, Coryell, Falls, Freestone, Grimes, Hamilton, Hill, Lampasas, Limestone, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, and Washington. *However, SWHP will still offer the SeniorCare – Medicare Cost Plan in the Central Texas region.*

SWHP will still offer the Vital Traditions (HMO) – Medicare Advantage Plan in the North Texas (Dallas/ Fort Worth) region after December 31, 2014. This includes the following counties: Collin, Dallas, Ellis, Johnson, Rockwall, and Tarrant. *Therefore, SWHP will not term the Medicare Advantage contract or amendment that we have with you as a participating provider.*

If you have any questions regarding this memo, please do not hesitate to contact the SWHP Provider Relations Department at (800)321-7947, ext. 203064 or (254)298-3064.

Again, thank you for the care and service that you provide to our SWHP members. We greatly enjoy partnering with you to provide a high-performing network for our members.

Out-of-Network Referrals

When Scott & White Health Plan (SWHP) members need non-emergency medical services they have a large network of contracted providers offering a comprehensive suite of services available to them. While some member plans offer the choice of using out-of-network providers, members do not receive the full benefits of their SWHP medical plan, and could be responsible for the full cost of any medical services received. Out-of-network rates are usually much higher than the SWHP allowed amount, leaving a large amount which can be balance billed to the member.

When a SWHP member receives services from a contracted (in-network) provider and needs a referral to a specialist or facility, a key step in the referral process is ensuring that the provider they are being referred to is contracted or in-network. The benefits of utilizing in-network providers and services are many and include the following:

- The health plan pays less for in-network services.
- Contracted providers receive referrals and a busy practice.
- Members pay less out-of-pocket for copays and deductibles.
- Some member plans do not cover out-of- network charges, so in-network services save money for our member population.

While referrals are no longer required by SWHP, some specialists may still require it and some services may also require prior authorization from SWHP. If there are times when a service or specialty is not available within the network and referral to an out-of-network provider is the only option, please ensure that you request a prior authorization before referring the member. This is important, as SWHP will only pay for certain services if prior authorization is obtained before the procedure. Please log in to *MyBenefits* for prior authorization and notification lists. You can request prior authorization of specific services through submission of the SWHP Authorization Forms available at https://swhp.org/providers/authorizations-and-referrals:

- General/Medical/Surgical Authorization Request Form
- Mental/Behavioral Health Authorization Request Form
- HMO Authorization Request Form
- PPO/POS Authorization Request Form
- SeniorCare Authorization Request Form
- Vital Traditions Authorization Request Form

Please visit our website at https://swhp.org/ for more information.

SWHP Provider Directories

When Scott & White Health Plan (SWHP) members are looking for an in-network provider or service, they have the option of either using our online provider search or a PDF version of our provider directories. SWHP directories are specific to their plan type, allowing members to search for doctors, hospitals, and other medical services in their area.

Therefore, it is very important that the information in the provider directories is current and accurate. Please take the time to go to our website at http://scottwhite.prismisp.com/ and review your provider information. If you find inaccurate information, such as address, phone number, etc., please complete the Provider Address Change Form located at https://swhp.org/providers/manage-your-information/provider-address-change-form, so that we can update your information and have it reflected accurately in our provider directories.

The Provider Address Change Form allows you to update information for your practice location, billing address, mailing address, or even add an additional location to your contract. You will need to attach a completed W-9 Form in order for us to be able to update your address in our systems. To attach the W-9 Form, please use the "Attachments" feature located at the bottom of the form.

SWHP Policies

SWHP Policies are posted online and available for review at https://swhp.org/providers/policies. Topics covered include:

- Medical Coverage Policies
- Reimbursement Policies
- Refusal of Treatment Policy
- Specialist as PCP Policy
- Physician Appeals Policy

If you have any questions regarding SWHP Policies, please feel free to contact Provider Relations at (254) 298 3064.

HIPAA Privacy

A message from Scout – The Integrity Dog: The Tail Wagging Facts of Handling Paper PHI

Keeping Protected Health Information (PHI) confidential is something that really gets my tail to wagging. Especially when it comes to protecting paper PHI!

