The Inside Story

Volume 21 Issue 4 WINTER 2015/2016

In This Issue

Provider Relations
- Enroll in Medicare as a Provider Now! 2
- Helpful Tools for Providers 4
- SWHP Provider Directory Accuracy 5

Compliance
- Healthcare Fraud, Waste and Abuse 6

Care Coordination Division (CCD)
- Authorization Requests through Clear Coverage 8
- SWHP/ICSW Utilization Management Criteria for Inpatient Services and Selected Benefit Coverage Determinations 2015 8

Quality Improvement (QI)
- Alternatives to a Colonoscopy for Colorectal Cancer Screening 10
- Breast Cancer Awareness is Not Over 11

Pharmacy
- SWHP Formulary Information 12
- High Risk Medication Formulary Changes for Medicare Members 13
- Common High Risk Medications in the Elderly (Age ≥ 65) and Suggested Alternatives 14

The Inside Story Staff 16

Scott & White Health Plan (SWHP) has had an extremely busy 2015. Our service area, provider network, and membership have grown over the past year. We successfully completed our NCQA survey this year, and received an accreditation status of Commendable for Commercial and Medicare. We could not have accomplished this without the support of our providers, so we want to say THANK YOU! In the last quarter of this year, we rolled out our brand new SWHP website to provide a better digital experience to our members and providers. The hard work does not end with 2015 coming to a close because 2016 will be just as busy for us as we prepare to launch our new Vital Traditions (HMO-POS) Medicare Advantage Plan on 01/01/2016. This new plan offering will be available along with our existing Vital Traditions (HMO) Medicare Advantage Plan in our North Texas region. We look forward to an exciting new year with our provider partners!

Provider Relations

Important official message for providers who prescribe drugs for Medicare patients.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR PROGRAM INTEGRITY

ENROLL IN MEDICARE AS A PROVIDER *NOW*!

This applies to all providers who prescribe drugs for Medicare patients and are not enrolled in (or validly opted-out of) Medicare. Because of a new Medicare requirement, it is crucial for your patients' health that you enroll in Medicare (or validly opt out, if appropriate). As soon as possible, please follow the below steps. A delay on your part could result in your Medicare patients not being able to obtain drugs you prescribe for them.

What's changed & when?

We have published rules that will soon require nearly all providers (for example, dentists, physicians, psychiatrists, residents, nurse practitioners, and physician assistants), including Medicare Advantage providers, who prescribe drugs for Part D patients to enroll in Medicare (or validly opt out, if appropriate). Beginning June 1, 2016, we will enforce a requirement that Medicare Part D prescription drug benefit plans *may not cover drugs* prescribed by providers who are not enrolled in (or validly opted out of) Medicare, except in very limited circumstances.

Why is this important to my patients and me?

Unless you enroll (or validly opt out), Medicare Part D plans will be required to notify your Medicare patients that you are not able to prescribe covered Part D drugs. *Please also note that if you opt out, you cannot receive reimbursement from traditional Medicare or a Medicare Advantage plan, either directly or indirectly (except for emergency and urgent care services; see 42 CFR 405.440 for details.)*

What steps do I need to take?

To help your Medicare patients, please **enroll in Medicare either fully to bill or for the limited purpose of prescribing Part D drugs.** There are **no fees** to complete the process. You can do so electronically or on paper:

1. *Electronic process:* Use the PECOS system at **go.cms.gov/pecos**. For limited enrollment, we recommend using the step-by-step instructions at **go.cms.gov/PECOSsteps** and a video tutorial at **Go.cms.gov/PECOSVideo**; *or*

2. *Paper process:* Complete the paper application for limited enrollment at **go.cms.gov/cms855o** and submit it to the MAC in your geographic area. To locate your MAC, please refer to the MAC list at: **go.cms.gov/partdmaclist**.

If you need assistance with the process of enrolling in (or validly opting out) of Medicare, please contact the MAC within your geographic area.

Thank you for your prompt and careful attention to this important matter, and for serving Medicare beneficiaries. These new CMS rules will enable federal officials to better combat fraud and abuse in the Part D program through verification of providers' credentials via the Medicare enrollment/opt-out process.

The Centers for Medicare & Medicaid Services

Provider Relations

QUESTIONS? NEED ASSISTANCE?

Please contact CMS at **providerenrollment@cms.hhs.gov** if you have questions about this letter, you do not prescribe drugs, or if you believe that:

- You are already enrolled in (or validly opted out of) Medicare.
- You have a pending application.
- You are not eligible to enroll in Medicare (for example, you are a pharmacist).

If you need assistance with the process of enrolling in (or validly opting out) of Medicare, please contact the MAC within your geographic area. To locate your MAC, please refer to the MAC list on the CMS website at: **go.cms.gov/partdmaclist.**

Please visit the CMS Part D Prescriber Enrollment website at **go.cms.gov/PrescriberEnrollment** for helpful information about the new requirement, such as resources to check your application status, or to sign up for the listserv to receive updates.

Background Information

The Medicare program is administered by the Centers for Medicaid & Medicare (CMS) within the U.S. Department of Health and Human Services. The Medicare program is divided into four parts: 1) Part A generally covers inpatient hospital services; 2) Part B generally covers physician services; 3) Part C (Medicare Advantage) refers to Medicare-approved private health insurance plans for individuals enrolled in Parts A and B; and 4) Part D covers the cost of most prescription medications.

The Part D prescriber enrollment rules referred to in this notice are CMS-4159-F *Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs* (79 FR 29843; May 23, 2014); and CMS-6107-IFC *Medicare Program; Changes to the Requirements for Part D Prescribers* (80 FR 25958; May 6, 2015).

