Provider NEWS

WellFirst Health®

Winter 2021
A newsletter for WellFirst Health providers

Coverage for Echocardiograms to Align with Medicare Standards

Alleviating administrative burden for providers while still supporting clinically appropriate care for our members.

WellFirst Health is updating our policy for covering echocardiograms, Echocardiogram and Stress Echocardiography MP9513, to be more consistent with Wisconsin Medicare Local Coverage Determinations (LCDs). This change became effective, December 1, 2021, and is in direct response to provider requests.

This policy change applies to:

- Transthoracic Echocardiogram (TTE)
- Transesophageal Echocardiogram (TEE)
- Stress Echocardiography

While the changes to the clinical content are minimal, WellFirst Health has expanded our list of allowable diagnoses to include those found in the CMS Articles associated with the echocardiogram LCDs. Accurate diagnosis coding is still critical to the appropriate processing of claims. Claims submitted without an allowable diagnosis will not be reimbursed. Any diagnosis reported on the claim must still be supported by the clinical documentation and available upon request.

Echocardiograms do **not** require prior authorization. However, all charges for echocardiograms billed to WellFirst Health are expected to meet the clinical criteria outlined in the medical policy.

This Issue

Illinois-Mandated Changes for ACA Plans in 2022

In compliance with Illinois-mandated requirements, WellFirst Health is adjusting review processes for authorization requests and implementing discharge notification timelines for substance use disorder treatment, both for members enrolled in an Illinois WellFirst Health ACA Plan. The Prior Authorization Reform Act (Illinois House Bill 711) establishes prior authorization standards that health plans must follow when requiring prior authorization for coverage of health care services. The Generally Accepted Standards of Behavioral Health Care Act of 2021 requires health plans to cover medically necessary mental health care and codify standards in making medical necessity determinations.

These changes specifically apply to WellFirst ACA plans in Illinois only, not to WellFirst Health ACA plans in Missouri. These changes also do not apply to WellFirst Health Medicare Advantage plans or the WellFirst Health SSM Employee Health Plan.

Authorization Review

Effective January 1, 2022, WellFirst Health authorization approvals for members enrolled in a WellFirst ACA plan in Illinois will remain valid for the lesser of either 12 months from the date the health care provider received the prior authorization approval or the length of treatment, as determined by the patient's health care provider.

For urgent requests, WellFirst Health will render a determination within 48 hours once all necessary information for the request is received. For non-urgent requests WellFirst Health will render a determination within 5 calendar days once all necessary information for the request is received.

Notification for Substance Use Disorder Treatment

Also, effective January 1, 2022, substance use disorder treatment providers or facilities must provide WellFirst Health at least 7 days advance notice of a planned discharge date from substance use disorder treatment for WellFirst Health ACA members. Additionally, the substance use disorder treatment provider or facility must provide notice to WellFirst Health on the day that the patient is discharged.

Virtual Tobacco Program Offers a Way Out of Dependency

Smoking, vaping or chewing tobacco can seem too powerful to stop. Studies show thousands of individuals quit every year and your patients can, too. Once they make the decision to quit, WellFirst Health can help them move along the path to success.

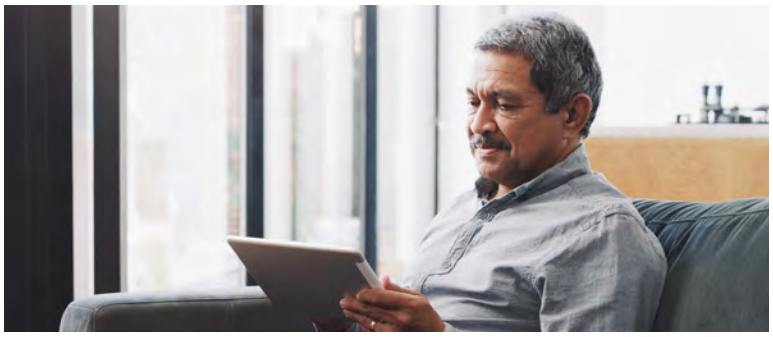
As part of their health benefit, WellFirst Health offers a virtual tobacco program called Freedom from Smoking. This small-group program includes eight one-hour sessions led by a certified Freedom from Smoking facilitator. The program features a step-by-step plan for helping all tobacco users quit, whether they use cigarettes, smokeless e-cigarettes or vaping. Each session is designed to help tobacco users understand their triggers, urges and 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. Freedom from Smoking is open to WellFirst Health members and community members (WellFirst Health insurance not required).

Group members have shared with facilitators that they appreciate the different tools and strategies they learn not only from the facilitator, but from the other participants. Often times, the group members share contact information in order to support one another through their quit journey. "It's so inspiring to see group members support one another throughout the program," said a Freedom from Smoking facilitator. "And to see people meeting their goals."

For the schedule of upcoming dates and locations, call **866-896-4602** or visit wellfirstbenefits.com.

Medicare Corner

Welcome to the Medicare Advantage Corner! This section of the newsletter highlights information about our Medicare Advantage plans. Look for the Medicare Advantage Corner in future newsletter issues.



Medicare Advantage Preferred Pharmacy Network

The 2022 Medicare Advantage preferred pharmacy network will be comprised of Walgreens, Walmart, Costco, SSM Pharmacies, and CPESN. CVS will no longer be part of the preferred pharmacy network but will be part of the standard network.

Medicare Advantage 2022 Formulary

WellFirst Health Medicare Advantage plans provide comprehensive prescription drug coverage. The WellFirst Health Medicare Advantage 2022 Formulary is now available on the WellFirst Health formulary web page. The 2022 formulary includes updates to coverage, some of the which are listed in the table below. This is not an exhaustive list as our drug formulary covers a wide-ranging list of generic, brand name and specialty drugs.

Providers are encouraged to review the formulary in its entirety to assess any updates that may affect their patients in 2022. Additionally, please refer to the Part D benefits and drug list/formulary section on the WellFirst Health Advantage Members web page for more prescription drug information for WellFirst Health Medicare Advantage.

