PREMERA | BLUE CROSS

# PHARMACY POLICY – 5.01.547

# Medical Necessity Criteria and Dispensing Quantity Limits for Exchange Formulary Benefits

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|---|---|
| Effective Date: | July 1, 2018 |
| Last Revised: | June 22, 2018 |
| Replaces: | N/A |

RELATED PHARMACY/MEDICAL POLICIES:

| | |
|---|---|
| 5.01.541 | Medical Necessity Exception Criteria for Closed Formulary Benefits and Dispense as Written (DAW) Exception Reviews |
| 5.01.605 | Medical Necessity Criteria for Pharmacy Edits |

**Select a hyperlink below to be directed to that section.**

POLICY CRITERIA | CODING | RELATED INFORMATION
EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

## Introduction

Step therapy is a way to provide safe and effective drugs. In step therapy, at least one drug on the health plan's list of covered drugs (the formulary) needs to be tried first. The first-use drugs are usually generic. A quantity limit is the amount of a specific drug that can be approved for a specific time period. This guideline describes the plan's step edits and quantity limits for specific drugs in the plan's formulary.

**Note:** The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

## Policy Coverage Criteria

**Note:** This policy applies only to closed formulary pharmacy benefits designed to be sold on state and federal insurance exchanges. (See **Definition of Terms** below.) As used in this policy, "Formulary" refers to the applicable formulary list specified in a member's contract. The policy

does not apply to open benefit designs in which non-formulary drugs are covered, though in some cases at a higher tier.

New regulatory requirements generated by implementation of the Affordable Care Act and the resulting creation of federal and state insurance exchanges have led to the creation of novel pharmacy benefit designs that differ substantially in structure, breadth of formularies and utilization management requirements. The following additional criteria will apply to these benefits:

| Medical Necessity Review | |
|---|---|
| **Drug** | **Medical Necessity** |
| **Actimmune® (interferon gamma-1b)** | **Actimmune® (interferon gamma-1b) may be considered medically necessary for:**<br>• Chronic granulomatous disease<br>• Severe malignant osteopetrosis |
| **Leukine® (sargramostim)** | **Leukine® (sargramostim) may be considered medically necessary for:**<br>• Acute myelogenous leukemia (following induction chemotherapy)<br>• Mobilization and following transplantation of autologous peripheral blood progenitor cells<br>• Myeloid reconstitution after (allogenic or autologous) bone marrow transplantation<br>• Bone marrow transplantation (allogenic or autologous) failure or engraftment delay |
| **Jakafi® (ruxolitinib)** | **Jakafi® (ruxolitinib) may be considered medically necessary for:**<br>• Myelofibrosis<br>• Polycythemia vera, after trial and failure of hydroxyurea |
| **Ilaris® (canakinumab)** | **Ilaris® (canakinumab) may be considered medically necessary for:**<br>• Periodic fever syndromes<br>  ○ Cryopyrin-associated periodic syndromes (CAPS)<br>  ○ Familial MediterraneanFever (FMF)<br>  ○ Hyperimmunoglobulin D syndrome (HIDS)/mevalonate kinase deficiency (MKD)<br>  ○ Tumor necrosis factor receptor associated periodic syndrome (TRAPS) |

| Medical Necessity Review | |
|---|---|
| **Drug** | **Medical Necessity** |
| | • Systemic juvenile idiopathic arthritis |

## Step Therapy Protocol

**A step therapy edit is a requirement that one or more specified first step agents be tried and failed before coverage will be provided for another second step agent.**

**Manual review for medical necessity is required, based on the following criteria:**

- Use of a second step agent may be considered medically necessary when the prescribing provider has documented that the required number of first step agents were tried and these agents were ineffective, not tolerated or contraindicated.

**OR**

- Use of a second step agent may be considered medically necessary when the prescribing provider has documented a patient-specific reason why this agent should be used as first-line therapy. These requests will be evaluated on a case-by-case basis.

## Drugs Subject to the Step Therapy Protocol

| Drug Class | Second Step Drugs | First Step Agents |
|---|---|---|
| Fluoroquinolones | Factive | ciprofloxacin, levofloxacin, moxifloxacin |
| Antiemetics | Anzemet | ondansetron, granisetron |
| | Cesamet | dexamethasone, granisetron. metoclopramide, ondansetron |
| Inhaled Antibiotics | Cayston | tobramycin (inhaled) |
| Nitroglycerin | Minitran, Nitro-Dur | nitroglycerin patch |
| Opioids, Long-acting | Nucynta ER | morphine ER, OxyContin, fentanyl transdermal, tramadol hcl ER |
| Opioids, Short-acting | Nucynta, Oxecta | morphine sulfate, oxycodone, hydromorphone, tramadol hcl |
| Overactive Bladder | Myrbetriq, Toviaz, Vesicare | oxybutynin chloride, tolterodine, trospium |
| Topicals, Corticosteroid | U-Cort | hydrocortisone + urea |
| Respiratory | Ventolin HFA | Proair |
| Gout | Colchicine | Colcrys |
| Pain | Butrans | 1 non-opioid medication (i.e. gaba-analogues, tricyclic antidepressants, SNRI's, NSAID's, etc.) AND 1 immediate-release opioid (i.e. oxycodone, morphine, hydromorphone, |