Helpful Tools for Providers

Here at Scott & White Health Plan (SWHP), we understand that our providers' primary focus is delivering high-quality healthcare to patients (our members). With that in mind, we want to make it as easy as possible for you to obtain the information that you need. SWHP is continuously working on implementing various tools in order to provide you with the information that you need at your fingertips.

SWHP would like to invite and encourage our providers to utilize the following tools for the information needed on a routine basis:

- ***SWHP Website*** – can be used to view SWHP's Provider Manual, policies and procedures, forms, educational material, and other important information
    - Accessed at: http://swhp.org/en-us/prov

- ***Provider Interactive Voice Response (IVR) System*** – can be used to verify member eligibility and benefits and check claims status
    - Accessed directly by dialing 1-800-655-7947 or by calling the main Customer Service phone number at 1-800-321-7947 and pressing option 1

- ***MyBenefits Portal*** – can be used to view complete Prior Authorization Lists, check claims status, and verify member eligibility and benefits
    - Accessed at: https://swhpah.swhp.org/ (requires login)

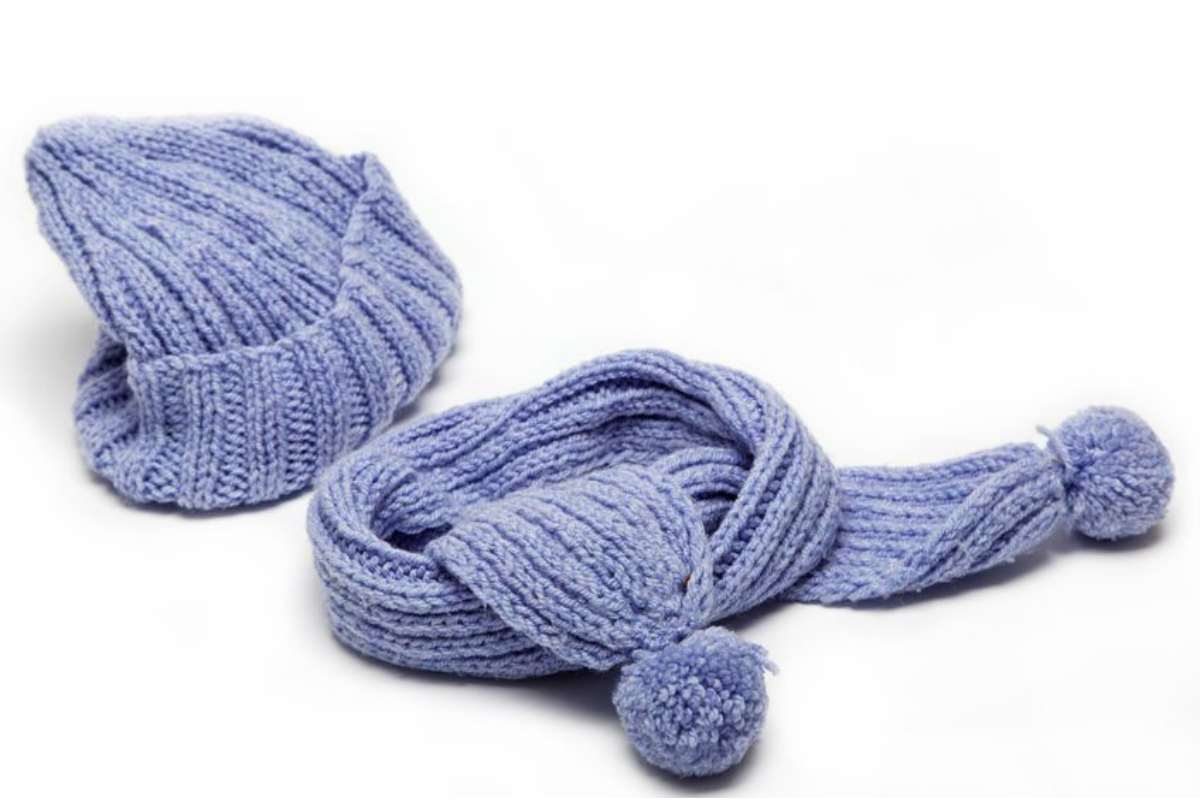
- ***SWHP Provider Directory*** – online provider search, which can be used to validate the demographic information that we have for you and to verify the physicians, facilities, and other providers that we have in our networks
    - Accessed at: https://portal.swhp.org/#/search

Our main goal is to provide you with the information that you need in a quick and efficient way. Again, we encourage you to take advantage of the tools listed above. If you have any suggestions on how we can improve them, please feel free to call the SWHP Provider Relations Department at 1-254-298-3064 or 1-800-321-7947, ext. 203064. You can also email us at SWHPPROVIDERRELATIONSDEPARTMENT@sw.org.

SWHP PROVIDER DIRECTORY ACCURACY

When Scott & White Health Plan (SWHP) members are looking for an in-network provider, they have the option of either using our online provider search or a PDF version of our provider directories. SWHP directories are specific to the type of plan members have, allowing them to search for doctors, hospitals, and other medical providers in their area. **It is *critical* that the information in the provider directories is current and accurate.**

Please take the time to go to our website at https://portal.swhp.org/#/search and review your provider information. If you find inaccurate information, such as address, phone number, and etc., please complete the Provider Address Change Form located at https://legacy.swhp.org/providers/resources/provider-address-change-form, so that we can update your information and have it reflected accurately in our provider directories. The Provider Address Change Form allows you to update information for your practice location, billing address, mailing address, or even add an additional location to your contract. You will need to attach a completed W-9 Form in order for us to be able to update your address in our system. To attach the W-9 Form, please use the "Attachments" feature located at the bottom of the form.



