Provider NEWS

WellFirst Health®

Summer 2021
A newsletter for WellFirst Health providers

Population Health Interest, Helping the Underserved Energizes New Medical Director

Q&A with Dr. Ken Schellhase

Ken Schellhase, MD, has taken on the role of a Senior Medical Director at the Health Plan. With more than a decade of experience in managed care, he has been a Medical Director at Children's Community Health Plan (CCHP) and most recently served as Chief Medical Director at MHS Health Wisconsin-Centene Corporation. He's also involved in clinical and residency practice at the Medical College of Wisconsin. Dr. Schellhase, a family medicine specialist, attributes his interest in the medical director role to his training as a researcher. He's interested in finding better ways to help patients, especially those who are underserved now.

How did you develop your interest in population health?

A lot of things we do in medicine, there's no evidence for or against it. We do it because "we've always done it this way." My interest in population health stems from my passion for caring for underserved populations. Can we do better? Unequivocally yes. Just look across our borders. We may not get our nation's health system to be less costly, but we certainly can do more to get more value out of the money we do spend.

How so?

One of the most important things we look at is how many people end up getting hospitalized. If our health care system is really firing on all cylinders, and you look at a key disease example like asthma, it should

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Population Health Interest, ... (continued)

be really, really rare that someone gets admitted for an asthma flare up. Many times, there's a failure of outpatient management, and that's not to say that the doctors are doing anything wrong. It's really a failure of our system. We're trying to fix that by figuring out better ways to manage populations of people, like those with asthma.

In the asthma example, we need to make sure patients have the knowledge and resources at their fingertips and know how to self-manage better. We're not going to prevent every asthma admission but there is probably a large percentage that probably never had to happen in the first place.

How important is primary care in this effort?

Primary care is foundational to any highly functioning health care system. Primary care can handle 90% of what walks in the door, but the system isn't always structured to allow us to operate in that way at the top of our license. So, the more we can adjust workflows and redesign clinic systems so family doctors are handling everything they can appropriately handle, then we can refer patients to specialists when necessary. It makes for a more efficient health system.

How do we address wasteful spending and procedures?

One of my key interests is overuse of health services, which leads to over-diagnosis and then to over-treatment. There's a growing realization in our health care system that we do have a tremendous amount of overuse of services. When we overuse health services, it means the recipient is getting little to no health value from the service, there is still a cost for delivering that service, and they still are exposed to the risk of harm that is inherent in the delivery of all health services. You could say that I am a therapeutic and diagnostic minimalist. I try to teach that approach to residents and students. That minimalism is also a piece of why I find it interesting to be a medical director: we try to identify those areas where we're providing services on a regular basis where there's little to no benefit, and develop approaches to reduce that low-value care.

From a health plan perspective, there are a couple of levers we have to reduce the amount of low-value care. Let's say way too many people are getting a certain pain management procedure. An example might be an epidural steroid injection of the spine to alleviate back pain. We know that the use of such procedures has exploded in recent years. To increase the chance that a given service will add health value, we can establish a prior authorization requirement so that a medical director reviews these requests to make sure they are necessary. If the request is appropriate according to clinical guidelines, then we will approve it. Many times, however, we get requests for an invasive procedure like that where the patient has not tried reasonable, conservative measures first, like a course of physical therapy.

How does your new medical director role integrate with your work at the Medical College of Wisconsin?

I practice a half day a week where I am precepting residents in the clinic setting. I've worked in the context of a residency program since the beginning of my career. I've been an academic doctor who mostly has taken care of underserved patients over the years—either uninsured, or those with Medicaid. That underserved population has been near and dear to my heart for my whole career. So, I still get to do that within the context of the residency program.

Dr. Ken Schellhase became a Senior Medical Director at the Health Plan earlier this year.

Medicare Part B Step Therapy

This year, the Health Plan implemented the Medicare Part B Step Therapy Program for WellFirst Health Advantage members. This program lists preferred drug strategies with physician-administered Part B therapies intended to improve the quality of care and lower costs for Medicare Advantage members.

Step therapy is a type of prior authorization that requires providers to try preferred therapies with their patients before non-preferred therapies, if appropriate.

The Health Plan's Medicare Part B Step Therapy program applies to members who are new to their therapy. It does not apply to members who were active users of non-preferred Part B Step Therapy medications prior to 2021. Members already on non-preferred therapies within the last 365 days can remain on their established treatment plans.

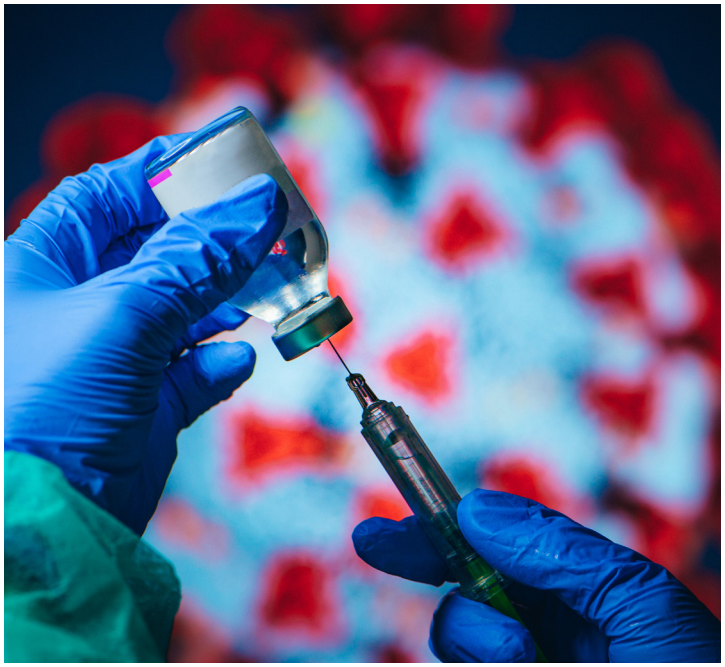
A prior authorization is required to administer a non-preferred medication. Once a prior authorization is submitted, the Health Plan will complete a 365-day lookback to determine if the drug therapy constitutes a new start of therapy. The Health Plan also uses this lookback period for new members who switch plans so as to avoid disruption in their ongoing therapies. Members and physicians can request coverage determinations and can appeal any decisions under timeframes used in CMS-regulated Part D programs with Part B Step Therapy edits.

