STAY CURRENT WITH THE LATEST NEWS FROM WELLMARK® BLUE CROSS® AND BLUE SHIELD®

Information for Iowa and South Dakota physicians, hospitals and health care providers

DECEMBER 2018

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Telehealth and telemedicine services

Wellmark will no longer restrict telehealth and telemedicine services to a defined list of specified procedure codes and provider types.

EFFECTIVE WITH DATES OF SERVICE JAN. 1, 2019, or after, Wellmark will no longer restrict telehealth and telemedicine services to a defined list of specified procedure codes and provider types. Wellmark will begin covering telehealth and telemedicine services consistent with the Iowa Telehealth Act (Iowa Code §514C.32). This applies to providers within Wellmark’s geographical service area. Therefore, covered services will be considered the same whether provided in person or delivered by telehealth or telemedicine.

Wellmark recognizes both telehealth and telemedicine as means to provide medical services. Wellmark differentiates telehealth and telemedicine, and these two terms are not interchangeable/synonymous.

Telehealth (virtual visit)

**TELEHEALTH** (virtual visit) is a method to provide health care services to patients through real time video interaction between a virtual visit provider and the patient. Virtual visit involves the provider in one location and the patient at another.

- A Wellmark credentialed and participating provider may provide services via telehealth.
- For a practitioner providing services via telehealth only, the physical presence and practice location requirements shall not apply.
- The practitioner must still be within Wellmark’s geographic service area (Iowa and contiguous counties; and South Dakota).
- Telehealth is a means to provide services and is not considered a provider type or specialty for network participation. Any application submitted to add telehealth as a provider type or specialty will be denied.
- Bill telehealth services with “02” Place of Service and the appropriate CPT or HCPCS code(s).
- The claim will be denied if you include a GT or 95 modifier on the claim.

Providers are responsible for verifying the patient’s benefits prior to providing services.

Telemedicine

**TELEMEDICINE** is a method to provide health care services to patients that involves a provider with a patient at one location and a provider at another. Telemedicine involves using interactive audio/video and/or electronic images to treat patients.

- A Wellmark credentialed and participating provider may provide services via telemedicine.
- Procedure codes for telemedicine are no longer restricted.
- Bill telemedicine services using the place of service where the patient was present (originating site).
- Providers must use modifiers GT or 95 with the appropriate CPT or HCPCS code(s).
- Do not use place of service “02” for Telemedicine claims.

Providers are responsible for verifying the patient’s benefits prior to providing services.

Resources

“Claims Filing” section of the Provider Guide
“Credentialing and Network Participation” section of the Provider Guide
Iowa Telehealth Act, Iowa Code §514C.32
Wellmark’s Payment Policies for Professional and Outpatient Facility Claims
Beginning March 1, 2019, providers may begin submitting non-FEP prior authorization (PA) requests for prescriptions online using the CVS/Caremark tool, NovoLogix, through the secure provider portal on Wellmark.com.

**NovoLogix**

NovoLogix is an industry-leading software system that streamlines the PA process for both medically and pharmacy benefited drugs, and enables real-time PA determinations. Medically-benefited drugs typically are administered by injection or infusion by MDs, DOs, or nurses. Pharmacy-benefited drugs are typically self-administered (orally, injected, or inhaled).

**Mark your calendar for these important dates**

Wellmark will be hosting a webinar on Jan. 9, 2019, to teach prescribers how to navigate the new, online drug PA tool. More information about the webinar will be distributed through the Wellmark Information Notification System (WINS). If you haven’t done so, register now and subscribe to the Education and Training category.

Prescribers with secure access to Wellmark’s online provider tools start using the online drug PA tool, powered by NovoLogix, on March 1, 2019. In addition to submitting PA requests, prescribers may use the tool to:

- Review pending PA requests
- Look up previously submitted PAs

PAs approved prior to March 1, 2019, will not need to be resubmitted through the online drug PA tool unless there is a material change to the original PA request.
Learn about the new Farm Bureau Health Plan

Providers in the Wellmark Blue HMO network are in-network.