Some 2022 Formulary Changes with Alternative Drugs	
Not Covered in 2022	**Alternative Covered in 2022**
AMPHETAMINE/DEXTROAMPHETAMINE ER, DEXMETHYLPHENIDATE HYDROCHLORIDE ER, and METHYLPHENIDATE HCL ER	modafinil, armodafinil, amphetamine IR, and methylphenidate IR
BYETTA®	Trulicity®, Ozempic®, and Rybelus®
PRALUENT®	Repatha®
TRADJENTA®	Glyxambi® and Truardy® ER
TRAMADOL HCL ER and XTAMPZA® ER	morphine, codeine, methadone, fentanyl, tramadol, oxycodone IR, and oxycodone/acetaminophen
WIXELA® INHUB/fluticasone/salmeterol inhaler	Advair®

When Statin Therapy is Not Appropriate

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

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

However, sometimes statins are not clinically appropriate. When a statin is not appropriate, *WellFirst Health encourages providers to document the rationale in the clinical note of an office visit every year.*

Below are some common reasons why statin therapy may not be appropriate:

- Myopathy or rhabdomyolysis
- Liver disease
- Prediabetes
- ESRD or Dialysis
- Polycystic ovary syndrome
- Pregnancy, lactation, or fertility

Annual documentation of these conditions ensures that accreditation and regulatory bodies account for conditions and treatments that are most reflective of quality of care.

How Risk Adjustment Benefits Patient Care

Risk adjustment is a way of improving patient care through the identification of certain risk factors, offering personalized health advice, referral to additional preventative services, and life-style interventions with an overarching goal of enhancing quality of life. With that in mind, another key component is that risk adjustment programs help ensure the costs are covered for the services required to maintain their health.

The Health Plan's Risk Adjustment program applies to members enrolled in Affordable Care Act (ACA) plans and Medicare Advantage plans. When chronic or complex conditions are documented annually for these member populations, the risk adjustment program is better able to balance pool funds to account for care cost differences across member populations with these conditions.

While many of the conditions that are applied to risk adjustment are the same for ACA and Medicare Advantage, as a provider, these differences do not affect patient care. In the clinical setting, it is best practice to document every condition to the highest level of specificity that is accurate for the patient or condition being monitored.

Risk adjustment puts the emphasis on patient quality of care. Complete and accurate documentation of all relevant conditions allows for a more meaningful exchange, as well as comprehensive care planning and targeted interventions.

[The next section provides guidance on how to document diagnoses with risk adjustment in mind.]

Consider Acronyms MEAT or TAMPER to Document all Diagnoses

Traditionally, diagnoses that are not currently being treated at an encounter are not reported. The opposite is true for risk adjustment purposes where the goal is to have all diagnoses correctly captured for all current conditions, without regard to the reason for the visit.

MEAT and TAMPER are acronyms that can assist in the effort to document all of a patient's conditions.

You do not need to use all of the elements of either acronym to document a condition fully. Select one component that would accurately portray the patient's condition status to another provider. If they are seen by a specialist, employ the "referral" option of the acronym and indicate the provider.

MEAT

Monitor: Signs, symptoms, disease progression/ regression, review

Evaluate: Test and lab results, medication treatment effectiveness, exam

Assess: Stable/ improving/ worsening, etc., order tests/ labs, discussion/counseling

Treat: Refer, prescribe/adjust/refill medications, therapy/surgery

TAMPER

Treat: Surgery, therapy, procedure, counseling, education, durable medical equipment (DME), prescribe/adjust medications

Assess: Acknowledge, status update, level of condition

Monitor: Order/reference labs or other tests

Plan: Strategy for management or follow up with condition

Evaluate: Examine and evaluate, physical exam

Refer: Referral to specialists, clinic, or consultation.

A few other general documentation tips:

- Document all cause and effect relationships between conditions.
- Report the most specific diagnosis available that is supported by the documentation.
- Identify diagnoses that are current or chronic problems rather than a past medical history or previous resolved condition.
- Document history of heart attack, status codes, etc., that affect the patient's care as "history of," or "PMH" when they no longer exist or are not current conditions.
- Document the thought processes used to assess each condition.
- Avoid "unspecified" codes and descriptions.
- Document the condition and reason a medication is being prescribed. Accurate documentation can be as simple as identifying the diagnosis as well as a status.

Did you Receive a 2021 Plan and Benefit Changes Notification?

To keep WellFirst Health in-network providers informed of changes that will affect their patients, we annually compile an informational packet summarizing some key plan and benefit changes for the upcoming year. This year's Plan and Benefit Notification for 2022 was emailed to in-network providers on November 4, 2021.

If you have questions about the 2022 information, refer to benefit plan information available on wellfirstbenefits.com. If you have further questions, please contact a WellFirst Health Provider Network Consultant at 314-994-6262 or ProviderRelations@wellfirstbenefits.com.

Not receiving our emails? Select "Opt-In for Electronic Communications" in your WellFirst Health Plan portal account settings.

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 WellFirst Health's medical policies, visit wellfirstbenefits.com, ➤ For Providers, and then ➤ Medical Management ➤ Search WellFirst Health's 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 **800-279-1301**.

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 WellFirst Health 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.

Reminder for 2022: Authorizations for physical therapy and occupational therapy are end-dated on December 31, 2021. To facilitate continuity of care for your patients, a new authorization request will need to be submitted to NIA if continued services are needed on and after January 1, 2022.

