CONTRA COSTA
HEALTH PLAN
A Division of Contra Costa Health Services

Agenda

Quarterly Community Provider Network (CPN) Meeting

Contra Costa Health Plan

When: **Time: 7:30 AM – 9:00 AM**
Date: July 21, 2015

Where: **West County Health Center**
13601 San Pablo Ave, San Pablo, CA
Room A-1194

Attention! Please enter by the side door (on San Pablo Ave.)

The agenda for the meeting is as follows:

I.	**CALL TO ORDER and INTRODUCTIONS**	Mary Berkery, RN
II.	**REVIEW and APPROVAL of MINUTES from previous meeting**	Mary Berkery, RN
III.	**REGULAR REPORTS**	
	• Health Plan Updates • HEDIS Update • Review Hand-outs from last Quarter meetings	Jose Yasul MD
IV.	**NEW BUSINESS**	
	• PM 160 billing changes • Preventive codes • Clinical Practice Guidelines • Behavioral Health Integration	Mary Berkery/Jose Yasul
VI.	**OTHER**	
	• Provider Concerns	Jose Yasul MD/CCHP Staff
VII.	**ADJOURNMENT**	

Unless otherwise indicated below, Contra Costa Health Plan – Community Plan hereby adopts all issues, findings, or resolutions discussed in the Agenda for Contra Costa Health Plan, dated April 21, 2015 and attached herein.

Our next scheduled meeting is:

TBA

CONTRA COSTA HEALTH PLAN

West County

Quarterly Community Provider Network (CPN)

Meeting Minutes – July 21, 2015

Attending:

CCHP Staff: M. Berkery, RN, Co-Chair; J. Yasul, MD; J. Galindo, RN; P. Richards,

CPN Providers: K. Ceci, MD; O. Eaglin, PA; D. Fernandes, MD; K. Kaminski, PA; P. Mack, MD; J. Mahony, MD; K. O'Hearn, PN; R. Paterson, PA; A. Wallach, MD; T. Wilson, DO; K. Winter, MD

Discussion		Action	Accountable
	Meeting called to order @ 7:40 A.M.		M. Berkery, RN
I.	Agenda was approved with no revisions.		M. Berkery, RN
II.	**Review and Approval of Minutes from April 21, 2015:** Minutes were approved as presented.		M. Berkery, RN
III.	**Regular Reports:** ▪ **HEDIS Update** – CCHP improved on 15 of the 24 Medi-Cal measures. Performance was essentially flat on 6. Overall average increase for all measures was 6%. 12 measures scored above the Medi-Cal mean. – Two measures scored above the national Medicaid 90th percentile: Avoidance of Imaging for Low Back Pain and Avoidance of Antibiotics for Adults with Acute Bronchitis. – CCHP is concerned about the decline in Early Childhood Immunizations (CIS), the Cervical Cancer Screening measure, and the persistent medication measures that will be addressed by mailings and possibly other interventions. – Readmissions rate got worse after excellent improvement last year, but the perinatal measures improved. – Childhood Obesity (WCC) all showed good improvements, but the diabetes (CDC) measures are mixed, mostly slightly down. – CCHP has recently initiated outreach that may help for childhood immunizations, cervical cancer screening, asthma, and annual testing for members on ACEI/ARBs. – Community Provider Network had increases in 13 measures, but was below the Minimum Performance Level on 12 of the 24 measures. The most dramatic drop was more than 13 points in early childhood immunizations. They had large increases for scores on physical activity counseling for children and in controlling high blood pressure. – Priorities for improvement are early childhood immunizations (almost half of two year olds in CPN are not fully vaccinated) and cervical cancer screening. Providers should consider referring appropriate patients to the CCHP's diabetes and pediatric obesity disease management programs to improve care in those areas. – Those with Electronic Health Records should take advantage of those to improve care and rates. CCHP can offer guidance from County experience with Epic.		J. Yasul, MD
IV.	**New Business** ▪ **Health Plan Updates** – **Important Change in Billing-PM 160** Starting **August 1, 2015**, the only billing forms CCHP will be able to accept will be the **CMS 1500 form, using the appropriate CPT codes and modifiers.** This is for preventive/well visits along with sick visits. – Continue to maintain certification with CHDP by filling out the PM 160 forms and mail to Medi-Cal/CHDP and to our local CHDP office. – Document well visit, include the exam, as well as nutritional counseling and physical activity, and document BMI percentile on the chart. – California Immunization Registry (CAIR) to document all immunizations. – **Preventive Codes** for billing Initial Health Assessments and Periodic Preventive Care Visits handout reviewed. – **Pharmacy and Therapeutic News Notes** – Preferred drug list (PDL) changes in August 2015.		J. Yasul, MD

	- Quantity Limits on Glucose Testing Strips- for non-insulin dependent diabetes patients, the quantity limit is reduced to100 strips/90days. The "Choosing Wisely" initiative. - DHCS released new guidance regarding the treatment of Chronic Hep C - **Treatment Policy for the Management of Chronic Hepatitis C** - As of July 1, 2015, CCHP has implement changes laid out in the treatment policy; policy changes ease restrictions to Hepatitis C treatment eligibility. See handouts for details. - **NEW Pharmacy Director and New Case Management Manager** - Andrew L. Haydon, Pharm.D. is the new Pharmacy Director - John Barclay, RN, BSN is the new Case Management Manager - **Preferred Drug List** - See attached handouts outs for preferred drug list, and the - **Emergency Temporary Supply** - Authorization code for a 5 day temporary supply is 397555 - See handout for list of emergency medications and process. - **Handout Reviews** - HPV update, Medi-Cal Incentives to Quit Smoking (MIQS) Project incentives to end by July 31, 2015; MERS; New incentive laws on Vaccines; SBIRT training coming up-each site must take a 4 hour training; Formularies for ADHD and Acne; - Provider Bulletin was reviewed. Provider Relations contacts and access on website.		M. Berkery, RN
V.	**Provider Concerns:** ▪ Group would like 3 years of HEDIS data; Expresses concerns over quantity of glucose test strips for diabetes management; Obese Management Form and Case Management Form on website; Development of a Vaccine Refusal document for patients; Post-Partum Care Transition between CCRMC and CPNs ▪ Counseling for Nutrition Codes		J. Yasul, MD M. Berkery, RN
VI.	**Adjournment:** Meeting adjourned @ 8:20 A.M.		M. Berkery, RN

Change in date of next meeting – October 13th, 2015

CONTRA COSTA HEALTH PLAN
West County
Quarterly Community Provider Network (CPN)
Meeting Minutes – April 21, 2015

Attending:
CCHP Staff: M. Berkery, RN, Co-Chair; P. Tanquary, MPH, Ph.D., CEO; B. Flowers, RN; L.M. Perez, CPCS

CPN Providers: : K. Ceci, MD; O. Eaglin, PA; D. Fernandes, MD; P. Gaitan, MD; K. Kaminski, PA; J. Mahony, MD; D. Miller, MD; A. Wallach, MD; B. Williamson, CNM; T. Wilson, DO; K. Winter, MD

Discussion		Action	Accountable
	Meeting called to order @ 7:45 a.m.		M. Berkery, RN
I.	Agenda was approved with no revisions.		M. Berkery, RN
II.	**Review and Approval of Minutes from January 20, 2015:** Minutes were approved as presented.		M. Berkery, RN
III.	**Regular Reports:** • **Health Plan Updates** ▪ **Doctors Medical Center (DMC) - Closure April 21, 2015** – DMC in San Pablo closed as of Tuesday, April 21st. – Reviewed information to help find urgent medical care in West Contra Costa or free medical advice by phone to help decide what kind of care is needed – **Anyone who does not have private insurance can call Contra Costa Health Services' Advice Nurse Line for free health advice (24/7 including holidays): 1-877-661-6230 Option 1** – Patients with private insurance should call their plans' advice nurse lines – Landing for Air Ambulance at DMC will remain open for the remainder of the transition period ▪ **LifeLong Medical Care (LMC) - New Urgent Care Center April 20, 2015** – LMC opened a new Urgent Care Center on April 20th across the street from where DMC was located in San Pablo. Patients can walk in or call for an appointment. **Hours: Noon to 8 p.m. 7 days a week - Phone # 510-231-9800** – LMC will be acknowledged for opening a highly needed Urgent Care Center – LMC may open a secondary urgent care center by August – Ambulances and EMS are on standby – Asking all providers in West County to support LifeLong Urgent Care ▪ **Practical Strategies for Providers to Support Breastfeeding** – Announced class to be held on Thursday, May 14th at the Pittsburg Health Center Cypress Room, presented by Diana Mahar, MD, IBCLC, pediatrician from Kaiser. **Training topics include**: milk supply issues, jaundice, cultural beliefs regarding breastfeeding, and knowing when and where to refer. Register online: bfprovidersandnurses.eventbrite.com ▪ **Department of Health Care Services (DHCS) Audit** – DHCS will be conducting a routine audit of CCHP from June 1, 2015 to June 12, 2015. Audit includes the review of medical records and practice interviews. Providers selected by DHCS will be contacted directly by DHCS Nurse Evaluators to schedule an onsite visit. – Contact Provider Relations as soon as possible with dates scheduled with DHCS – For questions call: Brenda Flowers, RN at (925) 313-9503 or Jenny Galindo, RN at (925) 313-9513 or email to ProviderRelations@hsd.cccounty.us		P. Tanquary, MPH, PhD, CEO M. Berkery, RN

	▪ **Immunization Updates** – Measles - CCC had one reported measles case in February – Pertussis – CCC has had over 80 pertussis cases already in 2015. Recommend up-to-date pertussis vaccinations, especially pregnant women – Additional information in meeting packet ▪ **Community Immunity: What You Can Do** – Reviewed information how providers can help promote immunity in the community – Resources: cchealth.org/communityimmunity or call (925) 313-6767 ▪ **Communicable Disease Outbreak Reporting** – Reviewed information to report a communicable disease outbreak – Contact Public Health's Communicable Disease Programs Phone # (925) 313-6740 – Reporting forms located at cchealth.org/cd/disease-reporting.php ▪ **Autism** – In process of contracting with a speech group that will cover speech services for autistic children		
IV.	**Other:** • **Provider Bulletin was reviewed.**		M. Berkery, RN
V.	**Adjournment:** Meeting adjourned @ 8:50 a.m.		

Next meeting – July 21, 2015

HEDIS 2015
Prepared for Community Provider Meetings by CCHP Quality Director

CCHP improved on 15 of the 24 Medi-Cal measures. Performance was essentially flat on 6. The overall average increase for all measures was 6%. 12 measures scored above the Medi-Cal mean.

Two measures scored above the national Medicaid 90th percentile, Avoidance of Imaging for Low Back Pain and Avoidance of Antibiotics for Adults with Acute bronchitis. Until last year, in addition to these two measures, CCHP also scored above the 90th percentile on Early Childhood Immunizations (CIS), but that rate has been declining. The three Monitoring for Patients on Persistent Medications were all below the national Medicaid 25th percentile. We are concerned about the Cervical Cancer Screening measure, as it is very close to the 25th percentile (AKA Minimum Performance Level established by the state). That measure and the persistent medication measures will be addressed by mailings and possibly other interventions.

Focus areas for the past year included Quality Improvement Projects in readmissions and in perinatal care. Results were mixed. The readmissions rate got worse after excellent improvement last year, but the perinatal measures improved. Through our Disease Management program, Diabetes and Childhood Obesity are also focus areas. The measures related to childhood obesity (WCC) all showed good improvement, but the diabetes (CDC) measures were mixed, mostly slightly down. CCHP has recently initiated outreach that may help measures reflecting care for early childhood immunizations, cervical cancer screening, asthma, and annual testing for members on ACEI/ARBs. We plan to continue the interventions described above and have not identified additional measures to work on improving.

The Community Provider Network had increases in 13 measures, but was below the Minimum Performance Level on 12 of the 24 measures. The most dramatic drop was more than 13 points in early childhood immunizations. They had large increases for scores on physical activity counseling for children and in controlling high blood pressure. Priorities for improvement are early childhood immunizations (almost half of two year olds in CPN are not fully vaccinated) and cervical cancer screening. Providers should consider referring appropriate patients to CCHP's diabetes and pediatric obesity disease management programs to improve care (and HEDIS rates) in those areas. Those with Electronic Health Records should take advantage of those to improve care (and rates). CCHP can offer guidance from County experience with Epic.

