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PARTNERS IN HEALTH UPDATE® is a publication of Independence Blue Cross and its affiliates (Independence), created to provide valuable information to the Independence-participating provider community. This publication may include notice of changes or clarifications to administrative policies and procedures that are related to the covered services you provide in accordance with your participating professional provider, hospital, or ancillary provider/ancillary facility contract with Independence. This publication is the primary method for communicating such general changes. Suggestions are welcome.

Contact information:
Provider Communications
Independence Blue Cross
1901 Market Street
27th Floor
Philadelphia, PA 19103
provider_communications@ibx.com

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Help fight against fraud, waste, and abuse

Last year, the Federal Bureau of Investigation estimated that between 3 and 10 percent of all health care spending in the U.S. went towards payment of fraudulent claims. Fraud has real effects on health care costs and quality of care. Independence’s Corporate and Financial Investigations Department (CFID) continues to add value to our fight against health insurance fraud, waste, and abuse (FWA). CFID detects and investigates potential areas of FWA with the help of confidential information received from many stakeholders, including providers, members, employees, and the general public.

Information received assists our analysts, auditors, and investigators in determining whether potential FWA has occurred. Some of the most common potential FWA schemes reported to CFID over the past year include:

- billing for services not rendered;
- health care identity fraud;
- prescribing of controlled substances for illicit purposes;
- improper use of procedure codes.

If you suspect health care fraud against Independence and/or you, we urge you to report it. All reports are confidential. You are not required to provide your name, address, or other identifying information.

Submitting a report

You can submit your report to us in one of three ways:

1. **Submit** the Online Fraud & Abuse Tip Referral Form electronically at [www.ibx.com/antifraud](http://www.ibx.com/antifraud).
2. **Call** the confidential anti-fraud and corporate compliance toll-free hotline at 1-866-282-2707 (TTY: 1-888-789-0429).
3. **Mail** your report. Write a description of your complaint, enclose copies of any supporting documentation, and mail it to:
   Independence Blue Cross
   Corporate & Financial Investigations Department
   1901 Market Street, 42nd Floor
   Philadelphia, PA 19103

As a result of CFID’s efforts last year, more than $100 million was recovered in FWA-related claims and 88 fraud cases were referred to law enforcement or regulatory agencies. Multiples of the recovered amount were saved through the detection, prevention, and shutting down of improper payments and schemes. Many of these recoveries and referrals started with information someone provided to CFID.

Please join us in the fight against health care fraud. ✉
Required lead time when updating your provider information

Independence would like to remind you about the importance of submitting changes to your provider information in a timely manner. Keeping your provider information current and up-to-date helps to ensure prompt payment of claims, delivery of critical communications, seamless recredentialing, and accurate listings in our provider directories. Per your Independence Professional Provider Agreement and/or Hospital, Ancillary Facility, or Ancillary Provider Agreement (Agreement), you are required to notify Independence whenever key practice information changes.

**Professional providers**

As outlined in the Administrative Procedures section of the *Provider Manual for Participating Professional Providers (Provider Manual)*, Independence requires 30 days advanced notice to process most updates, with the exceptions noted below:

- **30-day notice.** Independence requires 30 days advanced notice for the following changes/updates to your practice information:
  - updates to address, office hours, total hours, phone number, or fax number;
  - changes in selection of capitated providers (HMO primary care physicians [PCP] only);
  - addition of new providers to your group (either newly credentialed or participating);
  - changes to hospital affiliation;
  - changes that affect availability to patients (e.g., opening your panel to new patients).

- **60-day notice.** Independence requires 60 days advanced written notice for closure of a PCP practice or panel to additional patients.

- **90-day notice.** Independence requires 90 days advanced written notice for resignation and/or termination from our network.

*Note:* Independence will not be responsible for changes not processed due to lack of proper notice.

**Submitting updates and/or changes**

Professional providers can use the *Provider Change Form*, available at www.ibx.com/providerforms, to quickly and easily submit most of the changes to their basic practice information. Please be sure to print clearly, provide complete information, and attach additional documentation as necessary. Mail your completed *Provider Change Form* to:

Independence Blue Cross  
Attn: Network Administration  
P.O. Box 41431  
Philadelphia, PA 19101-1431

You can also fax the completed form to Network Administration at 215-988-6080. Please be sure to keep a confirmation of your fax.

*Note:* The *Provider Change Form* cannot be used if you are closing your practice or terminating from the network. Refer to “Resignation/termination from the Independence network” in the Administrative Procedures section of the *Provider Manual* for more information regarding policies and procedures for resigning or terminating from the network.

**Facility and ancillary providers**

As outlined in the Administrative Procedures section of the *Hospital Manual for Participating Hospitals, Ancillary Facilities, and Ancillary Providers*, Independence requires 30 days advanced notice to process the following changes to your information:

- updates to address, phone number, or fax number;
- adding or removing providers from your panels (either newly credentialed or participating).

*Note:* Independence will not be responsible for changes not processed due to lack of proper notice.

