**For Release September 2011**

Blue Cross and Blue Shield of Alabama's Pharmacy and Therapeutics (P & T) Committee recently approved updates to the Prescription Drug Guide and made clinical program changes to select medications. All information is accessible online at **www.bcbsal.com**.The P & T Committee consisting of doctors, pharmacists, nurses, and other healthcare professionals advises and makes recommendations based on clinical and cost-effective outcome reviews.

## Step Program for Diabetic Test Strips

As prescription costs continue to rise, employers, health plans and healthcare professionals are working together to find ways to manage usage. Blue Cross and Blue Shield of Alabama relies on a clinical team of physicians and pharmacists to identify, develop and approve clinical criteria for medications and products to encourage clinically appropriate, cost-effective use. Through this process, a decision was recently made to select **ACCU-CHEK® Aviva** (Roche), **ACCU-CHEK® Compact Plus** (Roche), **Bayer CONTOUR®** and **Bayer BREEZE® 2** as the preferred glucose test strip brands.

**Effective October 1, 2011**, Blue Cross will implement a step therapy program to encourage the use of ACCU-CHEK or Bayer brand glucose test strips. It will be necessary for physicians to complete and submit a prior authorization request if they feel it is medically necessary for a member to continue using a non-preferred brand of test strips. Letters are being sent to all members affected and their prescribing physician. Members previously identified that are on insulin pumps (Minimed by Medtronic or Animas OneTouch Ping by Johnson & Johnson) requiring the use of Lifescan OneTouch test strips are not affected. All existing members without a prior authorization must be transition to a preferred brand of test strip by January 1, 2012.

## Growth Hormone

**Effective October 1, 2011**, Blue Cross will change its prior authorization criteria for growth hormone therapy. When the medical criteria are met for coverage of growth hormone, approval will be given for our preferred brand of growth hormone, Omnitrope®. The Blue Cross pharmacy policy for growth hormone therapy will be available online September 9 and can be found on our website at www.bcbsal.com/providers.

**Effective January 1, 2012**, all members currently approved for growth hormone therapy will need to convert to Omnitrope for continued benefit coverage. All brands of growth hormone contain somatropin. Other brands of somatropin may be approved through physician-initiated prior authorization with documentation of the inappropriateness of Omnitrope. Members currently on other brands of somatropin will be notified of this change and instructed to work with their prescriber or pharmacy to change their prescriptions to Omnitrope.

A preferred drug is chosen based on safety, efficacy, uniqueness and cost. Omnitrope has been selected as our preferred growth hormone because it will significantly reduce the cost of this therapy compared to other growth hormone medications.

Omnitrope is available in 5-milligram and 10-milligram pen devices as well as 5.8-milligram vials. In-home training for the injection device through OmniSource can be arranged by our specialty network. They will work closely with OmniSource to ensure delivery of the drug and device and to coordinate training when requested.

**Prescription Drug Guide Updates – Effective October 1, 2011**

The following drugs may have changes that affect what a member will be required to pay at the time of purchase. All members that are negatively affected by a formulary change that is **not a result of a new generic being available** will receive a letter.

| **BRAND NAME (generic name if available)** | **Description of Change (Moved from Preferred to Non-Preferred)** | **Additional Comments** |
|---|---|---|
| NUTROPIN, NUTROPIN AQ (somatropin) | Move from Preferred Brand to Non-Preferred Brand | disruption letters **will** be sent to members as part of the growth hormone change mentioned above. |
| XALATAN (lantanoprost) | Move from Preferred Brand to Non-Preferred Brand | generic equivalent now available; disruption letters will **not** be sent to members |
| AROMASIN (exemestane) | Move from Preferred Brand to Non-Preferred Brand | generic equivalent now available; disruption letters will **not** be sent to members |
| FEMARA (letrozole) | Move from Preferred Brand to Non-Preferred Brand | generic equivalent now available; disruption letters will **not** be sent to members |
| FURADANTIN SUSP. (nitrofurantoin) | Move from Preferred Brand to Non-Preferred Brand | generic equivalent now available; disruption letters will **not** be sent to members |
| **BRAND NAME (generic name if available)** | **Description of Change (Moved from Non -Preferred to Preferred)** | **Additional Comments** |
| OMNITROPE (somatropin) | Move from Non-Preferred to Preferred Brand | None |
| VIRAMUNE XR | Move from Non-Preferred to Preferred Brand | None |
| CAPRELSA | Move from Non-Preferred to Preferred Brand | None |
| SYLATRON | Move from Non-Preferred to Preferred Brand | None |
| ZYTIGA | Move from Non-Preferred to Preferred Brand | None |
| EDURANT | Move from Non-Preferred to Preferred Brand | None |
| DOCEFREZ | Move from Non-Preferred to Preferred Brand | None |

For a complete listing of generic and preferred brand alternatives, please refer to the Prescription Drug Guide located in the Pharmacy section of the Blue Cross and Blue Shield of Alabama website at the address below:

**www.bcbsal.org/pharmacy/index.cfm**

## Clinical Program Updates – Effective October 1, 2011

The following medication dispensing limits (DL), prior authorization (PA), and/or step therapy (ST) programs have been added or revised:

### New or Revised PA or ST Programs

| Policy Name | Type of Policy | Coverage Criteria and Changes |
|---|---|---|
| Promacta | PA | **REVISED** – Increased the quantity limit for the 25mg strength to 90/month |
| Relistor | PA | **REVISED** – Removed the minimum age limit and removed the quantity limit |
| Amitiza | PA | **REVISED** – Removed the quantity limit |
| Growth Hormone | PA | **REVISED** – **Effective 10/1/2011,** require the use of Omnitrope for all new users of growth hormone. **Effective 1/1/2012,** require all existing users of growth hormone to change to Omnitrope. |
| Diabetic Test Strips | ST | **NEW** – **Effective 10/1/2011,** require the use of one of the preferred diabetic test strip products from Roche or Bayer to be tried first before coverage with a non-preferred product for new users. **Effective 1/1/2012,** require all existing users of non-preferred diabetic test strip products to use one of the preferred products. |
| Oral Hepititis C Agents (Incivek & Victrelis) | PA | **NEW** - The intent of the Incivek, Victrelis Prior Authorization (PA) Criteria is to appropriately select patients for therapy according to the Food and Drug Administration (FDA) approved product labeling and/or clinical guidelines and/or clinical studies. The oral agents Incivek and Victrelis will not be approved as monotherapy; they must be used in combination with peginterferon alfa and ribavirin. The PA process will evaluate the use of Incivek or Victrelis when there is supporting clinical evidence or prescriber-provided documentation supporting their use. |

### New or Revised Dispensing Limits

| Brand Name (generic if available) | Strength | Dispensing Limit per Month | New or Revised |
|---|---|---|---|
| Oxycontin | 80mg | 120 tablets | Revised- previously 90 |

* If strengths are not specifically listed, quantity limits apply to all available strengths.

Note: Coverage is subject to each member's specific benefits. Group specific policies will supersede these policies when applicable. Please refer to the member's benefit plans.

For complete details, pharmacy policies may be viewed on the Blue Cross and Blue Shield of Alabama website at [www.bcbsal.org/providers/pharmPolicies/final.cfm](www.bcbsal.org/providers/pharmPolicies/final.cfm)

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