



### **New Pharmacy Initiatives Effective October 1, 2012**

Blue Cross and Blue Shield of Alabama and Prime Therapeutics® will implement four new changes in October 2012. Members that are affected have been identified and a notification letter explaining these changes was mailed on August 27, 2012.

### **Triessent® Changes Name to Prime Therapeutics Specialty Pharmacy LLC**

One of the specialty pharmacy vendors, currently known as Triessent, will be named Prime Therapeutics Specialty Pharmacy LLC (Prime Specialty Pharmacy). Please note their new telephone and fax numbers below:

**Telephone:** 1-877-627-MEDS (6337)

**Fax:** 1-877-828-3939

Prime Specialty Pharmacy will provide specialty pharmacy services to Blue Cross and Blue Shield of Alabama members formerly served by Triessent.

### **Exclusive Specialty Pharmacy Network**

Many Blue Cross plans will be moving to an exclusive specialty pharmacy network. This will require that all affected members use only Prime Specialty Pharmacy to fill specialty drug prescriptions. Specialty drug prescriptions for these members will only be covered when filled by Prime Specialty Pharmacy.

### **Specialty Drug List Changes**

Blue Cross will align the Specialty Drug List with Prime Therapeutics' Specialty Drug List. The following drugs will be added to the Specialty Drug List:

Actemra	Egrifta	Glassia	Samsca
Ampyra	Extavia	Hexalen	Trelstar Mixject
Carbaglu	Feiba NF	Lysodren	Tretinoin
Cayston	Firmagon	Oforta	Vpriv
Chenodal	Fuzeon	Ribatab	Xyrem

A list of self-administered and physician-administered specialty medications will be available on the Blue Cross website, [www.bcbsal.com/pharmacy](http://www.bcbsal.com/pharmacy), on their effective date, October 1, 2012. Simply select "Prescription Drug Guide" beneath the heading *Prescription Drug References*. Please keep in mind, coverage is always subject to the exclusions and limitations noted in the benefit booklet.

### **Oral Oncology Drugs**

Many of our Blue Cross members who will need oral oncology drugs will need to obtain them through one of the specialty pharmacies. These drugs will no longer be available at retail pharmacies.

- Prime Specialty Pharmacy will need to fill the prescription for members in the exclusive network.
- Accredo Health Group, Inc., CVS/Caremark or Prime Specialty Pharmacy may fill prescriptions for all other members using a specialty drug.

We recognize that treatment decisions are always between the members and their physician. Notification is being sent to providers regarding this change.

## Drug Guide and Clinical Program Updates

Prime Therapeutics' Pharmacy and Therapeutics (P & T) Committee in association with Blue Cross and Blue Shield of Alabama's Pharmacy Business 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](http://www.bcbsal.com). The Prime Therapeutics P & T Committee consisting of doctors, pharmacists, nurses, and other healthcare professionals advises and makes recommendations based on clinical appropriateness and the Blue Cross and Blue Shield of Alabama Pharmacy Business Committee makes final approval of these clinical recommendations before implementation.

### Prescription Drug Guide Updates – Effective October 1, 2012

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.

<b>BRAND NAME (generic name if available)</b>	<b>Description of Change (Moved from Preferred to Non-Preferred)</b>	<b>Additional Comments</b>
Adderall XR (amphetamine-dextroamphetamine CP24)	Move from Preferred Brand to Non-Preferred Brand	Generic equivalents now available
Avelox	Move from Preferred Brand to Non-Preferred Brand	Generic alternatives available – notification not required as these are typically one-time use medications
Boniva (ibandronate)	Move from Preferred Brand to Non-Preferred Brand	Generic equivalents now available
Plavix (clopidogrel)	Move from Preferred Brand to Non-Preferred Brand	Generic equivalents now available
Seroquel (quetiapine)	Move from Preferred Brand to Non-Preferred Brand	Generic equivalents now available
Vancocin (vancomycin) caps	Move from Preferred Brand to Non-Preferred Brand	Generic equivalents now available
Viramune (nevirapine)	Move from Preferred Brand to Non-Preferred Brand	Generic equivalents now available
<b>BRAND NAME (generic name if available)</b>	<b>Description of Change (Moved from Non-Preferred to Preferred)</b>	<b>Additional Comments</b>
Androderm	Move from Non-Preferred to Preferred Brand	None
Bydureon	Move from Non-Preferred to Preferred Brand	None
Emend 150 mg solution	Move from Non-Preferred to Preferred Brand	None
Lialda	Move from Non-Preferred to Preferred Brand	None
Priftin	Move from Non-Preferred to Preferred Brand	None
Tamiflu	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 [www.bcbsal.org/pharmacy/index.cfm](http://www.bcbsal.org/pharmacy/index.cfm)

## Clinical Program Updates – Effective October 1, 2012

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
ARB/Renin Inhibitor	ST	<b>REVISED</b> – Brand ACE inhibitors no longer subject to step therapy requirements.
Arcalyst/Ilaris	PA	<b>REVISED</b> – Addition of quantity limits for Arcalyst (1-220 mg vial per week) and Ilaris (1-180 mg vial every 8 weeks) upon approval.
Fentanyl Oral, Nasal	PA	<b>REVISED</b> – Only 1 product in 1 strength will be approved at a time if prior authorization criteria are met.
Korlym	PA	<b>NEW – Effective 10/1/2012</b> , coverage may be provided for patients with Cushing’s disease who have diabetes or glucose intolerance, no contraindications to therapy, and have failed surgical resection.

### New or Revised Dispensing Limits

Brand Name (generic if available)	Strength	Dispensing Limit per Month	New or Revised
Avonex	30 mcg	4 vials or syringes	NEW
Betaseron	0.3 mg vial + syringe units	14 vial/syringe units (1 box)	NEW
Bio T-Gel	All strengths	60 packets	NEW
Cimzia Starter Kit	6 x 200 mg syringes, starter kit	1 starter kit/180 days	NEW
Copaxone	20 mg/mL syringe	1 carton of 30 syringes	NEW
Dymista	All strengths	23 grams (1 bottle)	NEW
Extavia	0.3 mg vial + syringe units	15 vial/syringe units (1 box)	NEW
Humira Psoriasis Starter Kit	40 mg/0.8 mL pen, Psoriasis starter kit	1 starter kit/180 days	NEW
Humira Crohn’s Starter Kit	40 mg/0.8 mL pen, Crohn’s starter kit	1 starter kit/180 days	NEW
Hydrocodone-acetaminophen	2.5-325 mg	360 tablets	NEW
Intencele	25 mg	120 tablets	NEW
Oxymorphone SR	15 mg	60 tablets	NEW
Rebif	22 mcg/0.5 mL, 44 mcg/0.5 mL	12 syringes (1 carton)	NEW
Rebif Titration Pack	(6 x 8.8 mcg/0.2 mL + 6 x 22 mcg/0.5 mL)	1 kit	NEW

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](http://www.bcbsal.org/providers/pharmPolicies/final.cfm)



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