What is PHI, you ask? PHI is any information that can identify the patient and is related to a person's past, present or future physical or mental health condition(s). It is also anything associated with healthcare services and/or treatment. Even though certain identifiers, such as name and date of birth, may be removed from the document it is still considered PHI and must be protected.

Every day we are exposed to paper PHI at work, and our patients trust us to keep their health information confidential. Examples of paper PHI include, but are not limited to, discharge documents, after visit summaries, patient labels, patient lists, appointment schedules and billing statements. To make sure you are doing your part to secure documentation containing PHI, always remember to follow these simple rules:

- Verify that you are handing the right documents to the right patient before handing out any PHI. Ask patients to verify their name and DOB and check against each piece of paper.
- Handle documents securely – Do not leave visible to the public or other staff that do not have a business reason to view.
- Double check all documents against the address on the envelope before placing in the envelope to mail.
- Faxes, printouts and reports should only be made accessible to authorized individuals.
- Do not leave documents containing PHI unattended in public areas.
- Practice a "Clean Desk Policy" by clearing your workstation of any paper PHI that is not needed. Place documents containing PHI face down at your workstation.
- Do not allow visitors at your workstation when PHI is present and visible.
- Lock bins, drawers and file cabinets that contain PHI when not in use.
- Dispose of documents with PHI using the appropriate confidential waste bins for shredding. **DO NOT** place PHI in the regular trash.
- Do not throw medication containers (i.e. prescription bottles, IV bags, etc.) in regular trash bins. Dispose of IV bags labeled with PHI in a hazardous waste bin. Remove labels from prescription bottles and dispose of labels in a confidential waste bin for shredding.
- Remove all documents containing PHI from copiers, printers and fax machines within a timely manner.
- Do not take documents containing PHI off the premises. If you absolutely must transport documents outside a facility, place them in a secure envelope and handle in a secure manner. Do not leave documents in your vehicle or take documents home.

We must all work together to protect our patients' health information! Remember that a breach of PHI, even if done by accident, is a violation of HIPAA and can have serious consequences. Don't worry though, following the rules for doing what's right is as easy as wagging my tail!

Potential or known breaches (accidental or intentional) should be reported to the Corporate Compliance Privacy Department immediately:

Compliance EthicsLine: (866) 245-0815 or http://ethicsline.baylorhealth.com
Privacy Line: (866) 218-6920
Email: HIPAA@sw.org or bhcsprivacy@baylorhealth.edu

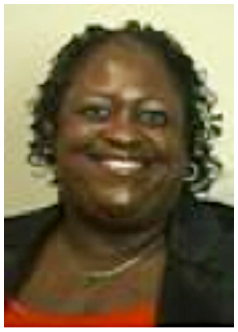
Questions related to Privacy? Give us a call or send us an email:

Barbara Hoffmann, BSWH Privacy Officer: (254) 215-9022 or bhoffmann@sw.org
Destiny Evans, Manager Privacy Department: (214) 820-1918 or destiny.lucas@baylorhealth.edu

Faithfully yours,

SCOUT

REMEMBER YOUR FRAUD, WASTE AND ABUSE (FWA) TRAINING!



Pamela O'Bannon
Compliance Officer

The Centers for Medicare and Medicaid Services (CMS) requires providers who perform services for Medicare members to complete FWA training on an annual basis. CMS states that managed care plans must provide this training to its First Tier Downstream and Related Entities. SWHP offers FWA training on our website at https://swhp.org/providers/resources, or you may choose to take the training through another venue who offers an equivalent training. If you choose to complete the training through another venue, SWHP requires that you attest that you and your staff have completed the mandatory FWA training. The Attestation Form is available through our website.

Also, please be aware that the OIG has begun a provider education series and the first topic is "Understanding Fraud, Waste and Abuse". You may check out the series at the following website http://oig.hhsc.state.tx.us/oigportal/ProviderEducation.aspx.

If you suspect fraud, please contact the Compliance Officer, Pamela O'Bannon, or report it anonymously through the Hotline at 1-888-484-6977.