The Iowa Farm Bureau Federation is offering a non-ACA health benefits plan to Iowans who meet plan requirements and are also members of the Iowa Farm Bureau Federation. The earliest effective date that a Farm Bureau Health Plan (FBHP) member may be covered is Jan. 1, 2019. FBHP members can be identified by the Farm Bureau Health Plan logo on their ID card.

Check ID cards

Wellmark Administrators, Inc., will provide claims administration for the new Farm Bureau Health Plan.

Wellmark Blue HMO Network

The FBHP offers coverage on the existing Wellmark Blue HMO Network (Wellmark Health Plan of Iowa/WHPI). Providers who participate with the Wellmark Health Plan of Iowa through the Universal Agreement will be in-network for this plan.

Blue RX Value Formulary

The FBHP will use the Blue RX ValueSM formulary.

Claims filing

Wellmark Administrators, Inc., will provide claims administration for the new Farm Bureau Health Plan. Providers should follow established processes for filing claims in addition to following the established inquiry and appeal process as outlined in Chapter 19 of the Claims Filing Provider Guide.

Additional education

A provider education webinar was held on Dec. 12, 2018. A recorded version and slides are accessible on the Wellmark Provider Portal.
Individual and family ACA plan options for 2019

Important network reminders.

**EFFECTIVE JAN. 1, 2019,** Wellmark Health Plan of Iowa (WHPI) and Wellmark Value Health Plan (WVHP) will be offering Affordable Care Act (ACA)-compliant plans on the health insurance marketplace in select service areas. A member’s network is determined by where the contract holder lives.

**Verify network participation status**

Please verify that you are in-network for the member prior to scheduling appointments and accepting new patients. Members who carry these plans do not have out-of-network benefits except in emergency situations. Verifying network status is only clicks away — please access the [Find a Provider Tool](#).

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Inpatient Only List update

Effective with dates of service on or after Jan. 1, 2019.

Please visit the following pages for updated information regarding the Inpatient Only List, effective with dates of service on or after Jan. 1, 2019.

- Professional claims
- Outpatient facility claims

These pages can also be found under the “Payment and Coding Policies for Billers” section of the [Claims and Payment page](#).
2019 FEP benefit updates

Federal Employee Program® (FEP) benefits updated, effective Jan. 1, 2019.

New product available

In 2019, a third FEP product, FEP Blue Focus, will be available for FEP members in addition to the already existing Standard and Basic Option products. FEP Blue Focus was designed for our cost-conscious and low-utilization members. While in-network preventive services are covered, many other benefits are subject to 30 percent coinsurance after the deductible has been met.

FEP Blue Focus also has a closed formulary comprised of only two tiers. Dental care, non-preferred drugs, skilled nursing care, hearing aids, and long-term care are not covered. Finally, FEP Blue Focus has an expanded list of services requiring prior approval. If prior approval is not obtained, a $100 penalty will be applied. Please reference pages 19–23 of the 2019 FEP Blue Focus Service Benefit Plan Brochure for a listing of services requiring prior approval.

Brochures available

Please refer to the FEPBlue.org website for digital versions of both the 2019 Blue Cross Blue Shield Service Benefit Plan Standard and Basic Option Brochure as well as the 2019 FEP Blue Focus Brochure. Each contains an entire statement of FEP benefits as well as the FEP medical policies. You’ll find a summary of benefit changes included on pages 1 –16 of the Standard-Basic Option Brochure.*

Also, as a reminder, the FEP drug list is updated periodically during the year. It is important you review the appropriate list for up-to-date information. You may also obtain information related to pharmaceutical management procedures by checking FEPBlue.org/pharmacy or calling CVS/Caremark™ at (877) 727-3784.

Contact us with questions

As always, a team of dedicated FEP customer service representatives is available to answer provider questions or speak with FEP members at 800-532-1537.

*This is a summary of the features of the Blue Cross and Blue Shield Service Benefit Plan, RI 71-005. All benefits are subject to the definitions, limitations, and exclusions set forth in the federal brochure.

FEP Dental Payments will move to Fridays

Currently, Wellmark pays FEP dental provider claims on Tuesdays.