Abv.	Measure	CCHP overall rate 2015	RMC 2015	CPN 2014	CPN 2015	La Clinica 2014	La Clinica 2015	n	LifeLong 2014	LifeLong 2015	n	MPL 2015	HPL 2015	Medicaid Mean
ACR	All-Cause Readmissions	16.98%	17.58%	12.45%	14.52%	11.83%	12.00%	175	13.66%	14.00%	200			
MPM	Annual Testing for members on Persistent Medications: ACEI/ARB	85.55%	84.50%	82.73%	83.57%	85.71%	84.26%	216	80.66%	85.02%	247	84.58%	91.21%	86.23%
	Annual Testing for members on Persistent Medications: Digoxin	77.11%	82.46%	85.71%	63.64%	0.00%	33.33%	3	100.00%	100.00%	2	87.50%	94.95%	89.49%
	Annual Testing for members on Persistent Medications: Diuretics	84.60%	83.96%	82.51%	81.49%	84.71%	80.92%	131	79.37%	82.42%	182	83.76%	91.30%	86.34%
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	47.06%	52.36%	37.86%	33.68%	36.36%	62.50%	5	57.14%	82.35%	14	17.92%	35.45%	30.19%
CCS	Cervical Cancer Screening	55.47%	50.78%	49.48%	53.92%	52.00%	76.00%	25	50.00%	60.71%	28	54.50%	75.96%	65.11%
CIS-3	Early Childhood Immunizations (Combo 3)	77.86%	72.25%	64.00%	50.67%	71.43%	83.33%	18	64.29%	69.23%	39	66.08%	83.32%	75.43%
CDC	Comprehensive Diabetes Care (CDC)-HbA1c Testing	83.98%	83.33%	80.00%	85.56%	89.47%	82.61%	23	74.19%	83.33%	30	80.18%	91.73%	84.48%
	CDC: HbA1c Poor Control (>9.0%)	41.26%	36.23%	53.00%	56.67%	63.16%	52.17%	23	45.16%	70.00%	30	53.76%	30.28%	41.41%
	CDC: HbA1c Control (<8.0%)	44.17%	47.10%	41.00%	35.56%	26.32%	34.78%	23	45.16%	23.33%	30	38.20%	59.37%	48.86%
	CDC: Eye Exam	55.10%	52.90%	43.00%	52.22%	63.16%	60.87%	23	35.48%	56.67%	30	44.37%	67.64%	52.59%
	CDC: Medical Attention for Nephropathy	82.52%	80.43%	80.00%	84.44%	68.42%	86.96%	23	87.10%	83.33%	30	75.67%	86.86%	82.78%
	CDC: Blood Pressure <140/90	60.44%	64.13%	50.00%	45.56%	52.63%	47.83%	23	61.29%	33.33%	30	53.28%	75.18%	62.75%
CBP	Controlling High Blood Pressure	64.23%	65.23%	25.36%	50.63%	46.15%	62.50%	16	62.50%	75.00%	16	48.53%	69.79%	57.69%
IMA	Immunizations for Adolescents	72.51%	70.21%	52.50%	69.75%	69.23%	68.42%	19	80.65%	82.05%	39	61.70%	86.46%	73.96%
MMA	Asthma Medication Compliance 50%	59.10%	54.97%	25.36%	44.54%	36.84%	40.00%	30	51.92%	41.23%	114	44.83%	61.66%	58.85%
	Asthma Medication Compliance 75%	37.92%	34.41%	25.36%	21.26%	31.58%	23.33%	30	19.23%	17.54%	114	22.17%	38.71%	30.69%
PPC	Timely Prenatal Care	85.89%	90.36%	84.73%	85.39%	90.91%	96.00%	25	86.05%	72.73%	33	77.80%	93.10%	84.13%
	Timely Postpartum Care	67.15%	67.47%	57.25%	58.43%	69.70%	48.00%	25	62.79%	69.70%	33	56.18%	74.03%	61.68%
LBP	Use of Imaging Studies for Low Back Pain	87.31%	84.60%	88.10%	83.57%	97.37%	81.48%	54	88.10%	83.05%	59	71.52%	82.34%	81.69%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC): BMI %ile	69.34%	85.29%	40.37%	41.32%	14.29%	33.33%	33	80.95%	69.57%	46	41.85%	82.46%	70.16%
	WCC-Counseling for Nutrition	67.64%	79.41%	40.99%	44.31%	21.43%	54.55%	33	73.81%	58.70%	46	50.00%	77.47%	67.98%
	WCC-Counseling for Physical Activity	66.67%	79.41%	27.95%	41.92%	7.14%	42.42%	33	64.29%	67.39%	46	41.67%	69.76%	56.71%
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	79.81%	78.75%	73.78%	75.61%	52.94%	82.14%	28	91.38%	80.00%	40	65.97%	82.69%	74.06%

	CCHP Medi-Cal HEDIS Measures	2013 CCHP	2014 CCHP	2015 CCHP	2013 RMC	2014 RMC	2015 RMC	2013 CPN	2014 CPN	2015 CPN	2013 KSR	2014 KSR	2015 KSR	2015 MPL	2015 HPL	2014 Medi-Cal Mean	CCHP Overall improvement (if positive) from last year (in percentage points)	CCHP Percent improvement (if positive) from last year	CCRMC Overall improvement (if positive) from last year (in percentage points)	CCRMC Percent improvement (if positive) from last year
WCC	BMI %ile calculated for children	56.20%	62.29%	69.34%	55.80%	74.43%	85.29%	43.79%	40.37%	41.32%	82.89%	90.32%	92.59%	41.85%	82.46%	70.16%	7.05%	11%	10.86%	15%
	Nutrition counseling given for children	55.96%	59.37%	67.64%	50.28%	69.41%	79.41%	52.94%	40.99%	44.31%	76.32%	83.87%	88.89%	50.00%	77.47%	67.98%	8.27%	14%	10.00%	14%
	Physical activity counseling for children	46.23%	50.85%	66.67%	44.75%	63.01%	79.41%	33.33%	27.95%	41.92%	76.32%	83.87%	88.89%	41.67%	69.76%	56.71%	15.82%	31%	16.40%	26%
W34	*Yearly well child visit 3-6 yr.	73.31%	74.75%	79.81%	70.59%	71.20%	78.75%	73.42%	73.78%	75.61%	82.98%	87.50%	89.66%	65.97%	82.69%	74.06%	5.06%	7%	7.55%	11%
CIS	*Combo 3 immunizations	84.47%	74.70%	77.86%	76.12%	81.12%	72.25%	78.18%	64.00%	50.67%	96.67%	80.00%	89.66%	66.67%	80.86%	75.43%	3.16%	4%	-8.87%	-11%
PPC	*First trimester prenatal	86.86%	83.45%	85.89%	85.71%	81.93%	90.36%	88.80%	84.73%	85.39%	87.50%	90.32%	69.01%	77.80%	93.10%	84.13%	2.44%	3%	8.43%	10%
	Postpartum visit 21-56 days	62.53%	60.34%	67.15%	63.87%	61.85%	67.47%	60.00%	57.25%	58.43%	62.50%	61.29%	76.06%	56.18%	74.03%	61.68%	6.81%	11%	5.62%	9%
LBP	Avoiding Use of Imaging for Low Back Pain	92.06%	87.85%	87.31%	90.88%	85.60%	84.60%	92.26%	88.10%	83.57%	94.52%	93.94%	99.51%	72.15%	84.03%	81.69%	-0.54%	-1%	-1.00%	-1%
CCS	*Cervical cancer screening	66.04%	54.99%	55.47%	62.44%	46.40%	50.78%	58.70%	49.48%	53.92%	85.14%	96.88%	87.50%	54.50%	75.96%	65.11%	0.48%	1%	4.38%	9%
CDC	Diabetes Eye Exam 2 yrs.	51.09%	51.34%	55.10%	52.94%	53.74%	52.90%	45.37%	43.00%	52.22%	54.17%	56.67%	78.38%	46.25%	68.04%	52.59%	3.76%	7%	-0.84%	-2%
	*Diabetes HbA1c testing	85.40%	84.43%	83.98%	85.49%	85.41%	83.33%	84.26%	80.00%	85.56%	87.50%	90.00%	86.49%	80.18%	91.73%	84.48%	-0.45%	-1%	-2.08%	-2%
	Diabetes HbA1c(>9%) (lower is better)	40.39%	41.61%	41.26%	40.39%	37.72%	36.23%	36.11%	53.00%	56.67%	50.00%	40.00%	37.84%	53.76%	30.28%	41.41%	0.35%	1%	1.49%	4%
	Diabetes HbA1c (<8%)	49.88%	48.18%	44.17%	47.06%	51.25%	47.10%	60.19%	41.00%	35.56%	41.67%	43.33%	45.95%	38.20%	59.37%	48.86%	-4.01%	-8%	-4.15%	-8%
	Diabetes Nephropathy screen or treatment	82.00%	83.94%	82.52%	82.75%	83.99%	80.43%	75.93%	80.00%	84.44%	91.67%	96.67%	94.59%	75.67%	86.86%	82.78%	-1.42%	-2%	-3.56%	-4%
	Diabetes BP <140/90	59.37%	61.31%	60.44%	57.25%	65.48%	64.13%	54.63%	50.00%	45.56%	81.25%	60.00%	72.97%	53.28%	75.18%	62.75%	-0.87%	-1%	-1.35%	-2%
AAB	Avoidance of Antibiotics in Adults With Acute Bronchitis	43.27%	44.09%	47.06%	38.27%	45.30%	52.36%	46.49%	37.86%	33.68%	46.15%	77.27%	54.05%	20.20%	38.66%	30.19%	2.97%	7%	7.06%	16%
IMA-1	Immunizations for Adolescents: Combo 1	71.61%	73.24%	72.51%	66.67%	73.12%	70.21%	67.30%	69.94%	69.75%	90.00%	82.26%	79.63%	61.70%	86.46%	73.96%	-0.73%	-1%	-2.91%	-4%
CBP	*Controlling High Blood Pressure	51.34%	53.28%	64.23%	50.36%	56.03%	65.23%	45.26%	35.05%	50.63%	75.00%	84.38%	79.25%	48.53%	69.79%	57.69%	10.95%	21%	9.20%	16%
MMA	Medication Management for People with Asthma 50%	56.90%	43.46%	59.10%	48.02%	54.98%	54.97%	41.06%	52.50%	44.54%	85.32%	0.58%	87.94%	47.88%	66.96%	58.85%	15.64%	36%	-0.01%	0%
MMA	Medication Management for People with Asthma 75%	33.95%	22.79%	37.92%	24.32%	31.90%	34.41%	16.91%	25.36%	21.26%	64.68%	0.00%	67.73%	24.55%	43.08%	30.69%	15.13%	66%	2.51%	8%
ACR	All-Cause Readmissions (lower is better)	16.99%	12.29%	16.98%	17.37%	12.13%	17.58%	16.56%	12.45%	14.52%	14.69%	13.20%	7.14%			14.43%	-4.69%	-38%	-5.45%	-45%
	All-Cause Readmission, SPDs	19.48%	13.05%	21.17%	19.38%	12.82%	22.58%	21.03%	13.02%	15.96%	14.06%	15.08%	4.76%				-8.12%	-62%	-9.76%	-76%
	All-Cause Readmission, Non SPDs	12.72%	9.50%	10.68%	13.48%	9.32%	10.48%	8.59%	10.66%	11.70%	15.04%	8.45%	14.29%				-1.18%	-12%	-1.16%	-12%
AMB	Ambulatory Care - Outpatient Visits per 1000 Member Months	217.23	246.81	257.12	166.26	119.88	133.81	185.03	85.54	75.00	293.81	41.28	48.11	314.03	467.26	329.56				
AMB	Ambulatory Care - Emergency Department Visits per 1000 Member Months	60.94	53.25	56.21	63.4	32.18	34.17	50.81	17.51	14.25	24.9	3.56	7.78	52.33	82.27	46.88				
MPM	Monitoring for Patients on persistent Medications - ACE or ARB	83.77%	86.52%	85.55%	87.83%	87.73%	84.50%	80.22%	82.73%	83.57%	72.36%	100.00%	94.33%	85.76%	92.01%	86.23%	-0.97%	-1%	-3.23%	-4%
MPM	Monitoring for Patients on persistent Medications - Digoxin	85.71%	95.45%	77.11%	100.00%	97.30%	82.46%	81.25%	85.71%	63.64%	61.54%	0/0	66.67%	88.89%	95.65%	89.49%	-18.34%	-19%	-14.84%	-15%
MPM	Monitoring for Patients on persistent Medications - Diuretics	83.68%	85.11%	84.60%	87.06%	85.83%	83.96%	82.75%	82.51%	81.49%	72.17%	100.00%	92.20%	85.69%	92.07%	86.34%	-0.51%	-1%	-1.87%	-2%
CAP	Children and Adolescents' Access to Primary Care Practitioners - 12-24 Months[2]	86.74%	94.62%	93.94%	94.65%	95.77%	92.47%	85.81%	91.77%	92.57%	53.89%	98.21%	98.90%	95.92%	98.53%	96.82%				
CAP	Children and Adolescents' Access to Primary Care Practitioners - 25 Months-6 Years[2]	76.18%	86.07%	84.21%	81.67%	85.70%	82.88%	73.49%	83.40%	82.31%	58.27%	94.36%	90.13%	86.07%	93.58%	88.96%				
CAP	Children and Adolescents' Access to Primary Care Practitioners - 7-11 Years[2]	77.96%	86.71%	86.56%	81.03%	83.56%	84.20%	78.69%	87.37%	86.07%	67.02%	94.94%	94.46%	87.78%	95.19%	87.61%				
CAP	Children and Adolescents' Access to Primary Care Practitioners - 12-19 Years[2]	74.86%	83.44%	83.80%	77.90%	80.13%	81.90%	75.44%	82.42%	81.44%	66.67%	93.59%	93.41%	85.83%	94.42%	85.97%				