The table lists preferred and non-preferred drugs which are subject to Medicare Part B Step Therapy program. Under the Medicare Part B Step program, providers are required to first try preferred drugs before a non-preferred drug can be prescribed for treatment.

Preferred Drugs	Non-Preferred Drugs
Herzuma, Trazimera, Kanjinti, Ogivri	Herceptin
Mvasi, Zirabev	Avastin
Truxima, Ruxience	Rituxan
Renflexis	Inflectra, Avsola, Remicade
Ziextenzo, Fulphila, Udenyca	Neulasta
Nivestym, Zarxio	Neupogen/Granix
Oral bisphosphonate trial - Part D Medication (Alendronate, Ibandronate, or Risedronate)	Prolia (for a diagnosis of osteoporosis with high risk of fractures)
Synvisc-One or Monovisc	Durolane, Glesyn-3, Supartz FX, Synvisc, Euflexxa, Gel-one, Genvisc 850, Hyalgan, Hymovis, Sodium Hyaluronate, TriLuron, TriVisc, Visco-3
Zario, Nivestym	Leukine
Fulvestrant	Faslodex
Retacrit	Procrit, Epogen

Vaccine Hesitancy and How to Address it

For WellFirst Health's service areas in Illinois and Missouri, public health data indicates different vaccination rates between counties and states. As trusted and informed health care professionals, providers play an important role in a patient's decision to receive the vaccine.



According to Illinois Department of Public Health data for early June, Madison County had 39.5% of its population fully vaccinated and St. Clair County had 37.6% of its population fully vaccinated, Missouri Department of Health and Senior Services data shows that St. Charles County and St. Louis County have some of the highest vaccination rates in the state. As reported in June, St. Charles County had the second highest vaccination rate with 39.9% of its population fully vaccinated. St. Louis County had the fourth highest vaccination rate with 38.8% of its population fully vaccinated. St. Louis City was lower on the list with 30.7% of its population fully vaccinated.

Nationally, Illinois state is listed as #20 with a vaccination rate of 85.14% of its population overall and Missouri state is listed as #31 with a vaccination rate of 81.19% of its population overall. In line with national trends, COVID-19 vaccine data in June for both states is showing a decline in the number of COVID-19 vaccine shots being administered.

Available Resources

As we continue to partner with patients/members regarding the COVID-19 pandemic, these resources can help encourage patients to weigh risk vs. reward and stay up to date on science-based vaccine information.

- American Medical Association's COVID-19 resource center for physicians
- We Can Do This – U.S. Department of Public Health and Human Resources Public education campaign for general public and providers offering fact-based information about vaccine development, safety, and effectiveness.
- Illinois Department of Public Health – includes COVID-19 updates and recent news for Illinois.
- Missouri Department of Health and Senior Services Get the Facts- includes safety and efficacy information about the COVID-19 vaccines.

Provider Network Consultant Stays Connected

Jamie Pagan

Her previous work experience as a Revenue Cycle Leader with SSM Health prepared Jamie Pagan for her current role as a Senior Provider Network Consultant (PNC). Jamie draws on her past experience with provider enrollment, claims and electronic billing in her current role. "My responsibilities included working with providers and vendors to ensure that enrollment and electronic data files were accurate and processed timely, very similar to provider setup needs in my PNC role," said Jamie. "Also, the experience gained from billing and claims follow up has proven very useful in resolving provider appeals and claim inquiries."

Jamie enjoys being part of the close-knit PNC team, a team that has been heavily involved in provider outreach and training with the launch of WellFirst Health last year. "I've really enjoyed network expansion and being able to connect with providers, establishing relationships with them, and providing them updates and education," Jamie said.

Jamie strives to be diligent in her interactions to ensure two-way communications by sharing important information from the Health Plan with providers as well as taking the time to listen to providers. And practicing kindness at every opportunity, she adds. "My goal is to end each day being able to answer the question, 'What did I do today to make things better?".

Contact the WellFirst Provider Network Consultant Team at **314-994-6262** or **ProviderRelations@wellfirstbenefits.com**.

New Member ID Cards for Health Plan Members

Copay Amounts Removed and New Wrap Network Added

WellFirst Health recently mailed new member ID cards to all members except those enrolled in a WellFirst Health Medicare Advantage plan.

Copay amounts were removed from the new member ID cards; however, group numbers and member IDs did not change. Copay amounts were removed to create space for deductible and out-of-pocket limitation amounts in preparation for the future federal No Surprises Act which mandates that these specific amounts be on member ID cards.

Current member eligibility and copay amounts are to be obtained from real-time eligibility sources only — the 270/271 Eligibility and Benefit Inquiry and Response transaction or the Eligibility application in the WellFirst Health Provider Portal. The information in these transactions also include real-time details about a member's cost share, deductible and coinsurance amounts. Providers may call our Customer Care Center at **866-514-4194** (for WellFirst Health ACA) or **877-274-4693** (for WellFirst Health SSM Health Employee Health Plan ASO) with any questions about a member's eligibility and coverage.

Additionally, effective July 1, 2021, we are changing our provider wrap networks from MultiPlan to First Health to deliver health care to members who have to seek care outside of the Health Plan's provider network service area. The new member ID cards also are updated with the First Health logo. This change does not affect WellFirst Health's primary network of providers in our online directory.

Pediatric Well-Child Check: Frequency of Coverage

The American Academy of Pediatrics (AAP) strongly supports the continued provision of health care for children during the pandemic. We appreciate your partnership in helping communicate accurate coverage information to Health Plan members and encouraging important preventive care.

WellFirst Health covers well-child checks for our pediatric members and we do not require a particular frequency between well-child visits to be fully covered. We encourage our mutual members/patients to get their children caught up with preventive care that may have been deferred at the beginning of the COVID-19 pandemic by:

- Posting reminders on social media around the importance of preventive care for children and adolescents, along with special precautions clinics are taking in light of the Coronavirus.
- Mailing childhood vaccine reminder letters to parents/guardians of children under age 2.