| Drugs Subject to the Step Therapy Protocol | | |
|---|---|---|
| **Drug Class** | **Second Step Drugs** | **First Step Agents** |
| | | etc.) |
| Acne | Epiduo forte, Tazorac, tazarotene | Generic benzoyl peroxide/clindamycin gel, AND generic topical tretinoin cream or gel, AND a generic tetracycline (doxycycline or minocycline) |
| Anti-platelet | Brilinta | Clopidogrel |
| Anti-hypertensive | Bystolic | Trial and failure of two preferred medications: metoprolol, atenolol, or bisoprolol |
| Anti-lipemic | Welchol | Trial and failure of two preferred medications: colestipol, cholestyramine, or Prevalite |
| Ophthalmic corticosteroids | Lotemax | Trial and failure of two preferred medications: prednisolone, dexamethasone, or FML eye drops |
| Angina | Ranexa | Trial and failure of at least 2 generic beta-blockers |
| Antidepressant | Emsam | Trial and failure of two preferred medications: generic SSRI and/or a generic SNRI |
| Bowel preps | Suprep | Generic PEG solution |

## Dispensing Quantity Limits

The following dispensing quantity limits are based on the maximum dose recommendations in the product's FDA-approved labeling. This information is available for each product at the manufacturer's web site or **www.fda.gov**. Drugs with Dispensing Quantity Limits are listed in the following table:

| Drug | Dosage / Strength | Quantity Limit |
|---|---|---|
| Advair Diskus | 100/50 with device (14 blister diskus) | Limit: 14 blisters per fill |
| Advair Diskus | 100/50 with device (28 blister diskus) | Limit: 28 blisters per fill |
| Advair Diskus | 100/50 with device (60 blister diskus) | Limit: 1 device per fill |
| Advair Diskus | 250/50 with device (14 blister diskus) | Limit: 14 blisters per fill |
| Advair Diskus | 250/50 with device (28 blister diskus) | Limit: 28 blisters per fill |
| Advair Diskus | 250/50 with device (60 blister diskus) | Limit: 1 device per fill |
| Advair Diskus | 500/50 with device (14 blister diskus) | Limit: 14 blisters per fill |
| Advair Diskus | 500/50 with device (28 blister diskus) | Limit: 28 blisters per fill |
| Advair Diskus | 500/50 with device (60 blister diskus) | Limit: 1 device per fill |

| Drug | Dosage / Strength | Quantity Limit |
|---|---|---|
| Advair HFA (120) | 45/21 mcg | Limit: 1 device per fill |
| Advair HFA (120) | 115/21 mcg | Limit: 1 device per fill |
| Advair HFA (120) | 230/21 mcg | Limit: 1 device per fill |
| Advair HFA (60) | 45/21 mcg | Limit: 1 device per fill |
| Advair HFA (60) | 115/21 mcg | Limit: 1 device per fill |
| Advair HFA (60) | 230/21 mcg | Limit: 1 device per fill |
| Aerospan | 80mcg/inh (8.9g) | Limit: 2 inhalers per fill |
| Akynzeo | 300-0.5mg | Limit: 1 capsule per fill |
| Alora | 0.025 mg/day patch | Limit: 8 patches per 30 days |
| Alora | 0.05 mg/day patch | Limit: 8 patches per 30 days |
| Alora | 0.075 mg/day patch | Limit: 8 patches per 30 days |
| Alora | 0.1 mg/day patch | Limit: 8 patches per 30 days |
| Alvesco | 160 mcg (120 actuations) 9.6 g canister | Limit: 1 inhaler per fill |
| Alvesco | 160 mcg(60 actuations) 6.1 g canister | Limit: 2 inhalers per fill |
| Alvesco | 80 mcg (60 actuations) 6.1g canister | Limit: 1 inhaler per fill |
| Anzemet | 50 mg tablet | Limit:3 tablets per fill |
| Anzemet | 100 mg tablet | Limit: 3 tablets per fill |
| Arnuity Ellipta | 100mcg (14 blisters) | Limit: 1 inhaler per fill |
| Arnuity Ellipta | 100mcg (30 blisters) | Limit: 1 inhaler per fill |
| Arnuity Ellipta | 200mcg (14 blisters) | Limit: 1 inhaler per fill |
| Arnuity Ellipta | 200mcg (30 blisters) | Limit: 1 inhaler per fill |
| Asmanex HFA | 100mcg/inh | Limit: 1 inhaler per fill |
| Asmanex HFA | 200mcg/inh | Limit: 1 inhaler per fill |
| Asmanex Twisthaler | 110 mcg/inh (7 inhalations) | Limit: 1 inhaler per fill |
| Asmanex Twisthaler | 110 mcg/inh (14 inhalations) | Limit: 1 inhaler per fill |
| Asmanex Twisthaler | 110 mcg/inh (30 inhalations) | Limit: 1 inhaler per fill |
| Asmanex Twisthaler | 220 mcg/inh (14 inhalations) | Limit: 1 inhaler per fill |
| Asmanex Twisthaler | 220 mcg/inh (30 inhalations) | Limit: 1 inhaler per fill |
| Asmanex Twisthaler | 220 mcg/inh (60 inhalations) | Limit: 1 inhaler per fill |
| Asmanex Twisthaler | 220 mcg/inh (120 inhalations) | Limit: 1 inhaler per fill |