*continued on the next page*
Submitting updates and/or changes
Per your Agreement, all changes must be submitted in writing to our contracting and legal departments at the following addresses:

Independence Blue Cross
Attn: Senior Vice President, Provider Networks and Value-Based Solutions
1901 Market Street, 27th Floor
Philadelphia, PA 19103

Independence Blue Cross
Attn: Deputy General Counsel, Managed Care
1901 Market Street, 43rd Floor
Philadelphia, PA 19103

Authorizing signature and W-9 Forms
Certain updates result in a change on your W-9 Form, including changes to a provider’s name, tax ID number, billing vendor or “pay to” address, or ownership. The following requirements apply when making these types of updates:

- **For professional providers:** A physician or office manager signature is required.
- **For facility and ancillary providers:** Written notification on company letterhead is required.

An updated copy of your W-9 Form reflecting these changes must also be included to ensure that we provide you with a correct 1099 Form for your tax purposes. If you do not submit a copy of your new W-9 Form, your change will not be processed.

If you have any questions about updating your provider information, please contact your Network Coordinator.

*Behavioral health providers contracted with Magellan Healthcare, Inc., an independent company, must submit any changes to their practice information to Magellan via their online Provider Data Change form at [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) by selecting the “Display/Edit Practice Info” link or by contacting their Network Management Specialist at 1-800-866-4108 for assistance.*

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Accessing the Provider Automated System
The way providers can access the Provider Automated System has recently changed. When you call 1-800-ASK-BLUE, be sure to say “Provider” or **press 1** when prompted to reach Provider Services.

For more information, an updated user guide for the Provider Automated System is available at [www.ibx.com/providerautomatedsystem](http://www.ibx.com/providerautomatedsystem).
Billing for observation services when combined with other outpatient services

Independence would like to remind our participating outpatient hospitals about our reimbursement policy for observation services when billed in combination with other outpatient services, as specified in your Hospital Agreement (Agreement).

In accordance with your Agreement, the Observation Fee Schedule includes all implants, biologicals, equipment, supplies, drugs, and ancillary services provided to the beneficiary during the visit or procedure, including the professional components of laboratory and radiology.

When billed with outpatient surgical and/or emergency services, observation services are reimbursed as follows:

- **Observation services billed with outpatient surgery.** Outpatient surgical services are reimbursed according to the Agreement; observation services are not separately reimbursed.
- **Observation services billed with an ER visit.** Emergency room/department (ER) visits and observation services are both reimbursed according to the Agreement.
- **Observation services billed with an ER visit and outpatient surgery.** Outpatient surgical services and the ER visit are both reimbursed according to the Agreement; however, observation services are not separately reimbursed.

The following table shows examples of how our reimbursement policy will pay when certain revenue codes are combined with Healthcare Common Procedure Coding System (HCPCS) and/or Current Procedural Terminology (CPT®) codes:

<table>
<thead>
<tr>
<th>Revenue code</th>
<th>HCPCS/CPT code</th>
<th>Reimbursement policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0490</td>
<td>67105</td>
<td>Reimbursed according to contracted rate</td>
</tr>
<tr>
<td>0762</td>
<td>99234</td>
<td>No separate reimbursement</td>
</tr>
<tr>
<td>Example 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0450</td>
<td>99281</td>
<td>Reimbursed according to contracted rate</td>
</tr>
<tr>
<td>0762</td>
<td>99234</td>
<td>Reimbursed according to contracted rate</td>
</tr>
<tr>
<td>Example 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0450</td>
<td>99281</td>
<td>Reimbursed according to contracted rate</td>
</tr>
<tr>
<td>0490</td>
<td>67105</td>
<td>Reimbursed according to contracted rate</td>
</tr>
<tr>
<td>0762</td>
<td>99234</td>
<td>No separate reimbursement</td>
</tr>
</tbody>
</table>

As noted above, the Observation Fee Schedule is inclusive of all ancillary services; therefore, observation services are not separately reimbursed.

Observation services must be billed with revenue code 0762, plus the appropriate number of units the patient spent in observation (one unit per hour). Reimbursement for observation services shall not exceed the contracted observation maximum.

In the past you may have been inadvertently paid for services that should not have been separately reimbursed. Please note that we will be enforcing our reimbursement policy for facility reporting of observation services as set forth in your Agreement and as clarified above. For more information regarding observation services, please refer to our Medical Policy Portal at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy).

If you have any questions, please contact your Network Coordinator.
New claims reporting requirements now in effect for home infusion vendors

Independence has adopted new claims reporting requirements for drugs obtained from in-network home infusion vendors. The following information is required when submitting drug claims for home infusion vendors that are not owned by a hospital or health system in the Independence provider network:

- **NDC.** Report the specific National Drug Code (NDC) that corresponds to the drug formulation administered to the member.
- **HCPCS or CPT® codes.** Report the specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) code for the drug. *Exception:* For drugs without a specific HCPCS/CPT code, report the J3490 or J3590 not otherwise classified (NOC) code, as appropriate.
- **Units of drug administered.** Report drug units in multiples of the dosage unit specified in the HCPCS/CPT code narrative. *Exception:* For drugs without a specific HCPCS/CPT code, report the units in multiples of the drug units specified in the NDC.

Failure to include these components in a claim may result in delayed processing and reimbursement.

*Note:* The submission process for precertification requests through the NaviNet® web portal has not changed.