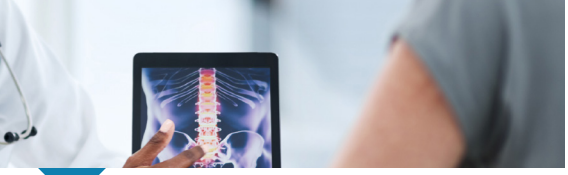
If you have questions about the frequency of covered well-child checks, please contact the Customer Care Center 866-514-4194 (TTY: 711).

Best Practices for Patients at Risk of Prescription Opioid Overdose

In 2019, opioid-related overdoses accounted for more than 49,000 deaths in the United States, according to the National Center for Health Statistics. Of those, 28% involved prescription opioids. According to NCQA.org, individuals who visit multiple prescribers and use multiple pharmacies are at higher risk of overdose. Individuals who receive opioids from four or more prescribers or four or more pharmacies, are more likely to die from opioid-related overdose than those who receive opioids from one prescriber or one physician.

Providers can help patients by:

- Coordinating care with the patient's other providers.
- Utilizing their state's prescription drug monitoring program before prescribing an opioid.
- Educating the patient regarding the safe use and risks of opioids. This includes education and access to Naloxone (Narcan®). The Centers for Disease Control and Prevention recommends anyone at increased risk for an opioid overdose should be offered a Naloxone (Narcan) prescription.



Changes to Prior Authorization for Inpatient and Outpatient Total Knee/Hip Arthroplasty

WellFirst Health's prior authorization process for inpatient and outpatient total knee arthroplasty and total hip arthroplasty procedures, as managed by NIA-Magellan Healthcare (Magellan), is being updated. Providers were sent communications regarding these changes in April.

Effective July 1, 2021:

Prior authorization will no longer be required for outpatient total knee arthroplasty and total hip arthroplasty procedures.

Prior authorization requests for inpatient total knee arthroplasty and total hip arthroplasty will be reviewed for place of service (also referred to as site of care) to ensure the appropriateness of the location, in addition to appropriateness as an inpatient service.

This prior authorization information applies to CPT codes 27447 and 27130 only; not all Musculoskeletal Care Management (MSK) procedures.

These updates apply to WellFirst Health ACA Individual, Medicare Advantage, and SSM Health Employee Health Plan Administrative Services Only (ASO) plans.

Inpatient Procedures

The Health Plan will continue to require prior authorization approval for inpatient total knee arthroplasty and total hip arthroplasty procedures. Effective for dates of service beginning on July 1, 2021, Magellan will review the place of service on prior authorization requests for inpatient total knee arthroplasty and total hip arthroplasty to determine if an inpatient setting is clinically appropriate. Magellan will continue to review these requests for medical necessity in addition to the place of service which could result in partial authorization approval (e.g., surgery is approved but not the place of service for the surgery).

The CMS 2018 Outpatient Prospective Payment System Final Rule removed total knee replacement from the Medicare inpatient-only list. Total hip replacement was also removed from the Medicare inpatient-only list starting calendar year 2020.

The Health Plan does not expect that all unilateral total knee and hip replacements will be performed on an outpatient basis. An inpatient setting may still be medically appropriate for certain patients who meet medical policy criteria, as detailed in our Total Knee and Hip Arthroplasty Ambulatory Level of Care, Medical Policy 9550.

Intraoperative Findings

If additional services beyond those authorized are rendered due to a finding during the surgery or a change in condition following the surgery, Magellan's Call Center at **866-307-9729** must be notified within seven business days of the date of the surgery. At that time, clinical information to support medical necessity of the additional services will be required.

Prior Authorization Request Submissions

Providers should continue to submit inpatient prior authorization requests for total knee and hip replacements to Magellan through its portal at **RadMD.com** or by calling toll-free at **866-307-9729**.

Outpatient Procedures

Effective July 1, 2021, the Health Plan will no longer require prior authorization approval for outpatient total knee arthroplasty (CPT code 27447) and total hip arthroplasty (CPT code 27130) procedures. This includes authorizations for medical necessity and place of service (also referred to as site of care). Outpatient includes the following level of care designations:

- Outpatient observation
- Outpatient ambulatory (same day) care
- Hospital outpatient day surgery (HOPD) overnight

If a patient develops intra-operative or post-operative complications and needs to move to an inpatient setting, the facility must notify WellFirst Health of the inpatient admission, per the current process for outpatient surgeries. Failure to do so may affect claim payments.

See our inpatient total knee and total hip prior authorization resources on our Musculoskeletal (MSK) Program web page for more information.

Provider Portal Maintenance

The Health Plan has updated the Provider Portal maintenance schedule to include the first Sunday of the month, as shown in the grid below. These standing maintenance windows are used for system updates and general maintenance, only when necessary. Because some portal applications or functions may not be available to providers during these maintenance windows, scheduled maintenance occurs on weekends or after hours to minimize provider disruption.

Occasionally, planned system updates or maintenance is necessary outside of the maintenance schedule. In these instances, flash messages are posted in Portal accounts in advance indicating when the downtime is planned and which applications or functionality will be unavailable during that time.

When system updates or maintenance is needed unexpectedly, flash messages are posted in Portal accounts, when possible, depending on the nature of the issue.

Day	Time
Every Thursday	8 p.m. – 11 p.m.
First Sunday of the month	8 p.m. Sunday – Midnight Monday
Third Saturday of the month	8 p.m. Saturday – 2 a.m. Sunday
Third Sunday of the month	6 p.m. Sunday – Midnight Monday

RadMD
the imaging experts

RadMD Enhancements

NIA-Magellan Healthcare (Magellan) has made enhancements to its portal for prior authorization submissions. Now, when submitting authorizations requests through RadMD, providers can drag and drop records and upload multiple records where they could not before. Providers can also access Clinical Training modules.

While providers are encouraged to submit all of their authorization requests electronically, faxes will continue to be accepted.