*included in default algorithm

below Minimum Performance Level (MPL), national Medicaid 25th percentile

above High Performance Level (HPL), national Medicaid 90th percentile

Bad data

[2] CAP measures are below MPL but do not require Improvement Plan

PATRICIA TANQUARY, MPH, PhD
Chief Executive Officer

JAMES TYSELL, MD
Medical Director

CONTRA COSTA
HEALTH PLAN
A Division of Contra Costa Health Services

A Culture of Caring

ADMINISTRATION

595 Center Avenue, Suite 100
Martinez, California 94553
Main Number: 925-313-6000
Member Call Center: 877-661-6230
Provider Call Center: 877-800-7423

Se Habla Español

June 30, 2015

Re: Important Change in Billing—PM 160

Dear Contracted Providers,

In accordance with the directive from the Department of Health Care Services, starting August 1, 2015, Contra Costa Health Plan (CCHP) can no longer require or accept billing for our Medi-Cal members' preventive services to be submitted on a **PM 160 form**. Per the directive from the state, the only billing form we are able to accept will be the **CMS 1500** form, using the appropriate CPT codes and modifiers. This is for preventive/well visits along with sick visits.

As required in CCHP's contract with the state Medi-Cal program, CCHP encourages you to continue to maintain certification with the Child Health and Disability Prevention Program (CHDP), and we expect the same standards in care to be provided to our members. The PM 160 form should still be filled out, and mailed to:

Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

And to our local CHDP office at:
597 Center Ave. Suite 280
Martinez, CA 94553

When documenting a well visit, be sure to include the exam, as well as nutritional counseling and physical activity, and document BMI **percentile** somewhere else on the chart. We also encourage all providers to use the California Immunization Registry (CAIR) to document all immunizations.

If you have questions regarding CCHP billing, please call CCHP Claims at (925) 313- 957-5185. For questions about PM 160s and the Child Health and Disability Prevention Program, please call CHDP at (925) 313-6150. For assistance with accessing the CAIR Network, call Contra Costa Public Health Immunization program at 925.313.6767.

For more information on this DHCS change see http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_23207.asp

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JAMES TYSELL, MD
Medical Director

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Se Habla Español

June 26, 2015

Preventive Services for Primary Care Providers

As part of comprehensive care, Contra Costa Health Plan (CCHP) requires that Primary Care Providers (PCPs) provide preventive services to all of our members. CCHP follows the American Academy of Pediatrics (AAP) periodicity schedule for preventive health services for members under 21 years; and the US Preventive Services Task Force (USPSTF) periodicity for members 21 and older.

CCHP recommends using the following Codes for billing Initial Health Assessments and Periodic Preventive Care Visits:

PREVENTIVE SERVICES PROCEDURE CODES FOR PEDIATRIC - MEDI-CAL MEMBERS	
CODE	**DESCRIPTION**
99381	PR initial comprehensive preventive E&M New PT less than 1 year old
99382	PR initial comprehensive preventive E&M New PT 1 -4 years old
99383	PR initial comprehensive preventive E&M New PT 5 -11 years old
99384	PR initial comprehensive preventive E&M New PT 12-17 years old
99391	PR periodic comprehensive preventive E&M Est PT less than 1 year old
99392	PR periodic comprehensive preventive E&M Est PT 1 -4 years old
99393	PR periodic comprehensive preventive E&M Est PT 5 -11 years old
99394	PR periodic comprehensive preventive E&M Est PT 12-17 years old
PREVENTIVE SERVICES PROCEDURE CODES FOR ADULTS - MEDI-CAL MEMBERS	
CODE	**DESCRIPTION**
99385	PR initial comprehensive preventive E&M New PT 18-39 years
99386	PR initial comprehensive preventive E&M New PT 40-64 years
99387	PR Initial comprehensive preventive E&M New PT 65 and older
99395	PR periodic comprehensive preventive E&M Est PT 18-39 years
99396	PR periodic comprehensive preventive E&M Est PT 40-64 years
99397	PR periodic comprehensive preventive E&M Est PT 65 and older
PREVENTIVE SERVICES PROCEDURE CODES FOR COMMERCIAL	
CODE	**DESCRIPTION**
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of enrollment
G0438	Annual Wellness Visit-Initial- patients enrolled for more than 12 months
G0439	Annual Wellness Visit-Annually

If you have any questions please contact Provider Relations at 925-313-9513 or 925-313-9503

CONTRA COSTA HEALTH PLAN
A Division of Contra Costa Health Services

Provider Issue Briefing

CONTRA COSTA
HEALTH PLAN
595 Center Avenue
Suite 100
Martinez, CA 94553
925.313.6000
Date: October 2014

Contra Costa Health Plan Pharmacy and Therapeutics Committee

Pharmacy and Therapeutics NewsNotes

Preferred Drug List (PDL) changes will be effective in August 2015

The CCHP Pharmacy and Therapeutics committee approved the ***addition*** of the following agent to the Preferred Drug List. This agent is ***subject to some restrictions***:

- Bevacizumab (Avastin) - approved for the indication of diabetic macular edema. Monthly limit of 5mg.

The CCHP Pharmacy and Therapeutics committee approved the addition of the following ***quantity limits*** to the Preferred Drug List. These agents are subject to some restrictions:

- Rivaroxaban (Xarelto) - For the indication of post-operative DVT prophylaxis, quantity limit is reduced from 35 tablets/year to 21 tablets/year.
- Glucose Testing Strips - For non-insulin dependent diabetes patients (excluding gestational diabetes patients), the quantity limit is reduced from 150 strips/month to a maximum of 100 strips/90days

Information presented at the P&T committee included the following:

The California Department of Health Care Services (DHCS) released new guidance regarding the treatment of Chronic Hepatitis C, Effective July 1, 2015:
As of July 1, 2015, CCHP has implement changes laid out in the treatment policy; policy changes ease restrictions to Hepatitis C treatment eligibility. The most significant changes include eligible treatment candidates who have Stage 2 or greater hepatic fibrosis (i.e, F2+, Apri score >0.7), HIV or HepB co-infection, hepatocellular carcinoma, and Type 2 diabetes mellitus, to name a few. Evidence for policy changes are based on recent guidelines published by IDSA, AASLD, EASL, and the WHO. Nationwide, only a fraction of health plans are able to implement these changes, as guidelines specify that "recommendations are based on available resources". California health plans are strongly encouraged to comply with the guidelines to ensure reimbursement. The introduction of new, albeit costly hepatitis C treatments has prompted new guideline recommendations to cure hepatitis C and reduce transmission.

NEJM article compared Aflibercept, Bevacizumab and Ranibizumab for Diabetic Macular Edema:
Results of the study demonstrate that bevacizumab is equally as efficacious for mild diabetic macular edema when compared to other more costly VEGF inhibitors such as aflibercept or ranibizumab. CCHP has added Bevacizumab as a preferred formulary option for the indication of diabetic macular edema, with a maximum monthly dose of 5mg. Aflibercept and Ranibizumab continue to be non-formulary and require a prior authorization request.
Reference: The Diabetic Retinopathy Clinical Research Network. Aflibercept, Bevacizumab, or Ranibizumab for Diabetic Macular Edema. New England Journal of Medicine, Feb 2015

Medication Prior Authorization processing turnaround time clarification by the state:
The California Department of Health Care Services has clarified new regulations regarding Prior Authorization processing turnaround times; the recommendation is to review prior authorizations within 24 hours and to render a decision within 72 hours to allow time for weekends and holidays.

The 'Choosing Wisely' initiative by the Society of General Internal Medicine does not recommend daily home finger glucose testing in non-insulin dependent type 2 diabetes mellitus patients:
"Self-monitoring of blood glucose (SMBG) is an integral part of patient self-management in maintaining safe and target-driven glucose control in type 1 diabetes. However, there is no benefit to daily finger glucose testing in patients with type 2 diabetes mellitus who are not on insulin or medications associated with hypoglycemia, and there is negative economic impact and potential negative clinical impact of daily glucose testing. SMBG should be reserved for patients during the titration of their medication doses or during periods of changes in patients' diet and exercise routines".

A literature review of multiple meta-analyses including non-insulin dependent diabetes patients reveals that little to no benefit is seen in this patient population with frequent daily glucose monitoring. A data report specific to CCHP members shows that a large portion of our non-insulin dependent patients are receiving quantities of 150 test strips per 30 days each quarter. Thus, CCHP quantity limits have been reduced to 100 strips per 90 days for non-insulin dependent patients who may not derive much benefit from glucose monitoring multiple times per day. (Pregnant patients with gestational diabetes are excluded from such quantity limitations.)

CCHP updates the Preferred Drug List (PDL) formulary after each quarterly Pharmacy & Therapeutics Committee meeting. CCHP invites and encourages practitioners to access each update through the following means:

A printable copy of the CCHP preferred drug list can be found here:
http://cchealth.org/healthplan/pdf/pdl.pdf

A searchable CCHP preferred drug list can be found here:
http://formularynavigator.com/Search.aspx?siteID=MMRREQ3QBC

EPOCRATES – *free* mobile & online formulary resource

How to add the CCHP formulary to your epocrates user profile:

1. Go to www.epocrates.com.
2. Click on "My Account" in the top right.
3. Sign in with your Epocrates username and password, if needed.
4. Click on "Edit Formularies."
5. Follow the on screen instructions to select and download formularies or to remove formularies.
    - For the 'Select State' filter, click **California**
    - For the 'Select Category' filter, click **Health Plan**
    - Choose the **Contra Costa Healthplan** formulary; click the 'Add' button
    - Click the "Done" button when you've finished.
6. Update your device, and the formularies on your mobile device will be changed accordingly.

Epocrates mobile is supported on the iOS (iPhone, iTouch, iPad), Android, & BlackBerry platforms
If you have any questions about the installation or use of Epocrates, please contact Epocrates Customer Support at goldsupport@epocrates.com or at (800)230-2150.

Questions and comments may be directed to CCHP Pharmacy by emailing
cchp_pharmacy_director@hsd.cccounty.us

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

California Department of Health Care Services

Treatment Policy for the Management of Chronic Hepatitis C

Effective July 1, 2015

This policy was developed by the California Department of Health Care Services (DHCS) based on a review of the medical literature, the most recent guidelines and reports published by the American Association for the Study of Liver Diseases (AASLD), Infectious Diseases Society of America (IDSA), European Association for the Study of the Liver (EASL), California Technology Assessment Forum (CTAF), Institute for Clinical and Economic Review (ICER), World Health Organization (WHO), federal Department of Veterans Affairs (VA), and recommendations from experts in the management of hepatitis C virus. The treatment of hepatitis C virus is rapidly evolving. Accordingly, this policy may be revised as new information becomes available.