**For more information**

Effective March 1, 2016, the following claim payment policies have been updated to address these new billing requirements and provide specific claims examples:

- **Commercial:** #00.01.49b: Reporting Requirements for Drugs and Biologics
- **Medicare Advantage:** #MA00.024a: Reporting Requirements for Drugs and Biologics

View these policies by visiting our Medical Policy Portal at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy). Select *Accept and Go to Medical Policy Online*, and then select the *Commercial* or *Medicare Advantage* tab from the top of the page, depending on the version of the policy you’d like to view. Then type the policy name or number in the Search field.

Please note that this change only applies to home infusion vendors that are not owned by hospitals or health systems in the Independence provider network. Home infusion vendors owned by hospitals or health systems in the Independence provider network should continue to bill according to the terms of their Provider Agreement.
Professional Injectable and Vaccine Fee Schedule updates effective April 1, 2016

Effective April 1, 2016, we will implement a quarterly update to our Professional Injectable and Vaccine Fee Schedule for all contracted providers. These updates reflect changes in market price (i.e., average sales price [ASP] and average wholesale price [AWP]) for vaccines and injectables.

Allowance Inquiry transaction
To look up the rate for a specific code, use the Allowance Inquiry transaction on the NaviNet® web portal. To do so, go to Independence NaviNet Plan Central, select Claim Inquiry and Maintenance from the Independence Workflows menu, and then select Allowance Inquiry. For step-by-step instructions on how to use this transaction, refer to the user guide available in the NaviNet Resources section of our Provider News Center at www.ibx.com/pnc/navinet.

Note: The Allowance Inquiry transaction returns current rates for professional providers only. The reimbursement rates that go into effect April 1, 2016, will be available through this transaction on or after this effective date. Provider payment allowances are for informational purposes only and are not a guarantee of payment.

If you have any questions about the updates, please contact your Network Coordinator.

Update on APC reimbursements
On January 1, 2012, Ambulatory Payment Classifications (APC) reimbursement was added to the Hospital Agreement (Agreement) for certain Independence products. According to that Agreement, the APC Grouper/Pricer and Fee Schedules published and distributed by the Centers for Medicare & Medicaid Services (CMS) are used to determine reimbursement. The reimbursement amount is the product of the CMS APC Pricer amount (or fee schedule amount) and the CMS Pricer Adjustment Factor.

In the event CMS makes updates to APC Grouper/Pricer and/or Fee Schedules, Independence will update the APC Grouper/Pricer within 60 days* of CMS publishing such updates. The parties agree, however, that retrospective changes made by CMS shall not apply.

If you have a concern regarding the way your claims are reimbursed, please use your applicable version of the CMS Outpatient Prospective Payment System (APC Pricer) to verify proper compensation.

If discrepancies remain, or if you have any questions, please contact your Network Coordinator.

*The time frame may vary. Please refer to your specific Agreement with Independence.
View up-to-date policy activity on our Medical Policy Portal

Changes to Independence medical and claim payment policies for our commercial and Medicare Advantage Benefits Programs occur frequently in response to industry, medical, and regulatory changes. We encourage you to view the Site Activity section of our Medical Policy Portal in order to keep up to date with changes to our policies.

The Site Activity section is updated in real time as changes are made to medical and claim payment policies. Topics include:

- Notifications
- New Policies
- Updated Policies
- Reissued Policies
- Coding Updates
- Archived Policies

For your convenience, the information provided in Site Activity can be printed to keep a copy on hand as a reference.

To access the Site Activity section, go to our Medical Policy Portal at www.ibx.com/medpolicy and select Accept and Go to Medical Policy Online. From here you can select Commercial or Medicare Advantage under Site Activity to view the monthly changes. To search for active policies, select either the Commercial or Medicare Advantage tab from the top of the page. You can also get to our Medical Policy Portal through the NaviNet® web portal by selecting the Reference Tools transaction, then Medical Policy.

2016 ePASS® incentive opportunity for professional providers

Based on a recent analysis, we have updated the requirements for submitting a SOAP (Subjective, Objective, Assessment, and Plan) Progress Note through ePASS® for Medicare Advantage HMO and PPO members, as well as certain commercial HMO, POS, and PPO members.

Our analysis showed that our ability to assist in closing remaining gaps is enhanced by receiving ePASS® information as close to the visit as possible. It also reduces our outreach to members who have already had gaps closed. Therefore, the total eligible incentive amount will remain the same for each submission as long as it is submitted within 90 days of the patient’s visit.

The submission for the second visit will be eligible only if the visit occurred more than four months after the first visit for which you submitted the initial SOAP Progress Note. Additionally, there remains a limit of two submissions per member, per calendar year.

If you have any questions regarding SOAP Progress Notes or using ePASS®, please contact Inovalon at 1-877-448-8125. For any questions about the ePASS® incentive or payment, please email incentive4chartsepass@ibx.com.
Criteria for endometrial ablation

Providers are reminded that endometrial ablation, with or without hysteroscopic guidance, is covered for premenopausal women with menorrhagia (excessive menstrual flow) and a benign endometrium who are unresponsive to, or have a contraindication to, hormone therapy and would otherwise be considered candidates for hysterectomy.