Healthcare Fraud, Waste and Abuse

Healthcare fraud can affect anyone... including you.

Certainly, only a small percentage of healthcare providers and consumers deliberately engage in Fraud, Waste and Abuse (FWA). However, even a small amount of FWA can raise the cost of healthcare benefits for everyone. See how you can help avoid and prevent FWA.

What is healthcare FWA?

Healthcare fraud is a crime. It's committed when a dishonest provider or consumer intentionally submits or causes someone else to submit false or misleading information for use in determining the amount of healthcare benefits payable.

Some examples of provider FWA are:

- Billing for services not actually performed
- Falsifying a patient's diagnosis to justify tests, surgeries or other procedures that aren't medically necessary
- Misrepresenting procedures performed to obtain payment for non-covered services, such as cosmetic surgery
- Upcoding – billing for a more costly service than the one actually performed
- Unbundling – billing each stage of a procedure as if it were a separate procedure
- Accepting kickbacks for patient referrals
- Waiving patient co-pays or deductibles and over-billing the insurance carrier or benefit plan
- Billing a patient more than the copay amount for services that were prepaid or paid in full by the benefit plan under the terms of a managed care contract

Some examples of consumer FWA are:

- Filing claims for services or medications not received
- Forging or altering bills or receipts
- Using someone else's coverage or insurance card

Help avoid and prevent FWA

Here are some easy ways you can protect yourself from FWA, and keep healthcare costs down for everyone:

- Ask questions about the services you receive, such as: Why are they needed? What do they cost?
- Fill out, sign and date one claim form at a time.
- Question advertisements or promotions that offer free tests, treatment or services, especially when the provider requests your insurance information or a copy of your Scott & White Health Plan (SWHP) ID card.
- In general, be careful about disclosing your insurance information. Protect your SWHP ID card. It represents your benefits.
- Compare your SWHP Explanation of Benefits (EOB) and/or your medical bills with your records. Are the dates of service correct? Were the services actually performed?

- For those with managed care coverage, question charges exceeding your copayment amount that you're asked to pay by a provider.
- Let us know if a provider has a practice of waiving copayments or deductibles.
- Report suspected fraud to the Special Investigations Unit.
- Never pay for any services in cash. Always use a credit card.

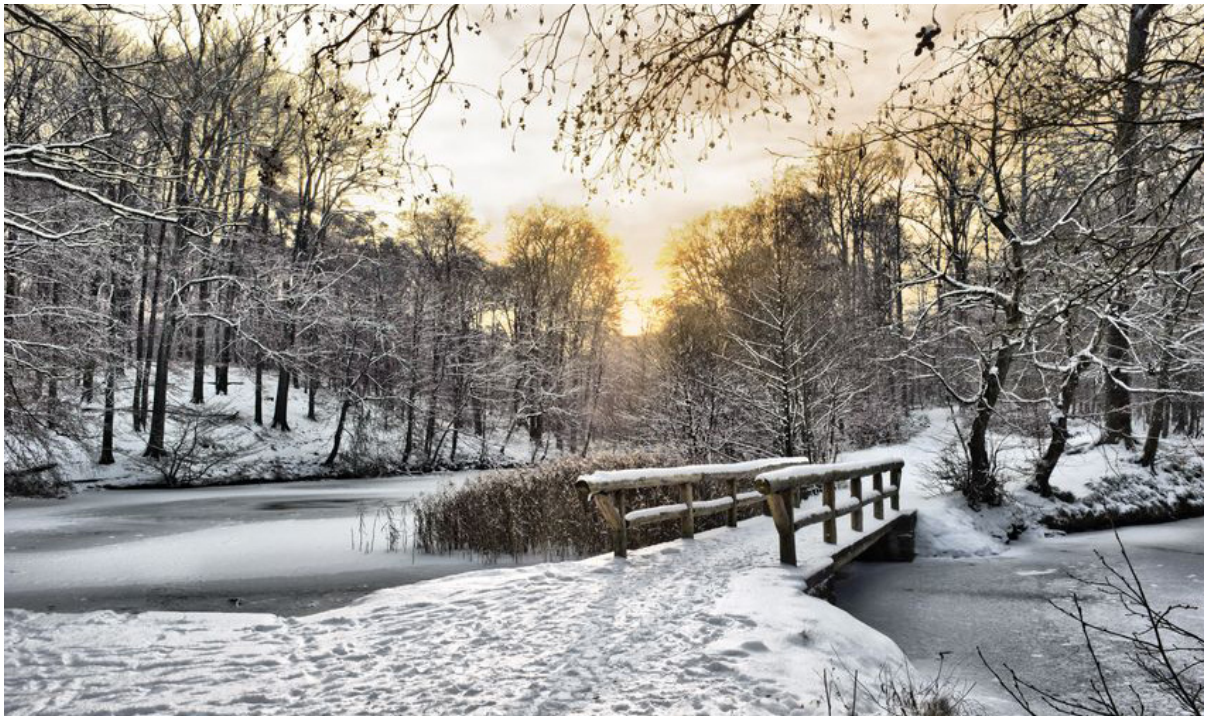
SWHP is working to minimize FWA

Our Special Investigations Unit (SIU) team is responsible for SWHP's risk to healthcare fraud. The SIU team partners with SWHP's Customer Service and Claims Departments and others to help identify suspicious claims, stop payments to fraudulent providers and punish wrongdoers.

The SIU team also works with state and federal law enforcement, regulatory agencies and other insurance companies to detect, prevent and prosecute healthcare fraud. The SIU team includes trained professionals with expertise in investigations, healthcare, nursing, law enforcement and accounting.