| Drug | Dosage / Strength | Quantity Limit |
|---|---|---|
| Atrovent HFA | 12.9 gm Aerosol | Limit: 2 inhalers per fill |
| Avinza | 30 mg capsule | Limit: 60 tablets per 30 days |
| Avinza | 45 mg capsule | Limit: 60 tablets per 30 days |
| Avinza | 60 mg capsule | Limit: 60 tablets per 30 days |
| Avinza | 75 mg capsule | Limit: 60 tablets per 30 days |
| Avinza | 90 mg capsule | Limit: 60 tablets per 30 days |
| Avinza | 120 mg capsule | Limit: 60 tablets per 30 days |
| Avonex | 30 mcg prefilled syringe | Limit: 4 syringes per 30 days |
| Avonex | 30 mcg vial | Limit: 4 vials per 30 days |
| Avonex Admin Pack | 30 mcg | Limit: 4 kits per 30 days |
| Avonex Pen | 30 mcg/0.5 ml pen | Limit: 1 box (4 pens) per 30 days |
| Betaseron | 0.3 mg vial | Limit: 14 prefilled diluent syringes per 30 days |
| Cesamet | 1 mg capsule | Limit: 30 capsules per fill |
| Climara (estradiol) | 0.025 mg/day patch | Limit: 4 patches per 30 days |
| Climara (estradiol) | 0.0375 mg/day patch | Limit: 4 patches per 30 days |
| Climara (estradiol) | 0.05 mg/day patch | Limit: 4 patches per 30 days |
| Climara (estradiol) | 0.06 mg/day patch | Limit: 4 patches per 30 days |
| Climara (estradiol) | 0.075 mg/day patch | Limit: 4 patches per 30 days |
| Climara (estradiol) | 0.1 mg/day patch | Limit: 4 patches per 30 days |
| Climara Pro | 0.045 mg/ 0.015 mg/day patch | Limit: 4 patches per 30 days |
| Combivent Respimat | 20mcg-100mcg | Limit: 2 inhalers per fill |
| Copaxone (glatiramer) | 20 mg prefilled syringe | Limit: 1 kit (30 prefilled syringes) per 30 days |
| Copaxone (glatiramer) | 40 mg prefilled syringe | Limit: 12 per 30 days |
| Divigel | 0.1% (0.25 g/packet) | Limit: 30 packets per fill |
| Divigel | 0.1% (0.5 g/packet) | Limit: 30 packets per fill |
| Divigel | 0.1% (1g/packet) | Limit: 30 packets per fill |
| Duetact | 30/2mg tablet | Limit: 30 tablets per fill |
| Duetact | 30/4mg tablet | Limit: 30 tablets per fill |
| Dulera | 100mcg/5mcg | Limit: 1 inhaler per fill |

| Drug | Dosage / Strength | Quantity Limit |
|---|---|---|
| Dulera | 200mcg/5mcg | Limit: 1 inhaler per fill |
| Elestrin gel | 0.06% gel meter dose pump | Limit: 52 grams (2 pumps) per fill |
| Embeda ER | 20mg-.08mg | Limit: 90 capsules per 30 days |
| Embeda ER | 30mg-1.2mg | Limit: 90 capsules per 30 days |
| Embeda ER | 50mg-2mg | Limit: 90 capsules per 30 days |
| Embeda ER | 60mg-2.4mg | Limit: 90 capsules per 30 days |
| Embeda ER | 80mg-3.2mg | Limit: 90 capsules per 30 days |
| Embeda ER | 100mg-4mg | Limit: 90 capsules per 30 days |
| Emend | 40 mg capsule | Limit: 1 capsule per fill |
| Emend | 80 mg capsule | Limit: 2 capsules per fill |
| Emend | 125 mg capsule | Limit: 1 capsule per fill |
| Emend | 150mg injection | Limit: 1 vial per fill |
| Emend | Bifold pack | Limit: 1 pack per fill |
| Emend | Trifold Pack, contains one 125 mg and two 80 mg capsules | Limit: 1 pack (package size 3) per fill |
| Estraderm | 0.05 mg/day patch | Limit: 8 patches per 30 days |
| Estraderm | 0.1 mg/day patch | Limit: 8 patches per 30 days |
| Estrasorb | 4.35 mg per 1.74 g pouch | Limit: 56 packets (97.44 g) per fill |
| Estrogel | 0.06% 50 gm pump | Limit: 1 pump per fill |
| Evamist | 1.53 mg spray | Limit: 2 pumps per fill |
| Exalgo | 8 mg tablet | Limit: 60 tablets per 30 days |
| Exalgo | 12 mg tablet | Limit: 60 tablets per 30 days |
| Exalgo | 16 mg tablet | Limit: 60 tablets per 30 days |
| Exalgo | 32 mg tablet | Limit: 60 tablets per 30 days |
| Extavia | 0.3 mg kit | Limit: 15 blister units/vials per 30 days |
| Extavia | 0.3 mg vial | Limit: 15 blister units/vials per 30 days |
| Flovent Diskus | Powder 100mcg (1 device = 60 doses) | Limit: 1 inhaler per fill |
| Flovent Diskus | Powder 250mcg (1 device = 60 doses) | Limit: 4 inhalers per fill |
| Flovent Diskus | Powder 50mcg (1 device = 60 doses) | Limit: 1 inhaler per fill |
| Flovent HFA | Aerosol 10.6 gm (120 doses; 44 mcg/dose) | Limit: 1 inhaler per fill |