1. Treatment considerations and choice of regimen for hepatitis C virus infected patients:
    A. Please refer to AASLD guidelines (hcvguidelines.org) for recommended treatment regimens and durations.
2. Identifying treatment candidates:
    A. Disease Prognosis and Severity—Any of the following clinical states identify candidates for treatment:
        i. Evidence of Stage 2 or greater hepatic fibrosis/cirrhosis including one of the following: Liver biopsy confirming a METAVIR score F2 or greater; OR Transient elastography (Fibroscan®) score greater than or equal to 7.5 kPa; OR FibroSure® score of greater than or equal to 0.48; OR APRI score greater than 0.7 OR FIB-4 greater than 3.25.
        ii. Evidence of extra-hepatic manifestation of hepatitis C virus, such as type 2 or 3 essential mixed cryoglobulinemia with end- organ

manifestations (e.g. vasculitis), or kidney disease (e.g. proteinuria, nephrotic syndrome or membranoproliferative glomerulonephritis).

iii. Persons with hepatocellular carcinoma with a life expectancy of greater than 12 months
iv. Pre- and post-liver transplant, or other solid organ transplant
v. HIV-1 co-infection
vi. Hepatitis B co-infection
vii. Other coexistent liver disease (e.g. nonalcoholic steatohepatitis)
viii. Type 2 diabetes mellitus (insulin resistant)
ix. Porphyria cutanea tarda
x. Debilitating fatigue impacting quality of life (e.g., secondary to extra-hepatic manifestations and/or liver disease)
xi. Men who have sex with men with high-risk sexual practices
xii. Active injection drug users
xiii. Persons on long-term hemodialysis
xiv. Women of childbearing age who wish to get pregnant.
xv. HCV-infected health care workers who perform exposure-prone procedures

B. Patient Readiness and Adherence:
   i. Patients shall be evaluated for readiness to initiate treatment.
   ii. Patients selected for treatment shall be able and willing to strictly adhere to treatment protocols prescribed by their provider.
   iii. Caution shall be exercised with patients who have a history of treatment failure with prior hepatitis C treatment due to non-adherence with treatment regimen and appointments.
   Patients shall be educated regarding potential risks and benefits of hepatitis C virus therapy, as well as the potential for resistance and failed therapy if medication is not taken as prescribed.

C. Age requirements: Treatment candidate must be 18 years of age or older.

3. Other considerations
   A. Quantity Limits:
      i. Prescription of hepatitis C therapy will be dispensed in quantities up to 28 days at a time.
   B. Criteria for Reauthorization/Continuation of Therapy:
      i. Initial authorization criteria have been met, and
      ii. Evidence of lack of adherence may result in denial of treatment reauthorization.
      iii. Missed medical appointments related to the hepatitis C virus may result in denial of treatment authorization.

C. Laboratory Testing:
    i. Documentation of baseline hepatitis C virus-RNA level
    ii. Documentation of hepatitis C virus Genotype
    iii. Laboratory testing should be consistent with current AASLD/IDSA guidelines

D. Populations Unlikely to Benefit from Hepatitis C Virus Treatment: According to AASLD/IDSA hepatitis C virus Guidelines, "patients with limited life expectancy for whom hepatitis C virus therapy would not improve symptoms or prognosis do not require treatment. Chronic hepatitis C is associated with a wide range of comorbid conditions. Little evidence exists to support initiation of hepatitis C virus treatment in patients with limited life expectancy (less than 12 months) due to non–liver-related comorbid conditions. For these patients, the benefits of hepatitis C virus treatment are unlikely to be realized, and palliative care strategies should take precedence." In patients with a life expectancy less than 12 months, treatment is not recommended.

E. Retreatment: Retreatment will be considered where there is evidence that such retreatment will improve patient outcomes. Please refer to AASLD guidelines for recommended retreatment regimens (hcvguidelines.org).

F. Criteria for coverage of Investigational Services (Title 22 § 51303)
    i. Investigational services are not covered except when it is clearly documented that all of the following apply:
    ii. Conventional therapy will not adequately treat the intended patient's condition;
    iii. Conventional therapy will not prevent progressive disability or premature death;
    iv. The provider of the proposed service has a record of safety and success with it equivalent or superior to that of other providers of the investigational service;
    v. The investigational service is the lowest cost item or service that meets the patient's medical needs and is less costly than all conventional alternatives;
    vi. The service is not being performed as a part of a research study protocol;
    vii. There is a reasonable expectation that the investigational service will significantly prolong the intended patient's life or will maintain or restore a range of physical and social function suited to activities of daily living;
    viii. All investigational services require prior authorization. Payment will not be authorized for investigational services that do not meet the

above criteria or for associated inpatient care when a beneficiary needs to be in the hospital primarily because she/he is receiving such non-approved investigational services.

G. Unlabeled use of medication: Authorization for unlabeled use of drugs shall not be granted unless the requested unlabeled use represents reasonable and current prescribing practices. The determination of reasonable and current prescribing practices shall be based on:
    i. Reference to current medical literature.
    ii. Consultation with provider organizations, academic and professional specialists.

Contra Costa Health Plan
Staffing Updates

1- New Pharmacy Director:

Andrew L. Haydon, Pharm.D.
Pharmacy Director
Contra Costa Health Plan
Direct Line: 925-313-6295
Fax: 925-313-6412

2. New Case Management Manager:

John Barclay, R.N., B.S.N.
Manager, Case management Department
595 Center Avenue, Suite 100
Martinez, CA 94553
John.Barclay@hsd.cccounty.us
Office: 925-313-6850
Cell: 925-724-4054
Fax: 925-313-6462

CONTRA COSTA HEALTH PLAN PREFERRED DRUG LIST

GENERIC NAME	BRAND NAME	NOTES
Fluticasone Propionate/Salmeterol Xinafoate	ADVAIR DISKUS, ADVAIR HFA	**PA:** Trial/failure or contraindications to Symbicort or Dulera. Formulary for 4 thru 11 years old.
Flunisolide	AEROBID, AEROBID-M	**PA:** Tried and failed or contraindications to other Formulary inhaled corticosteroids including Qvar.
Formoterol	FORADIL	
Levalbuterol Nebulizer	XOPENEX, XOPENEX HFA	**PA:** Tried and failed or contraindication to at least one preferred alternative including Albuterol solution for nebulization.
Mometasone furoate	ASMANEX	
Cromolyn	INTAL	
Metaproterenol	ALUPENT	
Montelukast Sodium	SINGULAIR	
Nedocromil Sodium	TILADE	
Pirbuterol	MAXAIR AUTOHALER	
Salmetrol	SEREVENT DISKUS	
Sodium Chloride for Inhalation	SODIUM CHLORIDE FOR INHALATION	**B**
Terbutaline	BRETHINE	
Theophylline Elixir	ELIXOPHYLLIN	
Theophyline SR	THEO-DUR, UNIPHYL	
Theophylline	SLO-PHYLLIN	
Triamcinolone	AZMACORT	**PA:** Tried and failed or contraindication to other formulary inhaled corticosteroids including Qvar.
Zafirlukast	ACCOLATE	**PA:** Diagnosis: Asthma – Tried and failed preferred inhaled corticosteroids or insufficient control with inhaled corticosteroids.
Zileuton	ZYFLOW CR	**PA:** Tried and failed OR contraindications to at least one preferred alternative in patients > 12 years old. Indication: Asthma.
• **Mucolytic Agent**		
Acetylcysteine	MUCOMYST	
SKIN MEDICATIONS (TOPICAL)		
• **Acne Medications**		
Benzoyl peroxide	DESQUAM-E, DESQUAM-X	Formulary: Only 2.5%, 5%, and 10% strengths for all dosage forms.
Clindamycin	CLEOCIN-T	
Erythromycin	ERYCETTE, ERY-GEL,	
Erythromycin/Benzoyl peroxide	BENZAMYCIN	**PA:** Tried and failed or contraindication to erythromycin or benzoyl peroxide as separate agents.
Metronidazole	METROGEL	**C1:** Treatment of acne rosacea
Tretinoin	RETIN-A, RETIN-A MICRO	Formulary for individuals ≤ 30 years old; PA required for patients > 30 years old. Formulary for CCRMC Dermatology regardless of age.
Isotretinoin	ACCUTANE	**PA:** Tried and failed OR contraindications to at least one preferred alternative. Severe recalcitrant nodular acne. For Dermatologist only.
• **Topical Antiparasitics/Anti-helmintic**		
Crotamiton	EURAX	**QL:** 120g (2 tubes) per rolling 365 days
Permethrin	ELIMITE	

BRANDS ARE LISTED FOR REFERENCE ONLY – ***GENERICS WILL BE USED WHENEVER AVAILABLE***
PA: NON-PREFERRED DRUG REQUIRING A PRIOR AUTHORIZATION REQUEST
C1 (CODE 1 RESTRICTION): NON-PREFERRED DRUG REQUIRING CERTAIN CRITERIA WHICH COULD BE CITED ON THE PRESCRIPTION OR COMMUNICATED TO THE PHARMACIST. A PHARMACIST COULD ALSO OBTAIN THIS INFORMATION. NO PA FORM IS NECESSARY.
Drugs that are not listed require Prior Authorization (PA)
OTC Coverage: (M)=Medi-Cal; (B)=Basic Health Care and Medi-Cal; (A)=Commercial, Medi-Cal and Basic Health Care

CONTRA COSTA HEALTH PLAN PREFERRED DRUG LIST

GENERIC NAME	BRAND NAME	NOTES
		Maximum six months treatment per year
Nicotine Lozenges	NICORETTE	QL: 324 pieces every 30 days Maximum six months treatment per year
MISCELLANEOUS MEDICATIONS AFFECTING THE BRAIN		
• **Alzheimer's Medications**		
Donepezil	ARICEPT	**PA:** 23mg tablet, consider 2x10mg tab
Donepezil ODT	ARICEPT ODT	
• **Myasthenia Gravis Medications**		
Guanidine	GUANIDINE	
Neostigmine	PROSTIGMIN	
Pyridostigmine	MESTINON	
• **Parkinson's Medications**		
Amantadine	SYMMETREL	Bill fee-for-service Medi-Cal for MCAL members
Benztropine Mesylate	COGENTIN	Bill fee-for-service Medi-Cal for MCAL members
Bromocriptine	PARLODEL	
Carbidopa/levodopa	SINEMET	
Carbidopa/levodopa CR	SINEMET CR	
Levodopa	DOPAR	
Ropinirole	REQUIP	
Selegiline	ELDEPRYL	
Trihexiphenidyl	ARTANE	Bill fee-for-service Medi-Cal for MCAL members
• **Sedative/Hypnotics**		
Flurazepam	DALMANE	
Hydroxyzine HCL	ATARAX	
Hydroxyzine Pamoate	VISTARIL	
Eszopiclone	LUNESTA	
Ramelteon	ROZEREM	**PA:** Tried and failed or contraindication to at least two preferred alternatives. Claim pays at point of sale when PA criteria are met.
Temazepam	RESTORIL	**PA:** 7.5 mg and 22.5mg capsules
Triazolam	HALCION	
Zaleplon	SONATA	
Zolpidem	AMBIEN	**PA:** Female new starts limited to 5mg QHS
Zolpidem CR	AMBIEN CR	**PA:** Tried and failed at least 14-days of (1) zolpidem AND (2) zaleplon
• **Stimulants**		
Amphetamine & dextroamphetamine mixture	ADDERALL, ADDERALL XR	Formulary for patients <18 years old. **PA:** Required for patients >18 years old or >1 capsule per day for Adderall XR.
Dextroamphetamine	DEXEDRINE	Formulary for patients <18 years old. **PA:** Required for patients > 18 years old.
Methylphenidate	RITALIN	Formulary for patients <18 years old. **PA:** Required for patients > 18 years old.
Methylphenidate Extended Release	RITALIN SR, METHADATE ER, CONCERTA, RITALIN LA	Formulary for patients <18 years old. **PA:** Required for patients >18 years old or >1 tablet per day for Concerta, Ritalin LA. Concerta 36mg limit: 2 tablets per day.
Modafinil	PROVIGIL	**PA:** Tried and failed OR contraindications to at least three preferred alternatives. Indicated for treatment of narcolepsy.

BRANDS ARE LISTED FOR REFERENCE ONLY – ***GENERICS WILL BE USED WHENEVER AVAILABLE***
PA: NON-PREFERRED DRUG REQUIRING A PRIOR AUTHORIZATION REQUEST
C1 (CODE 1 RESTRICTION): NON-PREFERRED DRUG REQUIRING CERTAIN CRITERIA WHICH COULD BE CITED ON THE PRESCRIPTION OR COMMUNICATED TO THE PHARMACIST. A PHARMACIST COULD ALSO OBTAIN THIS INFORMATION. NO PA FORM IS NECESSARY.
Drugs that are not listed require Prior Authorization (PA)
OTC Coverage: (M)=Medi-Cal; (B)=Basic Health Care and Medi-Cal; (A)=Commercial, Medi-Cal and Basic Health Care

Emergency Temporary Supply
The authorization code required when submitting a claim for a five (5) day temporary supply is **397555**. This code is to be placed in the prior authorization field. Please note that the temporary supply requirement is not applicable when the dispensing pharmacist determines that providing the temporary supply of medication could be hazardous to the member's health or when the medication is excluded from coverage by benefit design. In the event a DUR error needs to be overridden to process the five (5) day temporary supply, in addition to the authorization code, the pharmacy needs to submit the appropriate conflict, intervention and outcome codes. Temporary supply codes do not apply to Coordination of Benefits (COB) claims.

