BlueCross BlueShield of Montana

Blue Review℠

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS **SECOND QUARTER 2024**

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Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation,
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Contact Us

Confused about where to go for answers? Use our online Provider contact reference guide to help guide you to the best point of contact for your answer.

https://www.bcbsmt.com/provider/network-participation/contact-us

Our *Blue Review* newsletter is produced quarterly for participating professional and institutional providers across all lines of business (commercial and government programs). The newsletter serves as a vehicle to communicate **timely, consistent and relevant messaging** related to:

- New products, programs and services available at Blue Cross and Blue Shield of Montana
- Notification of changes as required by contract or other mandates
- Member initiatives and patient resources

Blue Review is a quarterly newsletter published for institutional and professional providers contracting with BCBSMT. We encourage you to share the content of this newsletter with your staff. *Blue Review* is located on our website at **bcbsmt.com/provider**.

The editors and staff of *Blue Review* welcome letters to the editor. Address letters to:

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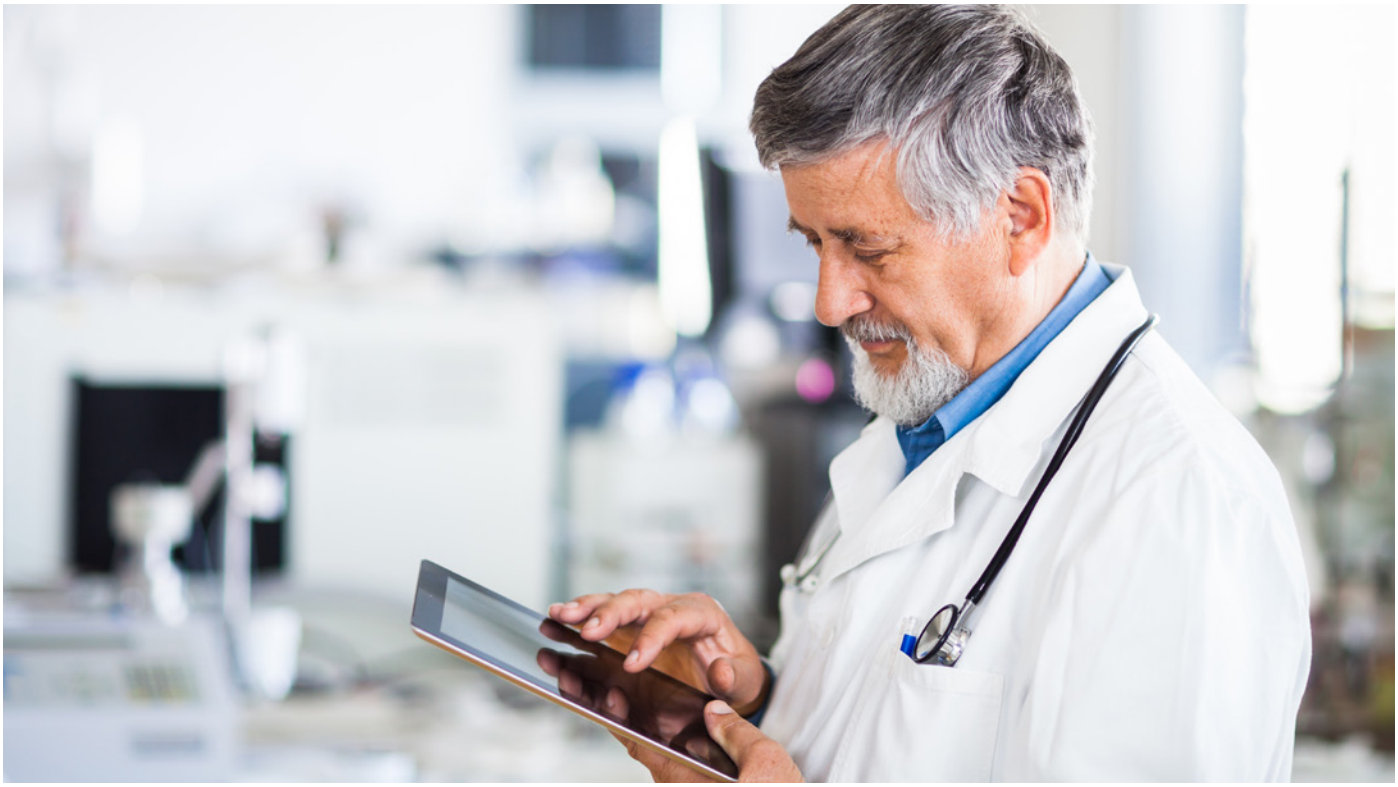

2024 Fee Schedule and Compensation Policy Update

The Fee Schedules are updated biennially. The latest full Fee Schedules' update occurred on June 1, 2024. Any interim compensation updates will be published on the Secure Provider Portal with a 60-day advance notification to providers.

Compensation Policies and Fee Schedules are published in our Payer Space on Availity® Essentials under Plan Document Viewer. For detailed information on the Biennial Update changes, please review the following compensation policies published on April 1, including:

- Codes with No Other Standard Compensation Methodology Policy V6
- Dental with Medical Benefits Compensation Policy V3
- Home Health Compensation Policy V6
- Durable Medical Equipment, Oxygen, Prosthetic/Orthotic and Supplies Compensation Policy V17
- Hospice Compensation Policy V2
- RBRVS and Anesthesia Conversion Factors Compensation Policy V12
- RBRVS Compensation Policy V22

Fee Schedule updates are posted no later than June 7 as per our Web Fee Schedule Compensation Policy. It is BCBSMT's intention to publish all updates prior to June 1.

Please check News & Updates and subscribe to the bi-weekly Provider eNews for important policy and pricing updates.

Professional providers participating with us may use Availity Essentials to obtain Fee Schedule listings for the patient services.

If you have not registered for Availity, you can sign up today. For registration assistance, contact Availity Client Services at 800-282-4548.

Behavioral Health Consultations During Hospitalization Can Improve Outcomes

Coexisting physical and behavioral health conditions can be difficult to manage. Studies have found that people hospitalized for physical health conditions who also have mental illness are more likely to be readmitted than people who don't have mental illness. Proper follow-up care for behavioral health after a hospitalization is often lacking, according to the National Committee for Quality Assurance.

Behavioral health consultations during a hospital stay can help our members who have physical and behavioral health conditions. Addressing behavioral health care with timely follow-ups can help **reduce hospital readmissions** and improve health outcomes, according to NCQA.

We encourage hospital staff/attending providers to discuss behavioral health with our members during a hospital stay and **to consider consultations and follow-up care coordination** when appropriate.

Tips for Behavioral Health Consultations and Follow-up Care

To help improve outcomes for our members receiving inpatient care, we encourage hospital staff/attending providers to consider the following:

- Discuss with our members and their medical teams how medical and behavioral health diagnoses are important and can be intertwined.
- Facilitate **behavioral health consultations** for our members when they're admitted to a medical unit for a medical concern and also exhibiting behavioral health symptoms.

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- Coordinate care with our members' medical and behavioral health providers and social support to help ensure **timely follow-ups**. A behavioral health follow-up within 30 days after discharge can be in the form of:
  - Behavioral health inpatient admission
  - Partial hospitalization program
  - Intensive outpatient program
  - Behavioral health outpatient appointment

Coding for Behavioral Health Consultations

When a member receives a psychiatric consultation while medically inpatient and receives a secondary behavioral health diagnosis, include the following on claims:

- The behavioral health diagnosis
- The correct Current Procedural Terminology (CPT®) codes for a psychiatric consult

Following is information from the American Medical Association about coding for behavioral health consultations (pages 24 and 28). Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter.

CPT code	Threshold Time	Description
99221	At least 40 minutes of total time on the date of the encounter	**Initial hospital inpatient or observation care**, per day, for the evaluation/management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making
99222	At least 55 minutes of total time on the date of the encounter	**Initial hospital inpatient or observation care**, per day, for the E/M of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99223	At least 75 minutes of total time on the date of the encounter	**Initial hospital inpatient or observation care, per day,** for the E/M of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making
99231	At least 25 minutes of total time on the date of the encounter	**Subsequent hospital inpatient or observation care**, per day, for the E/M of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making
99232	At least 35 minutes of total time on the encounter on a single date	**Subsequent hospital inpatient or observation care**, per day, for the E/M of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99233	At least 50 minutes of total time on the date of the encounter	**Subsequent hospital inpatient or observation care**, per day, for the E/M of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making

Breast Cancer Screening for Members Ages 40 to 74

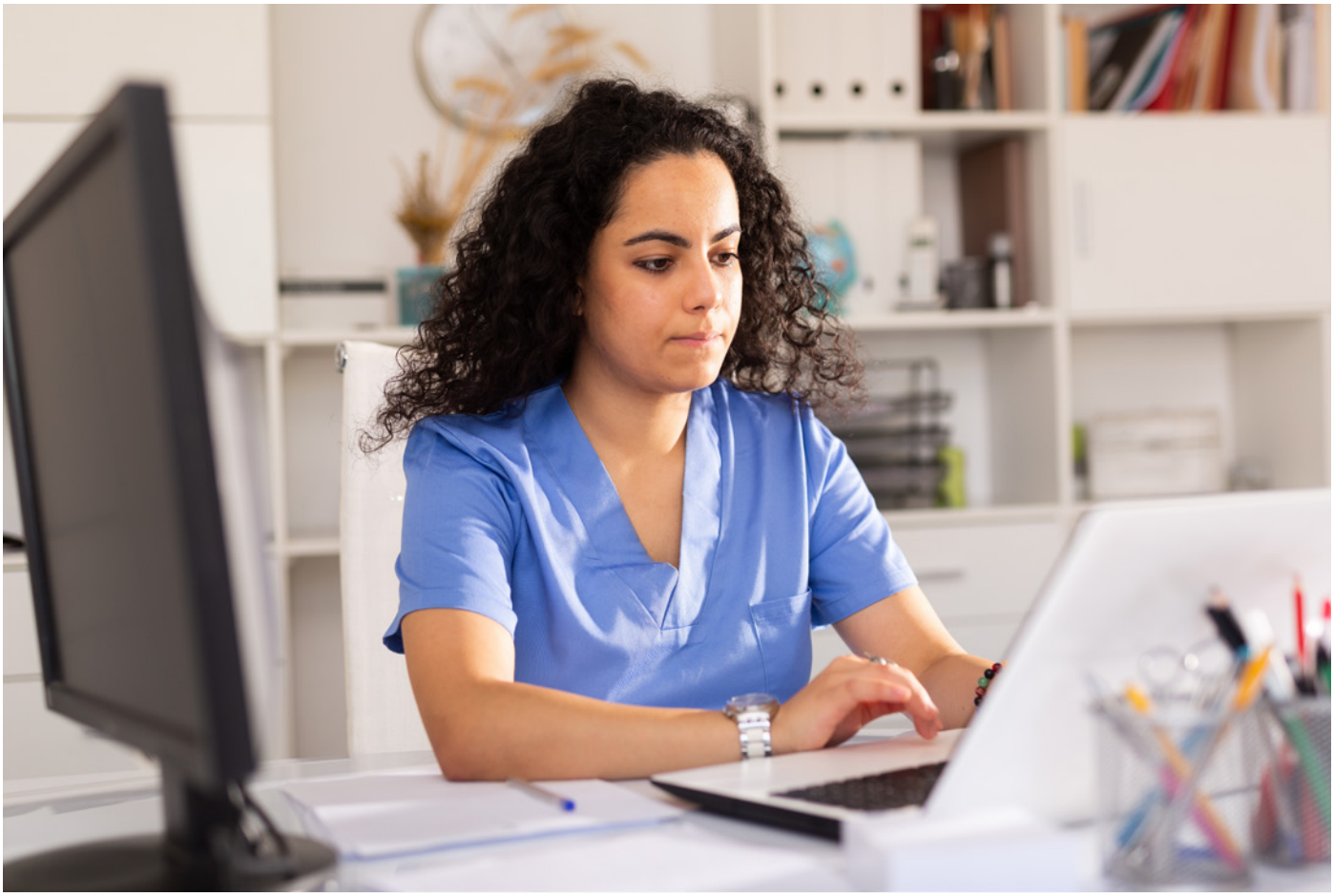
In line with new U.S. Preventive Services Task Force recommendations, Blue Cross and Blue Shield of Montana recommends that breast cancer screening for **our members begin at age 40 rather than 50**. We are updating our Preventive Care Guidelines to reflect this change. Screening should continue every other year until age 74.