Termination of Doctor/Patient Relationship

Practitioners sometimes feel it is necessary to terminate a relationship with a patient. WellFirst Health has an established policy for this, as part of our contract with providers while assuring continuity of care for the member.

A practitioner may terminate such care only for good cause, as determined by the Health Plan. Information regarding this process can be found in the Provider Manual.

Foodsmart. Eating healthy made simple.

Your patients are unique, so the nutritional advice and plan they need should be as well. Supplementing your clinical advice with a recommendation of the Foodsmart app can help patients get personalized nutritional guidance to keep healthy eating on track, makes your clinical advice applicable and helps build healthier habits.

Foodsmart helps simplify the process through nutrition assessments. The NutriQuiz tool takes patients through a detailed assessment of what they are currently eating and suggests what could change their diet to be healthier. It accounts for intolerances like gluten, milk and others disease factors like diabetes and heart disease.

The app also helps your patients create a meal planner for themselves and their families. As you've probably heard often, time is a barrier for creating healthy habits. What's great about Foodsmart is the ability to meal plan and turn the recipe into a digital grocery list instantly. Your patients can do the shopping themselves or have their groceries delivered.

Of more than 1 million Foodsmart users*:

- More than 400,000 **improved their nutrition**
- 235,000 have **lost weight**
- More than 200,000 **improved a clinical condition** such as diabetes, high blood pressure or obesity

Foodsmart's platform provides patients with a tool to support their clinical guidance and care plan for healthy eating that is easy, affordable and accessible. Learn more about the app and success stories at wellfirstbenefits.com/foodsmart.

Download and navigate the Foodsmart app to discover what your patients can do to help strengthen their nutrition. ⊕

**Zipongo, Inc. D/B/A Foodsmart; May 2020.*

Refer Older Patients for Medicare Dental Benefit

Tooth decay is the most common chronic disease among those 65 and older, which is one reason why regular dental check-ups are so important. WellFirst Health Advantage members have dental benefits through Delta Dental. We cover two routine preventive oral dental exams and cleanings per calendar year at no cost for our members. Additionally, members with cancer-related treatments, weakened immune systems, periodontal disease, high-risk cardiac conditions, kidney failure and diabetes may be eligible for up to two additional cleanings and one fluoride treatment per calendar year. Medicare members can visit any dentist in the Delta Dental Medicare Advantage network. ⊕

Freedom from Smoking Program Highly Recommended

Tobacco use is a powerful addiction. It may seem impossible to kick the habit, but thousands quit every year and your patients can, too. Once they make the decision to quit, WellFirst Health can help them along the path to success.

As part of member health benefits, we offer a virtual tobacco program called Freedom from Smoking. This small group program includes eight one-hour sessions led by a certified Freedom-from-Smoking facilitator. The program features a step-by-step plan for helping all tobacco users quit, whether they use cigarettes, smokeless e-cigarettes or vaping.

Each session is designed to help tobacco users understand their triggers and urges. These sessions also help participants develop coping strategies to stay committed to quitting. This engaging program uses a variety of evidence-based techniques to personalize and address individual needs along with the benefits of support from the group. Medications and nicotine-replacement therapy are also available at no cost for plan members.

Providers can refer any patient to the Freedom from Smoking program as it is not limited to WellFirst Health members.

Positive feedback from participants

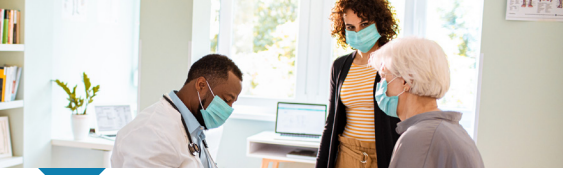
The Health Plan started offering the Freedom from Smoking program early this year. Since then, we have received positive feedback from participants:

"I have tried different approaches and therapies to quit using tobacco in the past, and this was the most successful one. I found the class sessions to be very supportive, both by the counselors and the fact I was going though it with my friends and coworkers. I'm proud to say that I'm still tobacco-free today. It worked!"

"This class is amazing! The instructors show compassion and are willing to do whatever it takes to help you succeed. They are in your corner for sure!"

"This was an amazing experience. The educators shared so many helpful tools to ensure our success. They also taught us to show compassion to ourselves, such a valuable lesson and one that I will continue to practice."

For the schedule of upcoming dates and locations, call 608-827-4344 (833-934-0987 – toll free) or email wellness@wellfirstbenefits.com wellfirstbenefits.com/quitnow.



Statins Beneficial for Eligible Patients with Diabetes or Cardiovascular Disease

The American College of Cardiology/American Heart Association guidelines recommend the use of moderate- or high-intensity statin drug therapy for adult patients with:

- Established atherosclerotic cardiovascular disease (ASCVD)
- Diabetes, when age 40-75 and an LDL-C ≥ 70 mg/dL

Based on these recommendations, accreditation and regulatory bodies like National Committee for Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS) have developed the Statin Use in Persons with Diabetes (SUPD) and Statin Therapy for Patients with Cardiovascular Disease (SPC) quality measures to ensure patients receive the most appropriate drug therapy. One of the follow statins must be prescribed in the measurement year to meet requirements in the chart on the right.

We encourage providers to assess the risks and benefits of adding a statin to their patients' drug regimen and provide education on the benefits of statin therapy. The Health Plan will contact providers with patients who may benefit from adding a statin to their drug regime.

Drug Category	Medications
High-intensity statin therapy	Atorvastatin 40-80 mg* Rosuvastatin 20-40 mg Simvastatin 80 mg*
Moderate-intensity statin therapy	Atorvastatin 10-20 mg* Rosuvastatin 5-10 mg* Simvastatin 20-40 mg* Pravastatin 40-80 mg* Lovastatin 40 mg* Fluvastatin 40-80 mg Pitavastatin 2-4 mg
*Health Plan covers at the lowest (Tier 1) cost share or $0 cost share. Other therapies may be covered at a higher cost share.	

Pharmacy and Therapeutics / Drug Policy / Formulary Change Update Highlights

Highlights of recent drug policy revisions, as well as any new drug policies approved by WellFirst Health's Medical Policy Committee, are shown below. *Drug policies are applicable to all WellFirst Health products, unless directly specified.* **Note: All changes to the policies may not be reflected in the written highlights below.** We encourage all prescribers to review the current policies.

