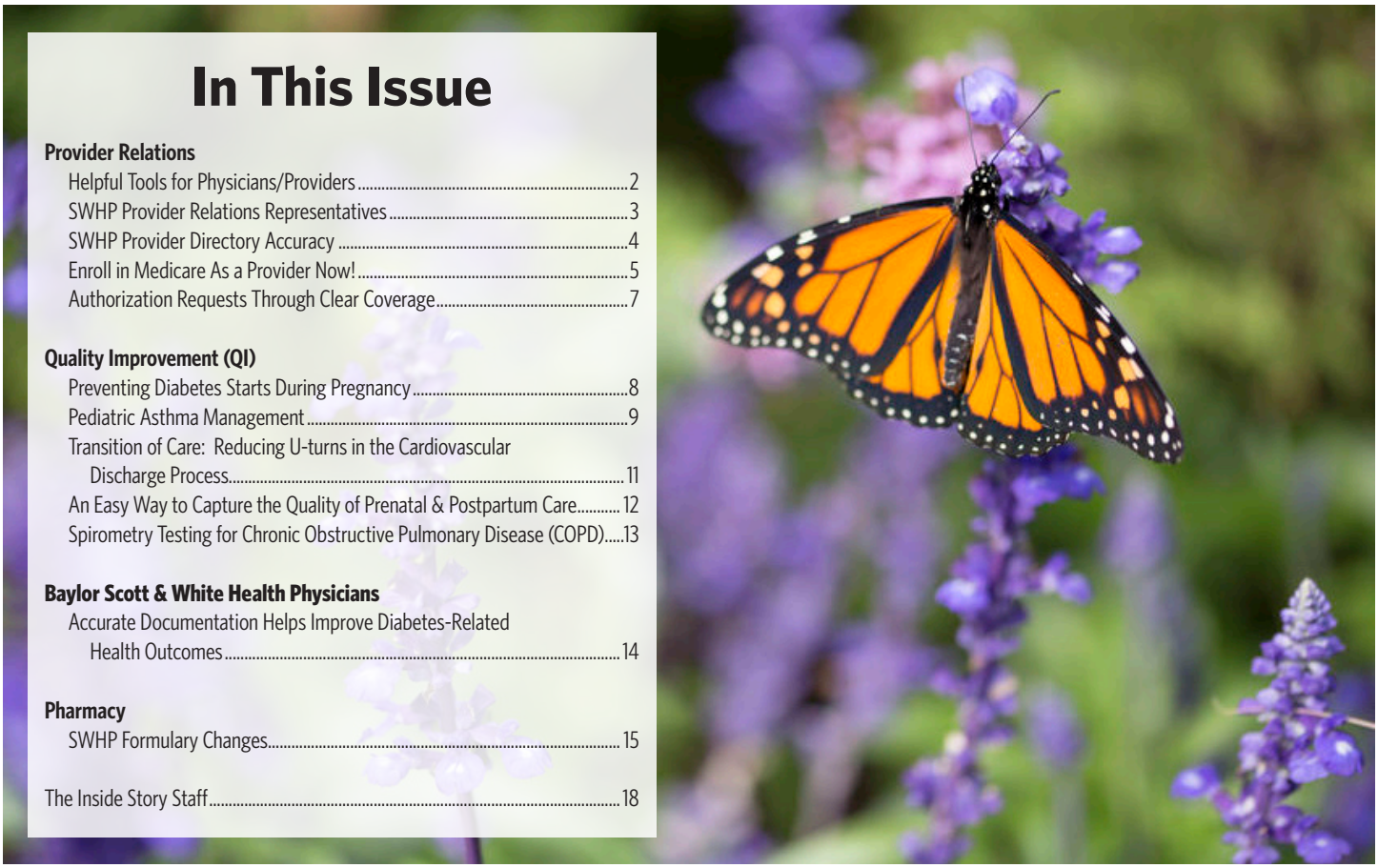
The Inside Story

Volume 22 Issue 1 SPRING 2016

The first three months of 2016 have been a very busy time for Scott & White Health Plan (SWHP). As many of you know, SWHP is participating as a Qualified Health Plan (QHP) on the Health Insurance Marketplace ("Exchange"). For 2016, SWHP is offering both Commercial HMO and PPO plans on the Exchange. As a result, we experienced a tremendous growth in membership due to members selecting one of our plans as their choice for coverage. Most of this new membership went into effect on January 1st. This significant growth in membership has been remarkable and impactful! SWHP has experienced extremely high call volumes in our Customer Advocacy Department throughout the first quarter of 2016, which has caused long wait times for all members and physicians/providers. We are diligently working to ensure that our operations support the growing membership and physician/provider network. SWHP has made great strides in improving the efficiencies within our Customer Advocacy Department, and we hope that you have noticed that the wait times have decreased tremendously. The Provider Relations Department has also been out visiting many of our physician/provider partners and introducing you to your dedicated Provider Relations Representative who can assist you with many of your questions and concerns. Finally, a team of SWHP staff members have been focused on enhancing the provider portal where you can go online to verify member benefits and eligibility, check claims status, and view other pertinent information. Our #1 goal continues to be to provide all SWHP members with access to a high-quality, high performing physician/provider network that offers cost effective healthcare to meet their needs. We enjoy working with our physicians/providers and want you to continue to be a part of our physician/provider network.