Beginning the week of December 17, 2018, Wellmark will begin paying dental providers on Fridays.
Prior approval requirements for new FEP Blue Focus product

FEP Blue Focus is a new product for 2019

FEP Blue Focus is a new product available to our Federal Employee Program (FEP) members effective Jan. 1, 2019. This product’s listing of procedures subject to prior approval is much larger than the existing FEP Standard and Basic Option Plans.

A prior approval review determines medical necessity and considers FEP benefits before a treatment, procedure, service, or supply is provided. FEP Blue Focus members will have the unique ID card pictured at right.

If you need to know whether a procedure requires prior approval, please contact our dedicated FEP Customer Service Unit at 800-532-1537. You may also view a copy of the entire Service Benefit Plan brochure that contains the prior approval information by accessing it on FEPBlue.org.

FEP Blue Focus services that require prior approval

**PENALTY NOTE:** You must obtain prior approval for these services. Failure to obtain prior approval will result in a $100 penalty for the provider. Pre-certification is also required if the service or procedure requires an inpatient hospital admission.

- **GENE THERAPY AND CELLULAR IMMUNOTHERAPY**
- **AIR AMBULANCE TRANSPORT (NON-EMERGENT)** — Transport related to immediate care of a medical emergency or accidental injury does not require prior approval
- **APPLIED BEHAVIOR ANALYSIS (ABA)** — Required for ABA and all related services, including assessments, evaluations, and treatments. For more details, refer to the [medical policy](#).
- **COCHLEAR IMPLANTS**
- **GENDER REASSIGNMENT SURGERY** — Prior to surgical treatment of gender dysphoria, a treatment plan must be submitted that includes all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and the plan is later modified.
- **BRCA/LGR TESTING** — Required for both preventive and diagnostic testing as well as diagnosis and/or management of existing medical condition.
- **RADIOLOGY, HIGH TECHNOLOGY** — Including CT scan/MRIs/PET scan services.
- **HOSPICE CARE** — Includes home hospice, continuous home hospice, or inpatient hospice care services.
- **TRANSPLANTS** — Required for all transplants, except cornea and kidney. See the [FEP Blue Focus Service Benefit Plan brochure](#) for the list of covered organ/tissue transplants. Prior approval is required for both the procedure and the facility. Prior approval is also required.
for travel benefits associated with a Blue Distinction Center for Transplants facility approval.

• ORAL AND MAXILLOFACIAL SURGERY — Prior approval is required, except when related to an accidental injury and provided within 72 hours of the accident.

• OUTPATIENT INTENSITY-MODULATED RADIATION THERAPY (IMRT) — Required for all outpatient IMRT services except IMRT related to the treatment of head, neck, breast, anal or prostate cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required for IMRT treatment of brain cancer.

• OUTPATIENT CARDIAC REHAB

• OUTPATIENT RESIDENTIAL TREATMENT — for any condition.

• CLINICAL TRIALS FOR CERTAIN ORGAN/TISSUE TRANSPLANTS — A transplant clinical trial may not be available for your condition. If you or your provider are considering a clinical trial, please contact us at the telephone number on the back of your FEP Blue Focus ID card for assistance in determining if a covered clinical trial is available in a covered facility.

• PRESCRIPTION DRUGS — Certain prescription drugs under our retail or mail-order pharmacy programs require prior approval. Contact CVS Caremark, our pharmacy program administrator, at 800-624-5060 to request prior approval or to obtain a list of drugs and supplies that require prior approval. Note: Updates to the list of drugs and supplies requiring prior approval are made periodically during the year.

• PROSTHETIC DEVICES (EXTERNAL) AND SPECIALTY DME — Includes but not limited to specialty hospital beds, deluxe wheelchairs, power wheelchairs, mobility devices including scooters, microprocessor limb prosthesis, electronic and externally powered prosthesis and related supplies.

• PULMONARY REHABILITATION

• RESIDENTIAL TREATMENT CENTER (RTC) — A preliminary treatment plan and discharge plan must be developed and agreed to by the member, provider (RTC), and case manager in the local plan where the RTC is located prior to admission.