When a prescription claim is rejected on-line, returning either of the following messages:

- **Non-preferred status**
- **Prior authorization required**

Pharmacies should immediately contact the prescribing physician, and/or PerformRx Pharmacy Services to resolve the problem.

In those instances when the pharmacy is unable to contact either PerformRx or the prescribing physician to resolve the issue, the pharmacy is required to provide a five (5) day temporary supply of emergency medication to the member. A list of appropriate emergency medications has been developed. Those drug agents are:

- **Anti-infectives**
- **Antineoplastics**
- **Antidiabetic**
- **Anticonvulsants**
- **Antiparkinsonians**
- **Antiasthmatics**
- **Analgesics**
- **Cardiovascular**
- **Thyroid**

All plan exclusions will remain in effect. The maximum that temporary supply medication can be dispensed is for a period of five days of treatment. The use of this override is closely monitored for appropriate use.

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People.™
Morbidity and Mortality Weekly Report (*MMWR*)

Use of 9-Valent Human Papillomavirus (HPV) Vaccine: Updated HPV Vaccination Recommendations of the Advisory Committee on Immunization Practices

Weekly
March 27, 2015 / 64(11);300-304

Emiko Petrosky, MD1,2, Joseph A. Bocchini Jr, MD3, Susan Hariri, PhD2, Harrell Chesson, PhD2, C. Robinette Curtis, MD4, Mona Saraiya, MD5, Elizabeth R. Unger, PhD, MD6, Lauri E. Markowitz, MD2 (Author affiliations at end of text)

During its February 2015 meeting, the Advisory Committee on Immunization Practices (ACIP) recommended 9-valent human papillomavirus (HPV) vaccine (9vHPV) (Gardasil 9, Merck and Co., Inc.) as one of three HPV vaccines that can be used for routine vaccination (Table 1). HPV vaccine is recommended for routine vaccination at age 11 or 12 years (*1*). ACIP also recommends vaccination for females aged 13 through 26 years and males aged 13 through 21 years not vaccinated previously. Vaccination is also recommended through age 26 years for men who have sex with men and for immunocompromised persons (including those with HIV infection) if not vaccinated previously (*1*). 9vHPV is a noninfectious, virus-like particle (VLP) vaccine. Similar to quadrivalent HPV vaccine (4vHPV), 9vHPV contains HPV 6, 11, 16, and 18 VLPs. In addition, 9vHPV contains HPV 31, 33, 45, 52, and 58 VLPs (*2*). 9vHPV was approved by the Food and Drug Administration (FDA) on December 10, 2014, for use in females aged 9 through 26 years and males aged 9 through 15 years (*3*). For these recommendations, ACIP reviewed additional data on 9vHPV in males aged 16 through 26 years (*4*). 9vHPV and 4vHPV are licensed for use in females and males. Bivalent HPV vaccine (2vHPV), which contains HPV 16, 18 VLPs, is licensed for use in females (*1*). This report summarizes evidence considered by ACIP in recommending 9vHPV as one of three HPV vaccines that can be used for vaccination and provides recommendations for vaccine use.

Methods

From October 2013 to February 2015, the ACIP HPV Vaccine Work Group reviewed clinical trial data assessing the efficacy, immunogenicity, and safety of 9vHPV, modeling data on cost-effectiveness of 9vHPV, and data on burden of type-specific HPV-associated disease in the United States. Summaries of reviewed evidence and Work Group discussions were presented to ACIP before recommendations were proposed. Recommendations were approved by ACIP in February 2015. Evidence supporting 9vHPV use was evaluated using the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) framework (*5*) and determined to be type 2 (moderate level of evidence) among females and 3 (low level of evidence) among males; the recommendation was categorized as a Category A recommendation (for all persons in an age- or risk-factor –based group) (*6*).

HPV-Associated Disease

HPV is associated with cervical, vulvar, and vaginal cancer in females, penile cancer in males, and anal cancer and oropharyngeal cancer in both females and males (*7–10*). The burden of HPV infection also includes cervical precancers, including cervical intraepithelial neoplasia grade 2 or 3 and adenocarcinoma in situ (≥CIN2). The majority of all HPV-associated cancers are caused by HPV 16 or 18, types targeted by 2vHPV, 4vHPV and 9vHPV (*2,11,12*). In the United States, approximately 64% of invasive HPV-associated cancers are attributable to HPV 16 or 18 (65% for females; 63% for males; approximately 21,300 cases annually) and 10% are attributable to the five additional types in 9vHPV: HPV 31, 33, 45, 52, and 58 (14% for females; 4% for males; approximately 3,400 cases annually) (*1,12,13*). HPV 16 or 18 account for 66% and the five additional types for about 15% of cervical cancers (*12*). Approximately 50% of ≥CIN2 are caused by HPV 16 or 18 and 25% by HPV 31, 33, 45, 52, or 58 (*14*). HPV 6 or 11 cause 90% of anogenital warts (condylomata) and most cases of recurrent respiratory papillomatosis (*15*).

9vHPV Efficacy, Immunogenicity, and Safety

In a phase III efficacy trial comparing 9vHPV with 4vHPV among approximately 14,000 females aged 16 through 26 years, 9vHPV efficacy for prevention of ≥CIN2, vulvar intraepithelial neoplasia grade 2 or 3, and vaginal intraepithelial neoplasia grade 2 or 3 caused by HPV 31, 33, 45, 52, or 58 was 96.7% in the per protocol population* (Table 2) (*2,16*). Efficacy for prevention of ≥CIN2 caused by HPV 31, 33, 45, 52, or 58 was 96.3% and for 6-month persistent infection was 96.0% (*16*). Few cases were caused by HPV 6, 11, 16, or 18 in either vaccine group. Noninferior immunogenicity of 9vHPV compared with 4vHPV was used to infer efficacy for HPV 6, 11, 16, and 18. Geometric mean antibody titers (GMTs) 1 month after the third dose were noninferior for HPV 6, 11, 16, and 18; in the 9vHPV group, >99% seroconverted to all nine HPV vaccine types (Table 3).

Two immunobridging trials were conducted. One compared 9vHPV in approximately 2,400 females and males aged 9 through 15 years with approximately 400 females aged 16 through 26 years. Over 99% seroconverted to all nine HPV vaccine types; GMTs were significantly higher in adolescents aged 9 through 15 years compared with females aged 16 through 26 years. In a comparison of 4vHPV with 9vHPV in approximately 600 adolescent females aged 9 through 15 years, 100% seroconverted to HPV 6, 11, 16, and 18 in both groups, and GMTs were noninferior in the 9vHPV group compared with the 4vHPV group.

Immunogenicity in males aged 16 through 26 years was compared with females of the same age group in a separate study. In both females and males, >99% seroconverted to all nine HPV vaccine types, and GMTs in males were noninferior to those in females (*4*).

The immunogenicity of concomitant and nonconcomitant administration of 9vHPV with quadrivalent meningococcal conjugate vaccine (Menactra, MenACWY-D) and tetanus, diphtheria, acellular pertussis vaccine (Adacel, Tdap) was evaluated. The GMTs were noninferior for all nine HPV vaccine types in the co-administered group (all $p<0.001$). For Menactra, the noninferiority criterion was met for all four serogroups, and for Adacel, for diphtheria, tetanus, and all four pertussis antigens.

Safety has been evaluated in approximately 15,000 subjects in the 9vHPV clinical development program; approximately 13,000 subjects in six studies were included in the initial application submitted to FDA (*2*). The vaccine was well-tolerated, and most adverse events were injection site-related pain, swelling, and erythema that were mild to moderate in intensity. The safety profiles were similar in 4vHPV and 9vHPV vaccinees. Among females aged 9 through 26 years, 9vHPV recipients had more injection-site adverse events, including swelling (40.3% in the 9vHPV group compared with 29.1% in the 4vHPV group) and erythema (34.0% in the 9vHPV group compared with 25.8% in the 4vHPV group). Males had fewer injection site adverse events. In males aged 9 through 15 years, injection site swelling and erythema in 9vHPV recipients occurred in 26.9% and 24.9%, respectively. Rates of injection-site swelling and erythema both increased following each successive dose of 9vHPV.

Health Impact and Cost Effectiveness

Introduction of 9vHPV in both males and females was cost-saving when compared with 4vHPV for both sexes in a cost-effectiveness model that assumed 9vHPV cost $13 more per dose than 4vHPV. Cost-effectiveness ratios for 9vHPV remained favorable compared with 4vHPV (9vHPV was cost-saving in most scenarios, and the cost per quality-adjusted life year gained did not exceed $25,000 in any scenario) when varying assumptions about HPV natural history, cervical cancer screening, vaccine coverage, vaccine duration of protection, and health care costs, but were sensitive to 9vHPV cost assumptions (*17*). Because the additional five types in 9vHPV account for a higher proportion of HPV-associated cancers in females compared with males and cause cervical precancers, the additional protection from 9vHPV will mostly benefit females.

Recommendations for Use of HPV Vaccines

ACIP recommends that routine HPV vaccination be initiated at age 11 or 12 years. The vaccination series can be started beginning at age 9 years. Vaccination is also recommended for females aged 13 through 26 years and for males aged 13 through 21 years who have not been vaccinated previously or who have not completed the 3-dose series (*1*). Males aged 22 through 26 years may be vaccinated.† Vaccination of females is recommended with 2vHPV, 4vHPV (as long as this formulation is available), or 9vHPV. Vaccination of males is recommended with 4vHPV (as long as this formulation is available) or 9vHPV.

2vHPV, 4vHPV, and 9vHPV all protect against HPV 16 and 18, types that cause about 66% of cervical cancers and the majority of other HPV-attributable cancers in the United States (*1,12*). 9vHPV targets five additional cancer causing types, which account for about 15% of cervical cancers (*12*). 4vHPV and 9vHPV also protect against HPV 6 and 11, types that cause anogenital warts.

Administration. 2vHPV, 4vHPV, and 9vHPV are each administered in a 3-dose schedule. The second dose is administered at least 1 to 2 months after the first dose, and the third dose at least 6 months after the first dose§ (*1*). If the vaccine schedule is interrupted, the vaccination series does not need to be restarted.

If vaccination providers do not know or do not have available the HPV vaccine product previously administered, or are in settings transitioning to 9vHPV, any available HPV vaccine product may be used to continue or complete the series for females for protection against HPV 16 and 18; 9vHPV or 4vHPV may be used to continue or complete the series for males. There are no data on efficacy of fewer than 3 doses of 9vHPV.

Special Populations. HPV vaccination is recommended through age 26 years for men who have sex with men and for immunocompromised persons (including those with HIV infection) who have not been vaccinated previously or have not completed the 3-dose series.

Precautions and Contraindications. HPV vaccines are contraindicated for persons with a history of immediate hypersensitivity to any vaccine component. 4vHPV and 9vHPV are contraindicated for persons with a history of immediate hypersensitivity to yeast. 2vHPV should not be used in persons with anaphylactic latex allergy.

HPV vaccines are not recommended for use in pregnant women (*1*). If a woman is found to be pregnant after initiating the vaccination series, the remainder of the 3-dose series should be delayed until completion of pregnancy. Pregnancy testing is not needed before vaccination. If a vaccine dose has been administered during pregnancy, no intervention is needed. A new pregnancy registry has been established for 9vHPV (*2*). Pregnancy registries for 4vHPV and 2vHPV have been closed with concurrence from FDA (*1,18*). Exposure during pregnancy can be reported to the respective manufacturer.¶ Patients and health care providers can report an exposure to HPV vaccine during pregnancy to the Vaccine Adverse Event Reporting System (VAERS).

Adverse events occurring after administration of any vaccine should be reported to VAERS. Additional information about VAERS is available by telephone (1–800–822–7967) or online at http://vaers.hhs.gov.

Cervical Cancer Screening. Cervical cancer screening is recommended beginning at age 21 years and continuing through age 65 years for both vaccinated and unvaccinated women (*19,20*). Recommendations will continue to be evaluated as further postlicensure monitoring data become available.

Future Policy Issues

A clinical trial is ongoing to assess alternative dosing schedules of 9vHPV. ACIP will formally review the results as data become available. HPV vaccination should not be delayed pending availability of 9vHPV or of future clinical trial data.

Acknowledgments

ACIP members (membership roster for July 2014–June 2015 available at http://www.cdc.gov/vaccines/acip/committee/members-archive.html). ACIP HPV Work Group.