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

Prior authorization requirements removed

Effective December 1, 2021

- Refractive and Therapeutic Keratoplasty MP9461

Procedures and Devices

Medically Necessary – Covered:

- Anorectal fistula repair with xenograft plug
- Lumbar discography for nonradicular neck or low back pain
- Left atrial appendage closure device (e.g., Amplatzer Amulet)

Experimental and Investigational – Non-Covered:

- Transcatheter debulking of intracardiac mass (e.g., AngioVac system)

- Transcatheter implantation of coronary sinus reduction device for refractory angina (e.g., Norvasc Reducer)
- Transcatheter left ventricular restoration device implantation (e.g., ventricular remodeling, surgical anterior ventricular endocardial restoration)
- Transcatheter tricuspid valve implantation/ replacement with prosthetic valve
- Distal transcutaneous electric nerve stimulator for functional abdominal pain (e.g., IB-Stim)
- Intra-oral device for snoring and obstructive sleep apnea (e.g., Slow Wave)

New Medical Policies

Effective March 1, 2022, two medical policies related to Behavioral Health facility admission and continued stay will be available on wellfirstbenefits.com. These will replace the current Milliman Care Guideline policies in use for Residential Treatment and Partial Hospitalization Programs. Prior authorization is required and admission or continued stay is approved when select criteria are met.

Residential Treatment – Behavioral Health MP9554

A Residential Treatment facility is either a stand-alone mental health facility or a distinct unit which provides 24/7 supervision and monitoring. Admission to and continued Residential Treatment requires prior authorization and is considered medically necessary if criteria are met. If the member is a child/adolescent or if Residential Treatment is related to substance abuse (alcohol and other drug abuse) additional criteria must be met.

Partial Hospitalization Program (PHP) – Behavioral Health MP9555

Partial Hospitalization programs may occur within a stand-alone mental health facility or a distinct unit, or a department within a health care system. Multidisciplinary treatment program should occur five (5) days a week and provide at least 20 hours of weekly clinical services intended to address the needs identified in the member's treatment plan. Activities that are primarily recreational or that do not address the presenting symptoms or problems do not count towards the total hours of treatment delivered. Admission to and continued Partial Hospitalization requires prior authorization and is considered medical necessary if criteria are met. If the member is a child/ adolescent or if the PHP is related to substance abuse (alcohol and other drug abuse) additional criteria apply.

Revised Medical Policies

Effective January 1, 2022

Dental Service and Treatment for Direct Treatment of a Medical Condition MP9552

Dental Services are limited to dental care required for the direct treatment of a medical condition, trauma/accidental injury to teeth, oral surgery and temporomandibular disorder as described in the medical policy and subject to the member's Certificate or Summary Plan Document. Prior authorization is required. To be eligible for coverage services must meet all of the following:

- Services must be medically necessary
- Treatment is medically necessary because of accidental damage
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry
- The tooth must meet the definition of "sound, natural tooth" that is fully erupted, has no restoration or minor restoration that does not compromise the strength and integrity of the tooth structure and has no evidence of periodontal disease that would predispose the tooth to injury

Effective March 1, 2022, breast and ovarian cancer risk management genes were revised per National Comprehensive Cancer Network (NCCN) guidelines. Prior authorization is not required.

Genetic Testing for Somatic Tumor Markers MP9486

Mi-Prostate Score (MiPS), an early detection test for prostate cancer, is considered experimental and investigational and therefore not medically necessary. ExoDxProstate and SelectMDx (Intelliscore) are considered medically necessary if either of the following apply:

- PSA > 3.0 ng/ml and previous benign prostate biopsy or focal high grade prostatic interpitherlial neoplasia
- PSA > 2.0 ng/ml and test will be used in place of either initial or repeat prostate biopsy

Neuropsychological Testing MP9493

The initial neuropsychological evaluation does not require

prior authorizations. Testing (96116, 96121, 96132, 96133) requires prior authorization and is considered medically necessary for the following (not an all-inclusive list):

- Huntington's disease which is either prodromal or active disease
- Infection-associated cognitive disorder with significant cognitive deterioration
- Cerebral dysfunction from toxic exposure
- Primary progressive aphasia
- Toxic effects of specific cancer treatment (e.g., intrathecal methotrexate, cranial irradiation)
- Cerebral mass

Responsive Cortical Stimulation MP9496

The replacement or revision of a responsive cortical neurostimulator is considered medically necessary for members with partial epileptic seizures who meet criteria. Prior authorization is not required.

Effective March 1, 2022

Breast Surgeries MP9026

Reduction mammaplasty requires prior authorization. Schnur Sliding Scale reference table was added to the policy.

Stereotactic Body Radiotherapy MP9459

Stereotactic body radiotherapy for small cell lung cancer is considered medically necessary for: Limited stage I or IIA disease (T1-2, N0, M0), member refuses surgery or is inoperable. Prior authorization is not required.

Genetic Testing for Polyposis MP9482

Diagnosis and screening for familial adenomatous polyposis is indicated for members with a personal history of ten (10) or more adenomatous colonic polyps on colonoscopy (cumulative). Prior authorization is required.

Effective September 1, 2021

Genetic Testing for High-Penetrance Breast and/or Epithelial Ovarian Cancer Susceptibility MP9478

Gene testing for members with a personal history of high-grade prostate score is considered medically necessary when either of the following apply:

- Metastatic, intraductal/cribriform histology, or high- or very-high-risk group prostate cancer at any age
- NCCN risk group with family history of: One or more close blood relatives with breast cancer at age 50 or younger. One or more close blood relatives with ovarian, pancreatic, metastatic or intraductal/cribiform prostate cancer at any age. Two or more close relatives with breast or prostate cancer at any age. Member has Ashkenazi Jewish ancestry.

Gene testing is considered medically necessary for a member who meets Li-Fraumeni or Cowden syndrome/PTEN harmartoma tumor syndrome criteria.

Effective November 1, 2021

LINX Reflux Management System MP9471

Barrett's esophagus is considered a medically necessary indication for the LINX procedure. Prior authorization is required.

Effective December 1, 2021

Genetic Testing for Somatic Tumor Markers MP9486

Gene expression profiling tests for cutaneous melanoma are considered medically necessary when criteria are met:

- myPath Melanoma: Ordered by a board-certified dermatopathologist. Specimen is a primary cutaneous melanocytic neoplasm for which the diagnosis is equivocal/uncertain. Member may be subjected to additional intervention based on diagnostic uncertainty.
- Decision-Dx-Melanoma: Member is diagnosed with a T1 or T2 cutaneous melanoma tumor and has clinically negative sentinel node basins. Member is being considered for sentinel lymph node biopsy to determine eligibility for additional therapy.

