2015 Delmarva Scores (Calendar Year 2014 Review)

The District of Columbia is required to evaluate the quality of care provided to District Medicaid recipients enrolled in Managed Care Organizations (MCOs) every year. Delmarva Foundation is the external quality review organization for the Department of Health Care Finance.

The purpose of the operational systems review (OSR) is to provide an annual assessment of the structure, process and outcome of MedStar Family Choice’s internal quality assurance program. The following standards were reviewed for calendar year 2014: Enrollee Rights and Protections, Grievance Systems, and Quality Assessment and Performance Improvement.

Of the fifty-four standards reviewed by Delmarva in 2014, only one standard was marked at ‘Partially Met’, while all others were ‘Met’. The standard that was partially met was regarding a typo in the Member Handbook which resulted in inconsistent information between the Handbook and content in letters sent to members. This typo has been corrected for the 2015 to 2016 Handbook that was sent to members a couple months ago.
Completing a NCQA HEDIS Compliance Audit™ is required of managed care organizations (MCOs) operating in the District of Columbia. MedStar Family Choice benchmarks its performance against the NCQA Means and Percentiles Report. NCQA accredits and certifies a wide range of health care organizations and manages the evolution of HEDIS, the performance measurement tool used by more than 90 percent of the nation’s health plans.

We are happy to report that MedStar Family Choice scored above or met the Medicaid 75th Percentile in the following areas:

- Adult BMI Assessment
- Appropriate Treatment for Children with Upper Respiratory Infection
- Appropriate Testing for Children with Pharyngitis
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Chlamydia Screening in Women - 16 to 20 Years
- Chlamydia Screening in Women - 21 to 24 Years
- Chlamydia Screening in Women - Total
- Human Papillomavirus Vaccine for Female Adolescents
- Nonrecommended Cervical Cancer Screening in Adolescents Females
- Use of Imaging Studies for Low Back Pain
- Weight Assessment and Counseling for Nutrition and Physical Activity - BMI Percentile - Total
- Weight Assessment and Counseling for Nutrition and Physical Activity - Counseling for Physical Activity - 3 to 11 Years
- Weight Assessment and Counseling for Nutrition and Physical Activity - Counseling for Physical Activity - Total

MedStar Family Choice would like to thank you for your cooperation and assistance in getting our members into care.

**Proposed Focus for HEDIS 2015:**

Areas targeted for the next HEDIS cycle are those areas where MedStar Family Choice feels its performance can be improved or where improvement can be sustained and increased:

- Pap Tests
- Comprehensive Diabetes Care
- Childhood Immunizations
- Well-child Visits
- Prenatal Care
- Postpartum Care
- Controlling High Blood Pressure

As we continue to improve and strive for high scores, your dedication to quality health care is very much appreciated.

NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA). HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA). CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
CAHPS® - 2015 Final Report (Calendar Year 2014 Data)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a standardized survey that asks our members to evaluate and rate their experiences with their health care, their personal doctor and their health plan. MedStar Family Choice contracts an independent vendor to conduct a member satisfaction survey once a year. The surveyed members are randomly chosen from three different population groups: adults, children and children with special needs/chronic conditions. The members are asked to rate their satisfaction on the following measures:

- How Well Doctors Communicate
- Shared Decision Making
- Getting Care Quickly
- Coordination of Care
- Getting Needed Care
- Customer Service
- Health Promotion and Education

The adult composite measures, when compared to the NCQA Quality Compass, concluded that MedStar Family Choice scored above the 75th percentile for the measures How Well Doctors Communicate and Health Promotion and Education. The other measures fell below this mark, thereby identifying areas of needed improvement. When comparing the 2015 MedStar Family Choice scores with the 2014 scores, improvement was documented in Getting Care Quickly and Health Promotion and Education. As a result, MedStar Family Choice has developed several interventions for 2016 to address performance in these areas. Some of these interventions include working to enhance our specialist network and improve customer service.