• SURGICAL SERVICES — See the FEP Blue Focus Service Benefit Plan brochure for details on the following surgeries:
  — Morbid obesity
  — Gender reassignment surgery
  — Oral maxillofacial
  — Congenital anomalies
  — Breast reduction / augmentation
  — Reconstructive surgery for conditions other than breast cancer
  — Orthognathic surgery procedures, bone grafts, ostotomies and surgical management temporomandibular joint (TMJ)
  — Other — hip, knee, ankle, spine, shoulder, rhinoplasty, septroplasty, varicose vein, and all orthopedic procedures using computer-assisted musculoskeletal surgical intervention

View FEP medical policies.
Medicare supplement plans
Learn more.

Did you know Wellmark’s Employer Group Retiree Programs (EGRP) and Medicare supplement plans, like MedicareBlue SupplementSM and Senior Blue®, will only coordinate with a true Medicare plan? Benefits are not coordinated on a Medicare supplement plan claim if the primary is a private carrier policy, or Medicare Advantage plan (Medicare Part C).

In fact, patients must choose between a Medicare supplement plan alongside a true Medicare policy or replace the true Medicare policy with a Medicare Advantage plan. Wellmark will not process a Medicare supplement claim if the primary remittance is not a true Medicare Remittance Notice (MRN), meaning the claims processed under an original Medicare plan (Part A and/or B). If Medicare does not automatically crossover the claim to the Medicare supplement for processing, Wellmark requires the true MRN information be either entered electronically or the actual MRN submitted with a paper claim. Within the Claim Filing section of the Provider Guide, you can learn what needs to be included on the MRN and how to file a claim for a Wellmark Medicare supplement plan.

New medical utilization management tool
All pre-service review requests will be submitted electronically.

In our October issue of BlueInk, we let you know about some changes that will be occurring in fall 2019 to the pre-service review process for medical utilization management (UM). These changes are in addition to the new drug utilization management tool, NovoLogix, that is scheduled to launch in the spring of 2019.

The new medical UM tool will continue to improve efficiencies in the pre-service review process, including electronic submissions for all types of pre-service requests. For example, some types of requests that are currently submitted via fax or paper will transition to the new online tool when it launches. Watch for more communication regarding educational opportunities on the new tool beginning in the summer of 2019!
Advanced Care nurses are a valuable patient resource
Help when patients need it most.

You never want a patient to leave your office confused or overwhelmed by a diagnosis. It’s not the best experience — especially when the patient is probably not feeling the best in the first place. Wellmark’s team of Advanced Care nurses are here to help. They’re included with Wellmark health plans, helping members get more from their health insurance.

What do Advanced Care nurses do?
To understand the role that Advanced Care nurses could play in your patients’ health, consider this real-life example from a member who was diagnosed with stage four bile-duct cancer. After diagnosis, an Advanced Care nurse stayed in touch, at least monthly, to help the member work through ways to ease some of the many side effects of chemotherapy treatment. The nurse also prepared the member for doctor’s appointments by listing current side effects, how they are being managed, and questions to ask about the condition and treatment.

Not only do Advanced Care nurses walk members through the medical side of illness, but they’re also available to help navigate claims, spending, approvals between levels of care, and health care coverage. They will ensure that the member’s benefits allow for the coverage they will receive, so the focus can be getting better.

Who are Wellmark’s Advanced Care nurses?
Advanced Care nurses are clinically skilled registered nurses committed to developing individualized care plans with you to make sure our members’ needs are met. They help members cope with difficult health situations and make sure no one has to walk through their health concerns alone. Members can ask for their help with:

- Guidance toward better health choices like diet, exercise, and taking necessary medications
- Tools and education to help understand and work through health concerns
- Connections to resources and trustworthy people to help get the right care

It’s even possible an Advanced Care nurse will preemptively reach out to a member. If they’ve recently had a hospital stay or a health or drug claim that shows a complex health concern, the member may get a phone call from an Advanced Care nurse to learn more about their health care needs. From there, members can develop a relationship with their Advanced Care nurse to create a unique care plan.

This was the case with a Spanish-speaking member who was diagnosed with thyroid cancer. An Advanced Care nurse was able to use an interpreter line to overcome a language barrier and help the member develop questions for doctor’s appointments.

Are Advanced Care nurses available to my patients?
These experienced, caring nurses are available at no extra cost and are part of Wellmark health plans. The program is confidential, voluntary, reliable, friendly, and here to help.