In This Issue



Helpful Tools for Physicians/Providers

Here at Scott & White Health Plan (SWHP), we understand that the primary focus of our physicians/providers is delivering high-quality healthcare to your patients – our members. With that in mind, we want to make it as easy as possible for you to obtain the information that you need. SWHP is continuously working on implementing various tools in order to provide you with the information that you need at your fingertips.

SWHP would like to invite and encourage our physicians/providers to utilize the following tools for the information needed on a routine basis:

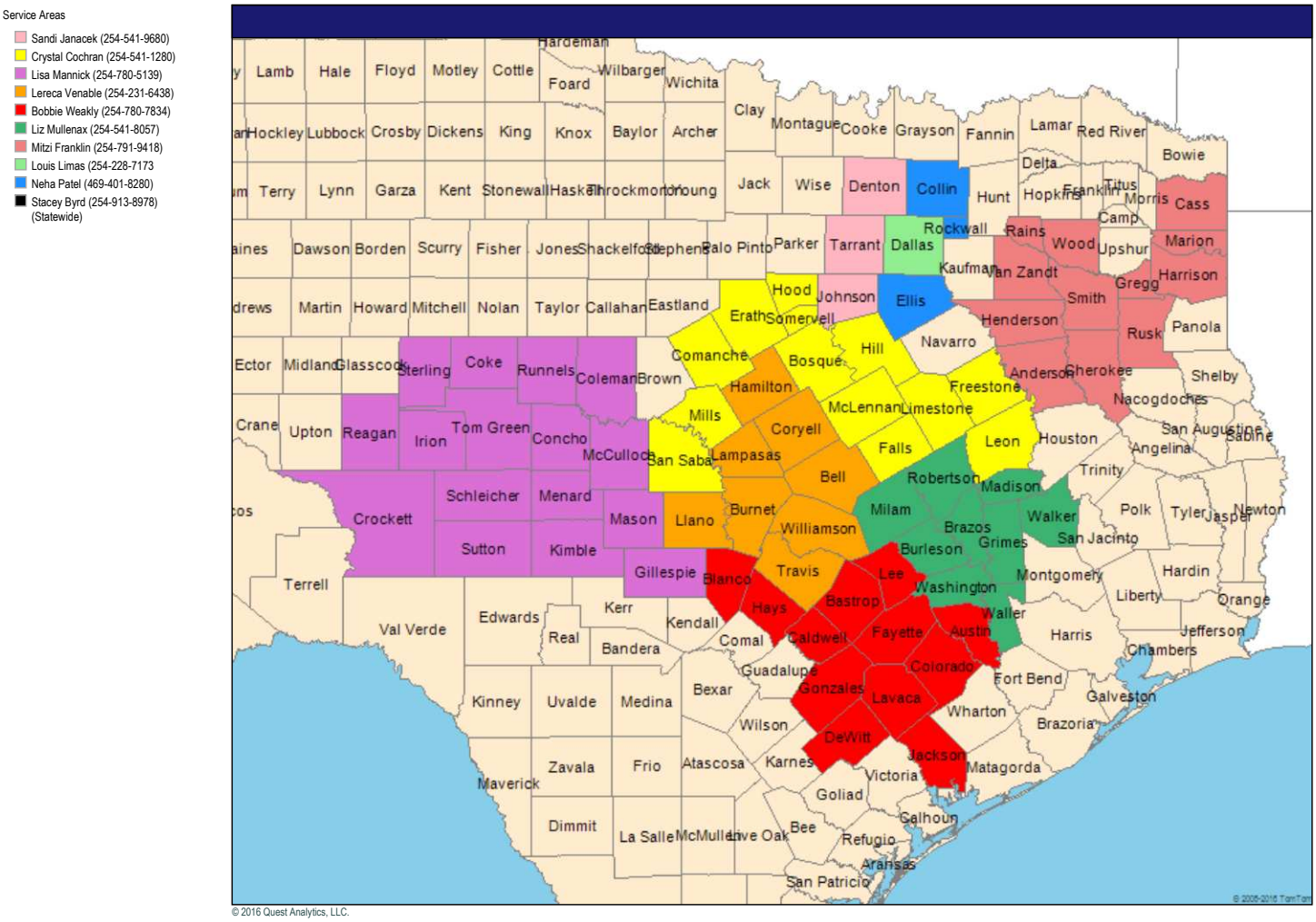
- ***SWHP Website*** – can be used to view SWHP's Provider Manual, policies and procedures, forms, educational material, and other important information
  - Accessed at: http://swhp.org/en-us/prov
- ***Provider Interactive Voice Response (IVR) System*** – can be used to verify member eligibility and benefits and check claims status
  - Accessed directly by dialing 1-800-655-7947 or by calling the main Customer Service phone number at 1-800-321-7947 and pressing option 1
- ***SWHP Provider Portal*** – can be used to view complete Prior Authorization Lists, check claims status, and verify member eligibility and benefits
  - Accessed at: https://portal.swhp.org/apps/provider/ (requires login)
- ***SWHP Provider Directory*** – online provider search, which can be used to validate the demographic information that we have for you and to verify the physicians, facilities, and other providers that we have in our networks
  - Accessed at: https://portal.swhp.org/#/search

Our main goal is to provide you with the information that you need in a quick and efficient way. Again, we encourage you to take advantage of the tools listed above. If you have any suggestions on how we can improve them, please feel free to call the SWHP Provider Relations Department at 1-254-298-3064 or 1-800-321-7947, ext. 203064. You can also email us at SWHPPROVIDERRELATIONSDEPARTMENT@sw.org.