How to Report Healthcare FWA

- Call the Compliance Office at 1-888-484-6977
- Visit the OIG Hotline website at: hhps://oig.hhsc.state.tx.us and select "Click Here to Report Fraud, Waste, and Abuse" to complete the form online
- Report directly to SWHP using the following information:
  Scott & White Health Plan
  1206 West Campus Drive
  Temple, Texas 76502



Authorization Requests through Clear Coverage

Scott & White Health Plan is excited to announce the upcoming implementation of Clear Coverage in the first quarter of 2016. Clear Coverage is a web-based system that provides an automated method for providers and health plans to manage authorizations for outpatient services, at the point of care. Clear Coverage enables automated authorization, notification, eligibility and direction of members to in-network service providers. Clear Coverage provides the following benefits:

- Providers have immediate access to coverage, medical appropriateness and network rules, driving the consistent application of evidence based medicine.
- Providers have transparency into the evidence based medical necessity.
- Allows for Health Plans to do exception based UM and only touch those requests that do not meet medical necessity.
- Secured PHI transmission
  - Scanning and attaching only required elements from the medical record, reducing the need to print and fax.
- Faster turnaround around times
  - Due to an instant decision based on medical necessity, when applicable
  - Eliminates need for numerous call backs when clinical is attached to the request.

SWHP /ICSW Utilization Management Criteria for Inpatient Services and Selected Benefit Coverage Determinations 2015

The Scott & White Health Plan (SWHP)/Insurance Company of Scott & White (ICSW) Insurance Policy, also referred to as Evidence of Coverage (EOC) or Standard Plan Document (SPD), is the contract for coverage of the health care services that an individual purchased or an employer purchased for their employees. SWHP/ICSW provides a variety of benefit plans to meet purchaser needs.

Benefit plans include benefits required by law, SWHP/ICSW, as well as purchaser preference (Administrative Services Only or ASO). The purpose of SWHP's Utilization Management (UM) Program is to manage services according to the terms contained in the Insurance Policy. All benefit plans require coverage to be contingent upon medical necessity. SWHP's UM Committee adopts and/or develops evidence-based criteria to determine medical necessity. Annually, SWHP/ICSW provides proposed criteria to physician directors of Baylor Scott & White Health's Medical Services Divisions and contracted network physicians for review and feedback. SWHP/ICSW Medical Directors evaluate all feedback provided. The resulting approved final criteria sets and the target length of stay (LOS) are forwarded to the SWHP/ICSW UM Committee for review and approval.

Care Coordination Division (CCD)

2015 criteria include InterQual®, internal policies, Healthcare Management Guidelines (target LOS), criteria developed and approved during Technology Assessment meetings, and medical coverage policies.

The approved criteria is used by the UM Staff as a guideline only. SWHP/ICSW Medical Directors make all denial of coverage determinations. UM decisions, including formulary coverage determinations, are based on meeting criteria for appropriateness of care and services and are subject to the terms and limitations of the Insurance Policy. SWHP/ICSW does not offer incentives, including compensation or rewards, to practitioners or other individuals conducting utilization review to encourage denials of coverage of services or offer financial incentives that encourage decisions that result in underutilization of services. SWHP/ICSW does not use incentives to encourage barriers to care and services.

SWHP/ICSW Medical Directors' compensation is not based on utilization of services denials. SWHP/ICSW does not make decisions regarding hiring, promoting, or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.

SWHP/ICSW monitors for evidence of underutilization, overuse, and misuse through the Quality Improvement (QI) Subcommittee's review of MEDInsight reports, HEDIS® measures, QI team measures, and complaint data. Evidence of underutilization, overutilization, and misuse will be discussed with the individual physician, as well as targeted member outreach as appropriate. Individual coverage requests are discussed with the individual physicians making the request on behalf of a member.

SWHP/ICSW UM staff, including Medical Directors, is available by telephone 24 hours/7 days per week at 1-254-298-3088 or toll free at 1-888-316-7947 or by appointment to discuss UM and/or coverage determinations, including benefit provisions, guidelines, criteria, or the processes used to make determinations. The SWHP "on-call" nurse who has access to a SWHP Medical Director on call is available after hours.

Appeal rights, including expedited appeals, reconsideration rights, and/or Independent Review Organization (IRO) options are always provided with any denial issued. Practitioners may request to review criteria at any time, including at the time of a case-specific determination. Criteria will be provided by fax, phone, and email or through an onsite appointment with the Care Coordination Division (CCD) management staff. CCD can be reached by calling 1-888-316-7947 (toll free) or 1-254-298-3088 (directly).

In an effort to improve communication with non-English speaking members, SWHP/ICSW uses the interpretive services of AT&T. Members do not have to call a special line for this service. When contacting SWHP/ICSW, members may notify the CCD staff and/or Customer Advocacy of their primary language and the call will be completed with the help of an AT&T interpreter at no charge to the member. CCD staff follows established internal SWHP/ICSW policies related to provision of interpretive services for SWHP/ICSW members.

SWHP/ICSW utilizes a toll free TTY number 1-800-735-2989 to assist with communication services for members with hearing or speech difficulties. The TTY number is listed on the SWHP webpage at www.swhp.org and is also included in the member correspondence and member publication materials.

Alternatives to a Colonoscopy for Colorectal Cancer Screening

According to the American Cancer Society (ACS), colorectal cancer is the "third leading cause of cancer death in both men and women in the US" (ACS, 2014, p. 1). And yet, according to the Centers for Disease Control and Prevention (CDC), only 54.5% of all Americans age 50-75 will comply with the recommendations for a colonoscopy (CDC, 2014, Table 78). Meanwhile, when rates were compared across the different ethnic cohorts, compliance rates were noted to drop as low as 31.2% (CDC, 2014, Table 78).