| Drug | Dosage / Strength | Quantity Limit |
|---|---|---|
| Flovent HFA | Aerosol 12 gm (120 doses; 110 mcg/dose) | Limit: 1 inhaler per fill |
| Flovent HFA | Aerosol 12 gm (120 doses; 220 mcg/dose) | Limit: 2 inhalers per fill |
| Granisetron | 1 mg tablet | Limit: 6 tablets per fill |
| Incruse Ellipta | 62.5mcg (7 blister) | Limit: 1 inhaler per fill |
| Incruse Ellipta | 62.5mcg (30 blister) | Limit: 1 inhaler per fill |
| Ipratropium/albuterol | 3ml vial | Limit: 180 vials per fill |
| Kadian (morphine sulfate er caps) | 10 mg capsule | Limit: 90 capsules per 30 days |
| Kadian (morphine sulfate er caps) | 20 mg capsule | Limit: 90 capsules per 30 days |
| Kadian (morphine sulfate er caps) | 30 mg capsule | Limit: 90 capsules per 30 days |
| Kadian | 40 mg capsule | Limit: 90 capsules per 30 days |
| Kadian (morphine sulfate er caps) | 50 mg capsule | Limit: 90 capsules per 30 days |
| Kadian (morphine sulfate er caps) | 60 mg capsule | Limit: 90 capsules per 30 days |
| Kadian | 70 mg capsule | Limit: 90 capsules per 30 days |
| Kadian (morphine sulfate er caps) | 80 mg capsule | Limit: 90 capsules per 30 days |
| Kadian (morphine sulfate er caps) | 100 mg capsule | Limit: 90 capsules per 30 days |
| Kadian | 130 mg capsule | Limit: 90 capsules per 30 days |
| Kadian | 150 mg capsule | Limit: 90 capsules per 30 days |
| Kadian | 200 mg capsule | Limit: 90 capsules per 30 days |
| Menostar | 14 mcg/day patch | Limit: 4 patches per 30 days |
| Minivelle | 0.0375 mg patch | Limit: 8 patches per 30 days |
| Minivelle | 0.05 mg patch | Limit: 8 patches per 30 days |
| Minivelle | 0.075 mg patch | Limit: 8 patches per 30 days |
| Minivelle | 0.1 mg patch | Limit: 8 patches per 30 days |
| MS Contin (morphine sulfate er tabs) | 15 mg tablet | Limit: 120 tablets per 30 days |
| MS Contin (morphine sulfate er tabs) | 30 mg tablet | Limit: 120 tablets per 30 days |
| MS Contin (morphine sulfate er tabs) | 60 mg tablet | Limit: 120 tablets per 30 days |
| MS Contin (morphine sulfate er | 100 mg tablet | Limit: 120 tablets per 30 days |

| Drug | Dosage / Strength | Quantity Limit |
|---|---|---|
| tabs) | | |
| MS Contin (morphine sulfate er tabs) | 200 mg tablet | Limit: 120 tablets per 30 days |
| Nucynta | 50 mg tablet | Limit: 181 tablets per fill |
| Nucynta | 75 mg tablet | Limit: 181 tablets per fill |
| Nucynta | 100 mg tablet | Limit: 181 tablets per fill |
| Nucynta ER | 50 mg tablet | Limit: 60 tablets per 30 days |
| Nucynta ER | 100 mg tablet | Limit: 60 tablets per 30 days |
| Nucynta ER | 150 mg tablet | Limit: 60 tablets per 30 days |
| Nucynta ER | 200mg tablet | Limit: 60 tablets per 30 days |
| Nucynta ER | 250mg tablet | Limit: 60 tablets per 30 days |
| Opana ER | 5 mg tablet | Limit: 90 tablets per 30 days |
| Opana ER | 7.5 mg tablet | Limit: 90 tablets per 30 days |
| Opana ER | 10 mg tablet | Limit: 90 tablets per 30 days |
| Opana ER | 15 mg tablet | Limit: 90 tablets per 30 days |
| Opana ER | 20 mg tablet | Limit: 90 tablets per 30 days |
| Opana ER | 30 mg tablet | Limit: 90 tablets per 30 days |
| Opana ER | 40 mg tablet | Limit: 90 tablets per 30 days |
| Oramorph SR | 15 mg tablet | Limit: 120 tablets per 30 days |
| Oramorph SR | 30 mg tablet | Limit: 120 tablets per 30 days |
| Oramorph SR | 60 mg tablet | Limit: 120 tablets per 30 days |
| Oramorph SR | 100 mg tablet | Limit: 120 tablets per 30 days |
| OxyContin | 10mg tablet | Limit: 90 tablets per 30 days |
| OxyContin | 15 mg tablet | Limit: 90 tablets per 30 days |
| OxyContin | 20mg tablet | Limit: 90 tablets per 30 days |
| OxyContin | 30 mg tablet | Limit: 90 tablets per 30 days |
| OxyContin | 40mg tablet | Limit: 90 tablets per 30 days |
| OxyContin | 60 mg tablet | Limit: 120 tablets per 30 days |
| OxyContin | 80mg tablet | Limit: 120 per 30 days |
| Plegridy | 125mcg/0.5ml pen | Limit: 2 pens per 30 days |
| Plegridy | 63/94mcg starter pack | Limit: 1 starter pack per 365 days |

