

PROVIDERFACTS



Update

Formulary and Medication Coverage Policy Updates

Formulary Update

Effective January 4, 2010

Preferred Drug List Removals:

- Abilify®
- Zyprexa®

Effective January 18, 2010

Preferred Drug List Removals:

- | | | |
|------------------------------------|---|--------------------------------|
| • Antara® | • Depakote® Sprinkles (generic available) | • Suprax® |
| • Cedax® | • Ketek® | • Topamax® (generic available) |
| • Covera-HS® | • Lamictal® (generic available) | • Verelan® PM |
| • Depakote® ER (generic available) | • PCE® | |

[Click here](#) for a complete listing of generic and preferred brand alternatives.

Medication Coverage Policies Update

The following medication quantity limit (QL) and prior authorization (PA) coverage policies have been added or revised:

New Policies—Effective Immediately Following Market Availability

Effective Date	Brand Name	Generic Name	Type of Policy	Coverage Guidelines
August 27, 2009	Onglyza™	Saxagliptin	QL	NEW —QL of 1 tablet per day. Onglyza™ should be taken once daily.
September 9, 2009	Embeda™	Morphine and naltrexone	QL	NEW —QL of 2 capsules per day. Embeda™ may be taken once or twice daily.
September 9, 2009	Tyvaso™	Treprostinil inhalation solution	PA	NEW —PA required to verify diagnosis of pulmonary arterial hypertension (PAH) with New York Heart Association (NYHA) Class III symptoms. Patients must have a trial and failure or intolerance to prior therapies. QL of 1 ampule per day (sufficient for all 4 treatment sessions in a single day).
September 18, 2009	Onsolis™	Fentanyl citrate buccal soluble film	PA	NEW —PA required to verify diagnosis of breakthrough cancer pain. QL of 4 units per day and patients must be at least 18 years of age.
Pending	Sumavel™ DosePro™	Sumatriptan succinate injection	QL	NEW —QL of 10 injections per month. Prior authorization required for patients less than 12 years of age. (Same edits as Imitrex injection.)

Revised Policies—Effective August 13, 2009

Brand Name	Generic Name	Type of Policy	Coverage Guideline Changes
Relenza®	zanamivir	QL	REVISED —QL revised to allow for 5-day treatment course or 10-day prophylactic course per month. Prior authorization may be required for additional quantities.
Tamiflu®	oseltamivir	QL	REVISED —QL revised to allow for 5-day treatment course or 10-day prophylactic course per month. Prior authorization may be required for additional quantities.

Revised Policies—Effective November 9, 2009

Brand Name	Generic Name	Type of Policy	Coverage Guideline Changes
Avinza®	Morphine ER	QL	REVISED —QL of 1 capsule per day added for additional strengths added: 45mg and 75mg.
Enbrel®	Etanercept	PA	REVISED —Patients must have had an inadequate response to first line treatment options for at least 6 months. For plaque psoriasis acitretin, cyclosporine, methotrexate, and phototherapy are appropriate first line treatment options.
Humira®	Adalimumab	PA	REVISED —Patients must have had an inadequate response to first line treatment options for at least 6 months. For plaque psoriasis acitretin, cyclosporine, methotrexate, and phototherapy are appropriate first line treatment options.
Ventavis®	Iloprost inhalation	PA	REVISED —No longer requires documentation of Acute Vasoreactivity Test.

Revised Policies—Effective January 18, 2010

Brand Name	Generic Name	Type of Policy	Coverage Guidelines
Flovent®	Fluticasone propionate	QL	REVISED —Flovent Diskus 50mcg QL reduced to 1 pack (60 blisters) per month. Introduction of 2 new strengths: 100mcg and 250mcg. Flovent Diskus 100mcg QL of 1 pack (60 blisters) per month. Flovent Diskus 250mcg QL of 2 packs (120 blisters) per month.
Sprycel®	Dasatinib	PA	REVISED —Sprycel 50mg QL reduced to 3 tablets per day. Sprycel 100mg QL reduced to 1 tablet per day. Maximum daily dose reduced from 200mg to 180mg.

Discontinued Policies—Effective October 7, 2009

Brand Name	Generic Name	Type of Policy	Coverage Guidelines
Oral and Injectable Androgens	testosterone	PA	No longer requires PA

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, [click here](#) to view Blue Cross and Blue Shield of Alabama’s pharmacy policies.

Important Information

The following disclaimer is applicable to all telephone inquiries and automated communications systems (i.e., InfoSolutions®, telephone, and fax) to Blue Cross and Blue Shield of Alabama: The information provided is only general benefit information and is not a guarantee of payment. Benefits are always subject to the terms and limitations of the plan and no employee of Blue Cross and Blue Shield of Alabama has authority to enlarge or expand the terms of the plan. The availability of benefits is always conditioned upon the patient’s coverage and the existence of a contract for plan benefits as of the date of service. A loss of coverage, as well as contract termination, can occur under certain circumstances. There will be no benefits available if such circumstances occur.

Note: Please refer to our web site, www.bcsal.com, for the most current benefit and policy information.