SWHP Provider Relations Representatives

Who is your Scott & White Health Plan (SWHP) Provider Relations Representative ("PR Rep")? To identify who your PR Rep is, please use the following map, which lists the name and cell phone number of each PR Rep along with a color-coded legend that shows the counties that each PR Rep covers. The PR Reps serve as your liaison for SWHP. They are available to assist you with information needed regarding SWHP's policies/procedures, questions, and issues or concerns.

SWHP Provider Relations Representative Territory Map



SWHP Provider Directory Accuracy

When Scott & White Health Plan (SWHP) members are looking for an in-network physician/provider, they have the option of either using our online provider search or a PDF version of our provider directories. SWHP directories are specific to the type of plan members have, allowing them to search for doctors, hospitals, and other medical providers in their area. **It is *critical* that the information in the provider directories is current and accurate.**

Please take the time to go to our website at https://portal.swhp.org/#/search and review your information. If you find inaccurate information, such as address, phone number, and etc., please complete the Provider Address Change Form located at https://legacy.swhp.org/providers/resources/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 update your address in our system. To attach the W-9 Form, please use the "Attachments" feature located at the bottom of the form.

Important official message for providers who prescribe drugs for Medicare patients.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR PROGRAM INTEGRITY

ENROLL IN MEDICARE AS A PROVIDER *NOW*!

This applies to all providers who prescribe drugs for Medicare patients and are not enrolled in (or validly opted-out of) Medicare. Because of a new Medicare requirement, it is crucial for your patients' health that you enroll in Medicare (or validly opt out, if appropriate). As soon as possible, please follow the below steps. A delay on your part could result in your Medicare patients not being able to obtain drugs you prescribe for them.

What's changed & when?

We have published rules that will soon require nearly all providers (for example, dentists, physicians, psychiatrists, residents, nurse practitioners, and physician assistants), including Medicare Advantage providers, who prescribe drugs for Part D patients to enroll in Medicare (or validly opt out, if appropriate). Beginning June 1, 2016, we will enforce a requirement that Medicare Part D prescription drug benefit plans *may not cover drugs* prescribed by providers who are not enrolled in (or validly opted out of) Medicare, except in very limited circumstances.

Why is this important to my patients and me?

Unless you enroll (or validly opt out), Medicare Part D plans will be required to notify your Medicare patients that you are not able to prescribe covered Part D drugs. *Please also note that if you opt out, you cannot receive reimbursement from traditional Medicare or a Medicare Advantage plan, either directly or indirectly (except for emergency and urgent care services; see 42 CFR 405.440 for details.)*

What steps do I need to take?

To help your Medicare patients, please **enroll in Medicare either fully to bill or for the limited purpose of prescribing Part D drugs.** There are **no fees** to complete the process. You can do so electronically or on paper:

1. *Electronic process:* Use the PECOS system at **go.cms.gov/pecos**. For limited enrollment, we recommend using the step-by-step instructions at **go.cms.gov/PECOSsteps** and a video tutorial at **Go.cms.gov/PECOSVideo**; *or*

2. *Paper process:* Complete the paper application for limited enrollment at **go.cms.gov/cms855o** and submit it to the MAC in your geographic area. To locate your MAC, please refer to the MAC list at: **go.cms.gov/partdmaclist**.

If you need assistance with the process of enrolling in (or validly opting out) of Medicare, please contact the MAC within your geographic area.

Thank you for your prompt and careful attention to this important matter, and for serving Medicare beneficiaries. These new CMS rules will enable federal officials to better combat fraud and abuse in the Part D program through verification of providers' credentials via the Medicare enrollment/opt-out process.

The Centers for Medicare & Medicaid Services

QUESTIONS? NEED ASSISTANCE?

Please contact CMS at **providerenrollment@cms.hhs.gov** if you have questions about this letter, you do not prescribe drugs, or if you believe that:

- You are already enrolled in (or validly opted out of) Medicare.
- You have a pending application.
- You are not eligible to enroll in Medicare (for example, you are a pharmacist).

If you need assistance with the process of enrolling in (or validly opting out) of Medicare, please contact the MAC within your geographic area. To locate your MAC, please refer to the MAC list on the CMS website at: **go.cms.gov/partdmaclist.**

Please visit the CMS Part D Prescriber Enrollment website at **go.cms.gov/PrescriberEnrollment** for helpful information about the new requirement, such as resources to check your application status, or to sign up for the listserv to receive updates.

Background Information

The Medicare program is administered by the Centers for Medicaid & Medicare (CMS) within the U.S. Department of Health and Human Services. The Medicare program is divided into four parts: 1) Part A generally covers inpatient hospital services; 2) Part B generally covers physician services; 3) Part C (Medicare Advantage) refers to Medicare-approved private health insurance plans for individuals enrolled in Parts A and B; and 4) Part D covers the cost of most prescription medications.