Echocardiogram and Stress Echocardiography MP9513

In response to provider feedback, detailed examples and additional clinical indications were added to Transthoracic (TTE) and Transesophageal (TEE) Echocardiography criteria. The policy now more closely aligns with Medicare standards. Prior authorization is not required. See the "Coverage for Echocardiograms to Align with Medicare Standards" article in this newsletter for more information.

Refer to the member's Certificate of Summary Plan Document, then to the medical policy as directed, for covered services and non-covered expenses related to dental care and oral surgery.

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 within the policy.* 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 WellFirst Health policies must be prior authorized, unless otherwise noted in the policy. Please note that most drugs noted below and with policies require specialists to prescribe and request authorization.

Criteria for pharmacy benefit medications may be found on the prior authorization form located in the 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.

New Drug Policies

COSELA (trilaciclib) MB2123

Effective November 1, 2021, COSELA, which is used to decrease the incidence of chemotherapy-induced myelosuppression in adult patients when administered prior to a platinum/etoposide-containing regimen or topotecan-containing regimen for extensive-stage small cell lung cancer. Will require prior authorization and must be prescribed by, or in consultation with, an oncologist or hematologist prescribers.

EVKEEZA (evinacumab) MB2124

Effective November 1, 2021, EVKEEZA, is an ANGPTL3 (angiopoietin-like 3) inhibitor indicated as an adjunct to other low-density lipoprotein-cholesterol (LDL-C) lowering therapies for the treatment of adult and pediatric patients, aged 12 years and older, with homozygous familial hypercholesterolemia (HoFH). Will require prior authorization and must be prescribed by, or in consultation with, a cardiologist, lipidologist, or endocrinologist prescribers.

JEMPERLI (dostarlimab) MB2126

Effective November 1, 2021, JEMPERLI, used for the treatment of adult patients with mismatch repair deficient (dMMR) recurrent or advanced: endometrial cancer (EC), as determined by an FDA-approved test, that has progressed on or following prior treatment with a platinum-containing regimen, or solid tumors, as determined by an FDA-approved test, that have progressed on or following prior treatment and who have no satisfactory alternative treatment options. Will require prior authorization and must be prescribed by, or in consultation with, an oncologist or OB/GYN prescribers.

ORGOVYX (relugolix) MB2127

Effective November 1, 2021, ORGOVYX, which is a gonadotropin-releasing hormone (GnRH) receptor antagonist indicated for the treatment of adult patients with advanced prostate cancer. Prior authorization is required and must be prescribed by or in consultation with, an oncologist or urologist.

OXLUMO (lumasiran) MB2125

Effective November 1, 2021, OXLUMO, the first and only FDA-approved treatment for primary hyperoxaluria type 1 (PH1) to lower urinary oxalate levels in children and adults. Will require prior authorization and must be prescribed by, or in consultation with, nephrologist or urologist prescribers.

Changes To Drug Policy

Botulinum Toxin MB9020

Effective October 1, 2021, Botulinum Toxin, which is used to treat certain eye disorders such as crossed eyes (strabismus) and uncontrolled blinking (blepharospasm), to treat muscle stiffness/spasms or movement disorders (such as cervical dystonia, torticollis), and to reduce cosmetic appearance. Additional diagnosis sialorrhea for Xeomin. Prior authorization is required.

DARZALEX (daratumumab) MB1832

Effective October 1, 2021, DARZALEX, which is used to treat a type of blood cancer called multiple myeloma. Additional indication added for DARZALEX FASPRO in multiple

myeloma after first or subsequent relapse (in combination with pomalidomide and dexamethasone. Prior authorization is required and is restricted to oncology prescribers.

KEYTRUDA (pembrolizumab) MB1812

Effective October 1, 2021, KEYTRUDA, which is used for treatment of melanoma, non-small cell lung cancer (NSCLC), head and neck squamous cell cancer (HNSCC), classical Hodgkin lymphoma (cHL), primary mediastinal B-cell lymphoma (PMBCL), urothelial carcinoma, microsatellite instability-high (MSI-H) or a mismatch repair deficient (dMMR) solid tumor, colon or rectal cancer, gastric or gastroesophageal junction (GEJ) adenocarcinoma that tests positive for "PD-L1, cervical cancer that tests positive for "PD-L1," hepatocellular carcinoma, Merkel cell carcinoma (MCC), renal cell carcinoma (RCC), cutaneous squamous cell carcinoma (cSCC), and triple-negative breast cancer (TNBC). Added indication for high-risk early-stage triple negative breast cancer and other revisions to match Navitus September MUPPET. Also duplicated Navitus policy language for ease of maintaining document. Prior authorization is required and must be prescribed by an oncologist or hematologist prescribers.

OPDIVO (nivolumab) MB1844

Effective October 1, 2021, OPDIVO, which is used for treatment of advanced stage lung cancer (called non-small cell lung cancer) when lung cancer has spread to other parts of the body (metastatic) and tumors are positive for PD-L1, but do not have an abnormal EGFR or ALK gene. Removal of hepatocellular carcinoma indication and language changed to directly match Navitus policy. Prior authorization is required and must be prescribed by, or in consultation with, an oncologist or hematologist prescribers.

YERVOY (ipilimumab) MB9945

Effective October 1, 2021, YERVOY, which is used in adults and children age 12 and older to treat melanoma (a kind of skin cancer) that has spread (metastatic) or cannot be removed by surgery (unresectable). Removal of NSCLC due to NCCN Category 1 and 2a, added new indication of Malignant pleural mesothelioma and adoption of Navitus policy. Prior authorization is required and must be prescribed by (or in consultation with) oncology or dermatology prescribers.