Endometrial ablation is a procedure used to treat menorrhagia in premenopausal women who have completed childbearing. During the procedure, an energy source is used to ablate (destroy) endometrial tissue to reduce menstrual flow. It is an alternative to hysterectomy that is used when other treatments, such as hormone therapy, have either failed to reduce menstrual flow or cannot be taken.

Endometrial ablation is contraindicated in individuals who have:
- confirmed pregnancy or desire for a future pregnancy;
- history of endometrial cancer or precancerous histology;
- active infection (genital or urinary tract) at the time of the procedure;
- active pelvic inflammatory disease;
- intrauterine device (IUD) in place at the time of the procedure;
- any anatomic or pathologic condition (e.g., history of previous classical caesarean sections or transmural myomectomy) in which weakness of the myometrium could exist.

For more information, please visit our Medical Policy Portal at www.ibx.com/medpolicy. Select Accept and Go to Medical Policy Online, and then select the Commercial or Medicare Advantage tab from the top of the page, depending on the version of the policy you’d like to view. Then type the policy name or number in the Search field:
- Commercial: #11.06.05c: Endometrial Ablation
- Medicare Advantage: #MA11.065a: Endometrial Ablation

You can also get to our Medical Policy Portal through the NaviNet® web portal by selecting the Reference Tools transaction, then Medical Policy.◆
Reminder: New preferred providers for Direct Ship Drug Program and IVIG/SCIG home infusion

As of March 1, 2016, Independence has new preferred providers for both our Direct Ship Drug Program and intravenous and subcutaneous immunoglobulin (IVIG/SCIG) drugs provided in the home. These changes do not affect medical necessity criteria or coverage determinations for our members.

Direct Ship Drug Program
Walgreens and PerformSpecialty (referred to in previous Independence communications as PerformRx), independent companies, were chosen as preferred providers for our Direct Ship Drug Program. All requests for direct ship drugs will be fulfilled by these providers, with the exception of Synagis®, which will continue to be fulfilled by ACRO Pharmaceutical Services, an independent company.

For more information on ordering drugs through our Direct Ship Drug Program, go to www.ibx.com/directship.

IVIG/SCIG home infusion
Option Care, an independent company, was selected as the preferred provider for IVIG/SCIG drugs given in the home.

The following communications occurred for this change:
- Independence sent letters to affected members notifying them that Option Care is the preferred home infusion vendor for IVIG/SCIG and detailing the transition plan of service.
- Option Care provided outreach to affected members to answer questions and schedule appointments with an Option Care home infusion nurse.
- Option Care contacted affected vendors to answer questions and obtain new prescriptions for our members.

Members who start home infusion therapy with IVIG/SCIG drugs on or after March 1, 2016, should receive such services from either Option Care or a home infusion vendor that is owned by a hospital or health system that participates in the Independence provider network.

Providers should talk to their Independence members who currently receive IVIG/SCIG drugs at home to see if they have any questions or concerns.

Note: Members who currently receive IVIG/SCIG drugs through home infusion vendors that are owned by a hospital or health system that participates in the Independence provider network are not affected by this change.

Coverage for Autism Spectrum Disorders

The Commonwealth of Pennsylvania autism mandate became effective on July 1, 2009, requiring health insurers to cover the diagnosis and treatment of Autism Spectrum Disorders (ASD). In addition, a recent court decision held that school is an eligible place of service for ASD as of January 20, 2016.

The mandate provides coverage for the diagnosis and treatment of ASD for Independence members enrolled in a 51+ fully insured commercial group product or the Children’s Health Insurance Program (CHIP). Coverage is provided for enrolled individuals under age 21 and requires coverage for the following:
- evaluations and tests needed to diagnose an autism disorder;
- medically necessary prescribed treatments such as applied behavioral analysis and rehabilitative care, blood level tests, psychiatric and psychological services, speech/language therapy, occupational therapy, physical therapy, and prescription drugs.

Services not covered under the mandate include benefits that are normally excluded from coverage under the member’s medical plan, including services that are not medically necessary.

Services for ASD, including those rendered in a school setting, must be medically necessary and must have a primary diagnosis of ASD. Depending on the service that is being requested, the member, or a health care provider on a member’s behalf, may be required to submit a treatment plan to Independence once every six months for review and approval. Services for ASD will not be subject to any limits on the number of visits. However, services are subject to applicable member cost-sharing, policy limits, maximums, exclusions, and precertification and referral requirements under the member’s benefits program.

If you have questions about this mandate, call Customer Service at 1-800-ASK-BLUE.
New 1500 Claim Submission and Claim Log transactions now available

Providers can now access the new 1500 Claim Submission and Claim Log transactions on the NaviNet® web portal. User guides for these new transactions are available in the NaviNet Resources section of our Provider News Center at www.ibx.com/pnc/navinet.