The Part D prescriber enrollment rules referred to in this notice are CMS-4159-F *Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs* (79 FR 29843; May 23, 2014); and CMS-6107-IFC *Medicare Program; Changes to the Requirements for Part D Prescribers* (80 FR 25958; May 6, 2015).

Authorization Requests Through Clear Coverage

Scott & White Health Plan (SWHP) is excited to announce the upcoming implementation of Clear Coverage in the summer of 2016. Clear Coverage is a web-based system that provides an automated method for physicians/providers and health plans to manage authorizations for outpatient services, at the point of care. Clear Coverage enables automated authorization, notification, eligibility and direction of members to in-network service providers. Clear Coverage provides the following benefits:

- Physicians/Providers have immediate access to coverage, medical appropriateness and network rules, driving the consistent application of evidence-based medicine.
- Physicians/Providers have transparency into evidence-based medical necessity.
- Allows for health plans to do exception based utilization management and only touch those requests that do not meet medical necessity.
- Secured PHI transmission.
  - Physicians/Providers can scan and attach only required elements from the medical record, reducing the need to print and fax.
- Faster turnaround times.
  - An instant decision can be made based on medical necessity, when applicable.
  - Eliminates need for numerous call backs when clinical information is attached to the request.

Preventing Diabetes Starts During Pregnancy

"Diabetes is becoming more common in the United States" (CDC, 2015, Para 1). These are the opening words of the Centers for Disease Control and Prevention's (CDC) December 1, 2015 report in which they published that the rates of diabetes have quadrupled since 1980 with the vast majority of these new cases being Type 2 Diabetes Mellitus (DM). In addition to the 9.3% of the American population with diabetes, the CDC also published that 1 in 3 American adults have pre-diabetes (CDC, 2016). The good news is that the American Diabetic Association (ADA), the CDC, and the National Institutes of Health (NIH) all agree that Type 2 DM is a metabolic disease that can be prevented or its onset prolonged, through lifestyle modification, diet control, and control of overweight and obesity.

It has long been known that gestational weight gain (GWG) has significant short- and long-term implications for both the mother and child. The Institute of Medicine (IOM) lists some of the risks for excessive GWG, such as macrosomia, postpartum weight retention, maternal obesity, and an increased risk of child obesity. And yet, in a recent IOM study regarding GWG, 47% of pregnant American women gained more than the recommended weight gains (Deputy, Sharma, & Kim, 2015). Putting this into context, it is a well-known fact that increased GWG, especially early in pregnancy, represents statistically significant, and yet modifiable, risk for gestational diabetes (GDM). It is also well-documented that of women with a history of GDM, nearly half will develop Type 2 DM over the course of the next 10 years. Meanwhile, according to studies done at Yale University School of Medicine, children who are born to mothers with GDM have six times higher risk of having diabetes (Rivas, 2014). Lastly, women who have had GDM with a previous pregnancy have a 60% chance of developing it again.

For years, researchers have been evaluating the effects of both genetics and lifestyle modifications on the incidence of diabetes. At first, it was proposed that Type 1 DM was genetic while Type 2 DM was the result of lifestyle choices on adults. At the turn of the century, research was looking into the effects of pediatric onset of diabetes in teens. Was the removal of physical education to blame? Now, Fox News Health reports a 3 year old Texan, has been diagnosed with Type 2 DM (Fox News, 2015). Again, researchers looked into the root cause. What they found was Type 2 DM travels down the family tree at rates well above that of Type 1 DM.

Risk of developing Type 2 Diabetes when another family member has Type 2 DM (Schneider, 2014):

- Father: 15-33 percent
- Sibling: 33 percent
- Mother: 40 percent

Quality Improvement (QI)

Based on this new understanding of Type 2 DM, the CDC has recommended a few simple steps that can be taken to cut these risks in half:

1) Pregnant women at risk should be screened for GDM during their first pre-natal visit.
2) Monitor gestational weight gain.
    a. Consider a referral to a dietician/nutritionist for the whole family.
    b. Encourage weight loss for the whole family.
3) Encourage breastfeeding until the age of 9 months.
4) Screen both the mother and child for diabetes at regular intervals post-delivery.

References

CDC. (2015, December 1). CDC - *Number of Persons - Diagnosed Diabetes - Data & Trends - Diabetes DDT.* Retrieved from http://www.cdc.gov/diabetes/statistics/prev/national/figpersons.htm

CDC. (2016, January 14). National Diabetes Prevention Program | Diabetes | CDC. Retrieved February 1, 2016, from http://www.cdc.gov/diabetes/prevention/index.html

Deputy, N. P., Sharma, A. J., & Kim, S. Y. (2015). Gestational Weight Gain - United States, 2012 and 2013. Morbidity and Mortality Weekly Report (MMWR), 64(43), 1215-1220. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6443a3.htm?s_cid=mm6443a3_e

Fox News Health. (2015, September 17). 3-year-old with Type 2 diabetes youngest diagnosed in world. *Children's Health*.