1Epidemic Intelligence Service, CDC; 2National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, CDC; 3Louisiana State University Health Sciences Center, Shreveport, Louisiana; 4National Center for Immunization and Respiratory Diseases, CDC; 5National Center for Chronic Disease Prevention and Health Promotion, CDC; 6National Center for Emerging and Zoonotic Infectious Diseases, CDC (Corresponding author: Emiko Petrosky, xfq7@cdc.gov, 404-639-1817)

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* Females who received all 3 vaccinations within 1 year of enrollment, did not have major deviations from the study protocol, were naïve (polymerase chain reaction [PCR] negative and seronegative) to the relevant HPV type (s) before dose 1, and who remained PCR negative to the relevant HPV type(s) through 1 month after dose 3 (month 7).

† Vaccination is also recommended through age 26 years for men who have sex with men and for immunocompromised persons (including those with HIV infection) if not vaccinated previously.

§ Minimum intervals are 1 month between the first and second dose, 3 months between the second and third dose, and 6 months between the first and third dose.

¶ 9vHPV exposure during pregnancy should be reported to the Merck Pregnancy Registry at telephone 1-800-986-8999; 4vHPV exposure during pregnancy can be reported to Merck at telephone 1-877-888-4231. 2vHPV exposure during pregnancy can be reported to GlaxoSmithKline at telephone 1-888-825-5249.

Recommendations for routine use of vaccines in children, adolescents and adults are developed by the Advisory Committee on Immunization Practices (ACIP). ACIP is chartered as a federal advisory committee to provide expert external advice and guidance to the Director of the Centers for Disease Control and Prevention (CDC) on use of vaccines and related agents for the control of vaccine-preventable diseases in the civilian population of the United States. Recommendations for routine use of vaccines in children and adolescents are harmonized to the greatest extent possible with recommendations made by the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Obstetricians and Gynecologists (ACOG). Recommendations for routine use of vaccines in adults are harmonized with recommendations of AAFP, ACOG, and the American College of Physicians (ACP). ACIP recommendations approved by the CDC Director become agency guidelines on the date published in the Morbidity and Mortality Weekly Report *(MMWR). Additional information about ACIP is available at http://www.cdc.gov/vaccines/acip/.*

What is currently recommended?

The Advisory Committee on Immunization Practices (ACIP) recommends routine HPV vaccination at age 11 or 12 years. The vaccination series can be started beginning at age 9 years. Vaccination is also recommended for females aged 13 through 26 years and for males aged 13 through 21 years who have not been vaccinated previously or who have not completed the 3-dose series. Males aged 22 through 26 years may be vaccinated. ACIP recommends vaccination of men who have sex with men and immunocompromised persons through age 26 years if not vaccinated previously.

Why are the recommendations being updated now?

9-valent HPV vaccine (9vHPV) was approved by the Food and Drug Administration on December 10, 2014. This vaccine targets HPV types 6, 11, 16, and 18, the types targeted by the quadrivalent HPV vaccine (4vHPV), as well as five additional types, HPV types 31, 33, 45, 52, and 58. ACIP reviewed results of a randomized trial among approximately 14,000 females aged 16 through 26 years that showed noninferior immunogenicity for the types shared by 4vHPV and 9vHPV and high efficacy for the five additional types. Other trials in the 9vHPV clinical development program included studies that compared antibody responses across age groups and females and males and concomitant vaccination studies. The evidence supporting 9vHPV vaccination was evaluated using the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) framework and determined to be type 2 (moderate level of evidence) among females and 3 (low level of evidence) among males; the recommendation was designated as a Category A recommendation (recommendation for all persons in an age- or risk-factor–based group).

What are the new recommendations?

9vHPV, 4vHPV or 2vHPV can be used for routine vaccination of females aged 11 or 12 years and females through age 26 years who have not been vaccinated previously or who have not completed the 3-dose series. 9vHPV or 4vHPV can be used for routine vaccination of males aged 11 or 12 years and males through age 21 years who have not been vaccinated previously or who have not completed the 3-dose series. ACIP recommends either 9vHPV or 4vHPV vaccination for men who have sex with men and immunocompromised persons (including those with HIV infection) through age 26 years if not vaccinated previously.

TABLE 1. Characteristics of the three human papillomavirus (HPV) vaccines licensed for use in the United States

Characteristic	Bivalent (2vHPV)*	Quadrivalent (4vHPV)†	9-valent (9vHPV)§
Brand name	Cervarix	Gardasil	Gardasil 9
VLPs	16, 18	6, 11, 16, 18	6, 11, 16, 18, 31, 33, 45, 52, 58
Manufacturer	GlaxoSmithKline	Merck and Co., Inc.	Merck and Co., Inc.
Manufacturing	*Trichoplusia ni* insect cell line infected with L1 encoding recombinant baculovirus	*Saccharomyces cerevisiae* (Baker's yeast), expressing L1	*Saccharomyces cerevisiae* (Baker's yeast), expressing L1
Adjuvant	500 μg aluminum hydroxide,		

	50 μg 3-O-desacyl-4' monophosphoryl lipid A	225 μg amorphous aluminum hydroxyphosphate sulfate	500 μg amorphous aluminum hydroxyphosphate sulfate
Volume per dose	0.5 ml	0.5 ml	0.5 ml
Administration	Intramuscular	Intramuscular	Intramuscular

Abbreviation: L1 = the HPV major capsid protein; VLPs = virus-like particles.

* Only licensed for use in females in the United States. Package insert available at http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM186981.pdf.

† Package insert available at http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM111263.pdf.

§ Package insert available at http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM426457.pdf.

TABLE 2. Results of a Phase III efficacy trial comparing 9-valent human papillomavirus (HPV) vaccine (9vHPV) with quadrivalent HPV vaccine (4vHPV), per protocol population* in females aged 16 through 26 years†

Endpoint-related types	Endpoint	9vHPV		4vHPV		Vaccine efficacy	
		No. participants	Cases	No. participants	Cases	%	(95% CI)
	≥CIN2, VIN2/3, VaIN2/3	6,016	1	6,017	30	96.7	(80.9–99.8)
HPV 31, 33, 45, 52, 58	≥CIN2	5,948	1	5,943	27	96.3	(79.5–99.8)
	6-month persistent infection	5,939	35	5,953	810	96.0	(94.4–97.2)
HPV 6, 11, 16, 18	≥CIN2§	5,823	1	5,832	1	—	—
	Anogenital warts	5,876	5	5,893	1	—	—

Abbreviations: CI = confidence interval; ≥CIN2 = cervical intraepithelial neoplasia grade 2 or 3 or adenocarcinoma in situ; VaIN2/3 = vaginal intraepithelial neoplasia grade 2 or 3; VIN2/3 = vulvar intraepithelial neoplasia grade 2 or 3.

Sources: Package insert available at http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM426457.pdf.

Joura EA, Giuliano AR, Iversen OE, et al. A 9-valent HPV vaccine against infection and intraepithelial neoplasia in women. N Engl J Med 2015;372:711–23.

* Females who received all 3 vaccinations within 1 year of enrollment, did not have major deviations from the study protocol, were naïve (polymerase chain reaction [PCR] negative and seronegative) to the relevant HPV type(s) before dose 1, and who remained PCR negative to the relevant HPV type(s) through 1 month after dose 3 (month 7).

† Participants were enrolled from sites in 18 countries; median duration of follow-up was 40 months.

TABLE 3. Human papillomavirus (HPV) 6, 11, 16, and 18 seroconversion and geometric mean titers (GMTs*) after 3 doses of 9-valent HPV vaccine (9vHPV) compared with quadrivalent HPV vaccine (4vHPV), per protocol population† in females aged 16 through 26 years§

	9vHPV			4vHPV		
Assay (cLIA)	No. participants	Seropositivity (%)	GMT (mMU/mL)	No. participants	Seropositivity (%)	GMT (mMU/mL)
Anti-HPV 6	3,993	(99.8)	893	3,975	(99.8)	875
Anti-HPV 11	3,995	(100)	666	3,982	(99.9)	830
Anti-HPV 16	4,032	(100)	3,131	4,062	(100)	3,157
Anti-HPV 18	4,539	(99.8)	805	4,541	(99.7)	679

Abbreviations: cLIA = competitive Luminex immunoassay; mMU = milli-Merck units.

Source: Joura EA, Giuliano AR, Iversen OE, et al. A 9-valent HPV vaccine against infection and intraepithelial neoplasia in women, and supplementary appendix. N Engl J Med 2015;372:711–23.

* The noninferiority criterion for GMTs was met for all four HPV types ($p<0.001$).

† Females who received all 3 vaccinations within 1 year of enrollment, did not have major deviations from the study protocol, were naïve (polymerase chain reaction [PCR] negative and seronegative) to the relevant HPV type(s) before dose 1, and who remained PCR–negative to the relevant HPV type(s) through 1 month after dose 3 (month 7).

§ Participants were enrolled from sites in 18 countries; median duration of follow-up was 40 months.

Announcement: Medi-Cal Incentives to Quit Smoking (MIQS) Project Incentives to End by July 31, 2015

The MIQS Project is excited to announce that over 43,000 Medi-Cal smokers have enrolled in tobacco cessation counseling services, gift cards and free nicotine patches from the California Smokers' Helpline as of May 1, 2015. The Helpline has received over 83,000 calls from Medi-Cal smokers during the project period from March 2012 through April 2015.

Due to the success of the MIQS project and the resulting high volume of calls to the Helpline, MIQS incentives are projected to end by **July 31, 2015**. After that date, Medi-Cal members may continue to call the Helpline at 1-800-NO-BUTTS for free telephone tobacco cessation counseling services.

Remember, smokers can also receive nicotine gum, nicotine lozenge, nicotine patch and bupropion (90 days x 2 times) through CCHP without an authorization. Nicotine inhaler and spray do need authorization. Some callers may qualify for other incentives offered through special projects like First Five (for parents of children 0 - 5) and the Asian Smokers' Quitline.

Here are some steps you can take to communicate in advance to Medi-Cal members about the end of the MIQS incentives:

1) **Notify** Medi-Cal members that the MIQS incentives (free nicotine patches and gift cards) will end by **July 31, 2015.**
2) **Remember** to **Ask, Advise and Refer** smokers to the Helpline, and encourage them to sign up for the Helpline's Web-Based Referral Service at https://forms-nobutts.org/referral.
3) **Send** smokers to the Helpline's newly redesigned web site at www.nobutts.org for more information on special projects, training and resources.

Thanks again for all you do to help Medi-Cal members quit smoking!

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HEALTH ADVISORY

JUNE 17, 2015

MIDDLE EAST RESPIRATORY SYNDROME CORONAVIRUS (MERS-COV) - UPDATE

SUMMARY:

Middle East Respiratory Syndrome (MERS) is a viral respiratory illness caused by a coronavirus (MERS-CoV). The illness is new to humans and was first reported in Saudi Arabia during April 2012.

- South Korea is having a large ongoing outbreak of MERS-CoV that was initiated through travel to the Arabian Peninsula and transmitted through healthcare facilities, beginning in May 2015.
- All identified cases have been linked to a country or territory in or near the Arabian Peninsula including: Saudi Arabia, United Arab Emirates (UAE), Qatar, Oman, Jordan, Kuwait, Yemen, Lebanon, and Iran.
- Individuals infected with MERS-CoV often develop symptoms of severe acute respiratory illness, including fever, cough, and shortness of breath.

ACTIONS REQUESTED OF HEALTHCARE PROFESSIONALS:

OBTAIN TRAVEL HISTORY TO REDUCE THE SPREAD OF MERS-COV AND OTHER INFECTIOUS DISEASES ASSOCIATED WITH TRAVEL

SUSPECT MERS-CoV in patients who develop fever (≥100.4°F) and symptoms of respiratory illness that were in health care facilities in South Korea and/or a country or territory in or near the Arabian Peninsula within 14 days of symptom onset.

IMPLEMENT standard, contact and airborne precautions immediately for a suspect MERS-CoV case. Mask and isolate patient in Airborne Infection Isolation Room (AIIR).

TEST any patient suspect for MERS-CoV; collect multiple specimens from different sites including a lower respiratory specimen (sputum, broncheoalveolar lavage fluid, tracheal aspirate), a nasopharyngeal/oropharyngeal swab and serum.

REPORT IMMEDIATELY TO PUBLIC HEALTH any suspect patient. Communicable Disease Staff may be reached by phone **(925) 313-6740** 24/7; after hours follow voice instructions to contact the on-call Health Officer.