That begs the question, if colonoscopies are the gold standard for colorectal cancer screening, why are more Americans not getting this done? Fact is, colonoscopies are the #1 most expensive screening exam and can cost more than delivering a baby (Rosenthal, 2013). Then there is the prep that one patient aptly described as, 'whoever named this stuff *Golytely*' (pronounced go-lightly) 'has a sick sense of humor.' (personal communication, 2013). After completing the prep, there is the drive to the facility and the time associated with pre-op and post-op recovery. Lastly, patients are rightly concerned about the risks associated with the insertion of a 165cm long scope.

As such, the American College of Gastroenterology (ACG) recognizes that many patients are simply not willing to undergo all of this for a screening. Instead, the ACG recommends that providers offer their patients alternative forms of screening, such as the Fecal Immunochemical Test (FIT) or iFOBT. In fact, when it comes to HEDIS scores, the FIT test is what has allowed the top scoring hospitals to move from the national average of 38% compliance with colonoscopies alone to the 90th percentile and above.

The FIT test has several advantages, including:

1) Lower cost than the colonoscopy
2) No pre-test dietary restrictions and no bowel prep
3) Completed in the privacy of one's own home
4) No risk to the colon
5) High specificity for colon cancer

Still, all the benefits do not come without a few draw backs. First, the FIT test cannot screen for polyps. Second, it must be done yearly. Lastly, if the results come back as positive (abnormal), a colonoscopy will need to be done for further evaluation. Thus, when a patient is not willing to undergo a colonoscopy, it is important for the provider and patient to discuss all the available options, their pros & cons, and come to a decision that is best for the individual member.

Simply put, even some gastroenterologists, have publically declared that colonoscopies are both a literal and a figurative "pain in the bum." If we want to reach the 90th percentile we need to be offering our members options such as the FIT test instead of relying solely on an age old "sore subject."

References:

ACS. (2014). *Colorectal Cancer Facts & Figures: 2014-2016.* Retrieved from http://www.cancer.org/acs/groups/content/documents/document/acspc-042280.pdf

CDC. (2014). *Use of colorectal tests or procedures among adults aged 50-75, by selected characteristics: United States, selected years 2000-2013.* Retrieved from http://www.cdc.gov/nchs/data/hus/2014/078.pdf

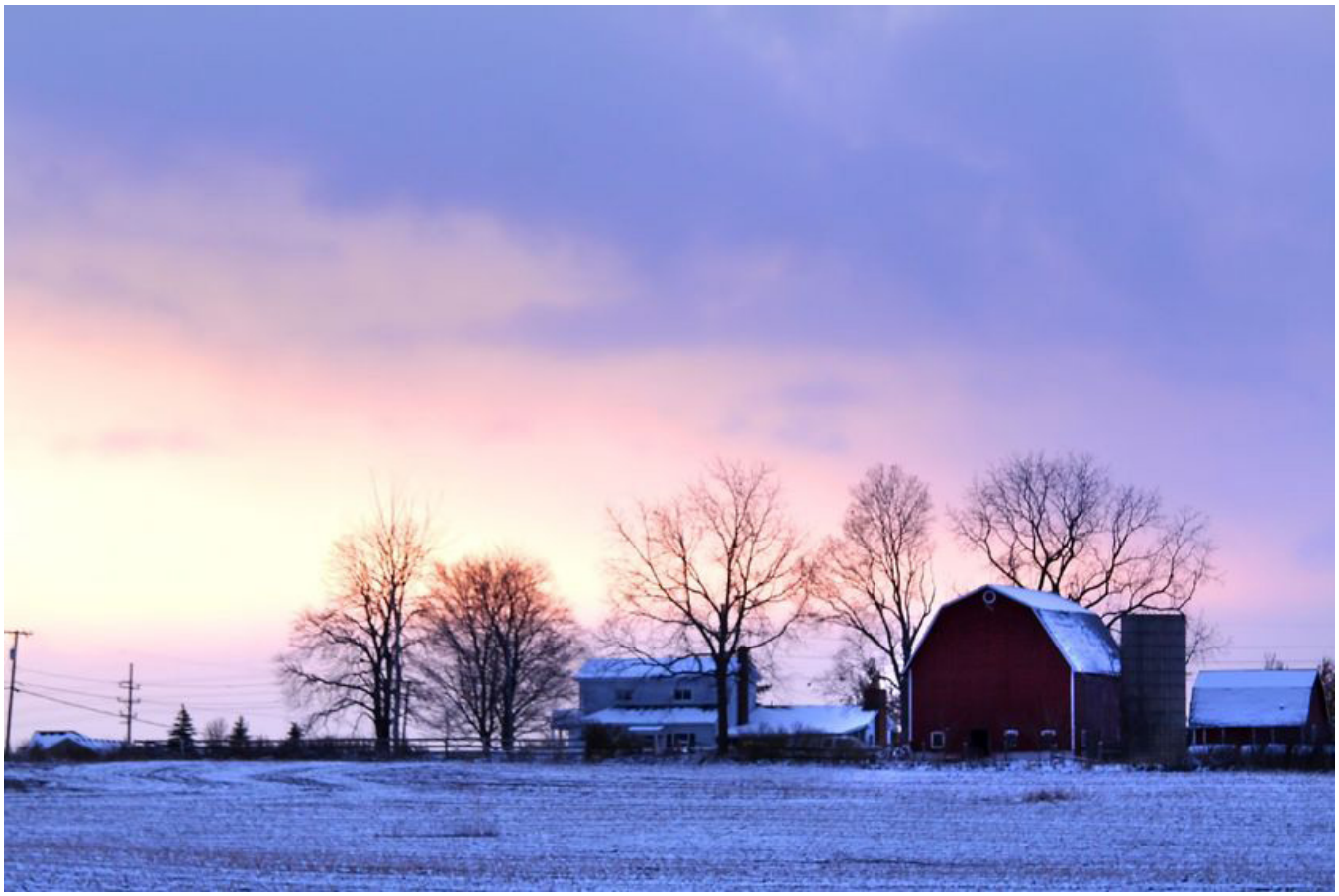
Rosenthal, E. (2013, June 1). The $2.7 Trillion Medical Bill: Colonoscopies Explain Why U.S. Leads the World in Health Expenditures. *The New York Times* [New York], p. Health.