Rivas, A. (2014, August 25). Exposure to Gestational Diabetes Makes Kids 6 Times More Likely to Have Diabetes. *Medical Daily*. Retrieved from http://www.medicaldaily.com/exposure-gestational-diabetes-makes-kids-6-times-more-likely-have-diabetes-299724

Schneider, C. (2014, September 8) *Diabetes and the Risk to Your Family Tree. DiabetesCare.Net* Retrieved from: http://www.diabetescare.net/authors/clara-schneider/diabetes-and-the-risk-to-your-family-tree

Pediatric Asthma Management

Asthma affects more than 5 million children in the United States. Each year, asthma accounts for more than 3 million physician visits, 570,000 emergency department visits, 164,000 hospital stays, 8.7 million prescriptions and 10 million missed school days (NIH, 2007). The National Asthma Education and Prevention Program provide guidelines for improving asthma care. By adhering to these guidelines, physicians can prescribe an asthma management plan to relieve symptoms, control disease and allow normal activity in children.

Before the age of five, 80 percent of children with asthma will develop symptoms. These symptoms include coughing, wheezing, shortness of breath, rapid breathing and chest tightness (Wright, 2004). These symptoms are usually worse during evening or early morning hours. There are certain triggers, such as exercise, cold weather or allergen that can precipitate symptom onset. In children, clinical assessment is the primary diagnostic tool. However, pulmonary function tests should be done to confirm the diagnosis of asthma.

An asthma management plan should include education, trigger avoidance and medication. The primary goal of the management plan is to enable children to function without limitations from asthma (Chipps, 2011). Education for patients and their caregivers must focus on the avoidance of triggers, the importance of compliance, the use of prescribed medication and proper training on the use of inhalation devices.

References

Chipps B, Zeiger RS, Murphy K, et al. Longitudinal validation of the test for Respiratory and Asthma Control in Kids in pediatric practices. Pediatrics 2011; 127:e737.

National Asthma Education and Prevention Program: Expert panel report III: Guidelines for the diagnosis and management of asthma. Bethesda, MD: National Heart, Lung, and Blood Institute, 2007. (NIH publication no. 08-4051)

Wright RJ, Mitchell H, Visness CM, et al. Community violence and asthma morbidity: the Inner-City Asthma Study. American Journal of Public Health 2004; 94:625

Transition of Care: Reducing U-turns in the Cardiovascular Discharge Process

The Centers for Medicare & Medicaid Services (CMS) recently released its *Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries* (CMS, 2016). As part of the introduction and background information, CMS opened this guide by reminding the reader that as part of healthcare reform and ongoing U.S. legislative and administrative initiatives, such as the Hospital Readmission Reduction Program (HRRP), the U.S. healthcare system is transitioning to models that promote increased access to care that is cost-effective, high quality, timely, patient-centered, and equitable.

While we cannot and should not prevent all readmissions, "researchers have found wide variation in hospitals' readmission rates" (Boccuti & Casillas, 2015, para 1). This research has led to numerous studies and position statements about the effectiveness of activities hospitals can and should engage in to reduce hospital readmission rates. If we want to deliver personalized health through exemplary care – and avoid the HRRP penalties – we must stay abreast of current research and recommended evidence-based best practices. In that regard, the first two diagnoses being monitored by CMS for potentially preventable readmissions are: Congestive Heart Failure & Heart Attacks.

The most recent data published by the Agency for Healthcare Research and Quality (AHRQ) clearly shows that Black and Hispanic patients experience statistically higher rates of potentially preventable readmissions for heart disease than do other races (AHRQ, 2013). These rates have been attributed to multiple factors, including: limited linkage with PCPs, language barriers, low health literacy, and socioeconomic factors. To combat these problems, the CDC has published the following 7 recommendations:

1) **Create a Strong Radar.** Collection of quality data is needed to accurately identify underlying problem(s).
2) **Identify the Root Cause.** Ask the 5 Whys.
3) **Start from the Start.** Discharge planning should begin at the time of admission.
4) **Deploy a Team.** Multidisciplinary teams that are enabled to communicate quickly, effectively, and respectfully can often anticipate and address the barriers that result in potentially preventable readmissions.
5) **Consider Systems and Social Determinants.** The patient's ability to successfully engage in self-care is directly influenced by the support systems available to the individual.
6) **Focus on Culturally Competent, Communication-Sensitive, High-Risk Scenarios.** In other words, communicate with the whole team to ensure a clear understanding of the diagnosis, care plan, and discharge instructions. Although not specifically mentioned by the CDC, incorporating a check for understanding with the member is a great way of ensuring the intended message has been received.
7) **Foster Community Partnerships to Promote Continuity of Care.** This is a key component in facilitating the transition of care. This can include post-discharge follow-up communication to ensure PCP appointments are available and kept, proactive phone calls from the pharmacist, lab, disease management or telehealth, and ensuring the member has access to non-medical resources, such as food, housing, transportation, and other basic needs.

By incorporating these 7 recommendations into our discharge process, we can deliver the personalized healthcare our patients need, thereby reducing the number of U-turns made during the discharge process.

References

AHRQ. (2013). National Healthcare Disparities Report, 2013 | Agency for Healthcare Research & Quality. Retrieved from http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/index.html

Boccuti, C., & Casillas, G. (2015, January 29). Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program | The Henry J. Kaiser Family Foundation. Retrieved from http://kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/

CMS. (2016, January 26). Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries. Retrieved from https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf

An Easy Way to Capture the Quality of Prenatal & Postpartum Care

There are hundreds of Current Procedural Terminology (CPT) codes that are used for reimbursement purposes, which may not always represent the quality of care a patient receives. However, there are some prenatal and postpartum category II codes that can be used for performance measurement. The use of 0500F, 0502F, 0503F patient management codes is an easy way to capture professional level performance for specific clinical purposes, such as prenatal and postpartum care (PPC). The use of category II codes will decrease the need for record abstraction and chart reviews, and thereby minimize administrative burden on physicians and other health care professionals, hospitals, and entities seeking to measure the quality of patient care.