To learn more about Wellmark’s Advanced Care nurses, call 800-552-3993 or encourage your patients to log in to their myWellmark® account.
Wellmark’s Pregnancy Support program is changing

All Wellmark members have access to this improved value-added benefit.

Wellmark’s improved Pregnancy Support program is available whenever your patients need us. It will continue to provide personalized, one-on-one support to members who need it, in addition to new, robust online resources via myWellmark®

What’s changing?

Effective Jan. 1, 2019, Wellmark’s Pregnancy Support program will be available as a value-added benefit to all members. The improved program will move to a more member-driven engagement model, with an interactive online experience via myWellmark. By simply logging in to myWellmark, your patients will have 24/7 access to new, trusted and helpful online resources, like WebMD® Pregnancy Assistant, Count the Kicks® and text4babySM.

One-on-one support is still available when needed

Members experiencing a high-risk pregnancy who choose to participate in the program will have the support of an Advanced Care nurse throughout their pregnancy journey. These high-risk cases will be identified via the self-assessment tool available in myWellmark and through claims data.

Members not experiencing a high-risk pregnancy may request a call from an Advanced Care nurse if they wish to participate.

TO LEARN MORE, view our Pregnancy Support flyer.
Recredentialing Tool has decreased administrative work for providers

E-credentialing Central launched two and a half years ago and, since then, significant strides have been made in providers’ ability to work efficiently with Wellmark.

Recredentialing with ease

The Recredentialing tool was made available from the beginning of E-cred Central, and has led to a reduction in manual data entry and time-consuming administrative steps for providers. Some of its main features include:

- **PRE-POPULATED APPLICATIONS**
  When using the Recredentialing Tool to complete a recredentialing application, much of the information will already be populated for you. This saves time and reduces the likelihood for human error. The recredentialing tool helps efficiency and accuracy because it displays information directly from Wellmark’s provider records.

- **NO PHYSICAL DOCUMENTS**
  Recredentialing notices arrive, are completed, and signed electronically. This improvement from the previous paper-only process has led to less back-and-forth between providers and Wellmark, and recredentialing applications being submitted quicker.

Learn more

Access educational webinars on [Wellmark.com/Provider/Webinars](http://Wellmark.com/Provider/Webinars). E-cred Central's Recredentialing Tool is specifically highlighted in the [E-Credentialing Central: Recredentialing Tool webinar](http://E-Credentialing Central: Recredentialing Tool webinar).

Access the E-cred Central User Guide located in the menu after you log in for help with various tools within E-cred Central. Use the user guide as your go-to resource.
Vitamin D removed from ACA preventive services recommendation

Effective Jan. 1, 2019, vitamin D will no longer be covered at zero cost share for adults 65 years of age and older.

The current Wellmark standard Affordable Care Act (ACA) preventive services list covers over-the-counter vitamin D supplements, either brand-name or generic, for adults 65 years of age and older. However, in April 2018, the United States Preventive Services Task Force (USPSTF) changed its recommendation for vitamin D for the prevention of falls in community-dwelling older adults to a ‘D’ rating. D-rated products are not required to be covered at zero cost share.

Effective Jan. 1, 2019

Wellmark will remove vitamin D supplements for adults 65 years of age and older from its standard coverage recommendation for ACA preventive services effective Jan. 1, 2019.

What does this mean?

Vitamin D supplements will no longer be covered at zero cost-share for members under ACA preventive benefits. Coverage will revert to the standard benefit design and cost share. Impacted members were mailed letters in November to alert them of this change.

Please reference the updated Preventive Services list at Wellmark.com/ACAPreventive.
Introducing the Specialty Copay Card Program from CVS Specialty™

Though specialty drugs are only a small portion of all drugs prescribed, they represent a large share of total drug spend.

By 2020, specialty drugs are expected to make up almost 50 percent of all drug sales.1 Additionally, the high cost of a new drug launch — due in part to expensive and complex research and development — leads to the increase in value of manufacturer-sponsored specialty copay card programs.