Routine screening for breast cancer is the best way to detect it early, according to the Centers for Disease Control and Prevention. Breast cancer is easier to treat when it's caught earlier.

Tips to Close Gaps in Our Members' Care

- Talk with our members about breast cancer risk factors and the importance of regular screening for women. We've created resources that may help.
- Breast cancer disproportionately affects Black women, according to the CDC. Talk with our members about the unique risks and barriers they may face, which can result in poorer outcomes than other women.
- Document screenings in members' electronic medical record. Indicate the specific date and result. This helps us track member progress on the quality measure Breast Cancer Screening from the National Committee for Quality Assurance.
- Document medical and surgical history in the medical record, including dates. Use correct diagnosis and procedure codes. Submit claims and encounter data in a timely manner.
- Offer telehealth services when available and appropriate for preventive care appointments.
- Follow up with members if they miss their appointment and help them reschedule.
- For members who need language assistance, let them know we offer help and information in their language at no cost. To speak to an interpreter, members may call the customer service number on their member ID card.
- See our Health Equity and Social Determinants of Health page for more information on health equity.

For men who are at high risk, the American Cancer Society recommends discussing with them how to manage risks.



ClaimsXten Quarterly Update Effective Aug 19, 2024

Blue Cross and Blue Shield of Montana will implement its third quarter code updates for the ClaimsXten auditing tool on or after Aug. 19, 2024.

These quarterly code updates aren't considered changes to the software version. Code updates may include additions, deletions and revisions to:

- Current Procedural Terminology codes
- Healthcare Common Procedure Coding System codes

When applicable, BCBSMT may also post advance notice of significant changes, like implementation of new rules, in the News and Updates section of our Provider website and the Blue Review monthly newsletter.

Use **Clear Claim Connection™** to determine how certain coding combinations may be adjudicated when we process your claim. C3 is a free, online reference tool that mirrors the logic behind our code-auditing software.

Please note that C3 doesn't contain all of our claim edits and processes. Its results don't guarantee the final claim decision.

For More Information

Refer to the Clear Claim Connection page in the Education and Reference/Provider Tools section of our provider website for more information on C3 and ClaimsXten. It includes a user guide, rule descriptions and other details.

Clarification Regarding Provisional Credentialing for TriWest Network

On July 15, 2023, BCBSMT implemented a provisional credentialing process for professional providers which allowed for provisional network participation while a provider was waiting to become fully credentialed. Provisionally credentialed providers will be able to participate in all contracted networks excluding TriWest and will receive a welcome letter stating as much. Once a provider is fully credentialled, they will also be added to the TriWest network (if a TriWest contract is in place) and receive another letter confirming this addition.

This change does not require any action on the part of the provisionally credentialled provider.

For more information on the provisional credentialling process please visit the Credentialing Process page on our website.

Closing Gaps in Care for Group Medicare Advantage (PPO) Members

Through the Blue Cross and Blue Shield National Coordination of Care program, you may receive medical record requests from us for Blue Cross Group Medicare Advantage (PPO)℠ members. These include members with coverage through Blue Cross and Blue Shield of Montana as well as members enrolled in other BCBS plans who are living in Montana. This data helps us monitor for gaps in our members' care.

What This Means for Medicare Providers

If we need medical records for Group Medicare Advantage PPO members, you will receive requests only from BCBSMT or a vendor, Advantmed. You won't receive requests from other BCBS plans. We may request medical records for:

- Risk adjustment gaps related to claims submitted to BCBSMT
- Healthcare Effectiveness Data and Information Set (HEDIS®) measures
- Centers for Medicare & Medicaid Services Star Ratings

Please respond quickly to requests related to risk adjustment, HEDIS and other government-required activities as your contract requires. You don't need patient-authorized information releases to fulfill medical records requests and risk adjustment gaps through this program.

Important Reminders

- Use Availity Essentials or your preferred vendor to verify members' eligibility and benefits before every appointment. Eligibility and benefit quotes include membership verification, coverage status, prior authorization requirements, provider's network status for the patient's policy and applicable copayment, coinsurance and deductible amounts.
- Ask to see the member's ID card and a photo ID to help guard against medical identity theft.
- Notify members that they may be billed directly when services may not be covered.

Questions?

Call the customer service number on the member's ID card.

Coming Soon – New Learning & Training Center in Availity Essentials

Starting in **August 2024**, some of the educational resources on our Provider website are **moving to a new Learning & Training Cente**r within Availity Essentials. All **instructional user guides for Availity tools and instructor-led Availity trainings** will be available in this new location.

To access the Learning & Training Center: Log in to Availity and go to the Blue Cross and Blue Shield of Montana-branded **Payer Spaces – Applications**. You must be a registered Availity user to view the information in the training center. If you haven't registered yet, go to Availity and get started today at no cost. For registration help, call Availity Client Services at 800-282-4548.

Our Provider Tools and Training pages will continue to include detailed overviews of online options and training topics. You'll be redirected to Availity, when applicable, to view user guides, register for training and attend upcoming training sessions.

Delay in Spinal Service Transition to Carelon

There have been some unexpected delays in transition of spinal services to our external vendor Carelon.

Who is Impacted: Individual Family Markets/Retail and some Fully-Insured Group accounts.

Actions Required: Call toll-free 1-855-258-3489 or the phone number listed on the member's ID card to determine if services require prior authorization, and where and how to request clinical review.

We apologize for the inconvenience and hope to complete transition of these services for all IFM/Retail members and applicable Fully-Insured Group accounts to Carelon by mid-July.

For questions, reach out to your Provider Network Representative.

Electronic Claim Review and Ensuring the Correct Use of our Claim Review Form

Electronic claim review through Availity Essentials is fast and easy. If you're unable to submit electronically, you can submit by paper by using our Claim Review form, Blue Cross and Blue Shield of Montana must have all the information requested to complete a proper claim review. **Effective Aug. 1, 2024, we'll return any incomplete form without conducting the claim review.**

Here are some **helpful tips** when submitting a claim review form:

- These requests are only to be used for **review of a previously adjudicated claim**.
- Don't attach the original claims to a review form, rather, you'll reference the claim number in the appropriate field on the form.
- Don't use this form to submit a corrected claim, instead, use our Corrected Claim Form.
- Don't use this form to respond to an additional information request. Use the Additional Information Form.
- If you submit this form as a request for a second review, you must provide information not previously submitted for the review to be eligible.

Reminder

Electronic submission is your fastest path to an efficient claim review at Availity Essentials. Be sure to provide all required information as we won't review electronic inquiries received with incomplete information.

Submit a Claim Review Online, Fast

To submit an online claim review request via Availity Essentials:

- First, perform a **Claim Status** search utilizing the Member or Claim tab
- Second, use the **Dispute Claim** or **Message This Payer** option to request a claim review
- Third, complete all needed information

More Information

Learn more at our Claim Submission web page.

Encourage Routine Vaccines and Well-Care Visits for Children and Teens

Many children and adolesents are still catching up on missed routine immunizations and well-care visits, according to the Centers for Disease Control and Prevention. The CDC recommends that doctors and health care professionals encourage families to **schedule vaccines and visits** for their children. See our Children's Wellness Guidelines for a **routine immunization schedule**.

Tracking Our Members' Care

We track these Healthcare Effectiveness Data and Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance to help close gaps in our members' care:

Child Immunization Status tracks the percentage of 2-year-olds who received the following vaccines by their 2nd birthday:

- Four diphtheria, tetanus and acellular pertussis (DTaP)
- Three polio (IPV)
- One measles, mumps and rubella (MMR)
- Three haemophilus influenza type B (HiB)
- Three hepatitis B (HepB)
- One chicken pox (VZV)

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- Four pneumococcal conjugate (PCV)
- One hepatitis A (HepA)
- Two or three rotavirus (RV) before 1 year of age
- Two influenza

Immunizations for Adolescents tracks the percentage of 13-year-olds who received the following vaccines by their 13th birthday:

- One dose of meningococcal vaccine
- One tetanus, diphtheria and pertussis (Tdap)
- The complete human papillomavirus vaccine (HPV) series

Child and Adolescent Well-Care Visits

- Well-Child Visits in the First 30 Months of Life measures the percentage of children who had at least six well-child visits with a primary care provider during their first 15 months, and two or more well-child visits during their next 15 months.
- Child and Adolescent Well-Care Visits tracks the percentage of members ages 3 to 21 who received at least one well-care visit with a PCP or OB/GYN during the measurement year.

Tips to Consider

- Identify members who have missed vaccines or well-child visits. Contact their caregivers to **schedule appointments**.
- Check at each visit for any missing immunizations. **Address common misconceptions** about vaccines.
- Remind our members that it's important to **get a flu shot every year** because new strains of flu virus appear each year. The CDC recommends that most people 6 months and older should get a flu vaccine every year.
- To document well-child visits, note that the visit was with a PCP and include in the medical record:
- Date of visit
- Health history
- Physical and mental development history
- Physical exam
- Height, weight and body mass index percentile
- Health education or anticipatory guidance, including physical activity, diet and nutrition
- We collect immunization data through claims and chart review. To document immunizations, you may include in the medical record any of the following:
- Certificates of immunizations
- Diagnostic reports
- Subjective, objective, assessment and plan notes
- Office or progress notes

Resources

- Our preventive care guidelines on immunization schedules
- Information on childhood vaccines and well-visits for our members
- CDC recommendations on COVID-19 vaccines for children and teens

Filing Claims for Behavioral Health Services – Use the Correct Place of Service Code

Remember to use the correct Place of Service code when filing professional claims for Applied Behavioral Analysis services. Place of Service codes designate where the patient is located when they received services from you.

Remember: If you use the wrong POS code your claim may be denied, or payment may be delayed.

Familiarize yourself with POS codes using guidance from the American Medical Association. Also, refer to our Applied Behavior Analysis for Spectrum Disorder and Telehealth Services policies in the Coding and Compensation Policy area in Availity Essentials under Montana Payers Spaces for more information.

When filing claims, follow these examples of POS code guidance from CMS:

- **POS 3** is for use on claims for services provided in a school
- **POS 11** is for use on claims for services provided in the office
- **POS 12** is for use on claims for services provided in the patient's home
- **POS 49** is for use on claims for services provided in an independent clinic
- **POS 53** is for use on claims for services provided in a community mental health center
- **POS 99** is for use on claims for services provided in settings not listed in Current Procedural Terminology. For instance, community and daycare locations.

Note: claims are subject to the terms of a member's coverage and medical necessity review.

GLP-1 New to Therapy Optional Benefit Program Available for Select Commercial Members

As of April 1, 2024, there is a new optional pharmacy benefit program available for Administrative Services Only groups with Prime Therapeutics called **GLP-1 New to Therapy**. This new program aims to reduce the drug waste and cost of care associated with beginning Glucagon-like peptide 1 (GLP-1) drug therapy. It can also help members utilize the medication as intended, based on FDA labeling, until they find their maintenance dosage. GLP-1 drugs that are indicated for Type 2 Diabetes and indicated for Weight Management may be included in the program.

How It Works

GLP-1 New to Therapy limits an initial fill(s) to 30 days when members are new to GLP-1 drug therapy. After the initial fill(s), members may be eligible for up to a 90-day supply, per their pharmacy benefits.

- A 30-day supply limit may continue to apply after the first fill if the member moves to a new dosing strength or changes to a different GLP-1 medication.
- Members may be impacted if they are new to GLP-1 therapy or have no claims history within the past 120 days.
- Members currently taking a GLP-1 drug on a maintenance dosage are not impacted.
- Drug products that can be included are: Adlyxin, Bydureon, Byetta, Mounjaro, Ozempic, Rybelsus, Saxenda, Trulicity, Victoza, Wegovy, and Zepbound. This list is subject to change.

The program categories and medications included, as well as any applicable prior authorization programs for GLP-1 and Weight Loss, would be based on the member's pharmacy benefits. Please call the number on the member's ID card to verify coverage, or for further assistance or clarification on your patient's benefits.

