

Network Update

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Announcements and General Updates

California Puts Patient Safety First

Launched in 2010, *Patient Safety First... a California Partnership for Health* is a groundbreaking three-year, \$6-million collaboration between Anthem Blue Cross, California's regional hospital associations, and the National Health Foundation to improve the consistency and quality of health care for Californians. In its first year, *Patient Safety First* data show that it has helped save more than 800 lives by working to prevent sepsis-related deaths.

The initiative, which brings together more than 160 participating hospitals from across the state to share best practices, has led to a:

- 41% reduction in ventilator associated pneumonia (VAP);
- 25% reduction in central line blood stream infections (CLBSI);
- 24% reduction in catheter associated urinary tract infections (CAUTI); and
- Reduction in birth trauma and elective deliveries prior to 39 weeks gestation.

Early data suggest the *Patient Safety First* initiative in California has already resulted in a cost-avoidance of over \$11 million. This is money that would have been used to care for patients who would have developed sepsis and other hospital acquired infections if they had not been able to avoid illness as a result of the shared learning made possible by the collaboration.

"It's vital that our members and health care consumers throughout the state have access to safe, quality health care," said Pam Kehaly, president of Anthem Blue Cross. "As we work together to prevent patients from getting sepsis and other hospital acquired conditions, we improve Californians' quality of life. The impact of *Patient Safety First* will be felt by even more Californians as the program expands to additional hospitals."

To learn more about *Patient Safety First*, read the recently published article in the [Los Angeles Times](#).

CalPERS 2012 Benefit Plan Changes

CalPERS made a change to its benefit plan effective January 1, 2012, that may influence your patient's choice of place of service for the following elective procedures:

- Colonoscopy
- Cataract Surgery
- Arthroscopy

To provide each PPO member with a choice of safe, quality services at a lower total cost for all PPO members, CalPERS has established a maximum benefit allowance as follows when services are not received at a PPO Ambulatory Surgery Center.

- Colonoscopy services are limited to a maximum payment of one thousand five hundred dollars (\$1,500) per procedure.
- Cataract surgery services are limited to a maximum payment of two thousand dollars (\$2,000) per procedure.
- Arthroscopy services are limited to a maximum payment of six thousand dollars (\$6,000) per procedure.

While this benefit change does not affect the processing of related professional services, you can help your CalPERS patients maximize their health plan benefits by directing them to an ambulatory surgery center in our PPO network.

If you feel an outpatient Hospital setting is warranted either because of the member's condition, safety or the location of the nearest Ambulatory surgery center, please contact Anthem Blue Cross Customer Service at **877-737-7776**. An exception

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request form will be provided to the physician to complete and return. The form will be reviewed to consider allowing the procedure to be performed in a Hospital outpatient facility waiving the benefit maximum.

Billing

5010 Compliance Reminder

Anthem Blue Cross fully supports the HIPAA 5010 mandate and will be able to support 5010 transaction transmission compliance **by January 1, 2012**. It is our expectation that all EDI trading partners support the mandate and be fully migrated to the 5010 standards by January 1, 2012 as well. Any Trading Partner (provider, employer group, software vendor, billing service or clearinghouse) concerned in their ability to migrate to 5010 by the January 1, 2012 mandate should contact the EDI Trading Partner Migration team immediately to discuss contingency planning options to ensure continuity of processing and payment post January 1, 2012 and establish a testing and transition plan for 5010.

For assistance please contact Custom Service at **800-227-3983** from 8:00 a.m. – 4:30 p.m. Pacific Time or by e-mail at 5010EHTS@anthem.com.

Attention Electronic Submitters: Have you filed all Claims for 2011?

As the year draws to a close, we encourage you to file all of your claims electronically, including outstanding A/R claims and claims with other coverage information. By filing electronic claims now, you can greet the New Year with a good start.

Filing claims electronically can help you save time, improving operating efficiency and cash flow for your practice or facility. Additionally, electronic claims filing helps decrease paperwork and reduce administrative expenses. You can also reduce the number of re-filed claims, errors and rejected claims by filing electronically. In addition, the electronic process provides easy-to-interpret reports and an audit trail to track claim submissions. If you have questions about the electronic filing process, contact our EDI Solutions specialists at:

Hours of Operation: Monday through Friday from 8 am – 4:30 pm Pacific Time.

Telephone: **800-227-3983**

E-mail: edi-ca@anthem.com

Web/Live Chat: www.anthem.com/edi

Updating our Systems for ICD-10

We are making progress toward implementing ICD-10. We are committed to being fully compliant and capable of accepting and processing ICD-10 diagnosis and procedure codes on the mandated deadline of October 1, 2013.

Our company recognized very early that the ICD-10 mandate would create business challenges and would affect nearly every part of our organization as well as our members and providers. As a result, we have conducted impact assessments, developed our overall strategy and finalized a number of key decisions. One of these early decisions defines how our systems will be updated for the transition from ICD-9 to ICD-10.

In order to maintain business operations and fully support our members and provider networks, **we will not use any crosswalks from ICD-9 to ICD-10 or vice versa for claims processing.** Our systems will be able to process both ICD-10 and ICD-9 codes, referred to as dual-processing.