The 1500 Claim Submission transaction allows providers who submit CMS-1500 claim forms to submit claims using NaviNet. Providers are then able to review the status of these submitted claims through the Claim Log transaction. Please keep in mind the following when using the 1500 Claim Submission transaction:

● Claims must have a date of service on or after October 1, 2015.
● Providers are able to use this transaction to submit Independence commercial and Medicare Advantage claims, as well as out-of-area Medicare Advantage PPO claims.
● Providers are not able to use this transaction to submit claims with secondary and tertiary payers.
● This transaction is available to providers seven days a week: Monday through Saturday from 5 a.m. to 10 p.m. and Sunday from 9 a.m. to 9 p.m.

Note that modifications will be made to the Claim Log transaction in April to assist providers with claim rejections. Rejections for individual claims will be grouped together, when appropriate, to help providers more easily correct and resubmit claims.

If you have questions about these new transactions, please call the eBusiness Hotline at 215-640-7410.

New NaviNet® look, same great resource

Independence NaviNet Plan Central has received a makeover. The new design provides a fresh look but still offers the same great information and resources.

Here are some highlights of the new navigation:

● **What’s New.** You’ll still find the latest news and alerts at the top center of the page. Just click to expand or collapse the desired message.
● **Current Publications.** Our publications, including Partners in Health Update, manuals, and bulletins, are now located on the left side of the page under the Workflows menu.
● **Administrative Tools & Resources.** Links to various forms and websites remain at the bottom center of the page. Click on each category to expand the list.
● **Additional information.** On the right side of the page, you’ll now find our contact information as well as links to various fee schedules and NaviNet Resources, which includes user guides and webinars.

If you have any questions about the new NaviNet Open Plan Central, please call the eBusiness hotline at 215-640-7410. If you are not yet NaviNet-enabled, go to www.navinet.net to sign up.
Select Drug Program® Formulary updates

The Select Drug Program Formulary, which is available for commercial members, is a list of medications approved by the U.S. Food and Drug Administration that were chosen for formulary coverage based on their medical effectiveness, safety, and value. The list changes periodically as the Pharmacy and Therapeutics Committee reviews the formulary to ensure its continued effectiveness. The most recent changes are listed below.

**Generic additions**

These generic drugs recently became available in the marketplace. When these generic drugs became available, we began covering them at the appropriate generic formulary level of cost-sharing:

<table>
<thead>
<tr>
<th>Generic drug</th>
<th>Brand drug</th>
<th>Formulary chapter</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>aripiprazole 1 mg/ml</td>
<td>Abilify® 1 mg/ml</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
<td>August 24, 2015</td>
</tr>
<tr>
<td>aripiprazole odt 10 mg and 15 mg</td>
<td>Not available</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
<td>October 12, 2015</td>
</tr>
<tr>
<td>budesonide 1 mg/2 ml</td>
<td>Pulmicort® 1 mg/2 ml</td>
<td>12. Allergy, Cough &amp; Cold, Lung Meds</td>
<td>August 3, 2015</td>
</tr>
<tr>
<td>fenofibrate 40 mg</td>
<td>Fenoglide® 40 mg</td>
<td>4. Heart, Blood Pressure, &amp; Cholesterol</td>
<td>September 28, 2015</td>
</tr>
<tr>
<td>memantine hcl 2 mg/ml</td>
<td>Namenda® 2 mg/ml</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
<td>October 19, 2015</td>
</tr>
<tr>
<td>naproxen sodium cr 375 mg</td>
<td>Naprelan® 375 mg</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
<td>August 31, 2015</td>
</tr>
<tr>
<td>pramipexole di-hcl 4.5 mg</td>
<td>Mirapex ER® 4.5 mg</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
<td>August 17, 2015</td>
</tr>
<tr>
<td>rivastigmine 9.5 mg/24 hr, 13.3 mg/24 hr, and 4.6 mg/24 hr</td>
<td>Exelon® 9.5 mg/24 hr, 13.3 mg/24 hr, and 4.6 mg/24 hr</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
<td>September 7, 2015</td>
</tr>
<tr>
<td>tretinoin</td>
<td>Atralin®</td>
<td>5. Skin Medications</td>
<td>September 7, 2015</td>
</tr>
</tbody>
</table>

*Generic requires prior authorization.

**Brand deletions**

Effective April 1, 2016, these brand drugs will be covered at the appropriate non-formulary level of cost-sharing:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify® 1 mg/ml</td>
<td>aripiprazole 1 mg/ml</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
<tr>
<td>Mirapex ER® 4.5 mg</td>
<td>pramipexole di-hcl 4.5 mg</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
<tr>
<td>Namenda® 2 mg/ml</td>
<td>memantine hcl 2 mg/ml</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
</tbody>
</table>

The generic drugs for the above brand drugs are on our formulary and available at the generic formulary level of cost-sharing.
Prescription drug updates

For commercial members enrolled in an Independence prescription drug program, prior authorization and quantity limit requirements will be applied to certain drugs. The purpose of prior authorization is to ensure that drugs are medically necessary and are being used appropriately. Quantity limits are designed to allow a sufficient supply of medication based upon the maximum daily dose and length of therapy approved by the U.S. Food and Drug Administration for a particular drug. The most recent updates are reflected below.