Helping Our Members Manage Diabetes

About 38 million Americans have diabetes, according to the Centers for Disease Control and Prevention. Because symptoms can develop slowly, one in five of them don't know they have it. You may play an important role in supporting our members through **regular screenings, tests and office visits**.

Monitoring Our Members' Care

We track Healthcare Effectiveness Data and Information Set (HEDIS®) measures from the National Committee for Quality Assurance related to diabetes care, including:

Hemoglobin A1c Control for Patients with Diabetes captures the percentage of our members ages 18 to 75 with diabetes (type 1 and type 2) whose HbA1c level during the measurement year is:

- Less than 8.0%, indicating controlled
- Greater than 9.0%, indicating uncontrolled. A lower rate on this measure indicates better performance

Eye Exam for Patients with Diabetes tracks members ages 18 to 75 with diabetes (type 1 and type 2) who have a retinal eye exam by an eye care professional to screen or monitor for diabetic retinal disease.

Blood Pressure Control for Patients with Diabetes captures members ages 18 to 75 with diabetes (type 1 and type 2) whose blood pressure was controlled (<140/90 mm Hg).

Kidney Health Evaluation for Patients with Diabetes tracks members ages 18 to 85 with diabetes (type 1 and type 2) who received a kidney health evaluation during the measurement year. An evaluation includes a blood test for kidney function (estimated glomerular filtration rate) and a urine test for kidney damage (urine albumin-creatinine ratio).

Statin Therapy for Patients with Diabetes tracks members ages 40 to 75 who have diabetes and do not have clinical atherosclerotic cardiovascular disease, and who received and adhered to statin therapy.

Tips to Close Gaps in Care

- Identify care gaps and schedule lab tests before office visits to review results and adjust treatment plans if needed.
- Monitor blood pressure status at each visit and adjust medications as needed for control.
- Document medication adherence to angiotensin-converting enzyme inhibitors and angiotensin II receptor blockers when applicable.
- **Repeat abnormal lab tests later in the year** to document improvement.
- Encourage members with diabetes to have annual retinal or dilated eye exams by an eye care specialist.
- For our members on statin therapy, discuss the proper dose, frequency and the importance of staying on the medication.
- Communicate with members and other treating providers to ensure all tests are completed and results are documented in the medical record.

Resources

Information on **Current Procedural Terminology (CPT®) Category II codes** is available in Availity Essentials in Payer Spaces in the Resources section. It includes information on coding for HbA1c Control for Patients with Diabetes and Blood Pressure Control for Patients with Diabetes.

We've created information that may help you **discuss diabetes with our members**. For more on diabetes, see our **preventive care** and **clinical practice guidelines**.

How to Reach Out with Questions about 1099 Forms

Providers with any questions about their 1099-MISC forms should use the following contact information:

Blue Cross and Blue Shield of Montana
Attn: Corporate Tax, A-2
PO Box 655730
Dallas, TX 75265

1099inquiries@bcbstx.com
Phone: 972-766-9057
Fax: 972-766-6657

To request a duplicate 1099, you must include the following information:

- Provider Name
- Tax Identification Number
- Correct Mailing Address
- Contact Name and Number

To request a corrected 1099, you much include the following information:

- Explanation of what needs to be corrected.
- Copy of 1099
- Current W-9 Form
- Contact Name and Number

Important Updates to Manage My Organization in Availity Essentials

Updates have been made to Manage My Organization in Availity Essentials to enhance security and ensure your organization's provider information remains current. Add, edit, and/or delete provider data functions in Manage My Organization are **now** reserved to Availity Administrators and Administrator Assistants.

Providers added with relationship selection of ***"This is third-party not directly affiliated with my organization"*** will not be available in 'Select a Provider' drop-down lists in various Availity tools. Attestation needs to be completed for each provider that has this relationship selected to ensure users can efficiently conduct transactions in Availity.

Administrators can follow the steps below to verify which providers are currently associated with their organization in Availity.

Administrator – Providers Report Criteria

- In Availity Essentials, from the Account dashboard select Manage My Organization
- Choose your Organization and click on the blue "Manage Provider" button
- Select Export Providers from the drop-down list

Next Steps

- Exported file includes the **Provider Type in Column A**.
  - If the value is Y, then the provider is associated with the organization.
  - If the value is empty or an N, then the provider has not been associated with the organization and an administrator needs to attest that the provider is part of the organization by selecting the relationship as ***"This provider is part of my organization."***

For More Information

- Refer to the Manage My Organization page that includes an instructional user guide on our provider website.
- If you need customized assistance and/or training, contact our Provider Education Consultants.

Late and Added Charges Must Be Submitted as a Corrected Claim

Effective July 1, 2024, all added and late charges must be submitted as a corrected claim after the original claim has been processed.

What are Late Charges?

Late or additional charges represent changes for items and services submitted after the claim was created and not included in the original claim.

How To Submit a Corrected Claim

When submitting a corrected claim for charges to a previously processed inpatient or outpatient claim for commercial members, remember these important tips:

- **The corrected claim should include all line items previously processed correctly.** Reimbursement for line items no longer included on the corrected claim may be subject to recoupment by BCBSMT.
- **The entire claim should be resubmitted with frequency code 7 (replacement of prior claim).** Do not submit a corrected claim using frequency code 5 (late charges). If the corrected claim is submitted using frequency code 5 this could result in a denial of the claim.

Refer to our Corrected Claim Submissions Policy in the Coding and Compensation Policy area in Availity Essentials under Montana Payers Spaces for more information.

New Coupe Health Plan: Update Your Member Records

Starting in October 2024, providers in our commercial PPO network may see members of our new Coupe Health benefit plan. This plan streamlines the payment process for your office and our Coupe Health members.

Coupe Health is a copay-only plan, and members pay no deductibles or coinsurance. **You won't collect any copay from Coupe Health plan members.** Instead, Blue Cross and Blue Shield of Montana will reimburse you directly for the full allowed amount, including the member share.

Check ID Cards to Identify Coupe Health Members

As with all our members, it's important to ask to see the member ID card before all appointments, and to check eligibility and benefits. **Update your records if member ID numbers have changed.** Use Availity Essentials or a preferred vendor to check membership, coverage and prior authorization requirements, and to confirm that you are in-network for the member's policy. Emergency services are covered at the in-network benefit level.

If you have questions, call the customer service number on the member's ID card.

New: Access MCG Care Guidelines Clinical Criteria via Availity

Blue Cross and Blue Shield of Montana uses some, but not all, clinical criteria from MCG Care Guidelines when reviewing requests to determine medical necessity. Our clinical rationale outlined in some provider correspondence and some Coding and Compensation Policies will guide you to the specific MCG Care Guidelines, when applicable.

As a helpful resource, you can now access MCG guidelines through your Availity Essentials login.

How to access MCG Care Guidelines through Availity

- Log onto Availity Essentials
- Select Payer Spaces on the upper navigation bar
- Select the BCBSMT tile to navigate to our payer space
- Select the Resources tab
- Select MCG Guidelines and then follow the prompts

Remember: BCBSMT does not rely on all MCG Care Guidelines to support our utilization management decision making. You may search for related MCG Guidelines by opening any category link and searching for services by name and topic using the "control F" key board function.

Prior Authorization Changes for Medicare Advantage and Healthy Montana Kids Members

What's Changing

BCBSMT is changing prior authorization requirements for Medicare Advantage and Healthy Montana Kids members to reflect new, replaced or removed codes due to updates from utilization management, prior authorization assessment, Current Procedural Terminology (CPT®) code changes released by the American Medical Association or Healthcare Common Procedure Coding System code changes from the Centers for Medicaid & Medicare Services.

A summary of changes is included below.

Important Reminder

Always check eligibility and benefits first through the Availity Essentials provider portal or your preferred vendor portal, prior to rendering services. This step will confirm prior authorization requirements and utilization management vendors, if applicable.

A summary of changes is included below:

- Oct 1, 2024 – **Addition of Lab codes to be** reviewed by eviCore

More Information

For a revised list of codes go to the Prior Authorization Requirements section of our provider website.

If prior authorization is required, services performed without prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

Prior Authorization Codes Updated for Commercial Members Effective Oct. 1

What's Changing

BCBSMT is changing prior authorization requirements that may apply to some commercial members, to reflect new, replaced or removed codes. These changes are based on updates from utilization management prior authorization assessment, including Current Procedural Terminology (CPT®) code changes released by the American Medical Association or Healthcare Common Procedure Coding System code changes from the Centers for Medicaid & Medicare Services. A summary of changes is included below.

Important Reminder

Always check eligibility and benefits first through the Availity Essentials Provider Portal or your preferred vendor portal, prior to rendering services. This step will confirm prior authorization requirements and utilization management vendors, if applicable.

Changes include:

- **Oct. 1, 2024** – Addition of Genetic Testing codes **to be reviewed** by Carelon
- **Oct. 1, 2024** – Removal of Genetic Testing codes **previously reviewed** by Carelon
- **Oct. 1, 2024** – Replacement of a Medical Oncology drug code **reviewed** by Carelon
- **Oct. 1, 2024** – Addition of Medical Oncology codes to be reviewed by Carelon
- **Oct. 1, 2024** – Removal of Specialty Drug codes **previously reviewed** by BCBSMT

More Information

For a revised list of codes go to the Prior Authorization and Recommended Clinical Review section of our provider website.

Prior Authorization Requests May Be Needed Due to Pharmacy Claims Processing Error

A system error resulted in some members, with Prime Therapeutics as their pharmacy benefit manager, receiving paid claims without following the necessary prior authorization steps. The error has been fixed. Affected members may now need prior authorization approval for continued coverage of their drug.

Impacted PA Programs

The PA programs are:

- Acute Migraine
- GLP-1 Agonists
- Topiramate ER
- Winlevi

Letters are being sent to members whose benefits require them to go through the PA process.

Next Steps

Please submit the PA request for your patient. Visit the Prior Authorization/Step Therapy Programs section for both forms and more information. The prior authorization program encourages safe, cost-effective medication use by allowing coverage when certain conditions are met. A clinical team of physicians and pharmacists develops and approves the clinical programs and criteria for medications that are appropriate for PA by reviewing U.S. Food and Drug Administration approved labeling, scientific literature, and nationally recognized guidelines.

Important Reminders

If your patients have any questions about their pharmacy benefits, please have them call the number on their member ID card. Members may also visit our member site and log in to Blue Access for Members or MyPrime.com for a variety of online resources.

As a reminder, treatment decisions are always between you and your patients. Coverage is subject to the terms and limits of your patients' benefit plans.

Proper Billing for Supplies for Transcutaneous Electrical Nerve Stimulation Units

Proper coding for Transcutaneous Electrical Nerve Stimulation Units and necessary supplies eliminates additional costs to you and our members. Here are some tips to help ensure you and our members get what is needed.

When Renting TENS Units

One month of necessary supplies are included in the rental of a TENS unit. There is no need to order additional items such as electrodes, lead wires and batteries for the first month of use.

Trial Before Purchase

Our Medical Policy MED201.040 recommends a trial use of a TENS unit used daily or near daily, for at least 30 days to establish efficacy of the treatment and compliance. The trial must be monitored by a physician. The ordering provider must deem the trial period successful, prior to ordering and dispensing a purchased TENS unit.

When Purchasing a TENS Unit

A purchased TENS unit includes lead wires, which usually last one year, and one month of necessary supplies including, all electrodes, conductive paste or gel (if needed) and batteries.

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Appropriate Coding

Use Healthcare Common Procedure Coding System codes E0720 or E0730 for the unit purchase or rental.

For additional supplies after the first month of use, use HCPCS code A4595. It includes all required electrodes and items such as conductive paste or gel, tape or other adhesive, adhesive remover, skin preparation materials, batteries and a battery charger.

Units Billed for Supplies

- A4595: Replacement Supplies:
  - 2 Leads/ 1 unit per month
  - 4 Leads/ 2 units per month
- A4557: Replacement Lead wires
  - Lead wires- 2 electrode system/1 unit per year
  - Lead wires- 4 electrode system/2 units per year

The following codes are **NOT** valid for claim submission for the TENS durable medical equipment benefit.