Breast Cancer Awareness Is NOT Over

Although October may be over, the fight for breast cancer awareness continues. Breast cancer is the second most common cancer in women affecting 1:8 women (Breastcancer.org, 2015). As health care providers, there is something we can do about it. While we may not be able to wear pink ribbons all year round, we can take the opportunity to spread the word about the steps women can take to detect breast cancer early.

These are just a few things we can and should do:

- Discuss the importance of annual screening exams for breast cancer.
- Encourage women ages 40-49 to talk with their health care providers about when to start getting mammograms.
- Stress the importance of women ages 50 to 74 getting a mammogram every 2 years.
- Be involved in the fight and encourage others to do the same.



SWHP Formulary Information

For the most current Scott & White Health Plan (SWHP) formulary information, including pharmaceutical management procedures, SWHP encourages providers to visit our website at http://swhp.org/en-us/.

The following information is available online at http://swhp.org/en-us/prov/resources/pharmacy-services/drug-list:

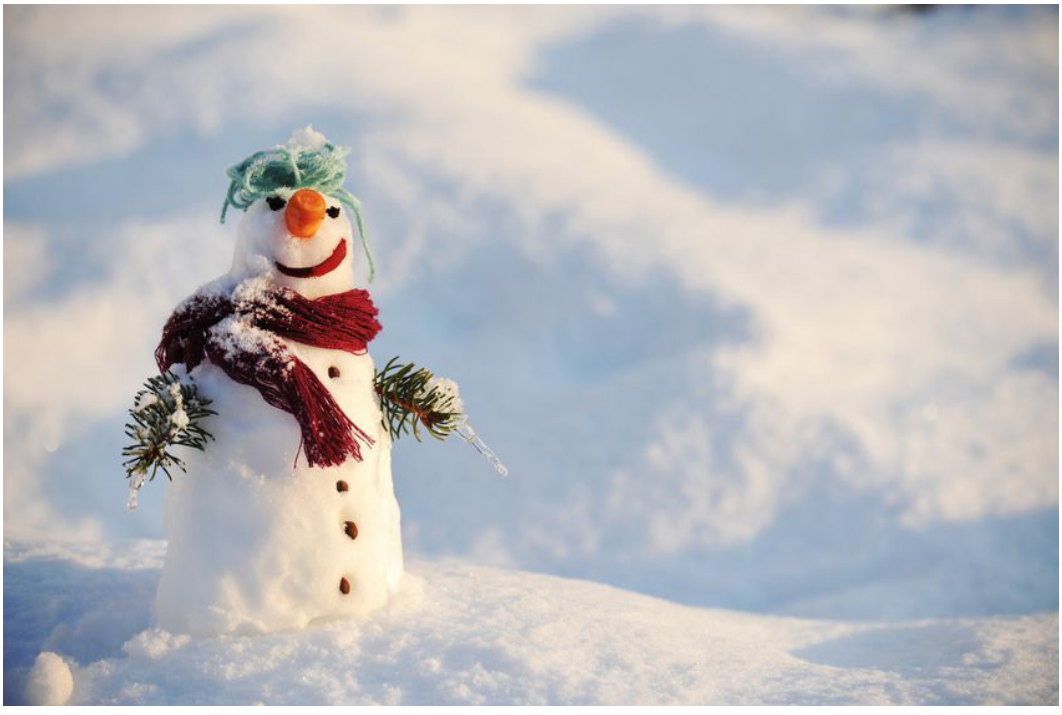
- **Prescription Drug Lists (formularies)**
- **Monthly Formulary Updates**

The following information can also be accessed online at http://swhp.org/en-us/prov/auth-referral/medications:

- **Prior Authorization Criteria**
- **Prior Authorization Request Forms**

Pharmaceutical management procedures are processes that help manage the drug formulary. In order to provide the most cost-effective therapy options, restrictions may be applied to certain drugs on the formulary. The SWHP formularies contain a description of pharmaceutical management procedures, including, but not limited to: prior authorization (PA), quantity limits (QL), step therapy (ST), therapeutic interchange, and generic substitution. If a medication has restrictions in place, those restrictions are listed on the formulary. The formularies also contain information regarding how to submit an exception request.

If you have any questions or wish to obtain a printed copy of the formularies or pharmaceutical management procedures, please contact the SWHP Pharmacy Department at 1-800-728-7947.



High Risk Medication Formulary Changes for Medicare Members

Medicare has established various quality measures, one of which is evaluating use of high risk medications (HRM) in the elderly. The HRM measure contributes to a Medicare plan's overall Star Rating and assesses the percentage of Medicare beneficiaries 65 years of age or older who receive two or more prescription fills of at least one high risk medication.