All drugs with documented Health policies must be prior authorized by sending requests to Navitus, unless otherwise noted in the policy. Most drugs noted below and with policies require specialists to prescribe and request authorization.

Policies regarding medical benefit medications may be found on wellfirstbenefits.com. From the home page, select the drop down from the **I am a...** screen to **Provider** and then to **Pharmacy Services**. Under **Up to Date Drug Policies**, click **See Library** and enter the drug name or assigned policy number into the **Search** for field.

Criteria for pharmacy benefit medications may be found on the prior authorization form located in the Navitus provider portal. Pharmacy benefit changes may be found on wellfirstbenefits.com. From the home page, drop down from the **I am a...** screen to **Provider** and then **Pharmacy Services**. Under **Covered Drugs/Formulary** there is a change notices link below each formulary.

Please note that the name of the drug (either brand or generic name) must be spelled completely and correctly when using the search bar. Medical injectable drugs may also be searched using the appropriate J-code (e.g., J9301 for Gazyva).

New Drug Policies

ACTHAR Gel (repository corticotropin injection) MB2103

Effective May 1, 2021, ACTHAR Gel, which is used to treat infantile spasms for infants and children under 2 years of age, exacerbations of multiple sclerosis (MS) in adults, and 17 other "labeled" uses. Will require prior authorization and is restricted to neurologist prescribers.

BELEODAQ (belinostat) MB2100

Effective July 1, 2021, BELEODAQ, which is used for treatment of relapsed or refractory peripheral T-cell lymphoma (PTCL) will require a prior authorization. It is restricted to oncology prescribers.

BLINCYTO (blinatumomab) MB2101

Effective July 1, 2021, BLINCYTO, which is used for treatment of MRD-positive B-cell Precursor acute lymphoblastic leukemia (ALL) and Relapsed or refractory B-cell Precursor (ALL) will require a prior authorization. It is restricted to oncology prescribers.

ERBITUX (cetuximab) MB2102

Effective July 1, 2021, ERBITUX, which is used for treatment of Squamous Cell Carcinoma of the Head and Neck (SCCHN) and K-Ras Wild-type and EGFR-expressing Colorectal Cancer (CRC). Will require a prior authorization and It is restricted to oncology prescribers.

CEREZYME® (imiglucerase) (Intravenous) MB2104

Effective July 1, 2021, CEREZYME, which is used for treatment of Gaucher disease type 1, will require a prior authorization. It is restricted to medical geneticist or other prescriber specialized in the treatment of Gaucher DX.

ELAPRASE® (idursulfase) (Intravenous) MB2105

Effective July 1, 2021, ELAPRASE, which is used for treatment of Mucopolysaccharidosis II (Hunter syndrome), will require a prior authorization. It is restricted to medical geneticist or other prescriber specialized in the treatment of mucopolysaccharidosis II.

ELELYSO® (taligucerase alfa) (Intravenous) MB2106

Effective July 1, 2021, ELELYSO, which is used for treatment of Gaucher disease type 1, will require a prior authorization. It is restricted to medical geneticist or other prescriber specialized in the treatment of Gaucher DX.

EVRYSDI (risdiplam) MB2111

Effective July 1, 2021, EVRYSDI, which is used for treatment of spinal muscular atrophy (SMA) in patients 2 months of age and older, will require a prior authorization. It is restricted to pediatric neurologist at a Muscular Dystrophy Association care center.

LUMIZYME® (alglucosidase alfa) (Intravenous) MB2107

Effective July 1, 2021, LUMIZYME, which is used for treatment of Pompe Disease (Acid Alpha glucosidase (GAA) deficiency), will require a prior authorization. It is restricted to medical geneticist or other prescriber specialized in the treatment of Pompe DX.

NAGLAZYME® (galsulfase) (Intravenous) MB2108

Effective July 1, 2021, NAGLAZYME, which is used for treatment of Mucopolysaccharidosis VI (MPS VI), will require a prior authorization. It is restricted to medical geneticist or other prescriber specialized in the treatment of mucopolysaccharidosis VI.

VIMIZIM® (elosulfase) (Intravenous) MB2109

Effective July 1, 2021, VIMIZIM, which is used for treatment of Mucopolysaccharidosis IV type A (Morquio syndrome), will require a prior authorization. It is restricted to medical geneticist or other prescriber specialized in the treatment of mucopolysaccharidosis IVA.

VPRIV® (velaglucerase alfa) (Intravenous) MB2110

Effective July 1, 2021, VPRIV, which is used for treatment of Gaucher disease type 1 and will require a prior authorization. It is restricted to medical geneticist or other prescriber specialized in the treatment of Gaucher DX.

Medically Administered Oncology Products MB2112

Effective September 1, 2021, new overarching oncology policy replacing most of the individual policies. Prior authorization is required and is restricted to oncology prescribers.

Changes to Drug Policy

EVENITY (romosozumab-aqqg) MB1940

Effective April 1, 2021, updated ST bypass criteria through Prolia based on updated guidelines, this allows for more exceptions. Will require prior authorization and is restricted to endocrinology or rheumatology prescribers.

FABRAZYME (agalsidase) MB9300

Effective May 1, 2021, updated policy due to taking other drugs in class to P&T Committee. Prior authorization is required and is restricted to medical geneticist or other prescriber specialized in the treatment of Fabry DX.

ALDURAZYME (laronidase) MB9400

Effective May 1, 2021, updated renewal authorization criteria and quantity limits in alignment with policies for other “zyme” drugs. Prior authorization is required and is restricted to medical geneticist or other prescriber specialized in the treatment of mucopolysaccharidosis I.

BLENREP (belantamab mafodotin-blmf) MB2012

Effective June 1, 2021, updated policy with age limit removed and updated HCPCS code to J9037. Prior authorization is required and is restricted to oncology prescribers.

BOTULINUM TOXIN MB9020

Effective August 1, 2021, added quantity limits to BOTOX J0585. Prior authorization is required.