ACTEMRA-IV (tocilizumab) MB9405

Effective November 1, 2021, ACTEMRA IV, which is an interleukin-6 (IL-6) receptor antagonist indicated for treatment of: Rheumatoid Arthritis (RA), Giant Cell Arteritis (GCA), Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Systemic Juvenile Idiopathic Arthritis (SJIA), and Cytokine Release Syndrome (CRS). Navitus policy adoption alignment, added indications of giant cell arteritis, adult onset stills and SSc-ILS, and changed to single step through infliximab or Humira for RA and PJIA. Prior authorization is required and is restricted to Rheumatology Specialists for the indications of RA, PJIA, or SJIA, and no specialist requirement for cytokine release syndrome.

ACTHAR GEL (repository corticotropin injection) MB 2103

Effective November 1, 2021, ACTHAR GEL, which is indicated as monotherapy for the treatment of infantile spasms in infants and children under 2 years of age, treatment of exacerbations of multiple sclerosis in adults, and may be used for the following disorders and diseases: rheumatic; collagen; dermatologic; allergic states; ophthalmic; respiratory; and edematous state. Added quantity limit and BSA requirement per Navitus policy. Prior authorization is required and must be prescribed by, or in consultation with, a neurologist prescriber.

BAVENCIO (avelumab) MB1936

Effective November 1, 2021, BAVENCIO, which is used for a programmed death ligand-1 (PD-L1) blocking antibody indicated for: Merkel Cell Carcinoma (MCC), Urothelial Carcinoma (UC), and Renal Cell Carcinoma (RCC). Navitus policy adoption. Prior authorization is required and must be prescribed by, or in consultation with, an oncologist prescriber.

Bevacizumab Products MB9431

Effective November 1, 2021, Bevacizumab products, which is a medication used to treat a number of types of cancers and a specific eye disease. Annual review and removal of effective date on policy statement regarding preferred products from back in 2020. Prior authorization is not required for preferred products MVASI and ZIRAVEV. Coverage of AVASTIN requires a failed trial or contraindication of both MVASI and ZIRABEV. Must be prescribed by (or prescribed in consultation with) oncology prescriber. Except for the indications of metastatic hepatocellular carcinoma, all off-label ocular indications, or NCCN recommended (1, 2a, or 2b) off-label indications for only a specific bevacizumab product, use of a non-preferred bevacizumab product will not be covered.

Botulinum Toxin MB9020

Effective November 1, 2021, Botulinum Toxin, which is used to treat certain eye disorders such as crossed eyes (strabismus) and uncontrolled blinking (blepharospasm), to treat muscle stiffness/spasms or movement disorders (such as cervical dystonia, torticollis), and to reduce cosmetic appearance. Removal of pharmacologic step therapy

requirement for achalasia. Prior authorization is required.

DARZALEX (daratumumab) MB1832

Effective November 1, 2021, DARZALEX, which is used to treat a type of blood cancer called multiple myeloma. Navitus policy alignment and added quantity limit for Darzalex and expanded prescriber specialty to include hematology. Prior authorization is required and is restricted to oncology or hematologist prescribers.

Duchenne NMN MB2118

Effective November 1, 2021, Duchenne NMN, which is used for treatments that can help to maintain comfort, function, and prolong life for people with Duchenne muscular dystrophy (DMD). Additional product (Amondys – casimersen) added to current product list (Vyondys 53, Exondys 51, and Viltepso). This policy is a non-covered service policy.

Immune Globulin MB9423

Effective November 1, 2021, Immune Globulin, which is used to treat primary immunodeficiency, increase platelets (blood clotting cells) in people with immune thrombocytopenic purpura, help prevent certain infections in people with B-cell chronic lymphocytic leukemia, and used in people with Kawasaki syndrome, to prevent aneurysm caused by a weakening of the main artery in the heart. Adjusted diagnosis criteria for multifocal motor neuropathy to more align with current guidelines. Prior authorization is required.

KRYSTEXXA (pegloticase) MB2113

Effective November 1, 2021, KRYSTEXXA, which is used for the treatment of chronic gout in adult patient's refractory to conventional therapy. Changed prescribing authority to rheumatology and nephrology specialists per Pharmacy and Therapeutics Committee (P&T) notes. Prior authorization is required and must be prescribed by, or in consultation with, a rheumatologist or nephrologist prescriber.

Rituximab Products MB9847

Effective November 1, 2021, Rituximab Products, which is used alone or together with other medicines to treat a type of cancer called non-Hodgkin's lymphoma (NHL). Nephrologists were added as prescribers and added off-label indications (membraneous nephropathy and SDNS). Prior authorization is required and must be prescribed by rheumatology, transplant, hematology, neurology, dermatology, ENT, nephrology or oncology prescribers.

TECENTRIQ (atezolizumab) MB1817

Effective November 1, 2021, TECENTRIQ, which is a prescription medicine used to treat adults with: a type of lung cancer called small cell lung cancer (SCLC). TECENTRIQ may be used with the chemotherapy medicines carboplatin and etoposide as the first treatment when lung cancer: is a type called "extensive-stage small cell lung cancer," which means that it has spread or grown. Adoption of Navitus policy and removal of indications for triple negative breast cancer and prior-platinum locally advanced or metastatic urothelial carcinoma. Prior authorization is request and must be prescribed by, or in consultation with, an oncologist prescriber.

TEPEZZA (teprotumumab-trbw) MB2005

Effective November 1, 2021, TEPEZZA, which is an insulin-like growth factor-1 receptor inhibitor indicated for the treatment of Thyroid Eye Disease. Adoption of Navitus policy and prescriber changes. Prior authorization is required and must be prescribed by, and or in consultation with, an ophthalmologist and endocrinologist prescribers.

YERVOY (ipilimumab) MB9945

Effective November 1, 2021, YERVOY, which is a prescription medicine used in adults and children age 12 and older to treat melanoma that has spread or cannot be removed by surgery (unresectable). Policy has been updated to reflect September 2021 Navitus Policy. Prior authorization is required and must be prescribed by (or in consultation with) oncology or dermatology prescriber.

