



## **Pharmacy Policy and Formulary Updates October 1, 2011**

### **Enteral Therapy**

Effective 10/1/2011, for non-Medicare members, enteral nutrition must be obtained at an MVP participating pharmacy and adjudicate through the MVP pharmacy benefits manager (PBM). Copays and/or coinsurances are subject to the member's enteral product benefit. Home infusion vendors that also participate with MVP as a pharmacy provider, must bill using a valid NDC/UPC product number. Enteral products indicated for inherited diseases of metabolism (ie: PKE, MSUD) will adjudicate without prior authorization. All other products require prior authorization to determine medical necessity as established in MVP policy.

### **MVP Option and MVP Option Family Pharmacy Benefit**

Beginning October 1, 2011, MVP will administer the prescription drug and medical supply benefit for our MVP Option (Medicaid) and MVP Option Family (Family Health Plus) members. Copays for drugs, when administered by MVP Health Plan, Inc., will remain the same.

MVP will re-issue our current ID cards that reflect pharmacy coverage to all Option and Option Family members prior to October 1. As new members enroll in our Option and Option Family plans, they will receive a new ID card.

There will be a unique MVP Option and MVP Option Family formulary that promotes generic utilization. Prescribing practitioners will be able to access this formulary on our Web site at [www.mvphealthcare.com/provider/pharmacy.html](http://www.mvphealthcare.com/provider/pharmacy.html) on or about September 1, 2011. Note that there are variations from the MVP Commercial formulary in certain drug classes. MVP has notified all MVP Option and MVP Option Family members if the medication they are currently taking is not on the formulary or requires step therapy or is subject to quantity limits. The health care professional who wrote the prescription has also been notified and has received an impacted member list to assist in changing to an MVP covered medication.

MVP Option and MVP Option Family members will be required to use CuraScript for specialty drugs. MVP will reach out to CuraScript to assist in transitioning specialty prescription from retail pharmacies. Impacted members and providers will also be notified.

Members may use any MVP participating pharmacy for non-specialty drugs. A mail order benefit will not be available and retail and specialty prescriptions will be limited to a 30-day supply of medication. The prior authorization process is the same as for MVP Commercial business, including all forms. Any pharmacy policy that has an MVP Option and MVP Option Family variation will be updated accordingly and posted in the Medical Policy Manual and in the *Provider Resource Manual* on or before October 1<sup>st</sup>.

### **Policy Updates**

#### **ACE/ARB**

- Prior authorization will be required for Azor, Tribenzor and Twynsta
- Option and Option Family variation was added. Losartan/HCTZ and Diovan/HCT are the preferred ARBs for these products

#### **Direct Renin Inhibitors**

- Tekamlo and Amturnide were added to the policy

**Gout**

- New policy requiring quantity limits of 60/30 for Colcrys and step therapy or prior authorization for Uloric and Krystexxa

**Growth Hormone**

- Option and Option Family variation was added. Tev-Tropin and Humatrope are the preferred growth hormones for these products

**Mail Service**

- Pradaxa was added as excluded from mail order

**Acthar**

- New indication for infantile spasms was added

**Proton Pump Inhibitors**

- MVP Option and MVP Option Family variation was added. Generic PPIs are preferred for these products

**Quantity Limits**

- MVP Option and MVP Option Family variation was added. Subutex, Suboxone and generic equivalents are limited to 60 units per 30 days

**Enteral Therapy New York**

- MVP Option and MVP Option Family variation was added. In addition to criteria established in the policy, these members would also need to be fed via nasogastric, gastrostomy or jejunostomy tube

**Androgens/Anabolic Steroids**

- This is a new policy for MVP Option and MVP Option Family members only. Prior authorization is required and is limited to FDA approved indications only

**Antineoplastic Enzyme Inhibitors**

- MVP Option and MVP Option Family variation was added that require prior authorization for Gleevec. Established criteria in the policy applies

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

- Acromegaly
- Fabry's Disease
- Hereditary Angioedema
- Kuvan
- Leukotriene Modifiers
- RSV
- Samsca
- Smoking Cessation Medications
- Xolair
- Zorbtive

## Formulary Updates for Medicare Part D Members

Medicare Part D Formulary Available From ePocrates®

You can now access and download the MVP Medicare Part D Formulary for 2011 from ePocrates®.

Simply follow the instructions on our Web site at <https://www.mvphealthcare.com/provider/pharmacy.html>

The tier and prior authorization status of the following medications have been approved. Policies, where applicable, can be found on our Web site at

<https://www.mvphealthcare.com/medicare/2011MedicarePARTDPAlist.html>. A complete list of formulary changes may be found at <https://www.mvphealthcare.com/medicare/documents/Formulary.pdf>

The following drugs were added to the Medicare Part D Formulary effective 10/1/2011:

<b>Drug</b>	<b>Strength</b>	<b>Route</b>	<b>Coverage</b>
ALFUZOSIN	10 MG	Oral	Tier 1
BOOSTRIX	2.5-8-5/.5	INTRAMUSCULAR	Tier 3 (PA)
DISULFIRAM	250 MG	ORAL	Tier 1
DISULFIRAM	500 MG	ORAL	Tier 1
EMOQUETTE	0.15-0.03	ORAL	Tier 1
FONDAPARINUX SODIUM	10MG/0.8ML	SUBCUTANEOUS	Tier 4
FONDAPARINUX SODIUM	2.5 MG/0.5	SUBCUTANEOUS	Tier 3 (QL)
FONDAPARINUX SODIUM	5MG/0.4ML	SUBCUTANEOUS	Tier 4
FONDAPARINUX SODIUM	7.5MG/0.6	SUBCUTANEOUS	Tier 4
LEVOFLOXACIN HEMIHYDRATE	250MG/10ML	ORAL	Tier 1
LEVOFLOXACIN-D5W	500MG/0.1L	INTRAVENOUS	Tier 1 (PA – IV vs PO)
METHYLERGONOVINE MALEATE	0.2 MG	ORAL	Tier 1
NULOJIX	250 MG	INTRAVENOUS	Tier 4 (B vs D)
ORSYTHIA	0.1-0.02	ORAL	Tier 1
PIPERACILLIN- TAZOBACTAM	4.5G	INTRAVENOUS	Tier 1
SUMATRIPTAN SUCCINATE	6 MG/0.5ML	SUBCUTANEOUS	Tier 1 (QL)
SYLATRON	444 MCG	SUBCUTANEOUS	Tier 4 (PA*)
SYLATRON	888 MCG	SUBCUTANEOUS	Tier 4 (PA*)
SYLATRON	296 MCG	SUBCUTANEOUS	Tier 4 (PA*)
TAMIFLU SUSP	6 MG/ML	ORAL	Tier 3 (QL)