

Responsible Rx Expansion for July 1, 2012

Effective July 1, 2012, Florida Blue will expand our Responsible Rx pharmacy program for BlueCare, BlueChoice and BlueOptions. Responsible Rx refers to an umbrella of programs including Prior Authorization, Responsible Steps and Responsible Quantity programs. Members with contracts that support these programs may be affected.

Responsible Steps Expansion

Drugs in the following categories will be added to the Responsible Steps Program **beginning July 1, 2012**, for members enrolled in our Under 65 products. This only applies to members in plans that are part of the Responsible Steps Program. Current users of targeted medications will be grandfathered based on a 365 day pharmacy claims lookback period.

Program	Update
Additions to existing programs	
Antidepressants	Fluoxetine 60mg added as a target
Diabetes	Bydureon [®] added as a target, Lantus [®] and Levimir [®] allowed as prerequisites to Bydureon [®] , Byetta [®] and Victoza [®]
Gabapentin ER	Generic gabapentin added as a prerequisite for Horizant [®]
Inhaled Nasal Steroids	Qnasl [®] added as a target
Insomnia agents	Intermezzo [®] added as a target
Osteoporosis	Generic ibandronate added as a prerequisite
Renin Inhibitors	Edarbyclor [®] added as a target

Authorization request forms are available on the provider website at www.bcbsfl.com under **Providers**, then **Pharmacy Info and Resources**, then the [Responsible Steps Program Information and Authorization Forms link](#).

Responsible Quantity Expansion

This program ensures coverage of certain prescription drugs that reflect dosing guidelines of drug manufacturers and the U.S. Food and Drug Administration (FDA). The table below lists all additional medications and limits added to the Responsible Quantity Program **effective July 1, 2012**. Current users of targeted medications will be grandfathered based on a 365 day pharmacy claims lookback period. You can find a complete list of prescription drugs included in the program at www.bcbsfl.com; select **Providers, Pharmacy Info and Resources**, and then click the [Responsible Quantity Program Information](#) link.

Responsible Quantity Program limits also apply to generic drugs where applicable		
Brand/ Generic Name	Strength	Dispensing Limit Per Month (unless noted)
New Drugs to Existing Programs		
Alagesic LQ [®] elixir		5400 ml
Bydureon [®]		4 syringes/28 days

Responsible Quantity Program limits also apply to generic drugs where applicable		
Brand/ Generic Name	Strength	Dispensing Limit Per Month (unless noted)
Combivent Respimat [®]		2 inhalers
Edarbyclor [®]		30 tabs
Erivedge [®]		30 tabs
Fluoxetine	60 mg	30 tabs
Gelnique [®]	3%	1 pump
Inlyta [®]	1 mg	180 tabs
Inlyta [®]	5 mg	120 tabs
Intermezzo [®]		30 tabs
Kalydeco [®]		60 tabs
Korlym [®]		120 tabs
Orbivan [®]		180 caps
Orbivan CF [®]		180 tabs
Oxecta [®]		120 tabs
oxycodone immediate release	all strengths	120 tabs
Qnasl [®]		1 inhaler
Subsys [®]		120 sprays
Tencon [®]		180 tabs
Xarelto [®]	15 mg, 20 mg	30 tabs

For members requiring a larger monthly quantity than the coverage maximum, based on medical necessity, you may submit a prior authorization request by filling out the [Quantity Limit Prior Authorization form](#) at www.bcbsfl.com, select **Providers**, and then **Pharmacy Info and Resources**.

Prior Authorization

Effective **July 1, 2012**, the medications listed below will require prior authorization for coverage under the member's pharmacy benefit. Current users of targeted medications will be grandfathered based on a 365 day pharmacy claims lookback period.

Drug	Coverage Criteria*
Erivedge [®] (vismodegib)	Metastatic basal cell carcinoma or locally advanced basal cell carcinoma that has recurred following surgery or when surgery and radiation are contraindicated
Inlyta [®] (axitinib)	Advanced renal cell carcinoma after failure of prior systemic therapy
Kalydeco [®] (ivacaftor)	Cystic fibrosis with confirmed G551D gene mutation
Korlym [®] (mifepristone)	Type 2 diabetes mellitus or glucose intolerance secondary to Cushing's syndrome with failure or contraindication to surgery

*Summary of criteria. Actual criteria available at mcgs.bcbsfl.com

Prior authorization request forms are available on the provider website at www.bcbsfl.com under **Providers**, then **Pharmacy Info and Resources**, and the **Prior Authorization Program Information and Authorization forms** link.

Pharmacy Coverage Exclusions

Effective **July 1, 2012**, BCBSF commercial pharmacy plans will no longer cover the brand name drugs listed in the table below. However, Florida Blue will cover many of their generic alternatives. This exclusion only applies to members in plans that allow pharmacy coverage exclusions. Current users of targeted medications will be grandfathered based on a 365 day pharmacy claims lookback period.

Drugs not covered	Covered alternatives
Edluar [®] , Intermezzo [®] , Zolpimist [®]	zolpidem
Nasonex [®] , Qnasl [®]	fluticasone or triamcinolone nasal
Zipsor [®]	diclofenac
Conzip [®] , Rybix ODT [®] , Ryzolt [®]	tramadol
Doral [®]	quazepam
Fexmid [®]	cyclobenzaprine
Lidocaine HC kit [®]	lidocaine/hydrocortisone generic
Loestrin [®] 1/20-21, Loestrin [®] 1.5/30-21, Ovcon-35 [®] , Ovcon-50 [®]	ethinyl estradiol/norethindrone generic
Lorzone [®]	chlorzoxazone generic
Mircette [®]	ethinyl estradiol/desogestrel generic
Silenor [®]	doxepin generic
Zuplenz [®]	granisetron generic