Overview of Quality Improvement (QI) Program

Purpose and Scope of the QI Program

The purpose of the Quality Improvement (QI) Program is to ensure SWHP is providing the highest quality care that is easy to access and affordable to our members regardless of plan type, age, race/ethnicity, or health status. SWHP supports and tries to reach "Triple Aim" goals: improving member's affordability, quality, and experience of care. The scope of the QI Program is to monitor, evaluate, and improve:

- The quality and safety of clinical care
- The quality of service provided by SWHP
- The quality of practitioners and providers
- Affordable and accessible health care and wellness
- The overall member experience

Clinical Practice Guidelines and HEDIS Work Teams

SWHP uses Clinical Practice Guidelines relevant to its member population to help providers and members make decisions appropriate for improvement of health outcomes. Providers are encouraged to participate on the SWHP Quality Improvement Subcommittee (QIS). Through this committee, practitioners provide input on clinical guidelines and recommend which clinical guidelines should be adopted by SWHP. Guidelines are prioritized for development based on highest volume diagnoses among members or for areas where there is high variation among provider practices. The QIS reviews, revises, and approves the guidelines biannually, which have been developed using nationally recognized evidence-based literature sources. The guidelines are published annually (and as needed during the year for any changes) to the SWHP contracted practitioners/providers through SWHP's online provider manual, provider newsletter (*The Inside Story*), email, and faxed notices. Below are the guidelines listed on the SWHP website:

- Osteoporosis Algorithm
- Hypertension
- COPD
- Depression Management (Non-Psychotic)
- ADHD
- Asthma
- Atherosclerotic Cardiovascular Disease
- Micro-hematuria
- Diabetes Annual Assessment
- Diabetes Guidelines
- Osteoarthritis (OA) of the Knee
- Depression Management (Non-Psychotic, Non-Bipolar)
- Alcohol Withdrawal Management
- Immunization Schedule – Age 0-18 Years
- Catch-up immunizations
- Post Natal Depression and Dictation Pocket Card
- Prenatal/Perinatal
- Colorectal Cancer Screening
- Colorectal Cancer Screening Guideline Link

SWHP has adopted a number of "ALL THINGS" HEDIS Teams to assist with improving HEDIS scores. These multidisciplinary teams have monthly workgroup meetings over different measures to coordinate the review and update of practice guidelines. Guidelines are based on evidence-based research. These work teams include SWHP staff, Baylor Scott & White Health providers, pharmacy, and other quality champions.

For a detailed description of the QI Program Description and Clinical Practice Guidelines, please visit the SWHP website at: https://swhp.org/providers/resources/quality-improvement-program or contact the SWHP QI Department at 1-888-316-7947.

**HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)*

Cervical Cancer Screenings: When to Start and How Frequently is it Recommended

Recommended Cervical Cancer Screenings

Women less than age 21: No pap test is recommended
Women ages 21 - 65: pap test to screen for cervical cancer every three years.
Women ages 30 - 65 with a negative HPV test: pap test and HPV test every five years.
Women ages 30 – 65 with no HPV test: pap test every 3 years

Any cervical cancer screening method that includes collection and microscopic analysis of cervical cells will count for appropriate cervical cancer screenings. Lab results that state inadequate or that "no cervical cells were present" is not considered adequate and it is recommended to repeat within a year. Cervical biopsies are not considered as primary cervical cancer screening.

Women who have had the following any time during their medical history can be excluded: **Women without a Cervix**

To document no remaining cervix accurately and clearly in the patient's record, please consider the following:

- Documentation of "complete", "total" or "radical" abdominal or vaginal hysterectomy indicates that the patient had a hysterectomy with no residual cervix.
- Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy" also is considered to indicate no residual cervix.
- Documentation of "no cervix" clearly indicates no remaining cervix

Please note: Documentation of hysterectomy alone does not absolutely indicate no remaining cervix; the patient could have had a supra-cervical hysterectomy with a subsequent remaining/residual cervix.

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)

Stop the Pap!! It is not recommended for patients under 21. However, it is recommended that you still encourage your patients to be screened for sexually transmitted infections (STI) including chlamydia via a urinalysis. HEDIS has established a measure to track how many patients under age 21 are having a pap test.

The patient can be excluded from this measure if they have a history of cervical cancer, HIV or immunodeficiency. This can be documented anytime during the member's history.

Scott & White Health Plan appreciates all that you do in helping our members to be compliant with these screenings.