ANDEXXA (andexanet alfa) MB1843

Effective December 1, 2021, ANDEXXA, which is a recombinant modified human factor Xa (FXa) protein indicated for patients treated with rivaroxaban or apixaban, when reversal of anticoagulation is needed due to life-threatening or uncontrolled bleeding. Annual Review and addition of references from package insert. Prior authorization is not required.

BENLYSTA (belimumab) MB1820

Effective December 1, 2021, BENLYSTA, which is used for treatment of Systemic lupus erythematosus patients age 5 and older. Minor language change to further clarify Navitus policy criteria. Prior authorization is required and may only be prescribed by, or in consultation with, a rheumatologist, dermatologist or nephrologist.

BLENREP (belantamab mafodotin-blmf) MB2012

Effective December 1, 2021, BLENREP, which is used to treat adults with multiple myeloma who have received at least 4 prior medications to treat multiple myeloma, and their cancer has come back or did not respond to prior treatment. Policy updated with references for resource, no clinical changes. Prior authorization is required and must be prescribed by (or in consultation with) an oncologist prescriber.

DARZALEX (daratumumab) MB1832

Effective December 1, 2021, DARZALEX, which is used to treat a type of blood cancer called multiple myeloma. Reassigned criteria to appropriate position in the policy (2.4.2 to 2.4.1.3.1) under use in multiple myeloma members who have received at least one prior therapy. Prior authorization is required and is restricted to oncology or hematologist prescribers.

Duchenne NMN MB2118

Effective December 1, 2021, Duchenne NMN, which is used for treatments that can help to maintain comfort, function, and prolong life for people with Duchenne muscular dystrophy (DMD). The drug Amondys, had a J Code updated from J3490 to J1426. This policy is a non-covered service policy.

ERWINAZE (asparaginase erwinia chrysanthemi) MB1919

Effective December 1, 2021, ERWINAZE, which is an asparagine specific enzyme indicated as a component of a multi-agent chemotherapeutic regimen for the treatment of patients with acute lymphoblastic leukemia (ALL) who have developed hypersensitivity to E. coli-derived asparaginase. Adoption of Navitus Formulary, wording changes but concepts still the same. Prior authorization is required and must be prescribed by an oncology/ hematologist prescriber.

Fertility Medications MB1942

Effective December 1, 2021, fertility medications, which are a regular and normal part of infertility treatments and the in vitro fertilization (IVF) procedure. These medications are used to prepare the body for treatment and to increase the probability that more healthy eggs are released from the ovaries. Policy updated to reflect criteria changes implemented summer 2021. Prior authorization is required and must be prescribed by a reproductive prescriber.

KEYTRUDA (pembrolizumab) MB1812

Effective December 1, 2021, KEYTRUDA, which is used for treatment of melanoma, non-small cell lung cancer (NSCLC), head and neck squamous cell cancer (HNSCC), classical Hodgkin lymphoma (cHL), primary mediastinal B-cell lymphoma (PMBCL), urothelial carcinoma, microsatellite instability-high (MSI-H) or a mismatch repair deficient (dMMR) solid tumor, colon or rectal cancer, gastric or gastroesophageal junction (GEJ) adenocarcinoma that tests positive for "PD-L1, cervical cancer that tests positive for "PD-L1", hepatocellular carcinoma, Merkel cell carcinoma (MCC), renal cell carcinoma (RCC), cutaneous squamous cell carcinoma (cSCC), and triple-negative breast cancer (TNBC). Aligned Health Plan policy with Navitus policy by adding new cervical cancer indication when used in combination with chemotherapy for treatment of persistent, recurrent, or metastatic cervical cancer whose tumors express PD-L1 (CPS ≥ 1) as determined by an FDA-approved test. Prior authorization is required and must be prescribed by an oncologist or hematologist prescribers.

RADICAVA (edaravone) MB9948

Effective December 1, 2021, RADICAVA, which is indicated for the treatment of amyotrophic lateral sclerosis (ALS). Adoption of Navitus Policy, changed wording and reduction in medical notes to an attestation. Prior authorization is required and is restricted to a neurology prescriber.

TROGARZO (ibalizumab) MB2014

Effective December 1, 2021, TROGARZO, which is used for the treatment of human immunodeficiency virus type 1 (HIV-1) infection in heavily treatment-experienced adults with multidrug resistant HIV-1 infection failing their current antiretroviral regimen. References added to policy from the Navitus Policy Adoption from June 2021. Prior authorization is required and must be prescribed by, or in consultation with, an infectious disease specialist.

ZEPZELCA (lurbinectedin) MB2015

Effective December 1, 2021, ZEPZELCA, which is an alkylating drug indicated for the treatment of adult patients with metastatic small cell lung cancer (SCLC) with disease progression on or after platinum-based chemotherapy. Annual review and reference section added referencing package insert. Prior authorization is required and must be prescribed by, or in consultation, with an oncologist prescriber.

Medically Administered Oncology Products MB2112

Effective January 1, 2022, Medically Administered Oncology Products, is the overarching oncology policy replacing most of the individual policies. New drugs added Asparlas, Danyelza, Isotodax, Jevtana, Margenza, Pepaxto, Unituxin, Zynlonta, Oncaspar, Lumoxiti, and Polivy. Prior authorization is required and is restricted to oncology prescribers.

Pegfilgrastim products MB1808

Effective January 1, 2022, Pegfilgrastim products, which are used to reduce the chance of infection in patients who have certain types of cancer and are receiving chemotherapy medications that may decrease the number of neutrophils (a type of blood cell needed to fight infection). J code update from J2505 to J2506 for NUELASTA and NEULASTA ONPRO. Prior authorization is required for Neulasta, Neulasta OnPro, Nyvepria, or Udenyca only. No prior authorization is required for Fulphila, or Ziextenzo. Must be prescribed by, or in consultation, with a hematologist or oncologist prescribers.