Drugs requiring prior authorization

The prior authorization requirement for the following non-formulary drugs was effective at the time the drugs became available in the marketplace:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addyi®</td>
<td>Not available</td>
<td>10. Female, Hormone Replacement, &amp; Birth Control</td>
<td>September 28, 2015</td>
</tr>
<tr>
<td>Keveyis™</td>
<td>Not available</td>
<td>15. Diagnostics &amp; Miscellaneous Agents</td>
<td>September 21, 2015</td>
</tr>
<tr>
<td>Lonsurf®</td>
<td>Not available</td>
<td>2. Cancer &amp; Organ Transplant Drugs</td>
<td>October 5, 2015</td>
</tr>
<tr>
<td>Odomzo®</td>
<td>Not available</td>
<td>2. Cancer &amp; Organ Transplant Drugs</td>
<td>October 5, 2015</td>
</tr>
<tr>
<td>Synjardy®</td>
<td>Not available</td>
<td>7. Diabetes, Thyroid, Steroids, &amp; Other Miscellaneous Hormones</td>
<td>September 7, 2015</td>
</tr>
</tbody>
</table>

Effective April 1, 2016, the following non-formulary drugs will be added to the list of drugs requiring prior authorization:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aczone®</td>
<td>Not available</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Amrix®</td>
<td>Not available</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
<tr>
<td>Arthrotec®</td>
<td>diclofenac sodium/misoprostol</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
<tr>
<td>Atralin®</td>
<td>tretinoin</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Avita®</td>
<td>tretinoin</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Azelex®</td>
<td>Not available</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Benzaclin® 1-5% gel</td>
<td>clindamycin phos/benzoyl peroxide</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Benzaclin® Pump</td>
<td>Not available</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Benzamycin® gel</td>
<td>erythromycin/benzoyl peroxide</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Benzamycinpak®</td>
<td>Not available</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Cleocin T®</td>
<td>clindamycin phosphate</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Clindagel®</td>
<td>Not available</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Daypro®</td>
<td>oxaprozin</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
<tr>
<td>Duac®</td>
<td>clindamycin phos/benzoyl peroxide</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Evoclin® foam</td>
<td>clindamycin phosphate</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Keppra®</td>
<td>levetiracetam</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
</tbody>
</table>
continued from the previous page

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lamictal®</td>
<td>lamotrigine</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
<tr>
<td>Lamictal ODT™</td>
<td>lamotrigine odt</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
<tr>
<td>Lorzone®</td>
<td>Not available</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
<tr>
<td>Mobic®</td>
<td>meloxicam</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
<tr>
<td>Onexton™</td>
<td>Not available</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Prozac®</td>
<td>fluoxetine hcl</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
<tr>
<td>Retin-A® and Retin-A Micro®</td>
<td>tretinoin</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Skelaxin®</td>
<td>metaxalone</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
<tr>
<td>Soma®</td>
<td>carisoprodol</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
<tr>
<td>Veltin™</td>
<td>Not available</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Voltaren-XR®</td>
<td>diclofenac sodium</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
<tr>
<td>Ziana®</td>
<td>Not available</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Zipsor™</td>
<td>Not available</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
</tbody>
</table>

**Drugs requiring prior authorization with new criteria**

Effective April 1, 2016, members currently taking these medications will require a new prior authorization:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duexis®</td>
<td>Not available</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
<tr>
<td>Vimovo®</td>
<td>Not available</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
<tr>
<td>Zecuity®</td>
<td>Not available</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
</tbody>
</table>

**Drugs with quantity limits**

Quantity limits were/will be added or updated for the following drugs as of the date indicated below:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Quantity limit</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Butrans® 5 mcg patch</td>
<td>Not available</td>
<td>4 patches per 28 days</td>
<td>April 1, 2016</td>
</tr>
<tr>
<td>Hycofenix™</td>
<td>Not available</td>
<td>450 ml per 30 days</td>
<td>August 17, 2015</td>
</tr>
<tr>
<td>Oxaydo™</td>
<td>Not available</td>
<td>180 tablets per 30 days</td>
<td>September 21, 2015</td>
</tr>
<tr>
<td>Zecuity®</td>
<td>Not available</td>
<td>4 patches per 30 days</td>
<td>August 31, 2015</td>
</tr>
</tbody>
</table>

**Drugs no longer requiring prior authorization**

Effective February 1, 2016, the prior authorization requirement was removed for the following drugs:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tivorbex™</td>
<td>Not available</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
<tr>
<td>Zorvolex®</td>
<td>Not available</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
</tbody>
</table>

For additional information on pharmacy policies and programs, please visit [www.ibx.com/rx](http://www.ibx.com/rx).
The benefits of statin therapy in diabetic patients

Diabetes is a chronic metabolic disease that can lead to serious complications, including cardiovascular disease (CVD). According to the Centers for Disease Control and Prevention (CDC), an estimated 29 million people in the United States had diabetes in 2014. Diabetic adults are 2 – 4 times more likely to have heart disease or stroke than adults without diabetes. In addition, the risk of death for diabetic adults is 50 percent higher than for adults without diabetes. Primary and secondary prevention of CVD is crucial for this population. Control of hyperglycemia is not sufficient to reduce the risk of CVD in diabetic patients. Studies have found that controlling individual cardiovascular risk factors in diabetic patients is effective in preventing or slowing CVD.