Similar to the adult survey, the 2015 child survey for the general population uses the same seven composite measures. When comparing the scores for 2015 to 2014, these composite measures either increased or stayed the same in ratings: Getting Needed Care, Getting Care Quickly and Customer Service. MedStar Family Choice decreased slightly in the other three categories and one could not be compared due to a change in scoring criteria. When compared to the NCQA Quality Compass, MedStar Family Choice scored above the 75th percentile in Health Promotion and Education. All other composite measures fell below this mark, thereby identifying additional opportunities for improvement. As with the adult survey, MedStar Family Choice has developed several interventions for 2016 to address performance in these areas.
The same 2015 child survey contains a section that is specific to children with chronic conditions (CCC). As compared to the scores from the previous year, MedStar Family Choice met or exceeded the ratings in How Well Doctors Communicate, Getting Needed Care, Getting Care Quickly, and Coordination of Care. MedStar Family Choice fell slightly below the ratings from the previous year in Health Promotion and Education and Customer Service. The final category could not be compared to the previous year due to a change in scoring criteria. The survey for the CCC population includes five additional measures, which are:

- Access to Prescription Medication
- Access to Specialized Services
- Personal Doctor Who Knows Your Child
- Getting Needed Information
- Coordination of Care for Children with Chronic Conditions

In these categories, MedStar Family Choice met or exceeded the ratings from the previous year in Access to Specialized Services, Personal Doctor Who Knows Your Child and Getting Needed Information. MedStar Family Choice fell slightly below the previous year’s ratings in the other two categories.

On a positive note, MedStar Family Choice is very excited that several attributes were identified as driving strengths. These include Doctor Listened Carefully to You and Doctor Spent Enough Time with You. These were identified as areas that MedStar Family Choice is performing at a higher level according to respondents. Stay tuned for upcoming articles in the provider newsletter that will be discussing ways we can improve the care that our members receive.

Coordination of Care

MedStar Family Choice members often need follow-up care by the primary care provider after an inpatient admission when care was provided by specialists and when laboratory or diagnostic testing was performed. It is important that there is a process for ensuring that care is delivered seamlessly across a multitude of delivery sites by different providers. There should be mechanisms in place to ensure that members and clinicians have access to and take into consideration all required information on the member’s conditions and treatments to ensure that the member receives appropriate healthcare services.

Therefore, it is important for the specialist to list on the referrals the name of the member’s primary care physician (PCP). This is particularly important for Ob/Gyns, who refer members for a Pap smear or mammogram. In most cases, the PCP is not aware that the member had a Pap smear or mammogram. Specialists, PCPs, ambulatory facilities, and hospitals are to share reports and other documentation with each other in order to provide the quality of care our members need. At the same time, members are to assume responsibility by informing their PCPs and specialists of their current health status, as well as ensure that their doctors are aware of hospitalizations or recent tests that have been ordered. They need to inform the appropriate practitioner so that the results can be obtained. The Quality, Outreach and Provider Relations departments at MedStar Family Choice will be working with the providers and members to try to improve this process. Please contact Provider Relations at 855-210-6203, option 5, with suggestions, comments and questions.
You Can Find It on the Web at MedStarFamilyChoice.com

The MedStar Family Choice website is updated regularly. Users can log on to MedStarFamilyChoice.com and view:

• Appeal process
• Availability of UM criteria
• Case management and disease management services
• Claims information (including a link to the online claims status check)
• Clinical practice guidelines
• Contact information for MedStar Family Choice
• Credentialing process
• False claims act/fraud and abuse
• Find-A-Provider (searchable provider directory)
• Formulary
• Hours of operation and after-hours instructions
• Interpreter services
• Medical record documentation guidelines
• Member rights and responsibilities
• Notice of privacy practices
• Outreach program
• Pharmacy protocols and procedures
• Pre-authorization requirements
• Provider alerts
• Provider manual
• Provider newsletters
• Quality improvement programs
• Quick reference guide
• Schedule of health education classes
• Topic of the month articles
• Transportation guidelines
• Utilization management decision making