The American Geriatrics Society (AGS) updated the Beers Criteria in 2015, which identifies high risk medications in older adults. These medications are associated with poor patient outcomes such as adverse drug events, hospitalizations, and mortality due to physiological changes with aging. HRMs typically have limited effectiveness in the elderly, are frequently unsafe, and risks associated with these medications are thought to outweigh the potential benefits.1 The Medicare HRM measure applies the AGS recommendations and was adapted from measures developed and endorsed by the Pharmacy Quality Alliance (PQA) and the National Quality Forum (NQF).2

Although a patient may tolerate a HRM currently, that patient is still vulnerable to experiencing dangerous adverse effects, especially as the patient continues to age and physiological changes occur. Discontinuation of a HRM before a safety issue arises is key in preventing patient harm.

Effective 1/1/2016, the following changes will occur on the SWHP Medicare Part D formularies, which will impact SeniorCare and Vital Traditions members:

- Cyclobenzaprine and metaxalone will be removed from formulary
- Prior authorization (PA) required for carisoprodol, chlorzoxazone, methocarbamol and orphenadrine
- PA for new starts for amitriptyline, imipramine, doxepin, clomipramine and trimipramine

Provided below is a listing of common high risk medications. Please carefully consider formulary alternatives, non-pharmacologic therapy, and your clinical judgment to help reduce use of these medications in the elderly.

References:

1. The American Geriatrics Society 2015 Beers Criteria Update Expert Panel. American Geriatrics Society 2015 updated Beers Criteria for potentially inappropriate medication use in older adults. J Am Geriatr Soc. published online 20 OCT 2015 | DOI: 10.1111/jgs.13919.
2. Centers for Medicare and Medicaid Services (CMS). (Sep 2014). Patient Safety Analysis: High Risk Medication Measures PDP/MA-PD Contacts Report User Guide. Burlingame, CA. 1-23.

Common High Risk Medications in the Elderly (Age ≥ 65) and Suggested Alternatives

The medications listed below reflect common High Risk Medications (HRM), developed and endorsed by the Pharmacy Quality Alliance (PQA) in June 2012. The safer treatment options provided represent potential alternatives to HRMs. Providers should evaluate whether these alternatives can be used in place of HRMs for their patients.

Therapeutic Class	High Risk Medications	Potential Risks	Safer Treatment Options
Sedative Hypnotics	Greater than 90 days cumulative supply during plan year: • Zolpidem (Ambien, Ambien CR) • Eszopiclone (Lunesta) • Zaleplon (Sonata)	Cognitive impairment, delirium, unsteady gait, syncope, falls, motor vehicle accidents, minimal benefit	• Consider non-pharmacologic interventions, focusing on proper sleep hygiene. When sedative hypnotic medications are deemed clinically necessary, use should be at the lowest possible dose for the shortest possible time. • Trazodone (low dose) • Silenor (Quantity Limit #30/30 days) • Rozerem (Quantity Limit #30/30 days)
Skeletal Muscle Relaxants	• Carisoprodol (Soma) • Cyclobenzaprine (Flexeril) • Methocarbamol (Robaxin) • Orphenadrine (Norflex) • Metaxalone (Skelaxin) • Chlorzoxazone (Parafon Forte) • All combination products containing one of these medications	Most muscle relaxants are poorly tolerated by elderly patients due to anticholinergic adverse effects, sedation, fall risk, delirium, and weakness. At doses tolerated by elderly patients, their effectiveness is questionable.	• Consider non-pharmacologic treatments, such as cryotherapy, heat, massage and stretching/exercise. • Baclofen • Tizanidine tablets
Tertiary Amine Tricyclic Antidepressants (TCAs)	• Amitriptyline • Clomipramine • Doxepin (>6 mg/day) • Imipramine • Trimipramine	Strong anticholinergic effects (dry mouth, constipation, vision disturbances), sedation, increased risk for falls	**For Depression / Anxiety / OCD:** • Secondary Amine TCAs (Nortriptyline, Protriptyline, Desipramine, Amoxapine) • SSRIs (Fluoxetine, Citalopram, Paroxetine, Sertraline) • SNRIs (Venlafaxine, Duloxetine) • Bupropion **For neuropathic pain / fibromyalgia:** Gabapentin, Duloxetine, Lyrica For prevention of migraine: Propranolol, Divalproex sodium, Topiramate
Oral Hypoglycemics	• Glyburide (Diabeta) • Chlorpropamide (Diabinese)	Greater risk of severe, prolonged hypoglycemia	• Glimepiride • Glipizide
Urinary Anti-Infectives	Greater than 90 days cumulative supply during the plan year: • Nitrofurantoin (Furadantin) • Nitrofurantoin monohydrate/ macrocrystals (Macrobid) • Nitrofurantoin macrocrystals (Macrodantin)	Associated with an increased risk of pulmonary toxicity, neuropathy and hepatotoxicity when renal function is decreased. Also, less effective when CrCl<60 mL/min.	**For prevention of recurrent UTIs:** • TMP-SMX • Fluoroquinolones • Beta-lactam antibiotics • Optimal dose, frequency and duration are not known • Consider antibiotic resistance patterns and patient antibiotic history