SOURCE: Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

Recommendations based on joint guidelines for cervical cancer screening issued by American Cancer Society (ACS), the American Society for Colposcopy and Cervical Pathology (ASCCP), and the American Society for Clinical Pathology (ASCP). In addition, the U.S. Preventive Services Task Force recommendations have also been issued. This is also reflected in ACOG Practice Bulletin 131, November 2012.

Adverse Effects of Marijuana on Children and Adolescents

The print media and television coverage of the legalization of marijuana use in Colorado and Washington state emphasize the allure and fun of the marijuana experience while overlooking the adverse health effects of marijuana and related compounds on children and adolescents. Very authoritative publications of the American Society of Addiction Medicine and the National Institute of Drug Abuse provide the information in this article.

Potency of marijuana and marijuana related automobile accidents and emergency room visits for marijuana intoxication have all increased significantly in recent years. Marijuana is addictive. 9% of those who experiment with marijuana will become addicted. Earlier and regular use in adolescence increases the risk of addiction (25-50%). An estimated 2.7 million Americans meet the criteria for marijuana addiction with the complications as follows:

Withdrawal syndrome symptoms include irritability, craving, sleep difficulty, unhappy mood and anxiety making cessation difficult and relapse common.

The adolescent brain does not fully mature until age 21-25. Marijuana use in childhood and adolescence alters brain development with resulting impaired short-term memory, motor coordination and altered judgment. Cognitive impairment may reduce IQ by 8-10%. These impairments lead to accidents, poor school performance, school dropout and diminished achievement and life satisfaction with unemployment, loss of income potential and a greater need for public assistance. Heavy marijuana use in adolescents may lead to psychosis and schizophrenia in those with pre-existing genetic vulnerability.

Since marijuana can be incorporated in cookies, brownies, "tootsie rolls" and "energy drinks," reports are emerging from Colorado of intoxication and death of small children who ingest cannabinoid-containing edibles. Cannabis can be taken together with alcohol doubling the intoxicating effect of either and more than doubling the auto accident rate. A featured article in Time magazine April 24, 2014 described the hazards of "fake pot." Chemists have developed over 100 synthetic cannabinoids which mimic the effects of marijuana, but are difficult to detect in screening urine tests. Synthetic cannabinoids are marketed as "legal pot" and sold at headshops, truck stops, and some convenience stores as Spice, K2, or Potpourri for $30-$40 for 3 gms in bright packages labelled "not for human consumption." These products may be accidentally taken by children and adolescents with the potential to cause acute intoxication, kidney failure, seizures, psychosis and death.

At this time, there is no FDA approved therapeutic use for cannabinoids though claims are made for use in pain control, nausea and anorexia of chemotherapy and AIDs. Some instances of improved control of seizures in children have been reported and highly publicized, but not scientifically proven. Marijuana possession for any purpose is outlawed in Texas. Thirty two states and the District of Columbia have approved programs for therapeutic use of cannabinoids. There may be a proposal to legalize therapeutic use of cannabinoids presented to the Texas Legislature in 2015. An adolescent medicine specialist from California speaking at McLanes Childrens Hospital in October confirmed the above observations and cautioned Texas to go slowly on consideration of legalization of marijuana.

In the meantime, the use of marijuana and cannabinoids by children and adolescents is illegal, dangerous and harmful to normal growth and development and should be discouraged.

Paxton Howard, Jr., M. D., Professor of Internal Medicine and Medical Ethics (Ret.)

Source: **American Society of Addiction Medicine meeting April 10-13, 2014 in Orlando; New England Journal of Medicine 370:2219 (June 5) 2014 titled "Adverse Health Effects of Marijuana Use" from the National Institute of Drug Abuse.**

SWHP/ICSW Utilization Management Criteria for Inpatient Services and Selected Benefit Coverage Determinations 2014

The Scott & White Health Plan/Insurance Company of Scott & White (SWHP/ICSW) Insurance Policy, also referred to as Evidence of Coverage (EOC) or Standard Plan Document (SPD), is the contract for coverage of the health care services that an individual purchased or an employer purchased for their employees. SWHP/ICSW provides a variety of benefit plans to meet purchaser needs.