Immune Globulin MB9423

Effective June 1, 2021, statement added that Asceniv is now not covered and clarification to code J1566. Prior authorization is required and is restricted to medically appropriate for the treatment of the following indications when the listed criteria have been met.

LIBTAYO (cemiplimab) MB1901

Effective May 1, 2021, removal of age limit criteria and two new FDA approved indications added per label. Prior authorization is required and is restricted to oncology prescribers.

Monjuvi (tafasitamab – CXIX) MB2016

Effective June 1, 2021, updated HCPCS code to J9349. Prior authorization is required and it is restricted to oncology prescribers.

ZOLGENSMA (onasemnogene abeparvovic-xioi) MB1941

Effective May 1, 2021, updated to change Risdiplam to document under Spinraza. Prior authorization is required and is restricted to a neurologist with expertise in the diagnosis of spinal muscular atrophy (SMA).

BENLYSTA IV (belimumab) MB1820

Effective May 1, 2021, removal of exclusion criteria of active lupus nephritis and CNS lupus. Prior authorization is required and is restricted to rheumatology or dermatologist prescriber.

OCREVUS (ocrelizumab) MB9941

Effective August 1, 2021, updated formatting and clarifying continuation criteria as provider attestation of disease improvement or stabilization, and addition of testing quantitative serum immunoglobulins in initial and continuation criteria. Prior authorization is required and is restricted to neurology prescribers.

LEMTRADA (alemtuzumab) MB9468

Effective May 1, 2021, updated formatting and changed continuation of therapy requirement of medical documentation of disease stability to provider attestation. Prior authorization is required and is restricted to neurology prescribers.

SINUVA (mometasone furoate) MB1833

Effective April 1, 2021, updated HCPCS code to J7402. Prior authorization is required and it is restricted to ENT prescribers.

TECARTUS (brexucabtagene autoleucel) MB2013

Effective June 1, 2021, updated HCPCS code to Q2053. Prior authorization is required and it is restricted to oncology prescribers.

RITUXIMAB-CONTAINING PRODUCTS MB9847

Effective May 1, 2021, updated criteria of adding off labeled use for MS. Prior authorization is required and is restricted to rheumatology, transplant, hematology, neurology, dermatology, ENT or oncology prescribers.

BEOVU (brolucizumab-dbll) MB1944

Effective May 1, 2021, removal of age limit criteria. No prior authorization is required.

EPOETIN ALFA PRODUCTS MB9715

Effective May 1, 2021, updated changes to clarify diagnoses. Prior authorization is required and is restricted to oncology, infectious disease, hematology, or nephrology prescribers.

EYLEA (aflibercept) MB1840

Effective May 1, 2021, removal of age limit criteria. No prior authorization is required.

BOTULINUM TOXIN MB9020

Effective June 1, 2021, dose limits added to non-botox drugs. Prior authorization is required.

CINQAIR (reslizumab) MB1811

Effective June 1, 2021, adoption of Navitus policy. Prior authorization is required and is restricted to pulmonology, allergy and immunology specialists.

FASENRA (benralizumab) MB1813

Effective June 1, 2021, adoption of Navitus policy. Prior authorization is required and is restricted to pulmonology, allergy and immunology specialists.

FLOLAN/VELETRI (epoprostenol sodium), REMODULIN (treprostinil) MB1934

Effective June 1, 2021, adoption of Navitus policy. Prior authorization is required and is restricted to cardiologist or pulmonologist.

NUCALA (mepolizumab) MB9914

Effective June 1, 2021, adoption of Navitus policy. Prior Authorization is required and Eosinophilic asthma: restricted to pulmonologists, immunologists or allergists; Eosinophilic granulomatosis with polyangiitis (EGPA): restricted to pulmonologists, immunologists, allergists, or rheumatologists; and Hyperesosinophilic syndrome (HES): restricted to pulmonologists, immunologist, allergists, rheumatologist, gastroenterologist, hematologist, or and other specialist experienced with diagnosis.

LIBTAYO (cemiplimab) MB1901

Effective June 1, 2021, adoption of Navitus policy. Prior authorization is required and is restricted to oncology prescribers.

XOLAIR (omalizumab) MB9309

Effective June 1, adoption of Navitus policy. Prior authorization is required and is restricted to allergy, pulmonary, immunology, otolaryngologist, or dermatology prescribers.

OPDIVO (nivolumab) MB1844

Effective June 1, 2021, adoption of Navitus policy. Prior authorization is required and is restricted to oncology or hematology prescribers.

SPRAVATO (esketamine) MB1921

Effective June 1, 2021, removal of psychiatric nurse PR actioner from allowed prescriber and adding Electro Convulsive Therapy as a step. Prior authorization is required and is restricted to psychiatrist prescribers.

Retired Policies, effective September 1, 2021

The drug policies listed below will be retired, but not the drugs themselves. The following drugs will remain covered, but under Medically Administered Oncology Products Medical Policy #2112:

- **ABRAXANE (paclitaxel albumin-bound) MB1801**
- **ADCETRIS (brentuximab-vedotin) MB1945**
- **ALIMTA (pemetrexed for injection) MB1837**
- **BELEODAQ (belinostat) MB2100**
- **Bendamustine Products MB1917**
- **BLINCYTO-blinatumomab MB2101**
- **CYRAMZA (ramucirumab) MB1918**
- **EMPLICITI (elotuzumab) MB1906**
- **ENHERTU (fam trastuzumab deruxtecan nxki) MB2007**
- **Monjuvi (afasitamab-CXIX) MB2016**
- **PADCEV (enfortumab vedotin-ejfv) MB2010**
- **SARCLISA (isatuximab) MB2004**
- **TRODELVY (sacituzumab govitecan) MB2009**
- **VECTIBIX (panitumumab) MB1810**
- **VELCADE (bortezomib) MB1922**

Medical Policy Updates

Highlights of recent medical policy revisions, as well as any new medical policies approved by WellFirst Health's Medical Policy Committee, are shown below. The Medical Policy Committee meetings take place monthly. We appreciate contributions by specialists during the technology assessment of medical procedures and treatments.