The code requirements are:

0500F	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report the date of visit and the date of the last menstrual period [LMP])
0501F	Subsequent prenatal care visit (Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care, such as an upper respiratory infection)
0503F	Used for a postpartum care visit

[1]American Medical Association: 2014 Professional Edition CPT

Reference

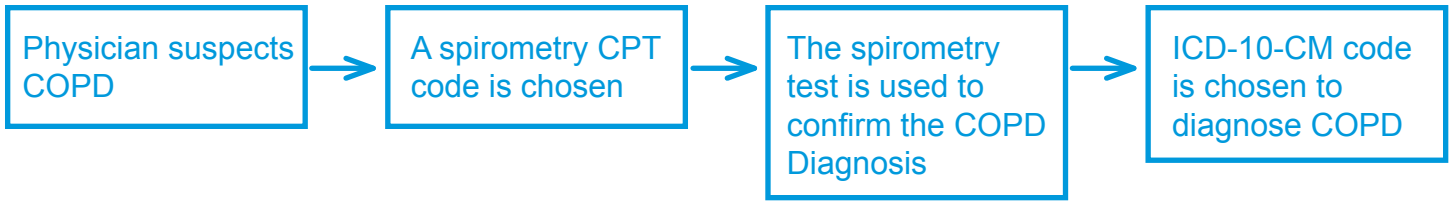
Abraham, M. (2013). CPT 2014: Current procedural terminology. Chicago: American Medical Association.

Spirometry Testing for Chronic Obstructive Pulmonary Disease (COPD)

On October 1st 2015, the new American Academy of Professional Coders (AAPC) implemented the new ICD-10-CM codes to replace the previously used ICD-9-CM codes. The implementation of the new ICD-10-CM codes increased the total number of codes for each individual disease or diagnoses from the old ICD-9-CM codes. Like most of the other diseases, COPD saw an increase in the number of codes used to identify the diagnosis.

You are probably asking yourself what does this have to do with spirometry testing? Well, the use of and the proper coding for spirometry testing is important based on the recommendation from the National Committee for Quality Assurance (NCQA). NCQA measures the use of spirometry testing for patients 40 years of age or older with a new diagnosis of COPD or newly active COPD. This is a measurement every accreditation seeking health plan must comply with, including the Scott & White Health Plan (SWHP).

Now that we know spirometry testing is important to NCQA, let's bring coding for spirometry testing and COPD together. NCQA recommends that patients receive appropriate spirometry testing to confirm the diagnosis of COPD in two years prior to the diagnosis or within six months of the diagnosis. In the past with ICD-9-CM, there was only one code for the diagnosis of COPD: 496. With ICD-10-CM, a physician can choose one of several codes to diagnose COPD: J44.0, J44.1, or J44.9. Not only is there an increase in the number of codes that can be used, but there are additional codes to identify specific circumstances as they relate to COPD, such as exposure to environmental tobacco smoke, history of tobacco use, or tobacco dependence. To ensure correct and timely process of claims, the appropriate COPD code should be selected with a spirometry Current Procedural Terminology (CPT) code to identify that a spirometry test was used to confirm the diagnosis of COPD: 94010, 94014-94016, 94060, 94070, 94375, or 94620. A flow chart for this process is shown below:



It will take time to learn the new ICD-10-CM codes, but in the meantime physicians can utilize the Epic 3M Encoder to help identify the proper code needed for any disease.

Reference

National Committee for Quality Assurance. (2015). HEDIS 2016 Technical Specifications for Health Plans (Vol. 2). Washington, DC: National Committee for Quality Assurance.

Accurate Documentation Helps Improve Diabetes-Related Health Outcomes

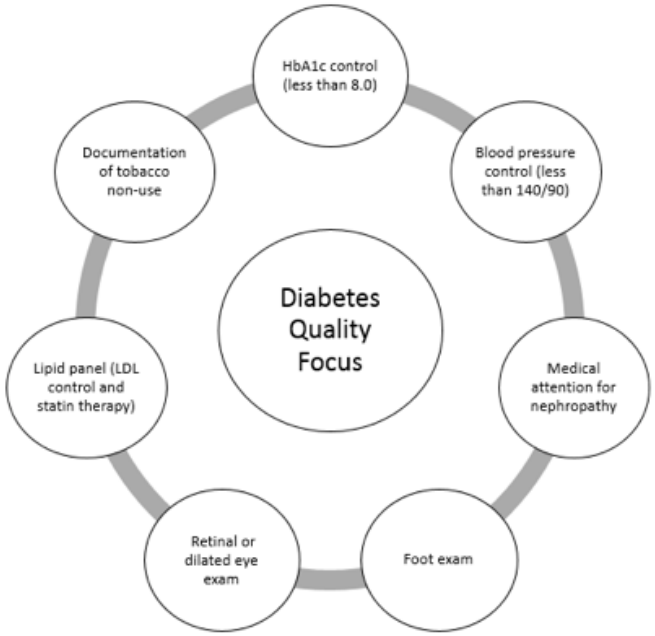
Improving diabetes-related health outcomes for our patient population is a priority in this quality-driven era. Proper documentation of diagnoses, complications, testing, screening, and follow-up in the EHR is imperative to tracking and improving health outcomes. Accurate documentation is the only way to effectively communicate the excellent level of care you are providing. Accurate documentation translates to better quality of care and improvement in the health of your patient population. Your documentation directly communicates the level of care you are providing.