Traditionally, copay cards are applied as a secondary transaction after member cost-share is calculated based on their plan design. This limits the effectiveness of a tiered benefit design because members receive credit toward their out-of-pocket maximum (OPM) for their initial payment before the manufacturer’s copay card is used. With the exclusive specialty copay card program from CVS Specialty, the copay card is taken into account and any member savings are accurately reflected in the OPM accumulation.

CVS Specialty and its dedicated CareTeam were specifically chosen for their ability to provide members with the highest quality customer service, professional expertise and competitive rates.

Things to know

- This program requires exclusive use of CVS Specialty for all specialty drug prescriptions.
- Members can still use copay cards to help decrease their out-of-pocket costs for specialty drugs. However, these savings will be reflected in their OPM accumulation.
- Financial-need-based copay cards are not impacted.
- **INDIVIDUAL AND FAMILY PLAN CUSTOMERS** are automatically included in the exclusive CVS specialty pharmacy network beginning Jan. 1, 2019.
- **FULLY INSURED GROUP CUSTOMERS** are automatically included in the exclusive CVS specialty pharmacy network at renewal beginning Jan. 1, 2019.
- **SELF-FUNDED GROUP CUSTOMERS** can decide to participate for the upcoming plan year at renewal beginning Jan. 1, 2019.

Please remember to check member ID cards when prescribing specialty medications.

1 Segal Consulting: 2018 Segal Health Plan Cost Trend Survey
Wellmark formulary changes for January 2019

Part of our commitment to keeping drugs affordable, effective and safe for all of our members.

Wellmark and a statewide committee of pharmacists and physicians review the Wellmark Drug List several times a year. This review enables us to identify drugs that are the safest and most-effective, while reducing costs and ensuring members have access to the drugs they need.

Some of the formulary updates will change a member’s coverage and/or cost share for certain drugs. Members affected by these changes have been notified by mail and instructed to speak with their physician about lower-cost options. The formulary changes effective Jan. 1 impact approximately 3,300 Wellmark members.

BEGINNING JAN. 1, 2019, the below formulary changes will be effective:

### Changes

#### Across all formularies

<table>
<thead>
<tr>
<th>DRUG CATEGORY/CLASS</th>
<th>FORMULARY CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verzenio</td>
<td>MOVING FROM Specialty Preferred (SP-P) to Specialty Non-Preferred (SP-NP). Also, moving from Level 3 to Level 4 (BlueSimplicity).</td>
</tr>
</tbody>
</table>
| Jentadueto, Jentadueto XR | PREFERRED DRUG: Janumet®  
  • Moving from Tier 2 to Tier 4.  
  • Moving from Level 3 to Level 4 (BlueSimplicity).  
  • Prior authorization (PA) will be required. Janumet will be the preferred product in this class of drugs. |
| Tradjenta            | PREFERRED DRUG: Januvia®  
  • Moving from Tier 2 to Tier 4.  
  • Moving from Level 3 to Level 4 (BlueSimplicity).  
  • PA will be required. Januvia will be the preferred product in this class of drugs. |
| Forteo               | PREFERRED DRUG: Tymlos®  
  • PA will be required. Tymlos will be the preferred product in this class of drugs.  
  • Duration of coverage will be limited to 24 months in the member’s lifetime. |
| Tymlos               | PA will be required. Duration of coverage will be limited to 24 months in the member’s lifetime. |
| Fluoxetine tablets   | MOVING TO NOT COVERED as lower-cost alternatives are available. Fluoxetine capsules are available and contain the same medication in capsule form. |
| Theophylline capsules| MOVING TO NOT COVERED as lower-cost alternatives are available. Theophylline tablets are available and contain the same medication in tablet form. |

continued next page
Across all formularies (cont.)