PROLIA-XGEVA (denosumab) MB9409

Effective January 1, 2022, PROLIA, which is used for the treatment of postmenopausal women with osteoporosis at high risk for fracture,

increased bone mass in men at high risk for fracture receiving androgen deprivation therapy for non-metastatic prostate cancer and for increased bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer. XGEVA, which is used for treatment to prevent skeletal-related events (need for radiation, fracture due to cancer in the bone, surgery to the bone or compression of the spinal cord) in patients with multiple myeloma and bone metastases from solid tumors and treatment of giant cell tumor of the bone. Policy was updated to match Navitus policy adoption. Prior authorization is required and is prescribed by, or in consultation with oncology, rheumatology, internal medicine, family medicine, orthopedic surgery or endocrinology prescribers.

Medicare Part B Step Therapy MB2011

Effective February 1, 2022, Medicare Part B Step Therapy, which is a Medical Benefit Injectable policy to provide for informational purposes only and does not constitute medical advice. This policy supplements Medicare NCDs, LCDs, and manuals for the purpose of determining coverage under Medicare Part B medical benefits. This policy implements a prior authorization requirement for prescriptions or administrations of medical benefit drugs only. Changes to 2021 Step B plus additional Step B therapy treatments for 2022.

ORENCIA (abatacept-IV) MB9457

Effective February 1, 2022, ORENCIA, which is a selective T cell costimulation modulator indicated for the treatment of (1.2, 1.3): adult patients with moderately to severely active rheumatoid arthritis (RA), patients 2 years of age and older with moderately to severely active polyarticular, juvenile idiopathic arthritis (pJIA), and adult patients with active psoriatic arthritis (PsA). Changes made to align with Navitus subcutaneous (SC) policy due to contract changes, double step from single step for all indications (RA, PJIA, PsA). Prior authorization is required and is restricted to rheumatology prescribers.

SIMPONI ARIA (golimumab) MB9847

Effective February 1, 2022, SIMPONI ARIA, which is a tumor necrosis factor (TNF) blocker indicated for the treatment of: adult patients with moderately to severely active rheumatoid arthritis (RA) in combination with methotrexate; active psoriatic arthritis (PsA) in patients 2 years of age and older; adult patients with active ankylosing spondylitis (AS); and active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older. Removal of non-first line therapies from step requirements. Prior authorization is required and is restricted to (or in consultation with) Rheumatology specialists (Rheumatoid Arthritis, Peripheral Ankylosing Spondylitis, or Psoriatic Arthritis) or Gastroenterology specialists (Ulcerative Colitis).

CRYSVITA (burosumab) MB1831

Effective March 1, 2022, CRYSVITA which is a fibroblast growth factor 23 (FGF23)–blocking antibody indicated for the treatment of X-linked hypophosphatemia (XLH) in adult and pediatric patients 6 months of age and older. Additional language was added regarding criteria, accepted prescriber specialties, reduced initial authorization period to 4 months for adult X-linked phosphatemia, and added quantity limits. Prior authorization is required and is restricted to be prescribed by an endocrinologist, nephrologist, medical geneticist, or specialist experienced in treatment of metabolic bone disorders.

FLOLAN-epoprpstenol-REMODULIN-treprostinil MB1934

Effective April 1, 2022, FLOLAN, which is a prostaglandin (a hormone-like substance that occurs naturally in the body) used to treat pulmonary hypertension. REMODULIN, which is a prostacyclin mimetic indicated for: Treatment of pulmonary arterial hypertension (PAH; WHO Group 1) to diminish symptoms associated with exercise and patients who require transition from epoprostenol, to reduce the rate of clinical deterioration. Adoption of Navitus Policy and only generic approvable through authorization, brand Remodulin not covered. Prior authorization is required for generic and be prescribed by, or in consultation, with a cardiologist or pulmonologist.

Retired Policies

Effective November 1, **2021 LARTRUVO (olaratumab) MB9956**

Effective January 1, **2022 LUMOXITI (moxetumomab) MB1920**

Effective January 1, **2022 ONCASPAR (pegasparagase) MB1903**

Effective January 1, **2022 POLIVY (polatuzumab vedotin-piiq) MB1938**

Using Z Codes to Document Social Determinants of Health

WellFirst Health encourages providers to collect and document Social Determinants of Health (SDOH) data for their patients using the appropriate SDOH-related Z codes. SDOH are the conditions in the environments where people are born, live, learn, work, play and age.

Z codes, a subset of ICD-10-CM codes, represent reasons for encounters and are used to capture factors that influence health status and contact with health services. Documenting this information as part of a patient's medical record can help improve care coordination and the quality and experience of a patient's care. Furthermore, the Health Plan can use this data to identify social risk factors and potential unmet needs within the member population to inform future quality improvement initiatives.

Per CMS's Z code resource, any clinician can document a patient's social needs. This includes, but is not limited to, providers, social workers, community health workers, case managers, patient navigators, and nurses. Per CMS guidance, SDOH may be collected at intake through health risk assessments, screening tools, person-provider interaction, and individual self-reporting. Providers are reminded to always follow best practices for collecting SDOH data in a sensitive and HIPAA-compliant manner.

Per CMS, providers can assign SDOH Z codes based on information documented in an individual's health care record by any member of that patient's care team.

Z codes apply to all health care settings. The Health Plan encourages the use of Z codes on claims to document SDOH data and accepts codes ranging from Z55-Z65 (e.g., housing, food insecurity, transportation, etc.). Z codes for SDOH data cannot be billed as the 'primary' diagnosis.