- A4556 (Electrodes, [e.g., apnea monitor], per pair)
- A4558 (Conductive paste or gel)
- A4630 (Replacement batteries, medically necessary TENS owned by patient)

Prescription Requirements

A prescription or order must be available if requested for DME rentals or purchase. The prescription or order must be signed by the member's treating, qualified health care provider. When a qualified health care provider completes and signs the prescription or order, they are attesting that the information indicated on the form is correct and that the requested services are necessary and appropriate. Provider's prescription or order must be renewed annually.

The prescription or order for DME should include:

- Member's name, date of birth
- Diagnosis (Dx)
- Type of equipment/supplies
- Provider's rationale
- Date of prescription/order
- Date and duration of expected use
- Quantity (if applicable)
- Provider name, address, and telephone number
- Legible provider signature and date

Reminder to Update Profile for Accreditation

Providers are encouraged to update and attest to their Council for Affordable Quality Healthcare profiles every four months by logging into the CAQH ProView database. Review to ensure your information and supporting documents are accurate and current, and update or re-attest as necessary.

Providers most often fail re-credentialing due to the following items being outdated or missing on their CAQH profile:

- Attestation is outdated.
- Missing a copy of current malpractice insurance listing the provider's name or a roster with the provider's name on the insurance company's letterhead.
- Missing Montana DEA license or a completed prescribing authority form.
- **Physicians (MDs and DOs):** If you do not have current admitting privileges, provide a formal letter signed by the physician or a physicians group who have agreed to admit and care for your patients as necessary is required. Admitting physicians must be the same specialty, located in the practicing physician's community, and provide 24/7 coverage of service reimbursed, you may submit additional medical records to support your claim.

Learn More

For more information on our ED claims editing, please review our Coding and Coding and Compensation Policies in Availity Essentials by using the Plan Documents Viewer application in our branded Payer Spaces section. Look for our Emergency Department Evaluation and Management Services – for Facility Services policy and our Emergency Department Evaluation and Management Services Coding – for Professional Services policy.

Reminder: Update Your Records with New Mailing Addresses

We announced new mailing addresses in November for faster claims processing and responses. **Starting Oct. 1, 2024**, mail sent to our previous addresses will be forwarded through the postal service to the new addresses. This will result in delays to claims processing and payment. To avoid delays, update your contact information for us if you haven't done so and **submit paper commercial claims to the new address**:

Blue Cross and Blue Shield of Montana
PO Box 660255
Dallas, TX 75266-0255

Electronic claim submission is preferred and is your fastest path to payment. See our Claim Submission page for more information.

Forms updated with the new address are available to download, including the Claim Review, Corrected Claim, Additional Information and Requests for Recommended Clinical Review forms.

Other address updates are:

Medicare Supplement Correspondence
Blue Cross and Blue Shield of Montana
PO Box 660694
Dallas, TX 75266-0694

Medicare Supplement Claims
Blue Cross and Blue Shield of Montana
PO Box 660071
Dallas, TX 75266-0071

Behavioral Health Correspondence
Blue Cross and Blue Shield of Montana
PO Box 660240
Dallas, TX 75266-0240

Dental Claims
Blue Cross and Blue Shield of Montana
PO Box 660247
Dallas, TX 75266-0247

The dental claim form is updated with the new address.

See our Claim Submission page and the Contact Us page for more information.

See Our Revised Coding and Compensation Policy for Anesthesia Services

What's changing?

Effective **Aug. 14, 2024**, Blue Cross and Blue Shield of Montana is updating its Anesthesia Compensation Policy.

The Details

Under this revised policy BCBSMT will no longer offer additional reimbursement for services based on the use of physical status (P code) modifiers when appended to anesthesia services.

What do I need to do?

Refer to our revised Anesthesia Compensation Policy in the Coding and Compensation Policy area in Availity Essentials under Montana Payers Spaces for more information.

Supporting Maternal Quality Care

Prenatal and postpartum care contributes to the long-term well-being of new mothers and their infants, according to the American College of Obstetricians and Gynecologists. We encourage you to talk with our members about the importance of **attending all care visits** during and after pregnancy.

We track the following Healthcare Effectiveness Data and Information Set (HEDIS®) measures related to our members' maternal health:

Prenatal and Postpartum Care measures the percentage of deliveries in which members:

- Had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment with Blue Cross and Blue Shield of Montana
- Had a postpartum visit on or between seven and 84 days after delivery

Prenatal and Postpartum Depression Screening and Follow-Up measures the percentage of deliveries in which members:

- Were screened for clinical depression during pregnancy and the postpartum period using a standardized instrument, and
- Received follow-up care within 30 days if the screening was positive

Tips to Close Gaps in Prenatal and Postpartum Care

- Check with our members to ensure that initial prenatal visits are scheduled in the **first 12 weeks of pregnancy** with an OB-GYN, primary care physician or other prenatal practitioner.
- A postpartum visit must take place on or between **seven and 84 days after delivery**. Be aware that post-operative visits within six days after discharge don't count as a postpartum visit. Members who have cesarean sections should be reminded to schedule their postpartum care visit during the C-section post-op visit.
- Data for this measure is collected from claims and chart review for services performed by an OB-GYN, midwife, family practitioner or other PCP. Services provided during telehealth visits, e-visits and virtual check-ups are eligible for reporting to meet the measure.

Tips to Close Gaps in Prenatal and Postpartum Depression Screening and Follow-Up

- Ask members during their pregnancy and postpartum to complete an age-appropriate depression screener, such as the Patient Health Questionnaire (PHQ)-9 or -2, or the Edinburgh Postnatal Depression Scale.
- If the depression screening is positive, follow up within 30 days with one or more of the following, as appropriate:
- Additional evaluation for depression
- Suicide risk assessment
- Referral to a practitioner qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression
- Coordinate care between behavioral health and other health care providers. Consider case management.

Resources

- Preventive Care Guidelines for providers
- Perinatal Wellness Guidelines for members
- **Earn continuing education credit**: Watch a recording of our webinar Maternal Mental Health: Pregnancy and Postpartum. Sign in here (registration required) to access the recording.

Updated PEAQ Methodology Is Now Available

The updated methodology for our Physician Efficiency, Appropriateness, & Quality℠ program is now available on our PEAQ page. The methodology explains how PEAQ evaluates physician performance.

What's New

We have refined the methodology based on new clinical data and input from practicing physicians. The updated methodology includes:

- New details on PEAQ uses
- New specialties (general surgery, neurology and otolaryngology)
- Updated quality measurements
- The Quality Practice Score, which indicates performance in certain specialties based on set measurements and indicators

How It's Used

The updated methodology is the foundation for future **Physician Performance Insights** reports. PPI reports show how physicians compare to peers and have information on improving performance. Provider Finder® includes summaries of performance ratings from PPI reports to **help our members make informed care decisions**.

PPI reports are posted in Availity Essentials. If you don't yet have an Availity account, register here.

For more details about PEAQ, visit our PEAQ page or email PEAQ Inquiries.

Community Health Improvement Planning

COMMUNITY HEALTH IMPROVEMENT PLANNING

BUILDING HEALTHY SYSTEMS

MONTANA DPHHS
DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

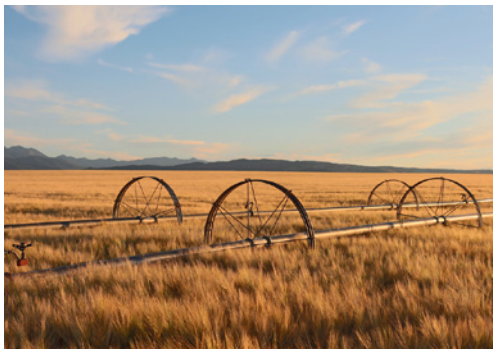
CHA Guide

- Step-by-step process
- Stakeholder resources
- Secondary data resources
- Primary data resources
- Survey question template
- And more!

Health Care and Public Health Partnership

Local health departments and non-profit organizations can work together to conduct a Community Health Assessment to determine what are the health needs of the communities they serve.

How can we help?
The local and tribal support team provides funding and TA for health departments completing a CHA, CHIP, and/or a strategic plan.
Contact us at:
HHSPHSDBuildingHealthySystems@mt.gov.



Scan the QR code to view the guide.

https://dphhs.mt.gov/publichealth/buildinghealthysystems/TrainingsandResources

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Montana Interfacility Blood Network

The Montana Interfacility Blood Network is a novel concept developed by the Montana State Trauma Care Committee to address the challenges of providing lifesaving blood transfusions to patients in rural areas during ground transportation to definitive care. For example, if a patient presents at a rural facility with no or limited blood supplies, and air transport is grounded due to weather, the ground ambulance can pick up uncrossmatched, emergent blood products from an intermediary facility along the transport route.

The key aspects of the innovation are:

a. Intermediary Facility "Hand-off": In cases where a patient requires blood transfusion (regardless of if trauma or non-trauma), and the initial facility lacks blood products or has a limited supply, the transporting ambulance can stop at an intermediate facility along the route to pick up uncross-matched, emergent blood products.

b. Direct Administration to the Patient: Qualified staff (Paramedic, Critical Care Paramedic, RN or medical provider) can administer the blood products directly to the patient during the remainder of the transport to the definitive care facility, without the patient needing to be registered or evaluated at the intermediate facility.

c. Guidelines and Resources: The Montana State Trauma Care Committee developed comprehensive guidelines and resources to facilitate the implementation of the Interfacility Blood Network which can be found on the EMS & Trauma Systems website: https://dphhs.mt.gov/publichealth/emsts/trauma/educationresources

The project was just internationally honored with the prestigious 2024 Peregrine Award for Trauma Innovation during a virtual awards ceremony on May 15, 2024.

Help Your Female Patients Understand & Reduce Their Risk of Heart Disease

The WISEWOMAN (**W**ell-**I**ntegrated **S**creening and **E**valuation for **WOM**en **A**cross the **N**ation) program helps women understand and reduce their risk for heart disease and stroke by providing services that promote lasting heart-healthy lifestyles.

The Montana WISEWOMAN Program offers heart disease screenings for low-income women, ages 35-64 years, who do not have health insurance, are not a Medicaid member, or who are under-insured. To be a part of WISEWOMAN, the participant must meet the following requirements:

- Age: 35 – 64 years
- Insurance: No insurance, insurance with a deductible of $250 or more, or coverage only through IHS/Tribal Health.
- Income: At or below 250% of the Federal Poverty Level.

Providers in higher-risk WISEWOMAN regions can apply to participate in the WISEWOMAN program. Please contact cardiovascularinfo@mt.gov for more information. Currently, the Montana WISEWOMAN program is available in Flathead County and will launch in Blaine County this summer.

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Interprofessional Team-Based Oncology Care: Engaging Primary Care Providers in collaborative oncology care delivery from diagnosis through survivorship

Providing high quality oncology care from diagnosis through survivorship in rural and frontier communities presents unique challenges and opportunities. The use of an interprofessional team-based approach to oncology care with oncologist and primary care providers collaboratively managing patients has the potential to improve health outcomes and patient experience.[1] Rural and Frontier residents with cancer have worse outcomes than their urban counterparts. This is due to geographic barriers, lower rates of health insurance, and socioeconomic disparities. Further, those living in the most remote areas appear to be forgoing any treatment at rates higher than those living closer to regional cancer centers. In Montana, as in much of the intermountain west, the geographic barrier to care is heightened by the scarcity of oncologists, as well as their clustering in larger regional centers: Nearly 90% of oncologists in Montana are based in just 6 of the 56 counties in the state.

Approximately 90% of direct cancer care in Montana is provided in regional cancer centers. Individuals undergoing treatment are returning to their home community between treatments, often greater than 60 miles from the regional center. This results in the need for the side effects of treatment, follow-up, and survivorship care to be managed, at least in part, by their primary care provider near the patient's home. Advantages of a team-based approach to care (Figure 1) for patients undergoing oncological treatment include reduced adverse events, decreased care fragmentation, and improved experience measures for patients.