<table>
<thead>
<tr>
<th>DRUG CATEGORY/CLASS</th>
<th>FORMULARY CHANGE</th>
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</thead>
<tbody>
<tr>
<td>Imipramine Pamoate capsules</td>
<td>MOVING TO NOT COVERED as lower-cost alternatives are available. Imipramine HCI tablets are available and contain a form of imipramine in tablet form.</td>
</tr>
<tr>
<td>Trazodone HCl 300mg tablet</td>
<td>MOVING TO NOT COVERED as lower-cost alternatives are available. Trazodone HCl 150mg tablets are available and contain the same medication but are half the strength, so require two tablets instead of one.</td>
</tr>
<tr>
<td>Tizanidine capsules</td>
<td>MOVING TO NOT COVERED as lower-cost alternatives are available. Tizanidine tablets are available and contain the same medication in tablet form. Zanaflex capsules will not be covered.</td>
</tr>
<tr>
<td>Copaxone 20mg and generics, including Glatopa 20mg</td>
<td>MOVING TO NOT COVERED as lower-cost alternatives are available. Brand and generic Copaxone 40mg, including Glatopa 40mg, are available. They contain a higher amount of the same medication that is in brand and generic Copaxone 20mg and only have to be administered three times per week.</td>
</tr>
</tbody>
</table>

BlueSimplicity only

<table>
<thead>
<tr>
<th>DRUG CATEGORY/CLASS</th>
<th>FORMULARY CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terbutaline tablets</td>
<td>Moving from Level 3 to Level 4.</td>
</tr>
<tr>
<td>Serevent Diskus</td>
<td>Moving from Level 3 to Level 4.</td>
</tr>
<tr>
<td>Fluoxetine 90mg capsule</td>
<td>Moving from Level 1 to Level 3.</td>
</tr>
<tr>
<td>Desipramine tablets</td>
<td>Moving from Level 2 to Level 4.</td>
</tr>
<tr>
<td>Duloxetine HCl 40mg capsule</td>
<td>Moving from Level 2 to Level 4.</td>
</tr>
<tr>
<td>Brand and generic Axert (almotriptan)</td>
<td>Moving from Level 2 to Level 4.</td>
</tr>
<tr>
<td>Brand and generic D.H.E. (dihydroergotamine) injection</td>
<td>Moving from Level 3 to Level 4.</td>
</tr>
<tr>
<td>Brand and generic Imitrex (sumatriptan) injection</td>
<td>Moving from Level 2 to Level 3.</td>
</tr>
<tr>
<td>Theophylline 12HR 300mg ER tablet</td>
<td>Moving from Level 3 to Level 4.</td>
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</table>
## Drugs moving to a lower tier

**Blue Rx**

<table>
<thead>
<tr>
<th>Drug Category/Class</th>
<th>Formulary Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amitiza</td>
<td>Moving from Tier 3 to Tier 2.</td>
</tr>
<tr>
<td>Linzess</td>
<td>Moving from Tier 3 to Tier 2.</td>
</tr>
<tr>
<td>Spiriva Respimat</td>
<td>Moving from Tier 3 to Tier 2.</td>
</tr>
<tr>
<td>Xiidra</td>
<td>Moving from Tier 3 to Tier 2.</td>
</tr>
<tr>
<td>Restasis</td>
<td>Moving from Tier 3 to Tier 2.</td>
</tr>
<tr>
<td>Latuda</td>
<td>Moving from Tier 4 to Tier 3.</td>
</tr>
<tr>
<td>Trintellix</td>
<td>Moving from non-formulary to Tier 4 (PA required).</td>
</tr>
</tbody>
</table>

**BlueSimplicity**

<table>
<thead>
<tr>
<th>Drug Category/Class</th>
<th>Formulary Change</th>
</tr>
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<tbody>
<tr>
<td>Striverdi Respimat</td>
<td>Moving from Level 4 to Level 3.</td>
</tr>
<tr>
<td>Anoro Ellipta</td>
<td>Moving from Level 5 to Level 3.</td>
</tr>
<tr>
<td>Trelegy Ellipta</td>
<td>Moving from Level 5 to Level 4.</td>
</tr>
<tr>
<td>Brand and generic Relpax (eletriptan)</td>
<td>Moving from Level 5 to Level 3.</td>
</tr>
<tr>
<td>Xiidra</td>
<td>Moving from Level 4 to Level 3.</td>
</tr>
<tr>
<td>Restasis</td>
<td>Moving from Level 4 to Level 3.</td>
</tr>
</tbody>
</table>

Wellmark updates its drug lists in January and July, and posts notices of changes at Wellmark.com. You can view all updates to the drug list on Wellmark.com ([For Providers > Drug Information > Wellmark Drug List](https://wellmark.com)) or request a copy by contacting Provider Service.