To view all of the Health Plan's medical policies, visit wellfirstbenefits.com, ➤ For Providers, and then ➤ Medical Management ➤ Search Medical Policies. wellfirstbenefits.com is updated as the medical policies become effective. For questions regarding any medical policy or if you would like copies of a complete medical policy, please contact our Customer Care Center at **866-514-4194**.

All other WellFirst Health clinical guidelines used by the Health Services Division, such as MCG (formerly known as Milliman) and the American Society of Addiction Medicine, are accessible to the provider upon request. To request the clinical guidelines, contact the Health Services Division at **800-356-7344, ext. 4012**.

General Information

Coverage of any medical intervention discussed in a WellFirst Health medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate and applicable state and/or federal laws. A verbal request for a prior authorization does not guarantee approval of the prior authorization or the services. After a prior authorization request has been reviewed in the Health Services Division, the requesting provider and member are notified. Note that prior authorization through the Health Plan Health Services Division is required for some treatments or procedures.

Prior authorization requirements for self-funded plans (ASO) may vary. Please refer to the member's Summary Plan Document or call the Customer Care Center number found on the member's card for specific prior authorization requirements.

For radiology, physical medicine and musculoskeletal surgery prior authorizations, please contact National Imaging Associates (NIA)/Magellan.

Radiology

Providers may contact NIA by phone at **866-307-9729**, Monday-Friday from 7 a.m. to 7 p.m. CST or via **RadMDSupport@MagellanHealth.com**. View details about the radiology prior authorization program on wellfirstbenefits.com.

Physical Medicine

Providers can contact NIA by phone at **866-307-9729** Monday-Friday from 7 a.m. to 7 p.m. CST or by email at **RadMDSupport@MagellanHealth.com**. View details about the physical medicine prior authorization program on wellfirstbenefits.com.

Musculoskeletal

Providers can contact NIA by phone at **866-307-9729** Monday-Friday from 7 a.m. to 7 p.m. CST or by email at **RadMDSupport@MagellanHealth.com**. View details about the musculoskeletal prior authorization program on wellfirstbenefits.com.

General Information

Technology Assessments

The following are considered experimental and investigational, and therefore not medically necessary:

- Intraosseous nerve ablation (e.g., Intracept) for chronic low back pain
- Esophageal mucosal integrity testing by electrical impedance (e.g., MiVu)
- Preterm labor predictive risk stratification (e.g., PreTRM)
- Trigeminal nerve stimulation system, non-implantable (e.g., eTNS)

Revised Medical Policies

Effective March 1, 2021

Breast Surgeries MP9026

Women age 50 and older are required to have a mammogram that was negative for cancer performed within two years prior to the date of the planned reduction mammoplasty. Surgery is considered medically necessary if pain symptoms have persisted despite a three-month trial of therapeutic measures.

Reduction mammoplasty or mastectomy for the surgical treatment of gynecomastia is considered medically necessary when gynecomastia did not regress after cessation of medications known to cause the condition, or medications cannot be discontinued. Prior authorization is required.

Pressure Reducing Support Surfaces MP9494

Group 2 support surfaces (e.g., power pressured reducing mattresses) are considered medically necessary when the following criteria are met: The member has multiple Stage II pressure ulcers on the trunk or pelvis which have failed to improve with a comprehensive ulcer treatment program over the last 30 days. The member has large or multiple Stage III and Stage IV pressure ulcers located on the trunk or pelvis. The member had a myocutaneous flap or skin graft on the trunk or pelvis within the past 60 days and the member has been on a Group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within 30 days. Prior authorization is required.

Genetic Testing for Stickler Syndrome MP9504

Stickler syndrome sequencing panel requires prior authorization and is considered medically necessary when two or more of the following are met: ocular findings including vitreous changes, retinal tears or retinal abnormalities; high-frequency sensorineural hearing loss and/or frequent ear infections; characteristic facial features including midfacial underdevelopment, malar hypoplasia, broad or flat nasal bridge and micro/retrognathia; cleft palate; or skeletal findings including slipped epiphysis or Legg-Perthes-like disease, scoliosis, spondylolisthesis, or Scheuermann-like kyphotic deformity.

Effective April 1, 2021

Bone Anchored Hearing Aid System (BAHAS) MP9018

The initial percutaneous or subcutaneous surgery and replacement for members age five and older requires prior authorization. Surgery is considered medically necessary for either of the following: bilateral or unilateral conductive or mixed hearing loss greater than 20 dBHL for the four (4) frequency pure tone average (PTA) of 500, 1000, 2000 and 3000 Hz or equivalent from Auditory Brainstem Response (ABR).

A bone anchored hearing aid system is considered medically necessary for unilateral sensorineural hearing loss (single sided deafness) when the following are met: bone conduction four (4) frequency PTA of 500, 1000, 2000, and 3000 Hz of the better ear less than or equal to the level appropriate for the model being implanted and an air conduction hearing aid would not allow for substantial improvement.

Enteral Therapy MP9069

A digestive enzyme cartridge (e.g., RELiZORB) is considered medically necessary for members with cystic fibrosis on enteral feedings.

Hospital Grade Breast Pumps MP9092

The purchase of one manual breast pump (E0602) or one personal-use electric breast pump (E0603) per birth may be requested up to four weeks prior to the member's estimated delivery date or prior to the infant's adoptive date if the member's certificate or benefit plan allows.

Hearing Aids MP9445

The Hearing Level Assessment tool is optional when requesting prior authorization for all adults age 18 and older. Prior authorization is not required for members through age 18.

Genetic Testing for Reproductive Carrier Screening and Prenatal Care MP9477

Sequencing-based non-invasive prenatal testing (NIPT) does not require prior authorization. Testing is considered medically necessary as a screening tool for trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome) or trisomy 13 (Patau syndrome) for members with a singleton pregnancy equal to or greater than ten weeks gestation.

NIPT is considered experimental and investigational, and therefore not medically necessary for the following: screening for microdeletions; screening for autosomal trisomies other than 13, 18, and 21; prenatal cell-free DNA testing for single gene conditions; screening for a sex-chromosome aneuploidy; vanishing twin syndrome; whole genome NIPT, when used to determine the genetic cause of a miscarriage or screening for non-medical traits.