Figure 1: Interprofessional Team-Based Oncology Care

During ongoing treatment most side effects become evident in the days following administration of anti-cancer medications. For patients living in rural areas, this occurs after they have returned to their home community. This often results in patients with side effects of treatment presenting to their primary care provider for acute management. In addition, patients often have pre-existing medical conditions, some of which may be exacerbated by cancer treatments that the primary care provider will need to take into consideration. However, there are few reported care models regarding the integration of PCPs into the ongoing care of cancer patients actively receiving therapy, although some large academic centers are developing such programs. Not surprisingly, surveys of PCPs indicate the need for education regarding the physical and psychosocial side effects of cancer treatments.

Follow-up and survivorship care is a time where the need for a team-based approach to care is vital as patients transition from active treatment to surveillance and any ongoing care needs. Survivorship is viewed to begin at diagnosis and extend through the lifetime of the patient, however, there are very specific survivorship care needs that begin upon completion of anti-cancer therapy. The goal of survivorship care is to address the physical, psychological, and social impacts of cancer treatment. Models for providing survivorship care have been developed since the Institute of Medicine's initial report on survivorship in 2006. In large, urban, resource-rich health care settings specific cancer survivorship clinics have been created to address the needs of patients upon completion of therapy. However, these models are not transferrable to small rural health care settings that lack the resources to develop and staff such a clinic. Thus, delivery of survivorship care falls to rural health care providers, as well as critical access hospitals, who may not be prepared to identify and address late and long-term effects of treatment. A survey of PCPs in Montana demonstrated only 1/3 felt fully comfortable with provision of survivorship care, a result that is consistent with national survey data. Thus, there is a need for education of PCPs regarding survivorship.

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The development of a team-based oncology care model that includes PCPs in rural areas in both supportive care and survivorship care for cancer patients requires a well-thought-out strategy to improve integration of PCPs into the care of their patients with cancer. Further underlying this need, surveys indicate that as many as 95% of PCPs would prefer a more active role in the care of their patients during all phases a cancer journey. Current models of cancer care are inadequate as oncology clinics focus on navigating the increasing complexity of treating cancer, and the patient's primary care provider is not consistently incorporated as part of the care team resulting in potential care gaps and poor patient experience. As noted above, some academic centers are beginning work on incorporation of PCPs into the care of their patients with cancer and publications have championed the need for team-based oncology care. Team-based oncology care incorporates oncologists, PCPs, social workers, nurse navigation, and community support services into the overall care for a patient diagnosed with cancer. However, implementation of team-based practices into the care for rural cancer patients is particularly challenging.

In addition to PCPs, a team-based oncology model needs to include community resources. Bringing these supportive organizations into the care team facilitates uptake of the vital services that they provide. The Montana Cancer Coalition, a division of the state Department of Public Health and Human Services, strives to ensure better quality of life and enhance the odds of survivorship through prevention, early detection, and state-of-the-art cancer care. The MTCC has focused on improving survivorship care in Montana for several years. Most recently the MTCC launched a pilot project utilizing Project ECHO for survivorship education. Lessons learned from this pilot project have informed a new initiative beginning in 2024. There are 3 goals for this initiative, 1) ENGAGEMENT of the care teams, including both oncology providers and PCPs to emphasize the importance of team-based care for cancer patients, 2) Delivery of an EDUCATIONAL component and 3) Development of a RESOURCE, to provide easily accessible supplemental educational information to providers regarding cancer survivorship. An overriding goal of this effort is to facilitate communication among care providers regarding the benefits of team-based oncology care and to encourage development of team-based care. Current strategies to meet these goals include a presentation scheduled at the annual meeting of the Montana chapter of the American College of Physicians in September 2024 as well as plans to provide this presentation at CME activities in healthcare facilities throughout the state.

While the rationale and the models for team-based care are being developed in academic centers, the greatest need for their application is in smaller communities that receive care from multiple health systems, where efficient utilization of the more limited resources is essential. The need for effective and efficient care delivery will only increase as cancer case numbers increase with the anticipated aging of the population and with the continued improvement in cancer therapies resulting in an increase in the number of cancer survivors. In addition, the national focus on increasing access to cancer care will increase the role of primary care providers as more cancer care is administered in rural areas in collaboration with the local health care system. New models for increasing access to oncology care, including throughout survivorship, in rural areas are already in place in Montana on a small scale including the utilization of telemedicine and the delivery of online psychosocial supportive programs to improve quality of life. With the continued emphasis on the role of access to high quality oncology care in improving outcomes in rural areas utilizing a team-based care model in rural areas has the potential to reduce the urban-rural outcome gaps.

[1] For an in-depth review of this subject, see https://doi.org/10.1200/EDBK_349391

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Free Lifestyle Blood Pressure Prevention Classes

Health Coaches for Hypertension Control is a FREE eight-week course that educates and empowers Montanans on lifestyle choices intended to help them reduce and control their high blood pressure. The courses are offered in several counties throughout the state and are conducted by local coaches in various settings. Program benefits include real-life guidance and coaching to help participants understand exactly how to best manage and reduce high blood pressure — and to feel supported while doing it.

The classes focus on several areas of self-care including nutrition, physical activity, measuring blood pressure at home, medication and stress management, tobacco use cessation, and creating goals and action plans. Lifestyle change may help participants lower their blood pressure or even reduce medications.

Participants are also given a free BP monitoring cuff, stress ball, cookbook, pedometer, and other health education materials.

You can find an interactive map of the current Montana coaches and their contact information at MT Community Programs Map.

Pharmacy Program Quarterly Update: Changes Effective July 1, 2024 – Part 1

Reminder: Quarterly Pharmacy Changes are published in two parts. The part 1 article covers changes that require member notification – drug list revisions/exclusions, dispensing limits, utilization-management changes and general information on pharmacy benefit program updates. Our members receive letters regarding these changes. The part 2 article includes updates that do not require member notification.

Drug List Changes

Based on the availability of new prescription medications and Prime's National Pharmacy and Therapeutics Committee's review of changes in the pharmaceuticals market, some revisions (drugs still covered but moved to a higher out-of-pocket payment level) and/or exclusions (drugs no longer covered) will be made to the Blue Cross and Blue Shield of Montana drug lists, effective on or after July 1, 2024.

The July Quarterly Pharmacy Changes Part 2 article with recent coverage additions will be published closer to the July 1 effective date.

Your patient(s) may ask you about therapeutic or lower cost alternatives if their medication is affected by one of these changes.

Drug-list changes are listed on the charts below, or you can view the July 2024 drug lists on our member website.

Drug List Exclusions/Revisions – Effective July 1, 2024

Balanced Drug List Exclusions		
Drug[1]	**Alternatives [1,2]**	**Drug Class/Condition**
ACCURETIC (quinapril-hydrochlorothiazide tab 10-12.5 mg, 20-12.5 mg)	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Hypertension
ALREX (loteprednol etabonate ophth susp 0.2%)	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Ocular Inflammation/Pain
AMJEVITA (adalimumab-atto soln auto-injector 40 mg/0.8 ml)	Cyltezo, Humira	Autoimmune Disorders
AMJEVITA (adalimumab-atto soln prefilled syringe 10 mg/0.2 ml, 20 mg/0.4 ml, 40 mg/0.8 ml)	Cyltezo, Humira	Autoimmune Disorders
BROMSITE (bromfenac sodium ophth soln 0.075% (base equivalent))	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Inflammation-Ophthalmic
CONDYLOX (podofilox gel 0.5%)	Please talk to your doctor or pharmacist about other medication(s) available for your condition.	External Genital Warts
EMFLAZA (deflazacort tab 6 mg, 18 mg, 30 mg, 36 mg)	prednisone tablet	Duchenne Muscular Dystrophy
EXKIVITY (mobocertinib succinate cap 40 mg)	Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Cancer

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Balanced Drug List Exclusions		
Drug[1]	**Alternatives [1,2]**	**Drug Class/Condition**
FORTEO (teriparatide (recombinant) soln pen-inj 600 mcg/2.4 ml)	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Osteoporosis
GRALISE (gabapentin (once-daily) tab 300 mg, 600 mg)	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Post-herpetic Neuralgia
INDOCIN (indomethacin susp 25 mg/5 ml)	indomethacin capsule	Inflammatory Conditions
KORLYM (mifepristone tab 300 mg)	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Cushing's Syndrome
LEXETTE (halobetasol propionate foam 0.05%)	clobetasol propionate solution 0.5%	Inflammation- Topical
NASCOBAL (cyanocobalamin nasal spray 500 mcg/0.1 ml)	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Vitamin B12 Deficiency, Pernicious Anemia
PENTASA (mesalamine cap er 500 mg)	mesalamine tablet DR	Ulcerative Colitis
PRADAXA (dabigatran etexilate mesylate cap 110 mg (etexilate base eq))	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Thromboembolism/Stroke Prevention, DVT/PE Prevention and Treatment
XIIDRA (lifitegrast ophth soln 5%)	Restasis single dose vials, Tyrvaya	Dry Eye Disease

Performance Drug List Exclusions		
Drug[1]	**Alternatives[1,2]**	**Drug Class/Condition**
ALREX (loteprednol etabonate ophth susp 0.2%)	permethrin	Scabies
AMJEVITA (adalimumab-atto soln auto-injector 40 mg/0.8 ml)	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Acute Repetitive Seizures
AMJEVITA (adalimumab-atto soln prefilled syringe 10 mg/0.2 ml, 20 mg/0.4 ml, 40 mg/0.8 ml)	estazolam, temazepam	Insomnia
EXKIVITY (mobocertinib succinate cap 40 mg)	NOVOLOG	Diabetes
FORTEO (teriparatide (recombinant) soln pen-inj 600 mcg/2.4 ml)	NOVOLOG	Diabetes
KORLYM (mifepristone tab 300 mg)	NOVOLOG	Diabetes
PRADAXA (dabigatran etexilate mesylate cap 110 mg (etexilate base eq))	NOVOLOG 70/30	Diabetes

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Performance Select Drug List Exclusions		
Drug[1]	**Alternatives[1,2]**	**Drug Class/Condition**
ALREX (loteprednol etabonate ophth susp 0.2%)	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Ocular Inflammation/Pain
AMJEVITA (adalimumab-atto soln auto-injector 40 mg/0.8 ml)	Cyltezo, Humira	Autoimmune Disorders
AMJEVITA (adalimumab-atto soln prefilled syringe 10 mg/0.2 ml, 20 mg/0.4 ml, 40 mg/0.8 ml)	Cyltezo, Humira	Autoimmune Disorders
BROMSITE (bromfenac sodium ophth soln 0.075% (base equivalent))	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Inflammation-Ophthalmic
clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%, 1.2-3.75%	clindamycin phosphate-benzoyl peroxide refrigerated gel 1.2-2.5%	Acne
EXKIVITY (mobocertinib succinate cap 40 mg)	Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Cancer
FORTEO (teriparatide (recombinant) soln pen-inj 600 mcg/2.4 ml)	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Osteoporosis
GRALISE (gabapentin (once-daily) tab 300 mg, 600 mg)	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Post-herpetic Neuralgia
KORLYM (mifepristone tab 300 mg)	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Cushing's Syndrome
LIPOFEN (fenofibrate cap 50 mg, 150 mg)	atorvastatin tablet, lovastatin, pravastatin, rosuvastatin, simvastatin	Hyperlipidemia, Hypercholesterolemia, Hypertriglyceridemia
NASCOBAL (cyanocobalamin nasal spray 500 mcg/0.1 ml)	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Vitamin B12 Deficiency, Pernicious Anemia
pitavastatin calcium tab 1 mg, 2 mg, 4 mg	atorvastatin tablet, lovastatin, pravastatin, rosuvastatin, simvastatin	Hyperlipidemia, Hypercholesterolemia
PRADAXA (dabigatran etexilate mesylate cap 110 mg (etexilate base eq))	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Thromboembolism/Stroke Prevention, DVT/PE Prevention and Treatment
XIIDRA (lifitegrast ophth soln 5%)	Restasis single dose vials, Tyrvaya	Dry Eye Disease

Health Insurance Marketplace Drug List Exclusions		
Drug[1]	**Alternatives[1,2]**	**Drug Class/Condition**
AMJEVITA (adalimumab-atto soln auto-injector 40 mg/0.8 ml)	Hadlima, Humira	Autoimmune Disorders

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Health Insurance Marketplace Drug List Exclusions		
Drug[1]	**Alternatives[1,2]**	**Drug Class/Condition**
AMJEVITA (adalimumab-atto soln prefilled syringe 10 mg/0.2 ml, 20 mg/0.4 ml, 40 mg/0.8 ml)	Hadlima, Humira	Autoimmune Disorders
EXKIVITY (mobocertinib succinate cap 40 mg	Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Cancer
FORTEO (teriparatide (recombinant) soln pen-inj 600 mcg/2.4 ml	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Osteoporosis

Basic, Multi-Tier Basic, Enhanced, and Multi-Tier Enhanced Revisions		
Drug[1]	**Preferred Alternatives[1,2]**	**Drug Class/Condition**
AMJEVITA (adalimumab-atto soln auto-injector 40 mg/0.8 ml)	Hadlima, Humira	Autoimmune Disorders
AMJEVITA (adalimumab-atto soln prefilled syringe 10 mg/0.2 ml, 20 mg/0.4 ml, 40 mg/0.8 ml)	Hadlima, Humira	Autoimmune Disorders
FORTEO (teriparatide (recombinant) soln pen-inj 600 mcg/2.4 ml	There is a generic equivalent available. Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Osteoporosis

[1]Third-party brand names are the property of their respective owner.
[2]This list is not all inclusive. Other medicines may be available in this drug class.