Benefit plans include benefits required by law SWHP/ICSW as well as purchaser preference (ASO). The purpose of SWHP's Utilization Management (UM) Program is to manage services according to the terms contained in the Insurance Policy. All benefit plans require coverage to be contingent upon medical necessity. SWHP's Utilization Management Committee adopts and or develops evidence-based criteria to determine medical necessity. Annually, in July SWHP provides proposed criteria to physician directors of Baylor Scott & White HealthCare's Medical Services Divisions and contracted network physicians for review and feedback. SWHP Medical Directors evaluate all feedback provided. The resulting approved final criteria sets and the target LOS are forwarded to the SWHP UM Committee for review and approval.

2014 criteria includes InterQual®, internal policies, Healthcare Management Guidelines (target length-of-stay) (LOS), criteria developed and approved during Technology Assessment meetings, and medical coverage policies.)

The approved criteria are used by the UM Staff as a guideline only. SWHP Medical Directors make all denial of coverage determinations. Decisions are UM, including formulary coverage determinations, are based on meeting criteria for appropriateness of care and services and are subject to the terms and limitations of the Insurance Policy. SWHP/ICSW does **not** offer incentives, including compensation or rewards, to Practitioners or other individuals conducting utilization review to encourage denials of coverage of services or offer financial incentives that encourage decisions that result in underutilization of services. SWHP/ICSW does **not** use incentives to encourage barriers to care and services.

Medical Director(s) compensation is not based on utilization of services denials. SWHP/ICSW does not make decisions regarding hiring, promoting or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.

SWHP/ICSW monitors for evidence of underutilization, overuse and misuse through the Quality Improvement (QI) Committee's review of MEDinsight reports, HEDIS® measures, QI Team measures and complaint data. Evidence of underutilization, overutilization and misuse will be discussed with the individual physician, as well as targeted Member outreach as appropriate. Individual coverage requests are discussed with the individual physicians/providers making the request on behalf of a Member.

SWHP/ICSW UM Staff (including Medical Directors) are available by telephone 24 hours/7 days per week at 1-254-298-3088 or (toll free 1-888-316-7947 or by appointment to discuss UM and/or coverage determinations, including benefit provisions, guidelines, criteria or the processes used to make determinations. The SWHP "On-Call" nurse who has access to a SWHP Medical Director on call are available after hours.

Appeal rights, including expedited appeals, reconsideration rights and/or Independent Review Organization (IRO) options are always provided with any denial issued. Practitioners may request to review criteria at any time including at the time of a case-specific determination. Criteria will be provided by fax, phone, and email or through an onsite appointment with the Care Coordination Division (CCD) management staff. CCD can be reached by calling (toll free) 1 -888-316-7947 or directly at 1-254-298-3088.

In an effort to improve communication with non-English speaking members, SWHP/ICSW uses the interpretive services of AT&T. Members do not have to call a special line for this service. When contacting SWHP, Members may notify the CCD staff and/or Customer Advocates of their primary language and the call will be completed with the help of an AT&T interpreter at no charge to the Member. CCD Staff follows established internal SWHP/ICSW policies related to provision of interpretive services for SWHP/ICSW members.

SWHP/ICSW utilizes a toll free TTY number 1-800-735-2989 to assist with communication services for Members with hearing or speech difficulties. The TTY number is listed on the SWHP webpage at www.swhp.org and is also included in your Member correspondence and Member publication materials.

Common High Risk Medications in the Elderly (Age 65) and Suggested Alternatives

The medications listed below reflect common High Risk Medications (HRM), developed and endorsed by the Pharmacy Quality Alliance (PQA) in June 2012. The safer treatment options provided represent potential alternatives to HRMs. Providers should evaluate whether these alternatives can be used in place of HRMs for their patients.