| Drug | Dosage / Strength | Quantity Limit |
|---|---|---|
| Pulmicort Flexhaler | 90mcg/actuation | Limit: 1 inhalers per fill |
| Pulmicort Flexhaler | 180mcg/actuation | Limit: 2 inhaler per fill |
| Pulmicort Respules (budesonide) | 0.25mg/2 mL | Limit: 60 respules per fill |
| Pulmicort Respules budesonide) | 0.5mg/2 mL | Limit: 60 respules per fill |
| Pulmicort Respules budesonide) | 1mg/2 mL | Limit: 30 respules per fill |
| Qvar HFA | 40mcg | Limit: 2 inhalers per fill |
| Qvar HFA | 80mcg | Limit: 3 inhalers per fill |
| Rebif | 22mcg syringe | Limit: 12 syringes per 30 days |
| Rebif | 44mcg syringe | Limit: 12 syringes per 30 days |
| Rebif | Titration pack | Limit: 1 package per 30 days |
| Relenza | 5 mg Diskhaler | Limit: 40 blisters (2 cartons) per 365 days |
| Sancuso | 3.1 mg/24 hour patch | Limit: 1 patch per fill |
| Spiriva | 18 mcg capsule for use with inhalation device, 30 capsules | Limit: 1 package per fill |
| Spiriva | 18 mcg capsule for use with inhalation device, 5 capsules (1 blister card) | Limit: 1 package per fill |
| Spiriva | 18 mcg capsule for use with inhalation device, 90 capsules (6 blister cards) | Limit: 1 package (90 doses) per fill |
| Spiriva Respimat | 4gm inhaler (28 spray) | Limit: 1 inhaler per fill |
| Spiriva Respimat | 4gm inhaler (60 spray) | Limit: 1 inhaler per fill |
| Suboxone | 12/3 mg film | Limit: 60 films per fill |
| Suboxone | 2/0.5 mg film | Limit: 90 films per fill |
| Suboxone | 2/0.5 mg tablet | Limit: 90 tablets per fill |
| Suboxone | 4/1 mg film | Limit: 90 films per fill |
| Suboxone | 8/2 mg film | Limit: 90 films per fill |
| Suboxone | 8/2 mg tablet | Limit: 90 tablets per fill |
| Symbicort | 80/4.5 mcg inhaler | Limit: 1 package per fill |
| Symbicort | 160/4.5 mcg inhaler | Limit: 1 package per fill |
| Tamiflu | 6 mg/ml suspension | Limit: 6 bottles per 365 days |
| Tamiflu | 12 mg/ml suspension | Limit: 6 bottles per 365 days |
| Tamiflu | 30 mg capsule | Limit: 40 capsules per 365 days |

| Drug | Dosage / Strength | Quantity Limit |
|---|---|---|
| Tamiflu | 45 mg capsule | Limit: 20 capsules per 365 days |
| Tamiflu | 75 mg capsule | Limit: 20 capsules per 365 days |
| Tudorza Pressair | 400 mcg inhaler | Limit: 1 inhaler per fill |
| Vivelle (estradiol) | 0.025 mg patch | Limit: 8 patches per 30 days |
| Vivelle (estradiol) | 0.0375 mg patch | Limit: 8 patches per 30 days |
| Vivelle (estradiol) | 0.05 mg patch | Limit: 8 patches per 30 days |
| Vivelle (estradiol) | 0.075 mg patch | Limit: 8 patches per 30 days |
| Vivelle (estradiol) | 0.1 mg patch | Limit: 8 patches per 30 days |
| Vivelle-Dot (estradiol) | 0.025 mg patch | Limit: 8 patches per 30 days |
| Vivelle-Dot (estradiol) | 0.0375 mg patch | Limit: 8 patches per 30 days |
| Vivelle-Dot (estradiol) | 0.05 mg patch | Limit: 8 patches per 30 days |
| Vivelle-Dot (estradiol) | 0.075 mg patch | Limit: 8 patches per 30 days |
| Vivelle-Dot (estradiol) | 0.1 mg patch | Limit: 8 patches per 30 days |
| Zofran (ondansetron) | 4 mg tablet | Limit: 9 tablets per fill |
| Zofran (ondansetron) | 8 mg tablet | Limit: 9tablets per fill |
| Zofran (ondansetron) | 24 mg tablet | Limit: 1 tablet per fill |
| Zofran (ondansetron) | 4mg/5ml solution | Limit: 2 bottles per fill |
| Zofran ODT (ondansetron ODT) | 4 mg tablet | Limit: 9 orally disintegrating tab per fill |
| Zofran ODT (ondansetron ODT) | 8 mg tablet | Limit: 9 orally disintegrating tab per fill |
| Zubsolv | 1.4 mg/0.36 mg tablet | Limit: 90 tablets per fill |
| Zubsolv | 5.7 mg/1.4 mg tablet | Limit: 90 tablets per fill |
| Zubsolv | 8.6mg/2.1mg tablet | Limit: 60 tablets per fill |
| Zuplenz | 4 mg soluble film | Limit: 9 films per fill |
| Zuplenz | 8 mg soluble film | Limit: 9 films per fill |
| Zinbryta | 150mg/mL | Limit: 1 syringe per 30 days |