Please note: If coverage of the member's medication is changed on their prescription drug list, the amount the member will pay for the same medication under this preventive drug benefit may also change.

Drug Tier Changes – As of July 1, 2024

The tier changes listed below apply to members on a managed drug list. Members may pay more for these drugs after July 1, 2024.

Balanced Drug List Tier Changes			
Drug[1]	**Alternatives[1,2]**	**Drug Class/Condition**	**New Tier**
ACETAMINOPHEN/CODEINE (acetaminophen w/ codeine soln 120-12 mg/5 ml)	acetaminophen/codeine tablet 300-15 mg	Pain	Non-Preferred Brand
FLUOCINOLONE ACETONIDE (fluocinolone acetonide cream 0.01%)	desonide cream 0.05%, triamcinolone acetonide cream 0.025%	Inflammation- Topical	Non-Preferred Brand
FLUTICASONE PROPIONATE (fluticasone propionate lotion 0.05%)	fluticasone propionate cream 0.05%	Inflammation- Topical	Non-Preferred Brand
GLUCAGON EMERGENCY KIT FO R LOW BLOOD SUGAR (glucagon (rdna) for inj kit 1 mg)	Baqsimi, Gvoke, Glucagon injection	Hypoglycemia	Non-Preferred Brand
GLYBURIDE MICRONIZED (glyburide micronized tab 1.5 mg, 3 mg 6 mg))	glyburide tablet 1.25 mg, glyburide tablet 2.5 mg, glyburide tablet 5 mg	Diabetes	Non-Preferred Brand

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Balanced Drug List Tier Changes			
Drug[1]	**Alternatives[1,2]**	**Drug Class/Condition**	**New Tier**
HYDROCORTISONE ACETATE/PRAMOXINE (hydrocortisone acetate w/ pramoxine perianal cream 1-1%)	Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Pruritus, Dermatoses	Non-Preferred Brand
HYDROCORTISONE BUTYRATE (LIPID) (hydrocortisone butyrate hydrophilic lipo base cream 0.1%)	betamethasone valerate cream 0.1%, triamcinolone acetonide ointment 0.25%	Dermatitis, Dermatoses	Non-Preferred Brand
LIPOFEN (fenofibrate cap 50 mg, 150 mg)	atorvastatin tablet, lovastatin, pravastatin, rosuvastatin, simvastatin	Hyperlipidemia, Hypercholesterolemia, Hypertriglyceridemia	Non-Preferred Brand
MORPHINE SULFATE (morphine sulfate oral soln 10 mg/5 ml)	morphine sulfate oral solution 20 mg/ml, morphine sulfate tablet 15 mg, morphine sulfate tablet 30 mg	Pain	Non-Preferred Brand
PERINDOPRIL ERBUMINE (perindopril erbumine tab 2 mg)	benazepril, captopril, enalapril, lisinopril, perindopril erbumine tablet 4 mg	Hypertension, Heart Failure	Non-Preferred Brand
VALSARTAN (valsartan oral soln 4 mg/ml)	valsartan tablet	Hypertension	Non-Preferred Brand

Performance Drug List Tier Changes			
Drug[1]	**Alternatives[1,2]**	**Drug Class/Condition**	**New Tier**
ACETAMINOPHEN/CODEINE (acetaminophen w/ codeine soln 120-12 mg/5 ml)	acetaminophen/codeine tablet 300-15 mg	Pain	Non-Preferred Brand
FLUOCINOLONE ACETONIDE (fluocinolone acetonide cream 0.01%)	desonide cream 0.05%, triamcinolone acetonide cream 0.025%	Inflammation - Topical	Non-Preferred Brand
GLUCAGON EMERGENCY KIT FOR LOW BLOOD SUGAR (glucagon (rdna) for inj kit 1 mg)	Baqsimi, Gvoke, Glucagon injection	Hypoglycemia	Non-Preferred Brand
GLYBURIDE MICRONIZED (glyburide micronized tab 1.5 mg, 3 mg 6 mg))	glyburide tablet 1.25 mg, glyburide tablet 2.5 mg, glyburide tablet 5 mg	Diabetes	Non-Preferred Brand
HYDROCORTISONE ACETATE/PRAMOXINE (hydrocortisone acetate w/ pramoxine perianal cream 1-1%)	Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Pruritus, Dermatoses	Non-Preferred Brand
MORPHINE SULFATE (morphine sulfate oral soln 10 mg/5 ml)	morphine sulfate oral solution 20 mg/ml, morphine sulfate tablet 15 mg, morphine sulfate tablet 30 mg	Pain	Non-Preferred Brand
PERINDOPRIL ERBUMINE (perindopril erbumine tab 2 mg)	benazepril, captopril, enalapril, lisinopril, perindopril erbumine tablet 4 mg	Hypertension, Heart Failure	Non-Preferred Brand

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Performance Select Drug List Tier Changes			
Drug[1]	**Alternatives[1,2]**	**Drug Class/Condition**	**New Tier**
ACETAMINOPHEN/CODEINE (acetaminophen w/ codeine soln 120-12 mg/5 ml)	acetaminophen/codeine tablet 300-15 mg	Pain	Non-Preferred Brand
FLUOCINOLONE ACETONIDE (fluocinolone acetonide cream 0.01%)	desonide cream 0.05%, triamcinolone acetonide cream 0.025%	Inflammation- Topical	Non-Preferred Brand
GLUCAGON EMERGENCY KIT FO R LOW BLOOD SUGAR (glucagon (rdna) for inj kit 1 mg)	Baqsimi, Gvoke, Glucagon injection	Hypoglycemia	Non-Preferred Brand
GLYBURIDE MICRONIZED (glyburide micronized tab 1.5 mg, 3 mg 6 mg))	glyburide tablet 1.25 mg, glyburide tablet 2.5 mg, glyburide tablet 5 mg	Diabetes	Non-Preferred Brand
HYDROCORTISONE ACETATE/PRAMOXINE (hydrocortisone acetate w/ pramoxine perianal cream 1-1%)	Please talk to your doctor or pharmacist about other medication(s) available for your condition.	Pruritus, Dermatoses	Non-Preferred Brand
MORPHINE SULFATE (morphine sulfate oral soln 10 mg/5 ml)	morphine sulfate oral solution 20 mg/ml, morphine sulfate tablet 15 mg, morphine sulfate tablet 30 mg	Pain	Non-Preferred Brand
PERINDOPRIL ERBUMINE (perindopril erbumine tab 2 mg)	benazepril, captopril, enalapril, lisinopril, perindopril erbumine tablet 4 mg	Hypertension, Heart Failure	Non-Preferred Brand

Health Insurance Marketplace Drug List Tier Changes			
Drug[1]	**Alternatives[1,2]**	**Drug Class/Condition**	**New Tier**
ACETAMINOPHEN/CODEINE (acetaminophen w/ codeine soln 120-12 mg/5 ml)	acetaminophen/codeine tablet 300-15 mg	Pain	Non-Preferred Brand
FLUOCINOLONE ACETONIDE (fluocinolone acetonide cream 0.01%)	desonide cream 0.05%, triamcinolone acetonide cream 0.025%	Inflammatory Conditions	Non-Preferred Brand
GLUCAGON EMERGENCY KIT (glucagon (rdna) for inj kit 1 mg	Baqsimi, Gvoke, Glucagon injection	Hypoglycemia	Non-Preferred Brand
GLYBURIDE MICRONIZED (glyburide micronized tab 1.5 mg, 3 mg and 6 mg)	glyburide tablet 1.25 mg, 2.5 mg and 5 mg	Diabetes	Non-Preferred Brand
MORPHINE SULFATE (morphine sulfate oral soln 10 mg/5 ml)	morphine sulfate oral solution 20 mg/ml, morphine sulfate tablet 15 mg and 30 mg	Pain	Non-Preferred Brand
PERINDOPRIL ERBUMINE (perindopril erbumine tab 2 mg)	benazepril, captopril, enalapril, lisinopril, perindopril erbumine tablet 4 mg	Hypertension, Heart Failure	Non-Preferred Brand

[1]Third-party brand names are the property of their respective owner.
[2]This list is not all inclusive. Other medicines may be available in this drug class.
[3]Coverage of medications is still subject to the limits, exclusions and out-of-pocket requirements based on the member's plan.
Please note: If coverage of the member's medication is changed on their prescription drug list, the amount the member will pay for the same medication under this preventive drug benefit may also change.

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Utilization Management Program Changes

Utilization Management programs are implemented to regularly review the appropriateness of medications within drug-therapy programs, and as a result, may adjust dispensing limits, prior authorization or step-therapy requirements. The following drug programs reflect those changes.

Changes to Standard Prior Authorization Program – Effective July 1, 2024

Changes to drug categories and/or medications will be made to the Prior Authorization programs for standard pharmacy benefit plans. This includes ASO groups with a standard UM package and/or subcategory selection with auto updates.

For groups that have not selected the auto update, these programs will be available to be added to their benefit design as of the program effective date.

Members received letters regarding the program changes in the following table.

Basic, Multi-Tier Basic, Enhanced, Enhanced and Multi-Tier Enhanced Drug Lists	
Drug Category	**Medication[1] Added**
Rapid to Intermediate Acting Insulin PAQL	Insulin Aspart, Insulin Aspart Mix, Insulin Lispro

[1]Third-party brand names are the property of their respective owner.

Updates to Prior Authorization Programs

Program Name	Program Type	Description of Change	Drug Lists	Effective Date
Agamree Emflaza PAQL	Prior Authorization Specialty	Name changed and added target Agamree (vamorolone) 40 mg/mL oral susp	Balanced, Performance, Performance Select, Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced and HIM	6/15/2024
Fabhalta PAQL	Prior Authorization Specialty	New program with target Fabhalta (Iptacopan) 200 mg caps	Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced	7/1/2024
Hyperhidrosis PAQL	Prior Authorization	Program now applying for select drug list(s) with target Qbrexa 2.4% pad	Performance, Performance Select	4/15/2025
Oral Tetracycline Derivatives PA	Prior Authorization	Added targets Tetracycline Tabs 250 mg and 500 mg	Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced, HIM, Balanced, Performance, Performance Select	2/19/2024
Substrate Reduction Therapy PAQL	Prior Authorization Specialty	Added target Opfolda (miglustat) 65 mg cap	Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced, HIM, Balanced, Performance, Performance Select	6/1/2024
Therapeutic Alternatives PAQL	Prior Authorization	Added target Coxanto (oxaprozin) 300 mg cap	Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced, HIM, Balanced, Performance, Performance Select	7/1/2024
Xphozah PAQL	Prior Authorization	New program with target Xphozah (tenapanor) 20 mg and 30 mg tab	Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced	7/1/2024

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Dispensing Limit Changes

Our prescription-drug benefit program includes coverage limits on certain medications and drug categories. Dispensing limits are based on U.S. Food and Drug Administration approved dosage regimens and product labeling.

BCBSMT may send letters to all members with a claim for a drug included in the Dispensing Limit Program, regardless of the prescribed dosage. This means members may receive a letter even though their prescribed dosage doesn't meet or exceed the dispensing limit.