Therapeutic Class	High Risk Medications	Potential Risks	Safer Treatment Options
Sedative Hypnotics	Greater than 90 days cumulative supply during plan year: • Zolpidem (Ambien, Ambien CR) • Eszopiclone (Lunesta) • Zaleplon (Sonata)	Cognitive impairment, delirium, unsteady gait, syncope, falls, motor vehicle accidents, minimal benefit	• Consider non-pharmacologic interventions, focusing on proper sleep hygiene. When sedative hypnotic medications are deemed clinically necessary, use should be at the lowest possible dose for the shortest possible time. • Trazodone (low dose) • Silenor (Quantity Limit #30/30 days) • Rozerem (Quantity Limit #30/30 days)
Skeletal Muscle Relaxants	• Carisoprodol (Soma) • Cyclobenzaprine (Flexeril) • Methocarbamol (Robaxin) • Orphenadrine (Norflex) • Metaxalone (Skelaxin) • Chlorzoxazone (Parafon Forte) • All combination products containing one of these medications	Most muscle relaxants are poorly tolerated by elderly patients due to anticholinergic adverse effects, sedation, fall risk, delirium, and weakness. At doses tolerated by elderly patients, their effectiveness is questionable.	• Consider non-pharmacologic treatments, such as cryotherapy, heat, massage and stretching/exercise. • Baclofen • Tizanidine tablets
Tertiary Amine Tricyclic Antidepressants (TCAs)	• Amitriptyline • Clomipramine • Doxepin (>6 mg/day) • Imipramine • Trimipramine	Strong anticholinergic effects (dry mouth, constipation, vision disturbances), sedation, increased risk for falls	**For Depression / Anxiety / OCD:** • Secondary Amine TCAs (Nortriptyline, Protriptyline, Desipramine, Amoxapine) • SSRIs (Fluoxetine, Citalopram, Paroxetine, Sertraline) • SNRIs (Venlafaxine, Duloxetine) • Bupropion **For neuropathic pain / fibromyalgia:** Gabapentin, Duloxetine, Lyrica **For prevention of migraine:** Propranolol, Divalproex sodium, Topiramate
Oral Hypoglycemics	• Glyburide (Diabeta) • Chlorpropamide (Diabinese)	Greater risk of severe, prolonged hypoglycemia	• Glimepiride • Glipizide
Urinary Anti-Infectives	Greater than 90 days cumulative supply during the plan year: • Nitrofurantoin (Furadantin) • Nitrofurantoin monohydrate/ macrocrystals (Macrobid) • Nitrofurantoin macrocrystals (Macrodantin)	Associated with an increased risk of pulmonary toxicity, neuropathy and hepatotoxicity when renal function is decreased. Also, less effective when CrCl<60 mL/min.	**For prevention of recurrent UTIs:** • TMP-SMX • Fluoroquinolones • Beta-lactam antibiotics • Optimal dose, frequency and duration are not known • Consider antibiotic resistance patterns and patient antibiotic history

Cardiovascular	• Digoxin (>0.125 mg/day)	In heart failure, higher dosages associated with no additional benefit and may increase risk. Decreased renal clearance may increase risk of toxicity.	Dose reduction (M0.125mg/day)
Estrogens and Estrogen / Progesterone Products (Oral and Transdermal)	• Conjugated estrogen (Premarin) • Conjugated estrogen / medroxy-progesterone (Prempro, Premphase) • Estradiol, oral (Estrace, Femtrace) • Estradiol patch (Alora, Climara, Estraderm, Estradiol, Menostar, Vivelle-Dot) • Estradiol / drospirenone (Angeliq) • Estradiol / levonorgestrel (ClimaraPro) • Estradiol / norethindrone (CombiPatch) • Estradiol / norgestimate (Prefest) • Estropipate (Ogen, Ortho-Est) • Esterified estrogen (Menest) • Esterified estrogen / methyltestosterone (Covaryx, Estratest) • Ethinyl estradiol / norethindrone (Activella, FemHRT)	Elderly patients on long-term oral estrogens are at increased risk for breast and endometrial cancer. In addition, results from the Women's Health Initiative (WHI) hormone trial suggest these medications may increase the risk of heart attack, stroke, blood clots, and dementia.	**For Hot Flashes:** Continuously re-evaluate the need for long-term estrogen therapy; evaluate non-drug therapy. Postmenopausal women should avoid using oral estrogens for more than 3 years. After 3 years patients should be titrated off therapy due to the risks outweighing the benefits. Consider the following alternatives: • Brisdelle • SSRIs, Gabapentin, and Venlafaxine have non-FDA labeled indications (medically accepted use) for hot flashes. **For Vaginal Symptoms:** Premarin Cream **For Bone Density:** • Alendronate • Actonel (risedronate) • Evista (raloxifene)

References:

1. The American Geriatrics Society 2012 Beers Criteria Update Expert Panel. American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. JAGS. 2012; 60: 616-31.
2. PQA. Use of High-Risk Medications in the Elderly: Review and Revision of Performance Measure. June 2012.