If your office does not have access to the Internet, all of these materials are available in print by contacting our Provider Relations department, Monday through Friday, 8 a.m. to 5:30 p.m., at 855-210-6203, option 5.
The National Correct Coding Initiative (NCCI) is a program developed by the Center for Medicare and Medicaid Services (CMS) that consists of coding policies and edits. NCCI edits address correct coding combinations submitted by a provider for multiple services in regards to the same patient, on the same anatomic site and on the same date of service. There are two types of edits: procedure to procedure edits and medically unlikely edits (MUEs). Procedure to procedure edits make certain that CPT and/or HCPCS codes billed together are eligible for separate reimbursement and medically unlikely edits (MUEs) ensure that the appropriate number of units for a particular service were billed. MedStar Family Choice claims processing center utilizes CCI edit software from Optum so that providers are reimbursed for services in accordance with the NCCI procedure to procedure edits. We also expanded our existing NCCI edits to include the MUEs for professional claims and some types of outpatient facility claims. This logic includes a maximum number of units of service for each HCPCS/CPT code. Claims that do not meet criteria set in the CCI edit software are denied. Instances when a claim is denied because of NCCI procedure to procedure edits include, but are not limited to:

- Mutually exclusive codes that could not be reported together were billed.
- Unbundling of codes when a single comprehensive CPT code is available

Since 2010, MedStar Family Choice has been using the NCCI methodologies in place for Medicare Part B because these methodologies are compatible with methodologies for Medicaid claims. Effective July 5, 2015, MedStar Family Choice is incorporating CMS/Medicaid MUEs into our policies. Therefore, additional MUEs that are compatible with Medicaid will be applied even though they are not applied by Medicare.

Please keep in mind that many procedure codes have CCI edits associated with them. Providers should use applicable modifiers when services are in fact separate and independent from each other in order for claims to be processed and paid as separate procedures. Since modifiers can be used to bypass CCI edits, MedStar Family Choice monitors their use. Therefore, if a modifier is to be used to bypass CCI edits, it is imperative that providers clearly document and explain the circumstances of the services that were provided in the member’s chart. The documentation must clearly show that the procedure code and modifier met the conditions for separate billing. At this time, coding edits affect professional and outpatient claims submitted on CMS-1500 forms, as well as outpatient facility claims submitted on UB-04 (CMS-1450) forms.

If you need more information regarding NCCI methodologies and the appropriate usage of modifiers, you can access CMS.gov/MedicaidNCCI Coding for the National Correct Coding Initiative policy manual for Medicaid Services as well as the Medicaid National Correct Coding Initiative edit design manual at:

**New Clinical Practice Guidelines for Community Acquired Pneumonia**

The MedStar Ambulatory Best Practices Committee has recently released a new clinical practice guideline for community acquired pneumonia. This guideline, in addition to other clinical practice guidelines, can be found on the MedStar Health StarPort. [StarPort.MedStar.net/MSH/Pages/Default.aspx](http://StarPort.MedStar.net/MSH/Pages/Default.aspx)

Community acquired pneumonia remains one of the leading causes of death in the United States. The guideline reviews severity of illness scoring and prognostic models to aide in determining the treatment setting, possible pathogens, indications for additional diagnostic testing, and drug therapy choices.

**EPSDT (HealthCheck) Providers**

HealthCheck/primary care providers seeing patients under the age of 21 are required to complete the District’s HealthCheck Provider Training prior to joining our network and every two years after the initial training. Providers who are not up-to-date on their training may not be re-credentialed with our health plan. This program is accessible online at [DCHealthCheck.net](http://DCHealthCheck.net) and requires a provider’s NPI to log in. The training program is free for participating MedStar Family Choice providers who are due to receive the training. Upon completion of the online training module, providers receive five free continuing medical education (CME) credits.

**Credentialing and Re-Credentialing**

All new providers wishing to participate in the MedStar Family Choice provider networks are required to complete and submit a MedStar Family Choice Council for Affordable Quality Healthcare medical data sheet (CAQH medical data sheet) along with a copy of their Disclosure of Ownership and Control interest statement. We use our CAQH Medical Data Sheet to add new providers to our CAQH provider roster. Existing groups that participate in MedStar Family Choice products do not need to complete this form for re-credentialing but must complete our CAQH form and attach a copy of their Disclosure of Ownership and Control interest statement as part of their request to credential new providers who have joined their group. Provider requests for initial credentialing will not be processed if the request is not on our CAQH medical data sheet or if the Disclosure of Ownership and Control interest statement is missing and/or incomplete. Providers who are not a member of CAQH can complete the Maryland Uniform Credentialing Form (MUCF). Please contact Provider Relations with questions at 855-210-6203, option 5.
Clinical Practice and Preventative Guidelines