## Coding

N/A

## Related Information

### Definition of Terms

**Closed formulary benefit:** A closed formulary benefit is one that routinely covers only formulary (preferred) drugs. A non-formulary drug may be covered when its use has been determined to be medically necessary after a review of the individual clinical case circumstances.

**Formulary:** A formulary is a list of drugs approved by the Pharmacy and Therapeutics Committee (P&T) for routine use. A well-designed formulary should provide adequate drug selection to meet the treatment needs of most patients; however, there will always be exceptional cases where a non-formulary drug may be the best therapeutic choice.

**Formulary drug:** A formulary drug (also known as a preferred drug) is a drug that is on the formulary list. Drugs that are not on the list are referred to as non-formulary drugs.

**Label:** Product label refers to the FDA approved prescribing information that is available for every legend drug approved for use in the U.S. The label includes indications, contraindications, recommended dosing, warnings, precautions, side effects, drug interactions and information on safety in pregnancy and other special populations. The drug's pharmacology, pharmacokinetics, and available dosage forms are also provided. The current format also includes a summary of the pivotal clinical trials that were submitted to FDA in support of the New Drug Application.

This prescribing information is included as a package insert with the product and is available on the manufacturer's Web site.

**Quantity limits:** A quantity limit is the maximum amount of a medication that may be dispensed during a given calendar period or at one prescription fill without an exception request. Dispensing of a larger quantity may be approved, based on individual case review. A specified larger quantity may be approved when patient-specific circumstances require it, or when published clinical evidence supports a higher dose protocol.

**Note:** Dispensing quantity limits are not intended to apply in circumstances where logistics may dictate otherwise. These circumstances include but are not limited to member vacation or business travel, disruption of normal prescription supply chains due to adverse weather events or other disasters and members living in remote areas where travel to the nearest pharmacy may sometimes be problematic.

**Step therapy:** A step therapy edit is a requirement that one or more specified first step agents be tried and failed before coverage will be provided for another second step agent. Step therapy requirements are based upon evidence from published, peer-reviewed clinical studies demonstrating that first-line use of the first step agents is clinically reasonable in most circumstances.

## Benefit Application

This coverage is managed through the Pharmacy benefit.

# Evidence Review

## Rationale

Step therapy edits are designed to channel utilization toward drugs that are at least as safe and effective and lower cost than other similar drugs that are also available. In many cases, the first step drugs in a particular edit algorithm are generics and the second step alternatives are brands that are more expensive and offer no proven incremental clinical benefit compared to the first step drugs. Step therapy, prior authorization and other similar utilization management tools are designed to steer members toward more cost-effective therapeutic choices and are thus an important component of affordable benefit designs.

Recent trends in prescription drug prices in the United States have led to an increased pressure on health care providers to keep down the cost of prescription medication while maintaining high levels of availability to the patient. Mandatory controls will become more important in plan designs that meet the Essential Health Benefit (EHB) requirements of the Affordable Care Act. In making care more accessible to members, the EHB requirements limit some of the financial incentives that have been developed to incent members to select lower cost alternatives. Furthermore, many manufacturers provide copay coverage, eliminating any additional cost impact to the member. Well designed and clinically based step therapy programs thus encourage proper drug selection without negative effects on members.

Motheral and colleagues published a retrospective database analysis of three step therapy programs implemented in a 20,000 member plan in 2002. The three edits targeted proton pump inhibitors, selective serotonin reuptake inhibitors and nonsteroidal anti-inflammatory drugs,

respectively. The investigators studied two years' worth of pharmacy claims of the intervention group against a comparator group of members from similar plans that did not have the three step therapy programs. Per member per month costs (PMPM) decreased by $0.83 in the intervention group, compared to a $0.10 rise on in the comparator group. A mailed self-administered member survey found that 30% received a generic, 23% were granted an exception and received the originally requested drug, 16% paid the full prescription price and 17% received no drug. Patients were 8 times more likely to receive a covered medication when the pharmacist called the prescriber. Failure to receive a covered medication reduced member satisfaction. The authors concluded that step therapy programs do reduce plan cost, but improving members' and providers' understanding of the programs would improve their outcomes and member satisfaction.[1]

A major objection to step therapy and other prior authorization programs has always been the administrative effort by provider office staff required to process exception requests. Historically, studies that attempted to measure this have reported conflicting results. A recent study by Morley, et al. estimated an average annual cost of $2,161 to $3,430 per clinic physician FTE. Over 50% of the staff time spent on prior authorization processing was by clerical staff. Less than 10% was by physicians, the remainder being provided by nurses and physician assistants.[2] The authors believe that further analysis is warranted, and with the expected improvement in ubiquity and interoperability of health information systems, it is likely that the administrative effort will be further reduced. A small convenience sample study at the Cambridge Health Alliance psychiatric emergency department found that prior authorization requirements for medications did add much to the time spent in ER prior to discharge.[3]