Tips on accurate documentation to help improve quality:

- Document the most accurate diagnosis. If a patient has diabetic complications, make sure to link the complication with the diabetic diagnosis instead of using two separate diagnoses; stage CKD and diabetic ulcers in a separate code.
  - Example: Document "Type 2 Diabetes Mellitus with Chronic Kidney Disease" and the stage of CKD, instead of documenting "Diabetes Mellitus" and "Chronic Kidney Disease" separately.
  - Be careful when choosing combination codes with Diabetes in your EHR. For example, in Epic, "due to" means "associated with." Unless you believe your patient's HTN or HLD is a ***direct result*** of the DM, do not choose diagnoses that include those phrases.
- Always document your patient's tobacco status in the social history. Always ask the question if you don't know!
- When documenting the diabetic foot exam, make sure all relevant portions of the foot exam are documented, including visual inspection, sensory exam with monofilament, and pulse exam.
- Make sure your diabetic patient has a HbA1c checked at least annually, but more often if not at goal below 8.0.
- Maintain blood pressure below 140/90 for all diabetic patients.
- Make sure your diabetic patient is getting medical attention for nephropathy by:
  - Screening for urine albumin
  - Using ACE-I/ARB as first line treatment for hypertension
  - Referring patient to nephrologist as needed
  - Documenting the stage of CKD, if present

Providers can leverage the reports in their EHR to manage the health of their diabetic population.

By focusing on these key quality measures, you can improve the health of your diabetic patient population!



Baylor Scott & White HEALTH

Formulary Changes
Scott & White Health Plan
Pharmacy & Therapeutics Committee

The SWHP Pharmacy and Therapeutics (P&T) Committee meets monthly to review drugs and policies. Recent changes are summarized in the table below.

You can find formulary updates, formularies/preferred drugs lists (PDLs) at http://swhp.org/en-us/prov/resources/pharmacy-services. Prior authorization criteria and prior authorization forms can be found at http://swhp.org/en-us/prov/auth-referral/medications.

SWHP P&T Formulary Changes (January – February 2016)

Medication	Copay	Comments	Indication(s)	SWHP Formulary Alternatives	Effective Date
Azilect® (rasagaline)	**SWHP Tier 3** **ACA Compliant- Tier 3** **MCD- Tier 4**	SWHP addition to Tier 3 formulary Maintenance eligible	Indicated for the treatment of Parkinson's disease	selegiline	4/1/2016
Tikosyn® (dofetilide)	**SWHP Tier 3** **ACA Compliant- Tier 3** **MCD- Tier 4**	SWHP addition to Tier 3 formulary Maintenance eligible	Indicated for pharmacologic conversion of atrial fibrillation or flutter (AF/AFl) to normal sinus rhythm (NSR), and for maintenance of NSR in patients with AF/AFl of greater than one week duration who have been converted to NSR	amiodarone sotalol Multaq®	4/1/2016
Orkambi® (lumicaftor/ivacaftor)	**Non-formulary**	Addition of non-formulary prior authorization criteria			4/1/2016
Subsys® (fentanyl sublingual spray)	**Non-formulary**	Addition of non-formulary prior authorization criteria			4/1/2016
Oral Oncology Drugs		Revision of prior authorization criteria			4/1/2016
Humira®(adalimumab)		Revision of prior authorization criteria			4/1/2016
Hepatitis C Drugs		Revision of prior authorization criteria			4/1/2016
aripiprazole	**SWHP Tier 1** **ACA Compliant -Tier 1** **MCD- Tier 2**	**Tier Change** from non-preferred to preferred generic Removal of prior authorization criteria (effective 3/1/2016)			4/1/2016
Hizentra® (human immune globulin subcutaneous) **Hyqvia™** (human immune globulin infusion with recombinant human hyaluronidase)	**Non-formulary**	Addition of non-formulary prior authorization criteria			4/1/2016