Avoid High Risk Medications in the Elderly

Medicare has established various quality measures, one of which is evaluating use of high risk medications (HRM) in the elderly. The HRM measure contributes to a Medicare plan's overall Star Rating and assesses the percentage of Medicare beneficiaries 65 years of age or older who receive two or more prescription fills of at least one high risk medication.

The American Geriatrics Society (AGS) updated the Beers Criteria in 2012 which identifies high risk medications in older adults. These medications are associated with poor patient outcomes such as adverse drug events, hospitalizations, and mortality due to physiological changes with aging. HRMs typically have limited effectiveness in the elderly, are frequently unsafe, and risks associated with these medications are thought to outweigh the potential benefits.1 The Medicare HRM measure applies the new AGS recommendations and was adapted from measures developed and endorsed by the Pharmacy Quality Alliance (PQA) and the National Quality Forum (NQF).2

Although a patient may tolerate a HRM currently, that patient is still vulnerable to experiencing dangerous adverse effects, especially as the patient continues to age and physiological changes occur. Discontinuation of a HRM before a safety issue arises is key in preventing patient harm.

Provided below is a listing of common high risk medications. Please carefully consider formulary alternatives, non-pharmacologic therapy, and your clinical judgment to help reduce use of these medications in the elderly.

References:

1. The American Geriatrics Society 2012 Beers Criteria Update Expert Panel. American Geriatrics Society updated Beers Criteria for potentially inappropriate medication use in older adults. J Am Geriatr Soc. 2012 Apr;60(4):616-31.
2. Centers for Medicare and Medicaid Services (CMS). (Sep 2014). Patient Safety Analysis: High Risk Medication Measures PDP/MA-PD Contacts Report User Guide. Burlingame, CA. 1-23.

SWHP Formulary Information

For the most up-to-date SWHP formulary information (including pharmaceutical management procedures), SWHP encourages providers to visit our website.

Go to **swhp.org** → **PROVIDERS** tab → **PHARMACY SERVICES** link.

The following documents are available online for the **SWHP Commercial & Exchange Plans:**

→ **PRESCRIPTION DRUG LISTS** link

- **SWHP Formulary** (updated quarterly)
- **Specialty SWHP Formulary** (updated quarterly)
- **ERS Formulary** (updated quarterly) [ERS – Employees Retirement System of Texas]
- **S&W Employees Formulary** (updated quarterly)
- **S&W Employees Specialty Formulary** (updated quarterly)
- **FEHBP Formulary** (updated quarterly) [FEHB – Federal Employees Health Benefits Program]
- **Qualified Health Plans (including Exchange Plans) Formulary** (updated quarterly)

→ **Formulary Updates from SWHP P&T Committee** (updated monthly)

→ **PRIOR AUTHORIZATION AND EXCEPTIONS** link

- Prior Authorization Criteria
  - **SWHP (non-Medicare & non-Medicaid)** link
- HMO Prior Authorization Request Forms
  - Download medication specific prior authorization forms

Pharmaceutical management procedures are processes that help manage the drug formulary. In order to provide the most cost-effective therapy options, restrictions may be applied to certain drugs on the formulary. The SWHP formularies contain a description of pharmaceutical management procedures (includes but not limited to prior authorization (PA), quantity limits (QL), step therapy (ST), therapeutic interchange, and generic substitution). If a medication has restriction(s) in place, those are listed on the formulary under the medication-specific "Coverage Details." The formularies also contain information regarding how to submit an exception request.

If you have any questions or wish to obtain a printed copy of the formularies or pharmaceutical management procedures, please contact Scott & White Prescription Services at (800) 728-7947.

Our Friday FOCUS editions may be found at
https://swhp.org/about-us/news/newsletters/providers-friday-focus

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