Prior authorization, step therapy and quantity limits are typical features of managed Medicare and Medicaid programs. Soumerai and colleagues, Hoadley and others have studied the effect of these interventions and generally report that they save plan cost and move utilization toward lower cost generic and preferred brand drugs without major impact on adherence.[4-6]

Quantity limits in this policy are based on maximum FDA approved dose as stated in the product label. These limits represent the upper bound of the dose range that has been shown to balance safety and efficacy as demonstrated by clinical trial data contained in the New Drug Application (NDA) or supplemental application (sNDA) for higher labeled dosing.[7] Quantities in excess of the limits in this policy may be approved based on adequate evidence from published peer reviewed clinical studies.

## 2018 Update

Review of current FDA labeling. Added Leukine indication for myeloid reconstitution after autologous bone marrow transplantation. No other changes required.

## References


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7. 21 CFR 201.5: Labeling Requirements for Prescription Drugs. Adequate Directions for Use. Available at **http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCFR/CFRSearch.cfm?CFRPart=201** Accessed June 2018.
8. Actimmune Prescribing Information. Horizon. Lake Forest, IL. Revised: 5/2017.
9. Leukine Prescribing Information. Sanofi-Aventis. Bridgewater, NJ. Revised: 4/2013.
10. Jakafi Prescribing Information. Incyte Corporation. Wilmington, DE. Revised: 10/2017.
11. Ilaris Prescribing Information. Novartis. East Hanover, NJ. Revised: 12/16.


## History

| Date | Comments |
|---|---|
| 09/09/13 | New policy, add to Prescription Drug section. |
| 12/09/13 | Replace policy. Policy section reflects updates to the Step Therapy and Dosing Limits tables. |

| Date | Comments |
|---|---|
| 03/10/14 | Annual Review. Step Therapy Protocol and Dosing Limit Tables updated within the Policy section. |
| 04/14/14 | Interim Review. Step Therapy Protocol and Dosing Limit Tables updated within the Policy section. Sedative hypnotic drugs quantity level limit for 30-day period added to the Policy Guidelines section. |
| 08/11/14 | Interim Update. Formulary table updated; Myrbetriq added to the list of approved second-step agents for overactive bladder; Ibuprofen and meloxicam replaced with diclofenac, generic NSAIDs under miscellaneous topicals; Hetlioz removed from the dosing table (addressed in a separate policy). Policy Guidelines updated within the Sedative Hypnotic Drugs Quantity Level Limit for 30-Day Period section. |
| 12/08/14 | Interim Review. Covered to Benefit Coverage Guideline template. Coverage criteria updated within the step-therapy table in the Coverage Guideline section. |
| 01/13/15 | Annual Review. Dispensing quantity limits table updated within the Policy section; Plegridy and Trulicity added. |
| 02/10/15 | Interim Review. Quantity limits updated on Relenza and Tamiflu to indicate the quantities are per 365 days and not per 30 days as previously indicated. |
| 03/10/15 | Interim Review. Updated quantity limits added to drugs as appropriate; drugs for which a PA is no longer required removed from the policy. |
| 04/14/15 | Interim Review. Updated quantity limits added to drugs as appropriate; drugs for which a PA is no longer required removed from the policy; new drugs added which are now on the PA list. |
| 06/09/15 | Interim Review. Step therapy table updated; anticoagulants and corticosteroid ApexiCon E removed. Dosing table updated with the removal of Alendronate, Ambien, Ambien CR, Atelvia, Dalmane, Doral, Edluar, Halcion, Intermezzo, Lunesta, Prosom, Restoril, Rozerem, Silenor, Sonata, and Zolpimist. Information stricken regarding sedative hypnotic drug quantity level limits. |
| 08/11/15 | Interim Update. Chantix removed edit as of 7/21/15, and Beta agonist inhalers: removed quantity limit as of 7/21/15. |
| 10/13/15 | Interim Update. Removed Lofibra and Tricor from Fibrate step edit as they are no longer formulary medications; removed Azelex, Finacea, Tazorac, Tretin-X from the Acne Topical section as housekeeping as these edits have been removed but policy was not updated; removed Ala-Scalp from Corticosteroid Topical section as it is no longer a formulary medication; removed Cortane-B and Vectical from Misc Topical section as they are no longer formulary medications; removed Triptans from this policy as the step edit has been retired from this policy; removed ActoPlus Met, Actos, Avandamet, Avandia, Avandryl, Bydureon, Byetta, Farxiga, Invokana, Invokamet, Janumet, Janumet XR, Januvia, Jardiance, Jentadueto, Kazano, Kombiglyze XR, Nesina, Onglyza, Oseni, PrandiMet, Symlin, Tradjenta, Trulicity, Victoza and Xigduo as the quantity limit rule is being removed; removed Brovana as housekeeping as the quantity limit was previously moved but medical policy was not updated; added |

