

Info-Link

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MEDICATION THERAPY MANAGEMENT PROGRAM

Inter Valley Health Plan's new Medication Therapy Management (MTM) program offers the advantage of integrated, individualized care to members who have multiple chronic conditions, take numerous medications and incur high drug costs. Designed to more effectively manage treatment, these services have been developed in cooperation with a team of pharmacists and physicians as part of Medicare's Part D Prescription Drug Benefit.

The program aims to assist Inter Valley Health Plan members to minimize potential risks for drug interactions, adverse reactions or medical complications related to medication therapy. At the same time, the program will help to identify and eliminate duplication of, or gaps in treatment through integrated disease and care management services.

How does it work?

Selected members are identified, contacted and provided additional information about Inter Valley Health Plan's MTM Program. These members will have the benefit of being part of a comprehensive telephone based case management program. Through the MTM Program, nurse case managers will:

- Provide an individualized care management program designed around the patients' health and medication profile.
- Optimize treatment through regular review of medical and pharmacy utilization records to ensure appropriate medication use.

- Serve as the patients' liaison to all providers involved in the care continuum.
- Educate patients on how to most effectively manage their condition and overall health through telephonic and mail based contacts.

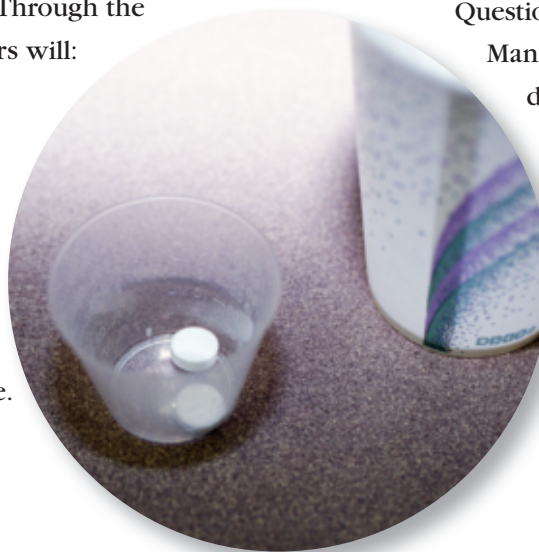
Who is eligible?

Eligibility to Inter Valley Health Plan's MTM Program is determined based on criteria defined by the Centers for Medicare Services (CMS). Patients must meet all of the following:

- Minimum of three chronic diseases: Patient must have diabetes or heart failure, and any two additional qualifying conditions (asthma, COPD, depression, dyslipidemia, hypertension) **and**
- Minimum of five prescriptions for medications covered under Medicare Part D **and**
- Annual related medication costs likely totaling \$4,000 or more.

These criteria apply whether the member is at home, hospitalized or in a long-term care facility.

Questions about the Medication Therapy Management (MTM) program can be directed to Inter Valley Health Plan's Pharmacy Department between 8:00 am and 5:00 pm, Monday through Friday at 800-523-3142.



DURABLE MEDICAL EQUIPMENT

Many of our Senior members rely on Durable Medical Equipment (DME) as a vital component to maintaining their health, mobility and independence. To achieve the best possible outcomes from DME—such as oxygen concentrators, CPAP and BiPAP machines—it is important that both physician and patient are aware of regular equipment maintenance needs, as well as certain service issues.

Some of the most common types of equipment seniors use and the applicable maintenance/service guidelines are:

CPAPs, BiPAPs and Nebulizers

To realize the optimal benefit of CPAPs, BiPAPs or Nebulizers, the filters, tubing and mask should be replaced every three months. The DME vendor will not contact the patient to arrange for the necessary replacement items. **It is the patient's responsibility to call the physician who ordered the machine to obtain authorization for the new filters, tubing and mask,** unless the requesting physician included these replacements with the original request.

Oxygen Concentrators

Oxygen concentrators are automatically serviced and maintained every three months and oxygen tanks are delivered on a regular basis. There is no need for patients to call either their physician or the DME vendor.