ADVISE patients who are not ill enough to be hospitalized to isolate at home until negative lab result or until contacted by Public Health. Provide patients with surgical masks. They should return home by private car, not public transportation.

CLINICAL INFORMATION

CDC Interim MERS-CoV Guidance for Healthcare Professionals is available at:
http://www.cdc.gov/coronavirus/mers/interim-guidance.html

TESTING

- Collect the following three specimens for MERS rRT-PCR assay
  1) **Lower Respiratory Tract** (broncheoalveolar lavage, tracheal aspirate, pleural fluid or sputum) 2-3 mL in a sterile screw-cap sputum collection cup or vial.
  2) **Upper Respiratory Tract** (nasopharyngeal and oropharyngeal swab) – use only a synthetic fiber swab with plastic shaft and place swabs immediately into the same sterile tube containing 2-3 mL of viral transport media (VTM).
  3) **Serum** (PCR testing if < 14 days since illness onset or for serological testing if >14 days since illness onset) collect 5-10mL of whole blood in a serum separator tube (red top)
- Send specimens for testing to Contra Costa Public Health Laboratory - 2500 Alhambra Ave., Room 209, Martinez, CA 94553 – telephone: (925) 370-5775. **Do NOT submit specimens to CDC or the California Department of Public Health (CDPH).**
- Refrigerate specimens between 2°C -8°C for up to 72 hours and freeze at -70°C if the specimen holding time is expected to exceed72 hours.

INFECTION CONTROL

- **Standard, contact, and airborne precautions** are recommended for the management of hospitalized patients with suspected or known MERS-CoV infection.
- **Home isolation is recommended for ill patients who do not require hospitalization** and are being evaluated for MERS-CoV infection. Provide patient with surgical masks. They should return home by private car, not public transportation. Instruct home isolation until a negative lab result or contacted by Public Health.
- CDC Interim Infection Prevention and Control Recommendations for Hospitalized Patients located at: http://www.cdc.gov/coronavirus/mers/infection-prevention-control.html

ADDITIONAL QUESTIONS

Contra Costa Public Health Communicable Disease Programs can be reached from 8AM-5PM, M-F at 925-313-6740 (phone) or 925-313-6465 (fax).

More information may be found at the following websites:

- California Department of Public Health (CDPH): http://www.cdph.ca.gov/programs/cder/Pages/MERS-CoV.aspx
- Centers for Disease Control and Prevention (CDC): http://www.cdc.gov/coronavirus/mers/index.html
- World Health Organization (WHO): http://www.who.int/csr/disease/coronavirus_infections/en/

California LEGISLATIVE INFORMATION

SB-277 Public health: vaccinations. (2015-2016)

Senate Bill No. 277

CHAPTER 35

An act to amend Sections 120325, 120335, 120370, and 120375 of, to add Section 120338 to, and to repeal Section 120365 of, the Health and Safety Code, relating to public health.

[Approved by Governor June 30, 2015. Filed with Secretary of State June 30, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 277, Pan. Public health: vaccinations.

Existing law prohibits the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any public or private elementary or secondary school, child care center, day nursery, nursery school, family day care home, or development center, unless prior to his or her admission to that institution he or she has been fully immunized against various diseases, including measles, mumps, and pertussis, subject to any specific age criteria. Existing law authorizes an exemption from those provisions for medical reasons or because of personal beliefs, if specified forms are submitted to the governing authority. Existing law requires the governing authority of a school or other institution to require documentary proof of each entrant's immunization status. Existing law authorizes the governing authority of a school or other institution to temporarily exclude a child from the school or institution if the authority has good cause to believe that the child has been exposed to one of those diseases, as specified.

This bill would eliminate the exemption from existing specified immunization requirements based upon personal beliefs, but would allow exemption from future

immunization requirements deemed appropriate by the State Department of Public Health for either medical reasons or personal beliefs. The bill would exempt pupils in a home-based private school and students enrolled in an independent study program and who do not receive classroom-based instruction, pursuant to specified law from the prohibition described above. The bill would allow pupils who, prior to January 1, 2016, have a letter or affidavit on file at a private or public elementary or secondary school, child day care center, day nursery, nursery school, family day care home, or development center stating beliefs opposed to immunization, to be enrolled in any private or public elementary or secondary school, child day care center, day nursery, nursery school, family day care home, or development center within the state until the pupil enrolls in the next grade span, as defined. Except as under the circumstances described above, on and after July 1, 2016, the bill would prohibit a governing authority from unconditionally admitting to any of those institutions for the first time or admitting or advancing any pupil to the 7th grade level, unless the pupil has been immunized as required by the bill. The bill would specify that its provisions do not prohibit a pupil who qualifies for an individualized education program, pursuant to specified laws, from accessing any special education and related services required by his or her individualized education program. The bill would narrow the authorization for temporary exclusion from a school or other institution to make it applicable only to a child who has been exposed to a specified disease and whose documentary proof of immunization status does not show proof of immunization against one of the diseases described above. The bill would make conforming changes to related provisions.

Vote: majority Appropriation: no Fiscal Committee: no Local Program: no

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 120325 of the Health and Safety Code is amended to read:

120325. In enacting this chapter, but excluding Section 120380, and in enacting Sections 120400, 120405, 120410, and 120415, it is the intent of the Legislature to provide:

(a) A means for the eventual achievement of total immunization of appropriate age groups against the following childhood diseases:

(1) Diphtheria.

(2) Hepatitis B.

(3) Haemophilus influenzae type b.

(4) Measles.

(5) Mumps.

(6) Pertussis (whooping cough).

(7) Poliomyelitis.

(8) Rubella.

(9) Tetanus.

(10) Varicella (chickenpox).

(11) Any other disease deemed appropriate by the department, taking into consideration the recommendations of the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services, the American Academy of Pediatrics, and the American Academy of Family Physicians.

(b) That the persons required to be immunized be allowed to obtain immunizations from whatever medical source they so desire, subject only to the condition that the immunization be performed in accordance with the regulations of the department and that a record of the immunization is made in accordance with the regulations.

(c) Exemptions from immunization for medical reasons.

(d) For the keeping of adequate records of immunization so that health departments, schools, and other institutions, parents or guardians, and the persons immunized will be able to ascertain that a child is fully or only partially immunized, and so that appropriate public agencies will be able to ascertain the immunization needs of groups of children in schools or other institutions.

(e) Incentives to public health authorities to design innovative and creative programs that will promote and achieve full and timely immunization of children.

SEC. 2. Section 120335 of the Health and Safety Code is amended to read:

120335. (a) As used in this chapter, "governing authority" means the governing board of each school district or the authority of each other private or public institution responsible for the operation and control of the institution or the principal or administrator of each school or institution.

(b) The governing authority shall not unconditionally admit any person as a pupil of any private or public elementary or secondary school, child care center, day nursery, nursery school, family day care home, or development center, unless, prior to his or her first admission to that institution, he or she has been fully immunized. The following are the diseases for which immunizations shall be documented:

(1) Diphtheria.

(2) Haemophilus influenzae type b.

(3) Measles.

(4) Mumps.

(5) Pertussis (whooping cough).

(6) Poliomyelitis.

(7) Rubella.

(8) Tetanus.

(9) Hepatitis B.

(10) Varicella (chickenpox).

(11) Any other disease deemed appropriate by the department, taking into consideration the recommendations of the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services, the American Academy of Pediatrics, and the American Academy of Family Physicians.

(c) Notwithstanding subdivision (b), full immunization against hepatitis B shall not be a condition by which the governing authority shall admit or advance any pupil to the 7th grade level of any private or public elementary or secondary school.

(d) The governing authority shall not unconditionally admit or advance any pupil to the 7th grade level of any private or public elementary or secondary school unless the pupil has been fully immunized against pertussis, including all pertussis boosters appropriate for the pupil's age.

(e) The department may specify the immunizing agents that may be utilized and the manner in which immunizations are administered.

(f) This section does not apply to a pupil in a home-based private school or a pupil who is enrolled in an independent study program pursuant to Article 5.5 (commencing with Section 51745) of Chapter 5 of Part 28 of the Education Code and does not receive classroom-based instruction.

(g) (1) A pupil who, prior to January 1, 2016, submitted a letter or affidavit on file at a private or public elementary or secondary school, child day care center, day nursery, nursery school, family day care home, or development center stating beliefs opposed to immunization shall be allowed enrollment to any private or public elementary or secondary school, child day care center, day nursery, nursery school, family day care home, or development center within the state until the pupil enrolls in the next grade span.

(2) For purposes of this subdivision, "grade span" means each of the following:

(A) Birth to preschool.

(B) Kindergarten and grades 1 to 6, inclusive, including transitional kindergarten.

(C) Grades 7 to 12, inclusive.

(3) Except as provided in this subdivision, on and after July 1, 2016, the governing authority shall not unconditionally admit to any of those institutions specified in this subdivision for the first time, or admit or advance any pupil to 7th grade level, unless the pupil has been immunized for his or her age as required by this section.

(h) This section does not prohibit a pupil who qualifies for an individualized education program, pursuant to federal law and Section 56026 of the Education Code, from accessing any special education and related services required by his or her individualized education program.

SEC. 3. Section 120338 is added to the Health and Safety Code, to read:

120338. Notwithstanding Sections 120325 and 120335, any immunizations deemed appropriate by the department pursuant to paragraph (11) of subdivision (a) of Section 120325 or paragraph (11) of subdivision (b) of Section 120335, may be mandated before a pupil's first admission to any private or public elementary or secondary school, child care center, day nursery, nursery school, family day care home, or development center, only if exemptions are allowed for both medical reasons and personal beliefs.

SEC. 4. Section 120365 of the Health and Safety Code is repealed.

SEC. 5. Section 120370 of the Health and Safety Code is amended to read:

120370. (a) If the parent or guardian files with the governing authority a written statement by a licensed physician to the effect that the physical condition of the child is such, or medical circumstances relating to the child are such, that immunization is not considered safe, indicating the specific nature and probable duration of the medical condition or circumstances, including, but not limited to, family medical history, for which the physician does not recommend immunization, that child shall be exempt from the requirements of Chapter 1 (commencing with Section 120325, but excluding Section 120380) and Sections 120400, 120405, 120410, and 120415 to the extent indicated by the physician's statement.

(b) If there is good cause to believe that a child has been exposed to a disease listed in subdivision (b) of Section 120335 and his or her documentary proof of immunization status does not show proof of immunization against that disease, that child may be temporarily excluded from the school or institution until the local health officer is satisfied that the child is no longer at risk of developing or transmitting the disease.

SEC. 6. Section 120375 of the Health and Safety Code is amended to read:

120375. (a) The governing authority of each school or institution included in Section 120335 shall require documentary proof of each entrant's immunization status. The governing authority shall record the immunizations of each new entrant in the entrant's permanent enrollment and scholarship record on a form provided by the department. The immunization record of each new entrant admitted conditionally shall be reviewed periodically by the governing authority to ensure that within the time periods designated by regulation of the department he or she has been fully immunized against all of the diseases listed in Section 120335, and immunizations received subsequent to entry shall be added to the pupil's immunization record.

(b) The governing authority of each school or institution included in Section 120335 shall prohibit from further attendance any pupil admitted conditionally who failed to obtain the required immunizations within the time limits allowed in the regulations of the department, unless the pupil is exempted under Section 120370, until that pupil has been fully immunized against all of the diseases listed in Section 120335.

(c) The governing authority shall file a written report on the immunization status of new entrants to the school or institution under their jurisdiction with the department and the local health department at times and on forms prescribed by the department. As provided in paragraph (4) of subdivision (a) of Section 49076 of the Education Code, the local health department shall have access to the complete health information as it relates to immunization of each student in the schools or other institutions listed in Section 120335 in order to determine immunization deficiencies.

(d) The governing authority shall cooperate with the county health officer in carrying out programs for the immunization of persons applying for admission to any school or institution under its jurisdiction. The governing board of any school district may use funds, property, and personnel of the district for that purpose. The governing authority of any school or other institution may permit any licensed physician or any qualified registered nurse as provided in Section 2727.3 of the Business and Professions Code to administer immunizing agents to any person seeking admission to any school or institution under its jurisdiction.

MORE ON SBIRT –SCREENING, BRIEF INTERVENTION, REFERRAL TO TREATMENT:

As you know effective January 1, 2014 **PCPs** are expected to screen and offer SBIRT services for **Medi-Cal** members ages 18 and older who misuse alcohol. In order to provide these services, at least one provider per clinic or practice must receive 4- hour SBIRT training and submit an attestation to CCHP. There are many trainings available. See below several suggestions.