Predictive algorithm reported as a risk score for preeclampsia (e.g., PIGF Preeclampsia Screen) is considered experimental and investigational, and therefore not medically necessary.

Effective May 1, 2021

Vagus Nerve Stimulation MP9232

Noninvasive vagus nerve stimulation (e.g., GammaCore Sapphire D) is considered experimental and investigational, and therefore not medically necessary for any indication.

Prostate Treatment MP9361

Prostatic urethral lift (e.g., UroLift) is considered medically necessary for the treatment of symptomatic benign prostatic hyperplasia (BPH) including lateral and median lobe hyperplasia when all of the following criteria are met: member is age 45 or older; estimated prostate volume is less than 100 cc; failure, contraindication, or intolerance to at least three months of conventional medical therapy.

Effective September 1, 2021

Hospital Beds MP9292

A variable-height hospital bed is considered medically necessary if the member requires a bed height other than a fixed-height bed to permit transfers to a chair, wheelchair or standing position. A semi-electric hospital bed is considered medically necessary if the member requires frequent changes in body position; and/or has an immediate need for a change in body position; and the member is able to operate the bed controls for adjustment. A heavy-duty, extra wide bed is considered medically necessary if the member's weight is more than 350 lbs. but less than 500 lbs. An extra-heavy-duty bed is medically necessary if the member's weight is more than 600 lbs. Trapeze equipment and bed cradles are considered medically necessary when criteria have been met for a hospital bed, and there is documentation to support the medical necessity. Prior authorization is required.

The following types of beds are considered not medically necessary and inappropriate for use in the home setting: institutional, kinetic therapy, oscillating, Stryker frame and continuous lateral rotation beds. ⊕

Notification Necessary for Provider Demographic Changes

WellFirst Health is committed to ensuring accurate provider information is displayed within its provider directories. As a health plan, we are required to keep provider information up to date by CMS and other regulatory and accreditation entities.

To ensure we have the most current, accurate provider information available for our members, we require providers to notify their designated Provider Network Consultant as soon as staff are aware of any of the following changes:

- Ability to accept new patients
- Practicing address
- Phone number
- Provider terminations
- Other changes that affect publicly posted provider accessibility and demographics information. This includes, but is not limited to:
- Practice location's handicap accessibility status
- Hospital affiliation
- Provider specialty
- Languages spoken by provider
- Provider website URL

The Health Plan is committed to ensuring that we present accurate provider information. Communication between the health plan and providers will assist in maintaining excellent quality of care and customer service to our members and patients.

Please review the current listing of practitioners and locations included in the online provider directory at wellfirstbenefits.com/find-a-doctor to ensure we are posting the most current information for you.

WellFirst Health *Provider News*

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Improving Access to Palliative Care

Effective July 1, 2021, WellFirst Health will waive member copay for ambulatory palliative care provider visits. Palliative care prioritizes patient preferences, dignity, comfort, and quality of life for those members facing an advanced illness. Benefits of care with a palliative care provider include:

- Specialized care for patients at a vulnerable time
- Enabling individuals to stay in the comfort of their own home longer, decreasing hospital stays, emergency room visits and ventilator use when possible
- Improved pain management
- Lower costs

This change will apply to all Health Plan products.

In addition, the Health Plan is developing a palliative care benefit for 2022 to include home nurse and social work visits.

Member certificates of coverage for eligible members will be updated for palliative care coverage in 2022.

Pandemic Calls Out Importance of Advance Directive

"Contemplating one's death may be the most profound form of meditation. Death is the backdrop of life, and at times like this it comes to the fore."

THIS PANDEMIC IS PERSONAL, IRA BYOCK, MD

The COVID-19 pandemic has reinforced the importance of expressing our end-of-life wishes with loved ones and providers to ensure we are better prepared in the case of a sudden accident or serious illness. These conversations are often uncomfortable to navigate for patients and families as well as for the health care professionals who are in the critical role of initiating and facilitating these conversations.

Advance Care Planning is the process of thinking about what matters most to us at the end of life, communicating our values and preferences to loved ones, physicians and spiritual advisers and documenting those wishes in legal documents called Advance Directives. It is important for all adults over age 18 to be educated about Advance Care Planning. For patients who have an Advance Directive in place and have communicated their wishes, the likelihood of family disagreement is greatly reduced and end-of-life care better aligns with expressed values and preferences. This pre-planning creates comfort to patients, the medical team and lessens burden on families. This past year has shown us the fragility of life and that advance care planning is more important than ever.

The Advance Directive is a legal document that allows a person to list one or more people as health care agents to speak for them if they are unable to make their own decisions and allows individuals to document their end-of-life preferences.

The Health Plan offers an Advance Care Planning Program with social workers who provide education and support with navigating the planning process. Social workers provide the following services:

- One-on-one phone support to provide Advance Care Planning education and assistance with completion of Advance Directives and facilitation of this conversation.
- Present educational sessions to members and the community.
- Organize system-wide events for National Health Care Decisions Day (April 16th).

Providers can learn more about Advance Care Planning.

Referrals Are Easy!

Providers/Clinic Care Managers

Refer via **608-827-4312**

Members can self-refer online at wellfirstbenefits.com/wellness/care-management or by calling the Advance Care Planning Line at **608-828-1915** or Customer Care Center number on the back of their membership card.

Many preventive care services are covered by us at no cost to your patients. Here are just a few.

Annual Preventive Visits

All ages are recommended to have an annual provider visit.

Covered at: **$0**

Patients who need a PCP can call our Customer Care Team or visit deancare.com/doctors to get one.

Breast Cancer Screening

Screening Age*: **40-74**

Screening Mammogram Covered at: **$0**

**We cover breast cancer screenings beginning at age 40.*

Colorectal Cancer Screenings**

Screening Age: **45-75**

Covered at: **$0**

- Colonoscopy every 10 years
- Sigmoidoscopy every 5 years
- FIT/FOBT test covered once every year
- FIT-DNA Cologuard once every 3 years

***Talk with your patients about which option is right for them.*