DME Repairs

Patients who indicate repairs are needed for their DME (i.e. wheelchair, hospital bed, oxygen concentrator, etc.) should be advised to contact the provider group's

DME vendor directly. In most cases, the name and contact information of the DME vendor is located on a tag attached to the equipment. The vendor will either diagnose the problem over the telephone or send a repair technician to examine the damaged equipment.

Maintenance Service Invoice

When a patient has had any DME item for more than fifteen (15) continuous months, they begin receiving a Maintenance Service Invoice or bill from the DME vendor in six-month intervals. Following receipt of the invoice, the patient needs to contact the DME vendor to schedule the recommended maintenance for their equipment, ensuring optimal operation reducing the risk of breakdowns or malfunctions.

Inter Valley Health Plan hopes these guidelines are helpful in ensuring your patients get the most from their DME.



WIN A \$100 GIFT CERTIFICATE



Do you enjoy reading *Info-link*—our physician newsletter? If you would like a chance to win a \$100 gift certificate, call and tell us your name as well as the name of the article you found most interesting in this issue of *Info-link*. That's it! Your name will be entered in the drawing to win a \$100 American Express gift certificate.

Names will be drawn on September 8, 2006. Contact us at (800) 251-8191 ext 269.

UNDERSTANDING "LOCK-IN" ENROLLMENT DATES

With Medicare changes continuing to be very much in the news we realize that seniors may still be confused. To that end, we want to make certain you and your office staff understands what the Medicare enrollment deadlines pertain to and how they apply to Inter Valley Health Plan members.

In most cases, for Medicare beneficiaries who did not enroll in a prescription drug plan by the past deadline May 15, 2006, the next chance to enroll will be November 15, 2006 for coverage beginning in 2007. What this means is that Medicare beneficiaries are "locked-in." This was a new rule that addresses Medicare beneficiaries joining and switching health plans. They

can no longer switch a plan until Open Enrollment period begins again on November 15, 2006.

As of July 1, 2006 Inter Valley Health Plan new enrollment will be limited. Inter Valley Health Plan will only be able to enroll newly eligible people for Medicare Part A and/or Medicare Part B, or those who have moved outside their current plan's service area and are selecting a new plan where they live.

This can be complicated for seniors since they have been able to switch and move around health plans freely, but that will no longer be the case.

Remember, if you or your staff have any questions please contact Inter Valley Health Plan.

DISEASE MANAGEMENT UPDATE - DIABETES

Inter Valley Health Plan's Diabetes Disease Management Program currently has 2026 members identified in the registry, 497 of whom, are actively managed. One major component in managing these members is monitoring laboratory tests that are an integral part of the standard of care for diabetes.

Hemoglobin A1c is an important marker for diabetes care. The American Diabetes Association (ADA) recommends the measurement of A1c as standard medical care for a long-term assessment of glycemic control in patients with diabetes.

An immediate A1c result is an important tool for physicians in their routine management of patients with diabetes mellitus. The A1c result available at the time of the visit can improve clinical decision-making. Results of self-monitoring of glucose provide physicians a snapshot of control at the time of the test, while the A1c test provides a bigger picture of glucose control over the past two months. Together, these tests represent whether the patient's blood glucose is under control. This is called "glycemic control."

The ADA recommends A1c testing as part of the initial work-up to document the initial level of glycemic control. In addition, quarterly A1c testing is recommended for patients with diabetes whose

therapy has changed or who are not meeting their glycemic control (<7%). Test stable patients semi-annually. The ADA's position is that vigorous treatment of diabetes can decrease the morbidity and mortality of the disease by decreasing its chronic complications. The decrease in A1c toward normal range (<7%) is likely to achieve better outcomes.

Significant scientific evidence for the current treatment goals have accumulated over the past decade. The results of the DCCT (Diabetes Control and Complications Trial) showed that an average A1c of 7.2% resulted in a 50-70% reduction in risk of developing retinopathy, nephropathy and neuropathy in people with diabetes.

Hemoglobin A1c provides an accurate and reliable assessment of the effectiveness of treatment and risk for development of acute and/or long-term chronic complications typically associated with sub-optimal diabetes control. Routine monitoring of A1c can greatly improve patient compliance when used as part of a comprehensive treatment plan.