Participating providers should review the clinical practice guidelines, as well as the preventive guidelines, posted on the MedStar Family Choice website, MedStarFamilyChoice.com, for updates. Currently, the clinical practice guidelines include:

- 2014 Recommended Screening Guidelines
- Outpatient Management of Patients with Community Acquired Pneumonia
- Cervical Cancer Screening for Primary Care Physician
- Diagnosis and Treatment of Low Back Pain
- The Assessment and Prevention of Falls in Older People
- Management of Adult Diabetes Mellitus
- Guidelines for the Diagnosis and Management of Asthma
- Management of Hyperbilirubinemia in Healthy Term Newborn
- Management of Hypercholesterolemia
- Identification and Management of Clinical Depression in Adults
- Management of Hypertension in Adults Age 18 Years and Older
- Identification, Evaluation, and Treatment of Overweight and Obesity in Adults
- Managing Otitis Media in Children Ages 6 months to 12 Years
- Management of Osteoporosis
- Management of Acute Group A Streptococcal Pharyngitis Infection
- Management of Venous Thromboembolism
- Global Strategy for Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease
- Management of Pediatric Attention Deficit & Hyperactivity Disorder (ADHD)
- Prevention, Assessment and Treatment of Child and Adolescent Overweight and Obesity
- Management of Perinatal Care
- Substance Abuse Guidelines
  - ValueOptions Guidelines
  - Treating Substance Abuse
  - Guideline for Treating Buprenorphine

All clinical practice guidelines are PDFs and can be downloaded. Please contact Provider Relations to request hard copies of materials at 855-210-6203, option 5.
Provider Appeal Process

MedStar Family Choice providers must follow steps when submitting both administrative and clinical appeals as a result of a denial or reduction in reimbursement for services rendered. All appeals must be sent to us in writing and within 90 days of the denial date on the coordination of benefits (COB). In order to help providers address simple administrative appeal requests and formal clinical appeal requests, we have created templates to help with this process. Using the templates is optional and the forms include a Medicaid Administrative Claim Reconsideration form, a Medicaid Provider Claim Assistance/Project Request, a Medicaid Claim Appeal and/or a Formal Clinical Appeal form.

For administrative appeal requests, providers can submit one or more of the following forms:

- **Medicaid Administrative Claim Reconsideration Form:** This form can be used when asking MedStar Family Choice to re-consider a previously submitted claim that was denied for timely filing (proof of timely filing required), a claim that was denied as a duplicate in error, a corrected claim (including modifiers), submission of information previously requested by MedStar Family Choice, coordination of benefits (COB), service not paid at contracted rates, processed PAR provider as out-of-network in error, claim processed with a TIN that was different from the TIN billed, denied for lack of authorization in situations where an authorization was obtained, requests for refunds/stop payments, or other administrative type claim denials.

- **Medicaid Provider Claim Assistance/Project Request:** This form can be used when providers request the assistance of Provider Relations with larger claim issues that involve multiple claims issues for one member or single claim issues for multiple members.

- **Medicaid Claim Appeal:** This form is a formal claim appeal that can be filed as the last step in the appeal process within 90 business days of the denial. The appeal must outline reasons for the appeal with all necessary documentation including a copy of the claim and the explanation of benefits.

For formal clinical appeal requests, provider can submit:

- **Formal Medical Necessity Appeal:** This form should be used when the provider is acting on their own behalf and is disputing an adverse determination when the service has already been provided to the member. Clinical claims appeals should be requested within 90 business days of the denial and include a written request outlining reasons for the appeal with all necessary documentation including a copy of the claim and the explanation of benefits. Providers will receive a response to their appeal within 30 calendar days. If a provider is not satisfied with the decision of the appeal because the initial denial of the claim was upheld, a second appeal can be submitted. Second level appeals must be sent within 30 calendar days of the first level appeal response. The second level appeal is the final level of appeal. Providers will receive a response within 30 calendar days of the receipt of the second level appeal. An acknowledgement of receipt of the appeal (first and second level) will occur within five business days of receipt.