Zepatier™ (elbasvir/grazoprevir)	**Non-formulary**	Addition of non-formulary prior authorization criteria			4/1/2016
Corlanor® (ivabradine)	**SWHP Tier 3** **ACA Compliant- Tier 3** **MCD- Tier 4**	Prior authorization required Maintenance eligible	Indicated to reduce the risk of hospitalization for worsening heart failure in patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction M 35%, who are in sinus rhythm with resting heart rate U 70 beats per minute and either are on maximally tolerated doses of beta-blockers (BB) or have a contraindication to BB use		3/1/2016
Entresto™ (sacubitril/valsartan)	**SWHP Tier 3** **ACA Compliant- Tier 3** **MCD- Tier 4**	Prior authorization required Maintenance eligible	Indicated to reduce the risk of cardiovascular death and hospitalization for heart failure (HF) in patients with chronic HF (NYHA Class II-IV) and reduced ejection fraction	lisinopril, ramipril, enalapril, losartan, valsartan	3/1/2016
Makena® (hydroxyprogesterone caproate injection for intramuscular administration)	**SWHP Specialty** **ACA Compliant- Tier 4**		Indicated to reduce the risk of preterm birth in women with a singleton pregnancy who have a history of singleton spontaneous preterm birth		3/1/2016
Xeomin® (incobotulinumtoxinA)	**SWHP Specialty** **ACA Compliant- Tier 4**	Prior authorization required	Indicated for the treatment of upper limb spasticity, cervical dystonia and blepharospasm	Botox® Myobloc®	3/1/2016
Alecensa™ (alectinib)	**SWHP Specialty** **ACA Compliant- Tier 4** **MCD- Tier 5**	Prior authorization required (SWHP Specialty and ACA Compliant)	Indicated for the treatment of patients with anaplastic lymphoma kinase-positive, metastatic non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to crizotinib	Zykadia™	3/1/2016
Ninlaro® (ixazomib)	**SWHP Specialty** **ACA Compliant- Tier 4** **MCD- Tier 5**	Prior authorization required (SWHP Specialty and ACA Compliant)	Indicated in combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received at least one prior therapy	Farydak® Darzalex™	3/1/2016
Tagrisso® (osimertinib)	SWHP Specialty ACA Compliant- Tier 4 MCD- Tier 5	Prior authorization required (SWHP Specialty and ACA Compliant)	Indicated for the treatment of patients with metastatic EGFR T790M mutation-positive NSCLC, as detected by an FDA-approved test, who have progressed on or after EGFR tyrosine kinase inhibitor therapy	Tarceva® Gilotrif® Iressa®	3/1/2016
Cosentyx™ (secukinumab)		Revision of prior authorization criteria			3/1/2016
Dysport® (abobotulinumtoxinA), **Myobloc®** (rimabotulinumtoxinB)		Revision of prior authorization criteria			3/1/2016
Xiaflex® (collagenase clostridium histolyticum)		Revision of prior authorization criteria			3/1/2016
Eliquis® (apixiban) **Pradaxa®** (dabigatran) **Savaysa®** (edoxaban) **Xarelto®** (rivaroxaban)		Removal of quantity limits			3/1/2016
aripiprazole **Abilify®**		Revision of prior authorization criteria			
Bydureon® (exenatide microspheres) **Byetta®** (exenatide)		Revision of prior authorization criteria			3/1/2016
Victoza® (liraglutide)		Removal of prior authorization criteria (ACA Compliant only)			
Gilenya™ (fingolimod)		Removal of prior authorization criteria			3/1/2016

Tecfidera® (dimethyl fumarate)		Removal of prior authorization criteria			3/1/2016
Cotellic™ (cobimetinib)	**SWHP Specialty** **ACA Compliant- Tier 4** **MCD- Tier 5**	Prior authorization required (SWHP Specialty and ACA Compliant)	Indicated for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, in combination with vemurafenib	Mekinist®	1/1/2016
Genvoya™ (elvitegravir/cobicistat/ emtricitabine/tenofovir alafenamide)	**ACA Compliant- Tier 4** **MCD-Tier 5**		Indicated as a complete regimen for the treatment of HIV-1 infection in adults and pediatric patients 12 years of age and older	Stribild™	1/1/2016
valsartan	**SWHP Tier 1** **ACA Compliant -Tier 1** **MCD- Tier 1**	**Tier Change** from non-preferred to preferred generic			1/1/2016
Brintellix® (vortioxetine)	**SWHP Tier 3** **ACA Compliant Tier 3** **MCD- Tier 4**	Addition of Step Therapy (ST) requiring failure of one generic SNRI (serotonin-norepinephrine reuptake inhibitor) Note: ST only applies to SWHP and ACA Compliant	Indicated for the treatment of major depressive disorder	venlafaxine IR, ER duloxetine citalopram escitalopram fluoxetine paroxetine sertraline bupropion	1/1/2016
Januvia® (sitagliptin) **Janumet®** (sitagliptin/ metformin) **Janumet XR®** (sitagliptan/ metformin extended release)	**SWHP Tier 2** **ACA Compliant Tier 2** **MCD-Tier 3**	**Tier change** from Tier 3 to Tier 2 (SWHP and ACA Compliant) **Tier change** from Tier 4 to Tier 3 (MCD) Removal of ST requiring failure of Tradjenta® or Jentadueto®			1/1/2016
Pradaxa® (dabigatran)	**SWHP Non-formulary** **ACA Compliant- Tier 3** **MCD- Tier 4**	**SWHP tier change** from Tier 2 to non-formulary status **ACA Compliant tier change** from Tier 2 to Tier 3 status **MCD tier change** from Tier 3 to Tier 4 Addition of step therapy (ST) requiring failure of preferred agents Eliquis® or Xarelto® Prior authorization required			1/1/2016
Olysio® (simeprevir)	**Non-formulary**	**Tier change** (removal): move from Specialty to non-formulary status Prior authorization required			1/1/2016

***MCD – SWHP Medicare Part D Formulary**

Our Friday Focus editions may be found at:
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