If you have any members to refer to our Inter Valley Health Plan Diabetes Disease Management Program, please contact Ray Whitt, RN, Lead Case Manager at (909) 623-6333 x448.

KUDOS CORNER

Inter Valley Health Plan would like to recognize the following Provider Groups and/or Hospitals for successfully passing their audits of delegated functions with a score of 95% or above:

- High Desert Primary Care Medical Group - Claims Processing Audit
- Regal Medical Group - Claims Processing Audit

Additionally, we would also like to take this opportunity to congratulate the following offices for obtaining their certification in Older Adult Sensitivity by attending one of the training sessions co-sponsored by Inter Valley Health Plan and Pfizer Pharmaceuticals:

- Dr. Daryoosh Valamanesh
- Staff off Dr. Michael Benavidez
- Staff of Dr. Yogesh Paliwal
- Staff of Chaparral Medical Group on Orange Grove.
- Staff of Chaparral Medical Group on Town & Bonita
- Staff of Hemet Community Medical Group
- Staff of United Family Care
- East Valley Hospital Medical Center.

Congratulations to all and keep up the good work.



Remedios L. Amirante, M.D. Medical Director
 Cyndie O'Brien Communications
 Fidel Valenzuela, Pharm. D. Health Services
 Susan Tenorio, BSN, R.N. Health Services
 Jeannie Lauppe, R.N. Health Services

CONTRIBUTING EDITORS

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EDITOR'S NOTE: We value your opinion. If you have any comments on this issue of Info-Link or have a topic suggestion for future issues, please contact Cyndie O'Brien at 909/623-6333 or e-mail cobrien@ivhp.com.

For Health. Not for Profit.
 300 South Park Avenue
 P.O. Box 6002
 Pomona, CA 91769-6002

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U P D A T E

NEW GENERIC DRUGS AVAILABLE

Many well known and frequently prescribed brand medications are now available in generic form or will soon become available.

The patent life of a drug is 17 years. This patent life is calculated from the time the New Drug Application (NDA) is filed. From this point, it may be 10 years before the drug is approved and available on the market. Since the approval process is very lengthy, each new drug is guaranteed a minimum of 5 years patent exclusivity allowing the manufacturer to regain research and development expenses. In many cases the patent life is extended due to new strengths, therapeutic indications, and dosage forms.

Approximately one year prior to a patent expiration interested manufacturers may submit an Abbreviated New Drug Application (ANDA) to the FDA. The approval process of an ANDA is much shorter than that of the NDA. The generic manufacturers are required to prove that the generic produced is therapeutically equivalent to the original product in that it contains the exact same amount of active ingredient in the same dosage form and route of administration. The generic form must also meet standards of strength, purity, and quality and adhere to manufacturing practices. Bioequivalence and pharmacokinetics must also be proven within federal parameters allowing only 5% variation.

Generic medications are an excellent alternative and are usually significantly less costly than brand medications. At Inter Valley Health Plan the average cost of a brand medication for 30 days supply is \$89.33 and \$17.83 for a generic. The average generic prescription is 20% of the average brand prescription cost. This will significantly affect the members' cost as tracked by CMS accounting and the copay differential between generic and brand is \$15.00 to \$25.00 savings to the member.

Many highly utilized brand medications are scheduled to lose their patent. Clopidogrel (Plavix), Finasteride (Proscar), Simvastatin (Zocor) and Sertraline (Zoloft) are the latest additions to the generic options available.

Brand medications are limited to Inter Valley's formulary list but all generic medications are covered under the 2006 pharmacy benefit.

Inter Valley Health Plan is dedicated to our members and providers. Please call our Pharmacy Help Desk in regard to formulary issues at (800) 523-3142.

Recently approved generic medications

Generic Name	Brand Name
CLOPIDOGREL	PLAVIX
CYCLOBENZAPRINE 5MG	FLEXERIL
DIVALPROEX SODIUM SR...	DEPAKOTE
FEXOFENADINE	ALLEGRA
FINASTERIDE	PROSCAR
FLUTICASONE NASAL	FLONASE
ISRADIPINE	DYNACIRC
MELOXICAM	MOBIC
PRAVASTATIN	PRAVACHOL
SERTRALINE	ZOLOFT
SIMVASTATIN	ZOCOR

INDICATIONS FOR USE OF ZELNORM

Chronic idiopathic constipation

Zelnorm is indicated for patients less than 65 years of age with Chronic Idiopathic Constipation. The effectiveness of Zelnorm in patients 65 years or older with Chronic Idiopathic constipation has not been established.