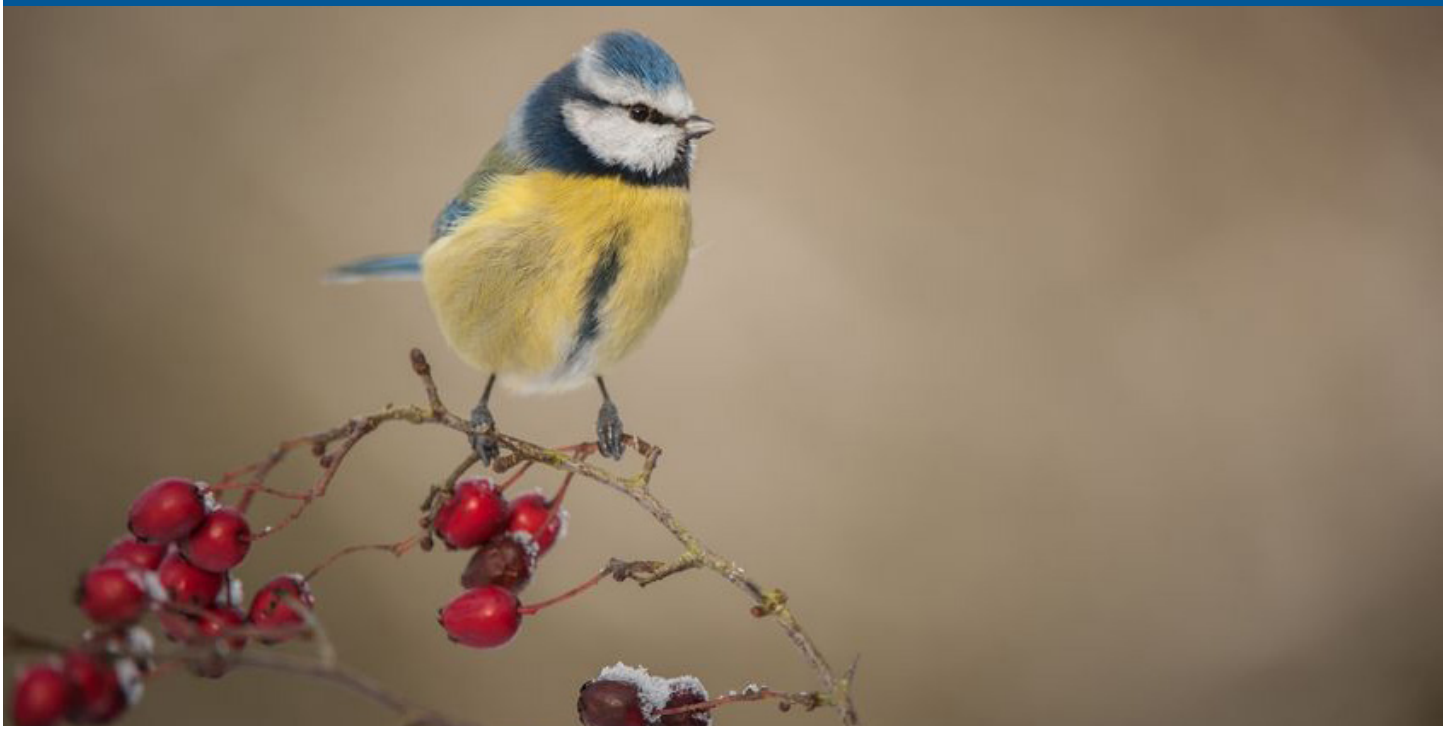
Common High Risk Medications in the Elderly (Age ≥ 65) and Suggested Alternatives *(continued)*

Therapeutic Class	High Risk Medications	Potential Risks	Safer Treatment Options
Cardiovascular	• Digoxin (>0.125 mg/day)	In heart failure, higher dosages associated with no additional benefit and may increase risk. Decreased renal clearance may increase risk of toxicity.	**For prevention of recurrent UTIs:** • TMP-SMX • Fluoroquinolones • Beta-lactam antibiotics • Optimal dose, frequency and duration are not known • Consider antibiotic resistance patterns and patient antibiotic history
Estrogens and Estrogen / Progesterone Products (Oral and Transdermal)	• Conjugated estrogen (Premarin) • Conjugated estrogen / medroxy-progesterone (Prempro, Premphase) • Estradiol, oral (Estrace, Femtrace) • Estradiol patch (Alora, Climara, Estraderm, Estradiol, Menostar, Vivelle-Dot) • Estradiol / drospirenone (Angeliq) • Estradiol / levonorgestrel (ClimaraPro) • Estradiol / norethindrone (CombiPatch) • Estradiol / norgestimate (Prefest) • Estropipate (Ogen, Ortho-Est) • Esterified estrogen (Menest) • Esterified estrogen / methyltestosterone (Covaryx, Estratest) • Ethinyl estradiol / norethindrone (Activella, FemHRT)	Elderly patients on long-term oral estrogens are at increased risk for breast and endometrial cancer. In addition, results from the Women's Health Initiative (WHI) hormone trial suggest these medications may increase the risk of heart attack, stroke, blood clots, and dementia.	**For Hot Flashes:** Continuously re-evaluate the need for long-term estrogen therapy; evaluate non-drug therapy. Postmenopausal women should avoid using oral estrogens for more than 3 years. After 3 years patients should be titrated off therapy due to the risks outweighing the benefits. Consider the following alternatives: • Brisdelle • SSRIs, Gabapentin, and Venlafaxine have non-FDA labeled indications (medically accepted use) for hot flashes. **For Vaginal Symptoms:** Premarin Cream **For Bone Density:** • Alendronate • Actonel (risedronate) • Evista (raloxifene)

References:

1. **The American Geriatrics Society 2012 Beers Criteria Update Expert Panel. American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. JAGS. 2012; 60: 616-31.**
2. **PQA. Use of High-Risk Medications in the Elderly: Review and Revision of Performance Measure. June 2012.**

Our Friday Focus editions may be found at:
http://swhp.org/en-us/prov/news/providers-friday-focus



Scott&White
HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

1206 West Campus Drive
Temple, TX 76502

INSIDE STORY STAFF
Operational Staff

Chief Editor
Omegia Walker

Publishing Coordinator & Distribution
Erica Martin

Graphic Design
Connie Horak

www.swhp.org