Appeals should be sent in writing to:
MedStar Family Choice
901 D St., SW, Suite 1050
Washington, DC 20024
Attn: Claims Appeals Department

Claim denials that are overturned on appeal will be paid within 30 calendar days of the decision.

Templates for claims appeals can be found in our provider manual and on our website at [MedStarFamilyChoice.com](http://MedStarFamilyChoice.com). Providers can also request hard copies of all forms by contacting Provider Relations by calling **855-210-6203**, option 5.
Re-determination and Peer-to-Peer Policies on Concurrent Review Denials

As of October 21, 2015, MedStar Family Choice instituted Re-determination and Peer-to-Peer policies on concurrent review denials. The following defines and outlines the process for Re-determination and Peer-to-Peer review.

Re-determination: review of additional material when a concurrent denial is issued for insufficient or missing clinical information with option to reverse the decision to deny.

A re-determination is not considered an appeal. If an urgent concurrent denial is issued for insufficient or missing clinical information and the facility or practitioner submits the clinical review or the missing information while the member remains an inpatient or up to 3 business days after discharge, MedStar Family Choice reserves the right to review the additional material and reverse the decision to deny. MedStar Family Choice staff will use the additional information submitted and apply the appropriate InterQual criteria. If the additional information meets the InterQual criteria, the nurse reviewer may approve the day. If the additional information does not meet the InterQual criteria, the nurse reviewer will pend the case to a physician advisor. The same reviewer or PA may review and reverse the decision to deny. If the same reviewer or PA would not overturn the denial, the facility or practitioner would be notified that the denial stands and referred to the content of the denial letter for guidance on the appeal process.

Peer-to-Peer Review: a communication between a practitioner and the MedStar Family Choice physician advisor to provide additional information, clinical insight or other information for pended or denied authorizations for inpatient services.

A Peer-to-Peer is not considered an appeal. If a facility day(s) is pended or an urgent concurrent denial is issued the facility or practitioner may request a Peer-to-Peer review while the member remains an inpatient or up to 3 business days after discharge. A Peer to Peer Review is a communication between a practitioner at the hospital and the MedStar Family Choice physician advisor. During a Peer-to-Peer, the facility based practitioner may provide additional information, clinical insight or other information to explain why the hospital day(s) should be approved. MedStar Family Choice reserves the right to request documentation to support information supplied verbally and will incorporate this information into the CCMS record. The same physician advisor involved in the case will participate in the Peer-to-Peer, when possible. This PA may reverse the decision to deny and approve the day if the information provided during the Peer-to-Peer warrants approval based on the PAs clinical opinion. If the PA would not overturn the denial, the facility based practitioner will be informed that the denial stands and referred to the content of the denial letter for guidance on the appeal process.
Member Complaint/Grievance and Appeal Process

The MedStar Family Choice complaint/grievance and appeal procedure that members follow can be found on our website at MedStarFamilyChoice.com and in your provider manual. If you do not have access to our website or a provider manual, you may call Provider Relations at 855-210-6203, option 5, for a copy of the manual. The process will tell you the following:

- How members can file a complaint, grievance or appeal, and the differences between them
- How quickly we will respond to the member and the provider
- What to do if the member does not agree with our decision

Please note that providers may not appeal a decision on the member’s behalf without written permission from the member. A form is available on our website that permits providers to appeal on a member’s behalf.

Members have the right to contact MedStar Family Choice Monday through Friday, from 8 a.m. to 5:30 p.m., at 855-210-6203, option 3, when they have a concern about a decision made by MedStar Family Choice.

Importance of HPV Vaccines for Adolescents

The Centers for Disease Control (CDC) states that there are 6 million new genital HPV disease cases in the United States each year. A high amount of them occur in 15 to 24 year olds. That means 12,000 teens and young adults each day are newly infected. That’s why it is very important that your patients get the vaccine, which can help protect them from the virus. HPV causes cancer of the mouth, throat, cervix, vulva, vagina, and penis. The HPV virus is passed from one person to another by skin-to-skin sexual contact. Boys and girls can start getting vaccinated by age 10. Both boys and girls can receive vaccinations through 26 years of age under their parent’s insurance plans.