For the most up-to-date drug list and list of drug dispensing limits, visit the provider pharmacy webpage.

If your patients have any questions about their pharmacy benefits, please advise them to contact the number on their member ID card. Members may also visit bcbsmt.com and log in to Blue Access for Members℠ or MyPrime.com for more online resources.

Dispensing Limit changes are on the chart below with their effective date.

View the most up-to-date drug lists and dispensing limits.

Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced Drug Lists			
Program	**Target Agent**	**Dispensing Limit**	**Effective Date**
Fabhalta PAQL	Fabhalta (iptacopan) 200 mg caps	60 caps per 30 days	7/1/2024
Xphozah PAQL	Xphozah (tenapanor hcl) 20 mg tab, 30 mg tab	60 tabs per 30 days	7/1/2024

Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced, Balanced, Performance, Performance Select, Health Insurance Marketplace (HIM) Drug Lists			
Program	**Target Agent**	**Dispensing Limit**	**Effective Date**
Agamree Emflaza PAQL	Agamree (vamorolone) 40 mg/mL oral susp	300 mLs per 30 days	6/15/2024
GLP-1 (glucagon-like peptide-1) agonist PAQL	Mounjaro (tirzepatide) soln pen injector 2.5 mg/0.5 mL	4 pens per 180 days	7/1/2024*
Substrate Reduction Therapy PAQL	Opfolda (miglustat) 65 mg cap	8 caps per 28 days	6/1/2024
Therapeutic Alternatives PAQL	Coxanto (oxaprozin) 300 mg caps	120 caps per 30 days	7/1/2024

* Members with quarterly updates were lettered on this change. Members with annual updates will be lettered prior to their 2025 renewal date.

Pharmacy Benefits Updates

Visit the Provider's Pharmacy page for resource materials. Stay tuned to Blue Review for additional Pharmacy Program updates.

Reminder: BCBSMT's Updated Approach to Managing GLP-1 Agonist Medications

BCBSMT is committed to providing its members access to safe, appropriate, and cost-effective health care within their plan benefits. To ensure the appropriate use of GLP-1s as indicated for diabetes, we are making it easier for providers to bypass our prior authorization process for some of our members with diabetes.

Members may have received a letter regarding this new approach. BCBSMT mailed letters in late April to members with annual changes with a July, August or September renewal date. For more information, review the article on bcbsmt.com.

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Zepbound Added as a Custom Benefit Option on Select BCBSMT Drug Lists

Following its FDA approval for weight management, the GLP-1 drug Zepbound (tirzepatide) was added as a custom benefit option on the Performance, Performance Select and Balanced drug lists, effective April 15, 2024. Coverage of weight loss drugs, including Zepbound, is not a standard benefit for BCBSMT plans. However, self-funded groups have the option to cover weight loss drugs, including Zepbound, as a custom benefit.

Please note: The drug addition was not printed in the April 2024 drug lists published on bcbsmt.com due to a late, formulary coverage decision. The drug will appear in the July 2024 publications with a notation for group-specific coverage. Members utilizing digital tools as of April 1, 2024, will see coverage notations as applicable. Members can refer to their benefit materials for coverage details or call the number on their member ID card for assistance.

Links to Commonly Used Forms Now Available

Links to some commonly used forms have been added to our provider website.

- The Affordable Care Act (ACA) Copay Waiver form can be used to request $0 member cost share for preventive drug products not covered on a BCBSMT commercial plan drug list. There is also a program summary with more details on when and how to use this form.
- The Formulary Coverage Exception form can be used to request coverage for drug products not covered on a BCBSMT commercial plan drug list.

Pharmacy Program Quarterly Update: Changes Effective July 1, 2024 – Part 2

Reminder: The Quarterly Pharmacy Changes are published as articles in two parts. This part-2 article is a continuation of the July Quarterly Pharmacy Changes Part 1, which included changes that require member notification — drug list revisions/exclusions, dispensing limits, utilization management changes and general information on pharmacy benefit program updates. This article contains recent coverage additions, utilization management updates and any other pharmacy program updates.

Drug List Changes

Based on the availability of new prescription medications and Prime's National Pharmacy and Therapeutics Committee's review of changes in the pharmaceuticals market, some additions (new to coverage) and/or some coverage tier changes (drugs moved to a lower out-of-pocket payment level) will be made to the drug lists. **Additions effective July 1, 2024, and prior updates are outlined herein.**

Drug List Additions – Effective July 1, 2024

Balanced Drug List Additions	
Drug[1]	**Condition**
AUGTYRO (repotrectinib cap 40 mg)	Cancer
BACLOFEN (baclofen oral soln 10 mg/5 ml)	Spasticity
CABTREO (adapalene-benzoyl peroxide-clindamycin gel 0.15-3.1-1.2%)	Acne
COXANTO (oxaprozin cap 300 mg)	Osteoarthritis, Rheumatoid Arthritis
FRUZAQLA (fruquintinib cap 1 mg, 5 mg)	Cancer
JYLAMVO (methotrexate oral soln 2 mg/ml)	Mycosis Fungoides, Non-Hodgkin Lymphoma, Rheumatoid Arthritis, Psoriasis
OGSIVEO (nirogacestat hydrobromide tab 50 mg, 100 mg, 150 mg)	Desmoid Tumors
OXAPROZIN (oxaprozin cap 300 mg)	Osteoarthritis, Rheumatoid Arthritis
OZOBAX DS (baclofen oral soln 10 mg/5 ml)	Spasticity
SOTYKTU (deucravacitinib tab 6 mg)	Plaque Psoriasis
TRUQAP (capivasertib tab 160 mg, 200 mg)	Cancer
TYRVAYA (varenicline tartrate nasal soln 0.03 mg/act)	Dry Eye Disease
VOQUEZNA (vonoprazan fumarate tab 10 mg (base equiv), 20 mg (base equiv))	Erosive Esophagitis, Helicobacter Pylori Infection
ZURZUVAE (zuranolone cap 20 mg, 25 mg, 30 mg)	Postpartum Depression

Performance Drug List Additions	
Drug[1]	**Condition**
AUGTYRO (repotrectinib cap 40 mg)	Cancer
FRUZAQLA (fruquintinib cap 1 mg, 5 mg)	Cancer
OGSIVEO (nirogacestat hydrobromide tab 50 mg, 100 mg, 150 mg)	Desmoid Tumors
SOTYKTU (deucravacitinib tab 6 mg)	Plaque Psoriasis
TRUQAP (capivasertib tab 160 mg, 200 mg)	Cancer
ZURZUVAE (zuranolone cap 20 mg, 25 mg, 30 mg)	Postpartum Depression

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Performance Select Drug List Additions	
Drug[1]	**Condition**
AUGTYRO (repotrectinib cap 40 mg)	Cancer
FRUZAQLA (fruquintinib cap 1 mg, 5 mg)	Cancer
OGSIVEO (nirogacestat hydrobromide tab 50 mg, 100 mg, 150 mg)	Desmoid Tumors
SOTYKTU (deucravacitinib tab 6 mg)	Plaque Psoriasis
TRUQAP (capivasertib tab 160 mg, 200 mg)	Cancer
TYRVAYA (varenicline tartrate nasal soln 0.03 mg/act)	Dry Eye Disease
VOQUEZNA (vonoprazan fumarate tab 10 mg (base equiv), 20 mg (base equiv))	Erosive Esophagitis, Helicobacter Pylori Infection
ZURZUVAE (zuranolone cap 20 mg, 25 mg, 30 mg)	Postpartum Depression

Basic, Basic Multi-Tier, Enhanced, and Enhanced Multi-Tier Drug Lists Revisions	
Drug[1]	**Condition**
OMNIPOD 5 G6 INTRO KIT (GEN 5) (insulin infusion disposable pump kit)	Diabetes
OMNIPOD 5 G6 PODS (GEN 5) (insulin infusion disposable pump reservoir)	Diabetes
OMNIPOD 5 G7 INTRO KIT (GEN 5) (insulin infusion disposable pump kit)	Diabetes
OMNIPOD 5 G7 PODS (GEN 5) (insulin infusion disposable pump reservoir)	Diabetes
OMNIPOD DASH INTRO KIT (GEN 4) (insulin infusion disposable pump kit)	Diabetes
OMNIPOD DASH PODS (GEN 4) (insulin infusion disposable pump reservoir)	Diabetes
ZURZUVAE (zuranolone cap 20 mg, 25 mg, 30 mg)	Postpartum Depression

Other Drug List Additions

Most additions to the drug list become effective quarterly, however, some drugs are added as part of formulary maintenance (e.g., new strength of covered drug) or re-evaluated during the quarter then added to the list. Those drugs are listed herein.

Balanced Drug List Additions		
Drug[1]	**Condition**	**Effective Date**
AEROCHAMBER PLUS FLOW-VU/INTERMEDIATE MASK (pacer/aerosol-holding chambers - device)	Asthma, Chronic Obstructive Pulmonary Disease (COPD)	5/5/2024
AKEEGA (niraparib tosylate-abiraterone acetate tab 50-500 mg, 100-500 mg)	Cancer	5/1/2024
BACLOFEN (baclofen tab 15 mg)	Spasticity associated with Multiple Sclerosis and Spinal Cord Lesions	4/7/2024
CARBINOXAMINE MALEATE (carbinoxamine maleate tab 6 mg)	Allergic Symptoms, Allergic Reactions	4/21/2024
OHC COVID-19 ANTIGEN SELF TEST	COVID-19	5/5/2024
ENTYVIO (vedolizumab soln pen-injector 108 mg/0.68 ml)	Crohn's disease, Ulcerative colitis	5/15/2024
estradiol gel 0.06% (0.75 mg/1.25 gm metered-dose pump)	Menopause symptoms	5/5/2024
FRAICHE 5000 PREVI (sodium fluoride-tribasic calcium phosphate gel 1.1-3%)	Tooth decay prevention	4/7/2024
FRAICHE 5000 SENSITIVE (sodium fluoride-potassium nitrate gel 1.1-4.5%)	Teeth sensitivity	4/7/2024

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Balanced Drug List Additions		
Drug[1]	**Condition**	**Effective Date**
INGREZZA (valbenazine tosylate capsule sprinkle 40 mg (base equiv), 60 mg (base equiv), 80 mg (base equiv))	Huntington's disease, Tardive dyskinesia	5/5/2024
OJJAARA (momelotinib dihydrochloride tab 100 mg, 150 mg, 200 mg)	Myelofibrosis with Anemia	5/1/2024
OPFOLDA (miglustat (gaa deficiency) cap 65 mg)	Pompe Disease	6/1/2024
TOLECTIN 600 (tolmetin sodium tab 600 mg)	Arthritis	5/5/2024
VUMERITY (diroximel fumarate capsule delayed release 231 mg)	Multiple Sclerosis	4/15/2024
XCOPRI (cenobamate tab 25 mg)	Seizures	4/28/2024

Performance Drug List Additions		
Drug[1]	**Condition**	**Date Added**
AEROCHAMBER PLUS FLOW-VU/INTERMEDIATE MASK (spacer/aerosol-holding chambers - device)	Asthma, Chronic Obstructive Pulmonary Disease	5/5/2024
AKEEGA (niraparib tosylate-abiraterone acetate tab 50-500 mg, 100-500 mg)	Cancer	5/1/2024
ENTYVIO (vedolizumab soln pen-injector 108 mg/0.68 ml)	Crohn's disease, Ulcerative colitis	5/15/2024
estradiol gel 0.06% (0.75 mg/1.25 gm metered-dose pump)	Menopause symptoms	5/5/2024
INGREZZA (valbenazine tosylate capsule sprinkle 40 mg (base equiv), 60 mg (base equiv), 80 mg (base equiv))	Huntington's disease, Tardive dyskinesia	5/5/2024
OJJAARA (momelotinib dihydrochloride tab 100 mg, 150 mg, 200 mg)	Myelofibrosis with Anemia	5/1/2024
OPFOLDA (miglustat (gaa deficiency) cap 65 mg)	Pompe Disease	6/1/2024
VUMERITY (diroximel fumarate capsule delayed release 231 mg)	Multiple Sclerosis	4/15/2024
XCOPRI (cenobamate tab 25 mg)	Seizures	4/28/2024

Performance Select Drug List Additions		
Drug[1]	**Condition**	**Date Added**
AEROCHAMBER PLUS FLOW-VU/INTERMEDIATE MASK (spacer/aerosol-holding chambers - device)	Asthma, Chronic Obstructive Pulmonary Disease	5/5/2024
AKEEGA (niraparib tosylate-abiraterone acetate tab 50-500 mg, 100-500 mg)	Cancer	5/1/2024
ENTYVIO (vedolizumab soln pen-injector 108 mg/0.68 ml)	Crohn's disease, Ulcerative colitis	5/15/2024
estradiol gel 0.06% (0.75 mg/1.25 gm metered-dose pump)	Menopause symptoms	5/5/2024
INGREZZA (valbenazine tosylate capsule sprinkle 40 mg (base equiv), 60 mg (base equiv), 80 mg (base equiv))	Huntington's disease, Tardive dyskinesia	5/5/2024
OJJAARA (momelotinib dihydrochloride tab 100 mg, 150 mg, 200 mg)	Myelofibrosis with Anemia	5/1/2024
OPFOLDA (miglustat (gaa deficiency) cap 65 mg)	Pompe Disease	6/1/2024
VUMERITY (diroximel fumarate capsule delayed release 231 mg)	Multiple Sclerosis	4/15/2024
XCOPRI (cenobamate tab 25 mg)	Seizures	4/28/2024

Basic, Basic Multi-Tier, Enhanced, and Enhanced Multi-Tier Drug Lists Revisions		
Drug[1]	**Condition**	**Date Added**
VUMERITY (diroximel fumarate capsule delayed release 231 mg)	Multiple Sclerosis	4/15/2024

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Drug Tier Changes – As of July 1, 2024

The tier changes listed below apply to members on a managed drug list. Tier changes effective July 1, 2024 are listed below.