| Date | Comments |
|---|---|
| | generic name of estradiol to Vivelle as there is now a generic available that is also targeted under quantity limit rule. |
| 02/09/16 | Annual Review. Policy updated; the following drugs were removed since there is no longer an edit: Ultravate PAC, Analpram-E, Lac-Hydrin, Momexin, and Voltaren Gel. |
| 07/01/16 | Interim Update, approved June 14, 2016. Crestor and Livalo removed from step edit as of 6/15/16; Cholesterol medications removed from quantity limit as of 6/15/16; Enablex and Synalar Solution removed from step edit as of 7/1/16 due to change to non-formulary status. |
| 01/01/17 | Interim Review, approved December 13, 2016. Removal of the quantity limits for the trans-mucosal fentanyl products (TURFs) due to implementation of the diagnosis-based edit for those products. Addition of the quantity limit for Zinbryta used for Multiple Sclerosis. |
| 03/01/17 | Annual Review, approved February 14, 2017. Copaxone 40mg quantity limit was added to the table, while Forteo quantity limit was removed. Also, removed Fenoglide and Lipofen from step-therapy table. |
| 07/01/17 | Benefit Coverage Guideline moved into new format. No changes to policy statement. |
| 12/01/17 | Interim Review, approved November 9, 2017. Added generic glatiramer. |
| 01/01/18 | Interim Review, approved December 12, 2017. Added new medications to be targeted on 1/1/18 (Actimmune, Leukine, Jakafi, Ilaris, Ventolin HFA, colchicine, Butrans, Epiduo Forte, Tazorac, tazarotene, Brilinta, Welchol, Lotemax, Ranexa, Emsam, Suprep). |
| 02/01/18 | Annual Review, approved January 30, 2018. Review of current FDA labeling; no changes to policy statements. |
| 05/01/18 | Annual Review, approved April 18, 2018. Review of current FDA labeling. Added Leukine indication for myeloid reconstitution after autologous bone marrow transplantation. |
| 07/01/18 | Interim Review, approved June 22, 2018. Updated indication and first-step agents for Emsam. |



**Scope**: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member

benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.

PREMERA | BLUE CROSS

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Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
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You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

## Getting Help in Other Languages

**This Notice has Important Information.** This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

**አማሪኛ (Amharic):**
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በእከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት።በስልክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

**العربية (Arabic):**
**يحوي هذا الإشعار معلومات هامة.** قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ800-722-1471 (TTY: 800-842-5357)

**中文 (Chinese):**
**本通知有重要的訊息。**本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。

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**Beeksisni kun odeeffannoo barbaachisaa qaba.** Beeksisti kun sagantaa yookan karaa Premera Blue Cross tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-722-1471 (TTY: 800-842-5357) tii bilbilaa.

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**Cet avis a d'importantes informations.** Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-722-1471 (TTY: 800-842-5357).

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**Avi sila a gen Enfòmasyon Enpòtan ladann**. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-722-1471 (TTY: 800-842-5357).

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**Diese Benachrichtigung enthält wichtige Informationen.** Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-722-1471 (TTY: 800-842-5357).

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**Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb.** Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Premera Blue Cross. Tej zaum muaj cov hnub tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-722-1471 (TTY: 800-842-5357).

**Iloko (Ilocano):**
**Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion.** Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti apliksayonyo wenno coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-722-1471 (TTY: 800-842-5357).

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**Questo avviso contiene informazioni importanti.** Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-722-1471 (TTY: 800-842-5357).

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**この通知には重要な情報が含まれています。**この通知には、Premera Blue Cross の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-722-1471 (TTY: 800-842-5357)までお電話ください。

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**본 통지서에는 중요한 정보가 들어 있습니다.** 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357) 로 전화하십시오.

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**ភាសាខ្មែរ (Khmer):**
**សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។** សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព ដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការជានាវ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញផ្លែ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

**ਪੰਜਾਬੀ (Punjabi):**
**ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ.** ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ਼ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

**فارسی (Farsi):**
این اعلامیه حاوی اطلاعات مهم میباشد .این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق Premera Blue Cross باشد. به تاریخ های مهم در این اعلامیه توجه نمایید .شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید .شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471 (کاربران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

**Polskie (Polish):**
**To ogłoszenie może zawierać ważne informacje.** To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross. Prosimy zwrócic uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-722-1471 (TTY: 800-842-5357).

**Português (Portuguese):**
**Este aviso contém informações importantes.** Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

**Română (Romanian):**
**Prezenta notificare conține informații importante.** Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin Premera Blue Cross. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-722-1471 (TTY: 800-842-5357).

**Русский (Russian):**
**Настоящее уведомление содержит важную информацию.** Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

**Fa'asamoa (Samoan):**
**Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai.** O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'amatalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-722-1471 (TTY: 800-842-5357).

**Español (Spanish):**
**Este Aviso contiene información importante.** Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

**Tagalog (Tagalog):**
**Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon.** Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).

**ไทย (Thai):**
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

**Український (Ukrainian):**
**Це повідомлення містить важливу інформацію.** Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-722-1471 (TTY: 800-842-5357).

**Tiếng Việt (Vietnamese):**
**Thông báo này cung cấp thông tin quan trọng.** Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).