There are two vaccines for HPV: Cervarix and Gardasil. These vaccines help protect against the HPV virus. Gardasil is approved for females 9 to 26 years old to prevent cervical cancers and genital warts; also for males 9 to 26 years of age to prevent genital warts, cancers of the mouth and throat, penis, and anus. Cervarix is approved for females 10 to 25 years of age to prevent cervical cancer and precancers.

HPV vaccines work best when preteens get all three vaccine doses because it allows time to work in the body before they begin sexual activity with another person.

In Washington D.C., if your patient is enrolled in the DCPS school system, he or she can get the vaccine for HPV for free. Vaccines are given in a series of three shots over six months and can safely be given at the same time or with other needed vaccines.
**Vaccines For Children Program**

The Vaccines for Children (VFC) program is part of the D.C. Department of Health Immunization program. It is a federally funded entitlement program that provides vaccines free of charge to providers with eligible patients.

**Requirements for Participation**

By participating in the VFC program, you agree to:

- Screen all children for eligibility.
- Submit documentation to the VFC program for each vaccine dose administered.
- Follow the recommended immunization schedule established by the ACIP, the American Academy of Pediatrics, the American Academy of Family Practitioners and state law, except where medically contraindicated.
- Not to charge for VFC-supplied vaccine
- Provide vaccine information materials as prescribed by law.
- Complete the Provider Profile and Enrollment form.
- Allow VFC staff access to your practice for technical assistance and program review.

To become a VFC provider you may request a provider enrollment packet through the VFC program at **202-576-7130, ext. 11**.
The D.C. Perinatal Collaborative is a gathering of representatives from all of the managed care organizations (MCOs) in the District of Columbia, the Department of Health Care Finance (DHCF) and Delmarva, including medical directors, Ob/Gyn providers, case managers, and quality improvement coordinators. The goal of the D.C. Perinatal Collaborative is to improve birth outcomes by implementing interventions to address risk factors associated with poor birth outcomes (low birth weight, early gestational age, HIV testing, miscarriage/fetal loss, unknown birth outcome, adverse perinatal outcome, and infant death). This is a multi-year (2014 to 2017) Performance Improvement project (PIP) of which MedStar Family Choice is a part. By working together as a group, and sharing ideas and interventions related to improving these outcomes, the Collaborative will institute District-wide initiatives to improve care coordination as well as medical, behavioral and psychosocial services.

Outcomes for the MedStar Family Choice D.C. PIP indicators for measurement year 2014 were as follows:

**Indicator #1: The number of neonates delivered with birth weight <2,500 grams.**
- The baseline performance of 7.08% did not meet the goal of less than or equal to 3%.

**Indicator #2: The number of neonates delivered with gestational age of less than 37 weeks.**
- The baseline performance of 8.4% did not meet the goal of less than or equal to 5%.

**Indicator #3: The number of pregnancies ending in miscarriage or fetal loss (early or late).**
- The baseline performance of 12.57% did not meet the goal of less than or equal to 5%.

**Indicator #4: The number of pregnancies for which the birth outcome is unknown.**
- The baseline performance of 0% met the goal of less than or equal to 1%.

**Indicator #5: The rate of adverse perinatal outcomes (age 0 to 365 days) in the measurement year.**
- The baseline performance of 27.54% did not meet the goal of less than or equal to 10%.

**Indicator #6: The number of infant deaths (age 0 to 365 days) due to any cause.**
- The baseline performance of 0.09% met the goal of less than or equal to 0.1% deaths.

MedStar Family Choice is meeting the goals set forth for indicators 4 and 6 and is not meeting the goals for indicators 1, 2, 3, and 5. In order to work toward meeting these important goals of decreasing prematurity, low birth weight, miscarriage, and fetal loss, MedStar Family Choice endorses continued collaboration and coordination of practitioners, case and care managers and mothers by encouraging the following:

1. Use of the Department of Health Care Finance (DHCF) webpage, [DHCF.DC.gov/page/Pregnancy-Resources](http://DHCF.DC.gov/page/Pregnancy-Resources), which is an excellent pregnancy resource with a wealth of great information for caseworkers, providers and pregnant women themselves. This site includes links to local and national resources on pregnancy and pregnancy related topics including:

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Update to the MedStar Family Choice Formulary

District of Columbia Healthy Families

This update combines the changes from the September and November MedStar Family Choice Pharmacy and Therapeutics committee meetings and also reports the upcoming changes for the 2016 Formulary made at the October 2015 Meeting. The most recent PDF was posted for October 1, 2015 update and does not necessarily include these latest changes.