Diabetics have increased prevalence of lipid abnormalities, which contributes to their increased risk of CVD. Diabetic dyslipidemia is the most frequently seen lipid disorder in diabetic patients. Diabetic dyslipidemia is characterized by high triglycerides, low HDL, and an increase in small, dense LDL particles. The levels of LDL could appear to be relatively normal in diabetics; however, the small dense LDL particles are considered more atherogenic than the larger LDL particles, leading to the increased risk of CVD in diabetic patients.

Guidelines for using statin therapy

Statins are considered first line therapy for diabetic dyslipidemia because they are the most potent medication to reduce LDL cholesterol levels. The American College of Cardiology/American Heart Association (ACC/AHA) and the American Diabetes Association guidelines both recommend using statins in diabetic patients. There have been multiple studies demonstrating that statin use showed significant primary and secondary prevention of CVD events and coronary heart disease deaths in diabetic patients. A meta-analysis by the American College of Physicians on lipid-lowering therapy for type 2 diabetes patients found that there was a 22 percent reduction of events in primary prevention and 24 percent in secondary prevention. Another meta-analysis demonstrated that there is a 9 percent proportional reduction in all-cause mortality and 13 percent reduction in vascular mortality, for each mmol/L reduction in LDL cholesterol.

The table below provides a list of statin intensities from the ACC/AHA guidelines.

<table>
<thead>
<tr>
<th>High-Intensity Statin Therapy</th>
<th>Moderate-Intensity Statin Therapy</th>
<th>Low-Intensity Statin Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily dose lowers LDL-C, on average, by approximately ≥50%</td>
<td>Daily dose lowers LDL-C, on average, by approximately 30% to &lt;50%</td>
<td>Daily dose lowers LDL-C, on average, by approximately &lt;30%</td>
</tr>
<tr>
<td><strong>Atorvastatin (40) – 80 mg</strong></td>
<td><strong>Atorvastatin 10 (20) mg</strong></td>
<td><strong>Simvastatin 10 mg</strong></td>
</tr>
<tr>
<td><strong>Rosuvastatin 20 (40) mg</strong></td>
<td><strong>Rosuvastatin (5) 10 mg</strong></td>
<td><strong>Pravastatin 10 – 20 mg</strong></td>
</tr>
<tr>
<td><strong>Simvastatin 20 – 40 mg</strong></td>
<td><strong>Pravastatin 40 (80) mg</strong></td>
<td><strong>Lovastatin 20 mg</strong></td>
</tr>
<tr>
<td><strong>Lovastatin 40 mg</strong></td>
<td><strong>Fluvastatin XL 80 mg</strong></td>
<td><strong>Fluvastatin 20 – 40 mg</strong></td>
</tr>
<tr>
<td><strong>Fluvastatin 40 mg BID</strong></td>
<td><strong>Pitavastatin 2 – 4 mg</strong></td>
<td><strong>Pitavastatin 1 mg</strong></td>
</tr>
</tbody>
</table>

Boldface type indicates specific statins and doses that were evaluated in RCTs (16-18, 46-49, 64-75, 77) included in CQ1, CQ2, and the Cholesterol Treatment Trialists 2010 meta-analysis included in CQ3 (20). All of these RCTs demonstrated a reduction in major cardiovascular events. Italic type indicates statins and doses that have been approved by the FDA but were not tested in the RCTs reviewed.

*Individual responses to statin therapy varied in the RCTs and should be expected to vary in clinical practice. There might be a biological basis for a less-than-average response.

1Evidence from 1 RCT only: down-titration if unable to tolerate atorvastatin 80 mg in the IDEAL (Incremental Decrease through Aggressive Lipid Lowering) study (47).

2Although simvastatin 80 mg was evaluated in RCTs, initiation of simvastatin 80 mg or titration to 80 mg is not recommended by the FDA because of the increased risk of myopathy, including rhabdomyolysis.

BID: Twice daily; CQ: Critical question; FDA: Food and Drug Administration; LDL-C: Low density lipoprotein cholesterol; RCTs: Randomized controlled trials.

continued on the next page
The recommendations are based on age and other CVD risk factors and not on LDL cholesterol levels. Both of the guidelines recommend that patients ages 40 – 75 should be on statin therapy regardless of other CVD risk factors. Currently, the guidelines only recommend using moderate- and high-intensity statins. In clinical practice, the intensity of the statin may need to be adjusted based on side effects and LDL cholesterol levels.

The ADA recommendations for statin treatment in diabetics are outlined in the table below.

### Recommendations for statin treatment

<table>
<thead>
<tr>
<th>Age</th>
<th>Risk factors</th>
<th>Recommended statin dose*</th>
<th>Monitoring with lipid panel</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40 years</td>
<td>None</td>
<td>None</td>
<td>Annually or as needed to monitor for adherence</td>
</tr>
<tr>
<td></td>
<td>CVD risk factor(s)†</td>
<td>Moderate or high</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overt CVD</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>40 – 75 years</td>
<td>None</td>
<td>Moderate</td>
<td>As needed to monitor for adherence</td>
</tr>
<tr>
<td></td>
<td>CVD risk factor(s)</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overt CVD</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>&gt;75 years</td>
<td>None</td>
<td>Moderate</td>
<td>As needed to monitor for adherence</td>
</tr>
<tr>
<td></td>
<td>CVD risk factor(s)†</td>
<td>Moderate or high</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overt CVD</td>
<td>High</td>
<td></td>
</tr>
</tbody>
</table>

*In addition to lifestyle therapy.