Training:

The University of California, Los Angeles (UCLA) integrated substance abuse programs (ISAP) is offering **free 4-hour SBIRT training** sessions throughout the state of California. For information about this training opportunity please visit **http://www.uclaisap.org/sbirt/. Next Training available in Sacramento on August 20, 2015 at 9:00 AM.**

Other Available Trainings Off-Site:

SBIRT Core Training Program:

http://www.sbirttraining.com/sbirtcore

- Four-hour training. $50 per individual; group rates are available. Continuing Education Units available.

Substance Use in Older Adults: Screening and Treatment Intervention Strategies

- Three-hour training. Free California Continuing Education Certificate. $15 to take the course and earn 3.00 NAADAC Continuing Education Units and 8.00 NBCC clock hours

SAMHSA-HRSA: Motivational Interviewing

- Three-part prerecorded webinar series; includes recording, presentation, transcript, and additional resources. No certificate available. Free.

Foundations of SBIRT

- 1.5-hour course developed by the Pacific Southwest ATTC that helps familiarize health professionals with the SBIRT process.

NIAAA Clinician's Guide Online Training

- Four interactive, 10-minute video cases, evidence-based clinical strategies, and free CME/CE credits for physicians and nurses through Medscape©.

Attestation:

After receiving your **4-hour training**, do not forget to submit an attestation of training to CCHP.

SBIRT- Attestation forms are available on our website: www.contracostahealthplan.org: go for providers, forms & resources, SBIRT, Attestation statement.

Formulary

Contra Costa Healthplan

ADHD

Drug Names	Generic Names	Formulary Status	Comments
clonidine	generic	On Formulary	
guanfacine	generic	On Formulary	
Adderall	dextroamphetamine/amphetamine	Age Restriction applies	Covered for individuals age <=18. PA required for age > 18. Dx: of ADHD or narcolepsy.
Adderall XR	dextroamphetamine/amphetamine	Age Restriction applies	Covered for individuals age <=18. PA required for patients age >18 > 1 tab per day.
Concerta	methylphenidate	Age Restriction applies	Covered for individuals age <=18. PA required for patients age >18 > 1 tab per day.
Dexedrine	dextroamphetamine	Age Restriction applies	Covered for individuals age <=18. PA required for age > 18. Dx: of ADHD or narcolepsy.
Ritalin	methylphenidate	Age Restriction applies	Formulary for individuals age <=18. PA required for patients age >18. Dx: of ADHD or narcolepsy. Max daily dose 60 mg/day.
Ritalin LA	methylphenidate	Age Restriction applies	Formulary for individuals age

			<=18. PA required for patients age >18. Dx: of ADHD or narcolepsy. Max daily dose 60 mg/day.
Ritalin SR	methylphenidate	Age Restriction applies	Formulary for individuals age <=18. PA required for patients age >18. Dx: of ADHD or narcolepsy. Max daily dose 60 mg/day.
Daytrana	methylphenidate transdermal	Prior Authorization required	
dexmethylphenidate	generic	Prior Authorization required	Tried and failed OR contraindications to at least two covered stimulant medications. Max dose 20mg/day
dextroamphetamine	generic	Prior Authorization required	Covered for individuals age <=18. PA required for age > 18. Dx: of ADHD or narcolepsy.
dextroamphetamine/amphetamine	generic	Prior Authorization required	Covered for individuals age <=18. PA required for age > 18. Dx: of ADHD or narcolepsy.
Focalin	dexmethylphenidate	Prior Authorization required	Tried and failed OR contraindications to at least two covered stimulant medications. Max dose 20mg/day
Focalin XR	dexmethylphenidate	Prior Authorization required	Tried and failed or contraindications

			to at least two formualry stimulant medications.
Kapvay	clonidine	Prior Authorization required	
Metadate CD	methylphenidate	Prior Authorization required	Covered for individuals age <=18. PA required for patients age >18. Dx: of ADHD or narcolepsy. Max daily dose 60 mg/day.
Metadate ER	methylphenidate	Prior Authorization required	Covered for individuals age <=18. PA required for patients age >18. Dx: of ADHD or narcolepsy. Max daily dose 60 mg/day.
Methylin	methylphenidate	Prior Authorization required	Covered for individuals age <=18. PA required for patients age >18. Dx: of ADHD or narcolepsy. Max daily dose 60 mg/day.
Methylin ER	methylphenidate	Prior Authorization required	Covered for individuals age <=18. PA required for patients age >18. Dx: of ADHD or narcolepsy. Max daily dose 60 mg/day.
methylphenidate	generic	Prior Authorization required	Covered for individuals age <=18. PA required for patients age >18. Dx: of ADHD or narcolepsy. Max daily dose 60 mg/day.
Strattera	atomoxetine	Prior Authorization required	Tried and failed OR

		contraindications to at least two preferred alternatives OR if patient has tics or Tourette's or history of substance abuse.
Catapres	clonidine	Generics preferred; brands non-formulary or higher copay
Tenex	guanfacine	Generics preferred; brands non-formulary or higher copay
Desoxyn	methamphetamine	Non-Formulary
Intuniv	guanfacine	Non-Formulary
methamphetamine	generic	Non-Formulary
ProCentra	dextroamphetamine	Non-Formulary
Vyvanse	lisdexamfetamine	Non-Formulary
Evekeo	amphetamine	No status assigned
Quillivant XR	methylphenidate	No status assigned
Zenzedi	dextroamphetamine	No status assigned

Formulary

Contra Costa Healthplan

Acne, Systemic

Drug Names	Generic Names	Formulary Status	Comments
doxycycline	generic	On Formulary	
spironolactone	generic	On Formulary	
tetracycline	generic	On Formulary	
Minocin	minocycline	Quantity limits apply	Quantity limit of #60 monthly for 50,75,100mg capsules. 45,90,135mg ER capsules are non-formulary.
minocycline	generic	Quantity limits apply	Quantity limit of #60 monthly for 50,75,100mg capsules. 45,90,135mg ER capsules are non-formulary.
Accutane	isotretinoin	Prior Authorization required	Tried and failed OR contraindications to at least one preferred alternative. Severe recalcitrant nodular acne. Per Dermatologist only.
Claravis	isotretinoin	Prior Authorization required	Tried and failed OR contraindications to at least one preferred alternative. Severe recalcitrant nodular acne. Per Dermatologist only.
Doryx	doxycycline	Prior Authorization required	Use preferred brand of Doxycycline Hyclate (generic Vibramycin)- Doryx (Doxycycline Hyclate delayed release particles) require PA.

Monodox	doxycycline	Prior Authorization required	Use preferred brand of Doxycycline Hyclate (generic Vibramycin).
Oracea	doxycycline	Prior Authorization required	
Sotret	isotretinoin	Prior Authorization required	Tried and failed of contraindications to at least one preferred alternative. Severe recalcitrant nodular acne. Per Dermatologist only.
Adoxa	doxycycline	Generics preferred; brands non-formulary or higher copay	
Aldactone	spironolactone	Generics preferred; brands non-formulary or higher copay	
Sumycin	tetracycline	Generics preferred; brands non-formulary or higher copay	
Vibramycin	doxycycline	Generics preferred; brands non-formulary or higher copay	
Amnesteem	isotretinoin	Non-Formulary	
Dynacin	minocycline	Non-Formulary	
Solodyn	minocycline	Non-Formulary	
Absorica	isotretinoin	No status assigned	
Acticlate	doxycycline	No status assigned	
Avidoxy	doxycycline	No status assigned	
Myorisan	isotretinoin	No status assigned	
Zenatane	isotretinoin	No status assigned	

Formulary

Contra Costa Healthplan

Acne, Topical

Drug Names	Generic Names	Formulary Status	Comments
benzoyl peroxide topical	generic	On Formulary	Only 2.5, 5, 10 % strengths in any dosage form is covered. All other strengths require PA.
clindamycin topical	generic	On Formulary	
erythromycin topical	generic	On Formulary	
MetroCream	metronidazole topical	Step Therapy applies	Treatment of acne rosacea.
MetroGel	metronidazole topical	Step Therapy applies	Treatment of acne rosacea.
MetroLotion	metronidazole topical	Step Therapy applies	Treatment of Acne Rosacea.
metronidazole topical	generic	Step Therapy applies	Treatment of acne rosacea.
Aczone	dapsone topical	Prior Authorization required	
adapalene topical	generic	Prior Authorization required	
Atralin	tretinoin topical	Prior Authorization required	
Avita	tretinoin topical	Prior Authorization required	C1: Indicated for treatment of acne in individuals <30 years of age. PA required for patients >30 years of age including a documented dermatology consult. Tried and failed at least one preferred alternative (i.e., one covered agent).
BenzaClin	clindamycin/benzoyl peroxide topical	Prior Authorization required	Use separate formulary agents: Clindamycin & Benzoyl Peroxide.
Benzamycin	erythromycin/benzoyl peroxide topical	Prior Authorization required	Tried & failed or contraindication to erythromycin and benzoyl peroxide used as separate agents.
clindamycin/benzoyl peroxide topical	generic	Prior Authorization required	Use separate formulary agents: Clindamycin & Benzoyl Peroxide.
Duac	clindamycin/benzoyl peroxide topical	Prior Authorization required	Use separate formulary agents: Clindamycin & Benzoyl Peroxide.
erythromycin/benzoyl peroxide topical	generic	Prior Authorization required	use separate agents benzoyl peroxide and erythromycin topical products.
sulfacetamide topical	generic	Prior Authorization required	

Tretin-X	tretinoin topical	Prior Authorization required	
Veltin	clindamycin/tretinoin topical	Prior Authorization required	
Ziana	clindamycin/tretinoin topical	Prior Authorization required	
Akne-mycin	erythromycin topical	Generics preferred; brands non-formulary or higher copay	
Benzac AC	benzoyl peroxide topical	Generics preferred; brands non-formulary or higher copay	Only 2.5, 5, 10% strengths are covered for all dosage forms.
Benzac W	benzoyl peroxide topical	Generics preferred; brands non-formulary or higher copay	Only 2.5, 5, 10% strengths are covered for all dosage forms.
Cleocin T	clindamycin topical	Generics preferred; brands non-formulary or higher copay	
Clindagel	clindamycin topical	Generics preferred; brands non-formulary or higher copay	
ClindaMax	clindamycin topical	Generics preferred; brands non-formulary or higher copay	
Desquam-E	benzoyl peroxide topical	Generics preferred; brands non-formulary or higher copay	Only 2.5, 5, 10 % strengths in any dosage form are covered. All other strengths require PA.
Retin-A	tretinoin topical	Generics preferred; brands non-formulary or higher copay	Covered for individuals age <=30; PA required for patients age >30. Covered for CCRMC Derm regardless of age.
Retin-A Micro	tretinoin topical	Generics preferred; brands non-formulary or higher copay	Covered for individuals age <=30; PA required for patients age >30. Covered for CCRMC Derm regardless of age.
tretinoin topical	generic	Generics preferred; brands non-formulary or higher copay	Covered for individuals age <=30; PA required for patients age >30. Covered for CCRMC Derm regardless of age.
Acanya	clindamycin/benzoyl peroxide topical	Non-Formulary	Tried & failed or contraindication to erythromycin and benzoyl peroxide used as separate agents.
Azelex	azelaic acid topical	Non-Formulary	
Brevoxyl	benzoyl peroxide topical	Non-Formulary	
Clenia	sulfacetamide/sulfur topical	Non-Formulary	
Differin	adapalene topical	Non-Formulary	
Epiduo	adapalene/benzoyl peroxide topical	Non-Formulary	
Evoclin	clindamycin topical	Non-Formulary	

Finacea	azelaic acid topical	Non-Formulary	
Klaron	sulfacetamide topical	Non-Formulary	
Noritate	metronidazole topical	Non-Formulary	
Plexion	sulfacetamide/sulfur topical	Non-Formulary	
Rosac	sulfacetamide/sulfur topical	Non-Formulary	
Rosanil	sulfacetamide/sulfur topical	Non-Formulary	
Rosula	sulfacetamide/sulfur topical	Non-Formulary	
Sulfacet-R	sulfacetamide/sulfur topical	Non-Formulary	
sulfacetamide/sulfur topical	generic	Non-Formulary	
Tazorac	tazarotene topical	Non-Formulary	
Triaz	benzoyl peroxide topical	Non-Formulary	Use generic Benzoyl Peroxide 2.5, 5, 10 % products.
ZoDerm	benzoyl peroxide topical	Non-Formulary	
Aveeno Clear Complexion	salicylic acid topical	Not Covered	
Fabior	tazarotene topical	No status assigned	
Onexton	clindamycin/benzoyl peroxide topical	No status assigned	