Source: Medscape

Irritable Bowel Syndrome

Zelnorm is indicated for the short-term treatment of women with IBS whose primary bowel symptom is constipation. Efficacy beyond 12 weeks has not been studied. The safety and effectiveness of Zelnorm in men with IBS with constipation has not been established.

DRUG PRECERTIFICATION PROGRAM

Inter Valley Health Plan's prescription drug benefit requires prior authorization through our precertification program for certain medications. This program is based on current medical findings and FDA-approved manufacturer labeling information, as well as cost/manufacturer rebate arrangements. Precertification helps ensure appropriate and cost-effective use of medications by allowing coverage only when specific conditions are met. Additional reasons for the precertification requirement include:

- Likelihood of patient taking incorrectly
- Potential of being prescribed for inappropriate reasons or used in amounts that exceed dosage or treatment duration recommendations
- Availability of less expensive medications that have been shown to be clinically or therapeutically similar
- Physicians must always request prior authorization of coverage for medications requiring precertification. If the request is approved, the physician will be notified and the medication will then be covered at the applicable copay. If the request is denied, both the physician and patient will be notified.

Zelnorm®, Lamisil® and Epogen®/Procrit® are three of the most frequently requested drugs that require precertification. The criteria for their approval through the program is listed below.

Zelnorm® (tegaserod) - will be approved only if all (1 through 7) of the following are met:

1. MD is a GI Specialist
2. Patient is female
3. Patient is age 55 or younger
4. DX is IBS w/ primary symptoms of constipation
5. Patient has tried and failed laxatives (paid claims for laxatives within the past two months must be presented)
6. Patient has no current claims for an antidiarrheal
7. Patient has no current claims for narcotics, anticholinergics or other constipating agents

Lamisil® (Terbinafine) - will be approved for a DX of Symptomatic Onychomycosis (finger/toenail fungus or Tinea Unguium) if a patient has pain or cellulitis infection associated with Onychomycosis, or any one of the following diagnoses/claims history:

1. Diabetes, DM
2. Peripheral Vascular Disease (PVD)
3. Currently taking steroids: Prednisone, Methylprednisolone
4. Cancer (eg., Leukemia, Lymphoma, etc.)
5. On immunosuppressant therapy (e.g., cyclosporine, azathioprine, etc.)
6. HIV/AIDS, Organ Transplant

Also required for treatment approval of all Onychomycosis patients:

Because of the possible association of hepatic adverse events, the manufacturer now recommends providers to confirm the diagnosis by sending nail specimens for laboratory testing prior to prescribing medications for onychomycosis.

Epogen®/Procrit® (Erythropoietin) -

will be approved if the patient has HCT < 30% or Hgb <10.1 gm%* and one of the following:

1. Anemia associated with chronic renal failure, including patients: a.) On dialysis (end stage renal disease) b.) Patients not on dialysis (to elevate or maintain the red blood cell level, as manifested by the hematocrit or hemoglobin determinations, and to decrease the need for transfusions)
2. Anemia related to AIDS and for HIV patients receiving AZT (retrovir)

NOTE: Whenever medically acceptable, the zidovudine dosage should be less/equal to 4200mg/week

3. Chemotherapy-induced anemia in cancer patients with nonmyeloid malignancies
3. Endogenous serum erythropoietin (EPO) levels that are inappropriately low for hemoglobin level (e.g., diagnosis = anemia of neoplasia)
4. Iron Deficiency (approved if on iron supplementation but still anemic with HCT values as above)
5. To reduce the need for allogeneic blood transfusions in anemic patients scheduled to undergo elective, noncardiac, nonvascular surgery

**The patient must have anemia with most recent HCT prior to starting EPO treatment 30% (or Hgb 10.1 gm%). Patients with Hct or Hgb exceeding that stated in the criteria must establish medical necessity.*