Balanced Drug List Tier Changes		
Drug[1]	**Condition**	**New Lower Tier**
OMNIPOD 5 G6 INTRO KIT (GEN 5) (insulin infusion disposable pump kit)	Diabetes	Preferred Brand
OMNIPOD 5 G6 PODS (GEN 5) (insulin infusion disposable pump supplies)	Diabetes	Preferred Brand
OMNIPOD 5 G7 INTRO KIT (GEN 5) (insulin infusion disposable pump kit)	Diabetes	Preferred Brand
OMNIPOD 5 G7 PODS (GEN 5) (insulin infusion disposable pump reservoir)	Diabetes	Preferred Brand
OMNIPOD DASH INTRO KIT (GEN 4) (insulin infusion disposable pump kit)	Diabetes	Preferred Brand
OMNIPOD DASH PODS (GEN 4) (insulin infusion disposable pump supplies)	Diabetes	Preferred Brand

Performance Drug List Tier Changes		
Drug[1]	**Condition**	**New Lower Tier**
OMNIPOD 5 G6 INTRO KIT (GEN 5) (insulin infusion disposable pump kit)	Diabetes	Preferred Brand
OMNIPOD 5 G6 PODS (GEN 5) (insulin infusion disposable pump supplies)	Diabetes	Preferred Brand
OMNIPOD 5 G7 INTRO KIT (GEN 5) (insulin infusion disposable pump kit)	Diabetes	Preferred Brand
OMNIPOD 5 G7 PODS (GEN 5) (insulin infusion disposable pump reservoir)	Diabetes	Preferred Brand
OMNIPOD DASH INTRO KIT (GEN 4) (insulin infusion disposable pump kit)	Diabetes	Preferred Brand
OMNIPOD DASH PODS (GEN 4) (insulin infusion disposable pump supplies)	Diabetes	Preferred Brand

Performance Select Drug List Tier Changes		
Drug[1]	**Condition**	**New Lower Tier**
OMNIPOD 5 G6 INTRO KIT (GEN 5) (insulin infusion disposable pump kit)	Diabetes	Preferred Brand
OMNIPOD 5 G6 PODS (GEN 5) (insulin infusion disposable pump supplies)	Diabetes	Preferred Brand
OMNIPOD 5 G7 INTRO KIT (GEN 5) (insulin infusion disposable pump kit)	Diabetes	Preferred Brand
OMNIPOD 5 G7 PODS (GEN 5) (insulin infusion disposable pump reservoir)	Diabetes	Preferred Brand
OMNIPOD DASH INTRO KIT (GEN 4) (insulin infusion disposable pump kit)	Diabetes	Preferred Brand
OMNIPOD DASH PODS (GEN 4) (insulin infusion disposable pump supplies)	Diabetes	Preferred Brand

Utilization Management Program Changes

Utilization Management programs are implemented to regularly review the appropriateness of medications within drug-therapy programs, and as a result, may adjust dispensing limits, prior authorization or step-therapy requirements. The following drug programs reflect those changes.

Program Changes

The following standard utilization management programs were updated on the dates indicated below.

Program Name	Program Type	Description of Change	Drug Lists	Effective Date
Androgens and Anabolic Steroids PAQL	Prior Authorization Quantity Limits	removed testosterone cypionate as a target	Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced, Health Insurance Marketplace, Balanced, Performance, Performance Select	4/15/2024

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Continuous Glucose Monitor PAQL	Step Therapy Quantity Limits	removed Dexcom G4 and Dexcom G5 products	Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced, Health Insurance Marketplace, Balanced, Performance, Performance Select	5/15/2024
Dipeptidyl Peptidase-4 Inhibitors and Combinations STQL	Prior Authorization Specialty Quantity Limits	removed Step Therapy from HIM	Health Insurance Marketplace	4/15/2024
Fabhalta PAQL*	Prior Authorization Quantity Limits	New program with target Fabhalta (Iptacopan) 200 mg caps	Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced, Health Insurance Marketplace, Balanced, Performance, Performance Select	7/1/2024
Multiple Sclerosis PAQL	Prior Authorization Quantity Limits	VUMERITY moved to preferred agent	Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced, Health Insurance Marketplace, Balanced, Performance, Performance Select	4/15/2024
Self-Administered Oncology PAQL	Prior Authorization Quantity Limits	removed EXKIVITY as a target	Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced, Health Insurance Marketplace, Balanced, Performance, Performance Select	6/15/2024
Therapeutic Alternatives PAQL	Prior Authorization Quantity Limits	removed Metaxalone 400 mg tab as a target	Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced, Health Insurance Marketplace, Balanced, Performance, Performance Select	4/15/2024
Xphozah PAQL*	Prior Authorization Quantity Limits	New program with target Xphozah (tenapanor) 20 mg and 30 mg tab	Basic, Multi-Tier Basic, Enhanced, Multi-Tier Enhanced, Health Insurance Marketplace, Balanced, Performance, Performance Select	7/1/2024

*These programs were previously reported as additions to only the open drug lists. However, a clinical decision has since added these programs to all drug lists. Members will not be lettered because drugs are new to market and there is no utilization to date.

Program Retirements

The following standard utilization management programs have been retired on the dates indicated below.

- **Human Fibrinogen Concentrate PAQL was retired April 15, 2024.**
  This program included the following medications: Fibryga and RiaSTAP

Please Note: The prior authorization programs for standard pharmacy benefit plans correlate to a member's drug list. Not all standard PA programs may apply, based on the member's current drug list. A list of PA programs per drug list is posted on the member pharmacy programs section of bcbsmt.com.

If your patients have any questions about their pharmacy benefits, please advise them to contact the number on their member ID card. Members may also visit bcbsmt.com and log in to Blue Access for Members or MyPrime.com for a variety of online resources.

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Change in Benefit Coverage for Select High-Cost Products

Several high-cost products with available lower cost alternatives will be excluded on the pharmacy benefit for select drug lists. This change impacts members who have prescription-drug benefits administered by Prime Therapeutics†. This change is part of an ongoing effort to ensure our members and employer groups have access to safe, cost-effective medications.

Please note: Members were not notified of this change because either there is no utilization, or the pharmacist can easily fill a member's prescription with the equivalent without needing a new prescription from the doctor. The following drugs are excluded on select drug lists.

Product(s) No Longer Covered[1]	Condition	Covered Alternative(s)[1,2]
AMCINONIDE cream 0.1%	eczema, dermatitis, allergies, rash	Lower cost, high potency steroids (e.g., Betamethasone cream/ointment, Fluocinonide)
CARBINOXAMINE MALEATE tab 6 mg	seasonal allergies	carbinoxamine 4 mg, RYVENT
diclofenac potassium tab 25 mg	inflammation	diclofenac potassium 50 mg, meloxicam, ibuprofen, naproxen
TOLMETIN SODIUM cap 400 mg	Inflammation	meloxicam, ibuprofen, naproxen
TOLMETIN SODIUM tab 600 mg	inflammation	meloxicam, ibuprofen, naproxen

Pharmacy Benefits Updates

Reminder: "GLP-1 New to Therapy" Pharmacy Option for Large ASO Groups

ASO groups (151+ members) using Prime Therapeutics can opt-in to a new pharmacy program called "GLP-1 New to Therapy." This program limits initial fill(s) of GLP-1s to a 30-day supply for members with no claims history within the past 120 days. Subsequent fills may be eligible for up to a 90-day supply, per the member's pharmacy benefits.

For more information regarding this new program, review the full article on your news and updates site.

Reminder: Links to Commonly Used Forms Now Available

Links to some commonly used forms have been added to our provider website.

- The Affordable Care Act Copay Waiver can be used to request $0 member cost share for preventive drug products not covered on a commercial plan drug list for BCBSMT. There is also a program summary with more details on when and how to use this form.
- The Formulary Coverage Exception can be used to request coverage for drug products not covered on a commercial plan drug list for BCBSMT.

[1]Third-party brand names are the property of their respective owner.
[2]This list is not all inclusive. Other medicines may be available in this drug class.
[3]Coverage of medications is still subject to the limits, exclusions and out-of-pocket requirements based on the member's plan.
+This drug is based on group-specific coverage. Members should refer to their benefit materials for coverage details or call the number on the back of their member ID card.

Please note: If coverage of the member's medication is changed on their prescription drug list, the amount the member will pay for the same medication under this preventive drug benefit may also change.

†Prime Therapeutics, LLC, is a pharmacy benefit management company. BCBSMT contracts with Prime to provide pharmacy benefit management and related other services. BCBSMT, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime. MyPrime.com is an online resource offered by Prime Therapeutics.

Advantmed, LLC is an independent company that has contracted with Blue Cross and Blue Shield of [STATE] to provider-focused cost/quality measures for members with coverage through BCBSMT.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSMT. BCBSMT makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

Carelon Medical Benefits Management (Carelon) is an independent company that has contracted with BCBSMT to provide utilization management services for members with coverage through BCBSMT. Checking eligibility and benefits and/or obtaining prior authorization is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations, and exclusions set forth in the member's policy certificate and/or benefits booklet and or summary plan description. Regardless of any prior authorization or benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider. If you have any questions, call the number on the member's BCBSMT ID card.

ClaimsXten and Clear Claim Connection are trademarks of Lyric, an independent company providing coding software to BCBSMT. Lyric is solely responsible for the software and all the contents.

Coupe Health is an independent company that has contracted with BCBSMT to provide an alternative health plan for members with coverage through BCBSMT.

eviCore healthcare (eviCore) is an independent company that has contracted with Blue Cross and Blue Shield of Montana to provide preauthorization for expanded outpatient and specialty utilization management for members with coverage through BCBSMT.

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MCG Care Guidelines are administered and provided by MCG Health, an independent company that has contracted with Blue Cross and Blue Shield of Montana to provide care and disease management for members with coverage through BCBSMT.

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The above material is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their member contract or member guide for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

The Council for Affordable Quality Healthcare, Inc. (CAQH) is a not-for-profit collaborative alliance of the nation's leading health plans and networks. The mission of CAQH is to improve health care access and quality for patients and reduce administrative requirements for physicians and other health care providers and their office staff. CAQH is solely responsible for its products and services, including ProView.

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The information provided here is only intended to be a summary of the law that has been enacted and is not intended to be an exhaustive description of the law or a legal opinion of such law. If you have any questions regarding the law mentioned here, you should consult with your legal advisor.

BlueCross BlueShield of Montana