October and November 2015 Meetings

Combined changes:

Additions that have or will go into effect in the next few weeks:

- Ciclopirox Solution 8% for fungal nail infections
- Dutasteride (Avodart)
- Fluticasone propionate nasal suspension OTC (Flonase OTC)

Additions with prior authorization:

- Odomzo (sonidegib) is a new Hedgehog pathway inhibitor indicated in the treatment of locally advanced basal cell carcinoma.
- Orkambi (lumacaftor/ivacaftor) is the second available treatment for cystic fibrosis (CF) that targets the defective cystic fibrosis transmembrane conductance regulator (CFTR) protein, which is the underlying cause of CF, and the first agent approved to treat the F508del mutation. Orkambi (lumacaftor/ivacaftor) combines the CFTR potentiator, Kalydeco (ivacaftor), with a new CFTR corrector, lumacaftor, and targets patients who are homozygous for the F508del mutation, which accounts for approximately 45% of CF patients in the United States.

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• Lonsurf (trifluridine/tipiracil) is a combination agent that is indicated for the treatment of patients with metastatic colorectal cancer who have been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy; an anti-vascular endothelial growth factor (VEGF) biological therapy; and if rat sarcoma viral oncogene (RAS) wild-type, an anti-epidermal growth factor receptor (EGFR) therapy.

• Praluent (alirocumab) proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitor for the treatment of elevated LDL cholesterol in selected populations.

• Repatha (evolocumab) proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitor for the treatment of elevated LDL cholesterol in selected populations.

Please see the PA Table on the MedStar Family Choice website for details of the requirements for approval and guidance on submission of clinical information

Removals effective:
• None

Removal of Prior Authorization:
• None

Managed Drug Limitations & Step Therapy:
• None

Details of the prior authorization criteria are on this website in the prior authorization table. Details of the step therapy criteria are on this website in the step therapy table.

FORMULARY 2016

The next updated PDF will be the January 2016 formulary. A copy can be downloaded from this website from our website at MedStarFamilyChoice.com on or about Jan. 1, 2016. Paper booklet versions of the 2016 formulary will be mailed. Additional copies may be obtained by contacting your MedStar Family Choice Provider relations representative.

Changes that will go into effect on Jan. 1, 2016:

Additions:
• Anoro Ellipta
• Benzoyl peroxide gel 2.5%
• Intuniv
• Kapvay
• Liletta (levonorgestrel intrauterine device)

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Members currently receiving medications that are being removed from the formulary will be grandfathered.

Managed drug limitations and step therapy:

- Advair (Diskus and HFA)-step therapy removed
- Dulera-step therapy removed
- Pantoprazole 20 mg-MDL changed to 60 tablets per 23 days
- Sumatriptan-MDL changed to 9 tablets per 23 days
- Symbicort-step therapy removed
- Zolmitriptan 5 mg-MDL changed to 12 tablets per 23 days

Updates continue to be available quarterly on MedStarFamilyChoice.com and more frequently on ePocrates. Paper booklets of the 2015 Formulary can be requested from the MedStar Family Choice Provider Relations department at 855-210-6203, option 5. Details of the prior authorization criteria and step therapy criteria are available on the MedStar Family Choice website with the other pharmacy protocols.

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- Potassium citrate CR tab- 15 meq strength added
- Renvela
- SF 5000 plus sodium fluoride
- Shur-seal gel 2% (OTC spermicide)
- Valganciclovir 450 mg
- Buprenorphine film (24 mg/day MDL, same as tablet)

Additions with prior authorization required:

- Hyalgan (replacing Synvisc and Synvisc One)

Please see the PA Table on the MedStar Family Choice website for details of the requirements for approval and guidance on submission of clinical information.

Removal of prior authorization:

- Abilify (aripiprazole)

Removals:

- Adcirca
- Econazole nitrate cream 2.5%
- Namenda
- Olysio
- Rimantadine
- Synvisc
- Synvisc-One
- Tudorza