†CVD risk factors include LDL cholesterol ≥100 mg/dL (2.6 mmol/L), high blood pressure, smoking, and overweight and obesity.

‡Overt CVD includes those with previous cardiovascular events or acute coronary syndromes.

We ask that you consider these guidelines when determining treatment options for your diabetic patients.

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Health Coaches: Supporting your patients, our members

Independence recognizes that the physician-patient relationship is at the heart of patient care. Through health coaching from our Registered Nurse Health Coaches, the following programs are offered to enhance your ability to provide coordinated care for your patients and promote integration of care among members and their families, physicians, and community resources:

- **24/7 Health Information Line.** Your Independence patients can call 1-800-ASK-BLUE anytime to speak with a Registered Nurse Health Coach about general health questions and concerns.
- **Case management.** Case management provides support to members who are experiencing complex health issues or challenges in meeting their health care goals.
- **Condition management.** Condition management is available to eligible members for specific chronic conditions such as asthma, diabetes, COPD, hypertension, and congestive heart failure.
- **Baby BluePrints® maternity program.** Your expecting Independence patients can self-enroll in this free program to receive support from an experienced Registered Nurse Health Coach throughout their pregnancy. Please encourage your expecting Independence patients to enroll by calling 1-800-598-BABY (1-800-598-2229). Independence also offers obstetrical Registered Nurse Health Coach support to expecting Independence patients who have been identified as high-risk to facilitate the best possible outcome.

If you would like to refer an Independence patient to one of the programs listed above, complete the online physician referral form, available at [www.ibx.com/providerforms](http://www.ibx.com/providerforms), or call 1-800-313-8628.

Important information about the Zika virus

In May 2015, the World Health Organization (WHO) announced the first transmission of the Zika virus in Brazil. However, evidence of the virus has now been identified in at least 14 countries in the Americas, including the United States. The virus is mosquito-borne and of particular risk to the unborn fetus. Although additional studies are planned to learn more about these risks, the WHO recommends that pregnant women traveling to areas known to have evidence of the virus talk with their doctors first and carefully follow steps to avoid mosquito bites during their trip.

The mosquito species that is spreading the virus does not circulate in this region, even though cases are already showing up in Pennsylvania, New Jersey, and Delaware. If the virus appears locally once mosquito season begins in April, public health officials may build upon mosquito-eradication programs that target the species that transmits West Nile virus.

The current main concern is among travelers to the affected areas. They should avoid mosquitoes, wear long sleeves and long pants, and use mosquito repellent containing DEET. For pregnant women who have traveled to any of the affected countries, the Centers for Disease Control and Prevention (CDC) recommends that testing for the virus should be offered to these women between 2 – 12 weeks after returning to the United States. This recommendation should be made whether or not the woman appears to have symptoms of the virus.

Keep in mind the following about the Zika virus:

- Zika virus infection symptoms include fever, maculopapular rash, arthralgia, or conjunctivitis.
- Testing for the Zika virus is performed at the CDC Arbovirus Diagnostic Laboratory and only a few state health departments.
- Mosquito bites are the primary way the virus is transmitted; however, sexual transmission of the virus is possible.
- No specific antiviral treatment is available for the virus.

For the most up-to-date information from the CDC, visit their website at [www.cdc.gov/zika](http://www.cdc.gov/zika).
## Important Resources

### Anti-Fraud and Corporate Compliance
- **Hotline**: 1-866-282-2707 or www.ibx.com/antifraud

### Care Management and Coordination
- **Baby BluePrints®**: 215-241-2198 / 1-800-598-BABY (2229)*
- **Case and Condition Management**: 1-800-313-8628

### Credentialing
- **Credentialing Violation Hotline**: 215-988-1413 or www.ibx.com/credentials

### Customer Service
- **Provider Services (prompt 1)**: 1-800-ASK-BLUE (1-800-275-2583)
- **Provider Automated System User Guide**: www.ibx.com/providerautomatedsystem

### Electronic Data Interchange (EDI)
- **Highmark EDI Operations**: 1-800-992-0246

### FutureScripts® (commercial pharmacy benefits)
- **Prescription drug prior authorization**: 1-888-678-7012
- **Pharmacy website (formulary updates, prior authorization)**: www.ibx.com/rx

### FutureScripts® Secure (Medicare Part D pharmacy benefits)
- **FutureScripts Secure Customer Service**: 1-888-678-7015
- **Formulary updates**: www.ibxmedicare.com

### NaviNet® web portal
- **Independence eBusiness Hotline**: 215-640-7410
- **Registration**: www.navinet.net

### Other frequently used phone numbers and websites
- **Independence Direct Ship Drug Program (medical benefits)**: www.ibx.com/directship
- **Medical Policy**: www.ibx.com/medpolicy
- **Provider Supply Line**: 1-800-858-4728 or www.ibx.com/providersupplyline

*Outside 215 area code*