Z Code Categories

- Z55 – Problems related to education and literacy
- Z56 – Problems related to employment and unemployment
- Z57 – Occupational exposure to risk factors
- Z58 – Problems related to physical environment
- Z59 – Problems related to housing and economic circumstances
- Z60 – Problems related to social environment
- Z62 – Problems related to upbringing
- Z63 – Other problems related to primary support group, including family circumstances
- Z64 – Problems related to certain psychosocial circumstances
- Z65 – Problems related to other psychosocial circumstances

More Information

For more information regarding Z codes, please refer to the following resources:

- America Hospital Association ICD-10-CM Coding for Social Determinants of Health ICD-10-CM Coding
- CMS's 2021 ICD-10-CM page
- ICD10data.com

At Your Service: The Navitus Prescriber Portal

WellFirst Health contracts with Navitus Health Solutions for the management of pharmacy benefit prior authorizations. The Navitus prescriber portal enables providers 24/7 access to plan specifications, formulary, and prior authorization forms for WellFirst Health. Providers also have access to additional resources, such as Pharmacy & Therapeutics (P&T) Committee minutes and an FAQ for Exclusion/ Preclusion Fix.

We encourage providers to take a moment to explore this convenient self-service tool. A direct link to the Navitus prescriber portal is located from our Account login page.

Providers may contact Navitus at **844-268-9789** with any questions about the prescriber portal or its resources.

WellFirst Health has a long-standing relationship with Navitus and shares their mission to continuously improve the provider experience. Navitus is offering a brief Prescriber Satisfaction Survey for users to share honest feedback regarding their experience using the prescriber portal. This feedback will help to identify future improvements as Navitus and WellFirst Health work together to create an optimal user experience.

Xolair and Nucala Now Available from Lumicera Health Services for Coverage through Patients' Pharmacy Benefit

By obtaining medical injectables Xolair and Nucala under the pharmacy benefit, patients often will save money on out-of-pocket expenses when compared to office visit charges.

If your patients or their caregivers choose to administer the medicine in the convenience of their home, Lumicera Health Services has clinical experts available to provide education and answer any questions. The Lumicera Health Services team can also assist with any copay and medication access assistance. The medicine is delivered free to your patients' preferred address, along with any injection supplies such as sharps containers, bandages and alcohol swabs. A Patient Care Specialists will help coordinate care with your team and will communicate as part of the patient care team throughout the patient's treatment. Lumicera Health Services provides convenient access to help manage your patients' care and a Pharmacist-on-Call is available for emergency assistance 24/7.

If you and your patients are interested, please call Lumicera Health Services toll free at **855-847-3553** to begin the transition of coverage through your patients' pharmacy benefit.

Antibiotic Stewardship Begins with Clear Communication

Antibiotic resistance continues to be a persistent and pervasive public health problem in the U.S. Overuse of antibiotics is common in primary care; for example, antibiotics are used in over 50% of cases of acute bronchitis which, in most cases, are caused by viral infections that antibiotics are not effective in treating. The consequences of antibiotic overuse include more than 2.8 million antibiotic-resistant related infections occurring in the U.S. annually, with over 35,000 deaths, according to the Centers for Disease Control and Prevention (CDC). Hence outpatient antibiotic stewardship is critical.

Patients have a specific agenda when visiting their providers, which usually reflects concerns and problems they want addressed during the visit. It might also include a desire for specific services such as a prescription for an antibiotic. According to an American Society for Microbiology article titled, "Systemic Review of Factors Associated with Antibiotic Prescribing for Respiratory Tract Infections," most patients' expectations are focused more on their health care provider's ability to listen to their concerns and discuss their problems and doubts—and less on actually walking out of the office with prescription in-hand.

For most patients, the risks associated with antibiotic use outweigh the benefits, so discussing the risks and benefits for patients who desire antibiotics is especially important. Some key messages for aligning expectations with the patient include mentioning that antibiotics for their particular viral infection:

- Will not cure the infection
- Will not keep other people from getting sick
- Won't help them feel better any quicker
- May cause unnecessary and harmful side effects including most commonly, upset gastrointestinal tract, and most significantly, allergic reaction
- Will alter their microbiome (which could impair immune function) and carries the risk of inducing antibiotic-resistant organisms both in the individual patient and the community.

Online Educational Tool Available for Providers to Share with Patients

WellFirst Health offers Emmi®, free online educational programs, that all in-network providers can use to further educate their patients. Emmi® is a series of evidence-based online programs that walk patients through important information about a health topic, condition or procedure. In-network providers can sign up for an account by contacting Emmi customer support at **866-294-3664** or **support@my-emmi.com**. Once a provider has established an account, they can send interactive educational content directly to their patients via email.

Members enrolled in any WellFirst Health product are eligible to access Emmi. By clicking the link in the email sent by their provider, members will be prompted to create a login to access the content.

Each program runs from 15-30 minutes. Members can watch at their convenience and refer back as often as they wish.

Provider Network Clinical Liaison Brings Multifaceted Experiences to the Role

As the Health's Plan Provider Network Clinical Liaison, Kathy Sellnow, wears many hats, as the saying goes. Whether she is educating on medical policy and coverage criteria, offering provider assistance with individual member issues, or educating providers on a significant medical policy change or quality initiative, Kathy has a hat for the occasion. "I enjoy the energy and collaboration here at the Health Plan, as well as my direct interaction with providers and their teams," Kathy said.

Kathy previously served as the Health Plan's Medical Policy Analyst before rejoining the Health Plan earlier this year. She brings a wide variety of work and life experience in multiple areas to her new role, including more than 40 years as a Registered Nurse active in Emergency Medicine, Critical Care, Cardiology, Ambulatory Care, and the Newborn Intensive Care Unit. She has also been a teacher in higher education of Emergency Medicine, Emergency Preparedness, and Medical Assistant Programs, to name a few.

In fact, earlier in her career, she worked in St. Louis to assist in introducing medical and authorization policies to SSM Health providers.

Kathy enjoys the variety her new role brings. "I like that I am not isolated into one topic or role," she said. "I am a lifelong learner and I learn something every day."

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

WellFirst Health 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.

"How does my morning look?"

WellFirst Health *Provider News*

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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 WellFirst Health. Information regarding this process can be found in the WellFirst Health Provider Manual published in our Document Library.