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However, to remain in alignment with the CMS directive, we will only accept ICD-10 codes on claims for dates of service or discharge dates on or after October 1, 2013. Additionally, if Congress or the federal government modifies the compliance requirements in any way, Anthem will be positioned to quickly adapt to these changes without business disruption.

Please take time to understand how this will impact your clinical and business processes. It is important that you continue your plans to be ready to bill ICD-10 codes by the compliance date.

Do you have questions about Anthem Blue Cross and ICD-10? Send them to us at ICD10-Inquiry@anthem.com. We will respond promptly to your inquiry.

Starting the Transition to ICD-10: Questions you Should Ask

If you have not begun your preparation for ICD-10, it is imperative that you start planning now. Below is a list of questions to help you.

How much do I know about ICD-10? Start reviewing ICD-10 code set changes now to plan for upcoming changes. There is no magic bullet or program to translate ICD-9 codes to ICD-10. Know the changes to the codes that you primarily use in your practices so you can develop plans to address gaps.

How will this affect my existing workflows and processes? Assess necessary changes to your existing practice workflow and business processes. This could include your clinical documentation, encounter forms/super bills, practice management system, electronic health record system, contracts, and public health and quality reporting protocols.

How are my business partners preparing for the ICD-10 transition? Payers, clearinghouses and systems vendors are already working on ICD-10 transitions. Reach out to them to understand how they are becoming compliant. Also know your role in the transition. Don't assume your system vendors or clearinghouses will automatically translate codes for you.

Is my ICD-10 plan comprehensive? ICD-10 compliance means changes in how payers will process claims and authorizations. Budget for time and costs related to ICD-10 implementation, including expenses for system changes, resource materials, and training. Also, know the timelines for system installations from vendors and testing milestones with payers.

Will I have HIPAA 5010 implemented by the compliance date? As you may know, 5010 is a prerequisite for ICD-10. Apply lessons from the 5010 efforts to your ICD-10 preparation. Many payers and vendors are taking similar testing and communications approaches for these mandates.

Who will need to be trained on ICD-10 and when? Perform a thorough assessment of who will need training on how to handle ICD-10 codes, keeping in mind the procedure changes in coding, authorizations and billing, etc. Include physicians in your assessment, since complete documentation is critical to successful ICD-10 coding. Look for information on training courses offered locally or online through professional associations.

If you have any questions about the ICD-10 transition, you can contact us at ICD10-Inquiry@anthem.com.

Network

Provider Network Education – 2012 Seminars and e-Solutions

Are you up to date on Anthem Blue Cross?

The Anthem Blue Cross Provider Network Education team develops, delivers and supports quality educational programs and materials specially designed for the office staff of physicians, hospitals, medical groups, ancillary and other health care professionals. Our education programs offer 'blended learning' via face-to-face and web-based learning opportunities exclusively for our contracted provider population. For locations and registration information, log on to the [Anthem Blue Cross website](#). Scroll down to the **SPOTLIGHT** section and click on the [Provider Education Seminars](#) link.

Seminars are opportunities, Spring and Fall, for Anthem Blue Cross staff to meet with you face-to-face in an interactive learning environment. During these sessions, 'Tools for Success' are provided that explain best practices, process improvement methodologies, and 'tips' to simplify your interaction with Anthem Blue Cross. You will also receive current information on changes and enhancements taking place at Anthem Blue Cross as well as materials relevant to the seminar topics. Neither billing guidelines nor clinical guidelines are covered during these sessions. However, some topics are:

- Availity Health Information Network – second multi payer access
- ICD-10
- . HIPAA 5010
- BlueCard Program
- Medicare Advantage
- AIM® (American Imaging Management)
- ProviderAccess® online resources and navigation
- Anthem.com/ca online resources and navigation

e-Solutions are on-line educational opportunities available via the Internet:

- **On-Demand e-Courses** offer short, informative, self-paced instruction on a variety of individual topics. They are available 24/7 at your convenience. A listing of the topics is available on the Provider Network Education web page.
- **Webinars** offer "live" interactive sessions conducted remotely via the internet and facilitated by the Provider Network Education team and Subject Matter experts every month. A listing of the upcoming topics and dates are available on the Provider Network Education web page.

On-Line Registration is accomplished by logging in to <http://wellpoint.intevista.com/Home.aspx>.

- The **Home** tab provides additional information you need to participate in these learning opportunities. You can view all available offerings by clicking on the desired tab.
- To view details about how the registration process works, place your cursor over the **Home** tab. The **Registration Details** drop-down menu will display. Click this drop-down link to view more guidelines about how to register.
- You must first register on this Education web site, established your own **Personal Education Account**, and establish your personal user name and password. When you have registered, you will receive an e-mail confirmation with your newly established username and password. Important: Keep this e-mail in a safe location for future reference.
 - **Note:** Your username and password for this web site is separate from your ProviderAccess username and password.
- Once you have a **Personal Education Account** established, you only have to log in with your personal username and password and choose any of the above learning opportunities.
- **Note:** Each individual must have their own Personal Education Account in order to attend the above learning opportunities.

QUESTIONS: email us at: network.education@wellpoint.com.

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Sign Up Now for Our Network Rapid Update Today – It's Free!

Connecting with Anthem Blue Cross and staying informed will be even easier, faster and more convenient than ever before with our Network Rapid Updates.

Network Rapid Update is our web tool for sharing vital information with you. It features short topic summaries and links that let you dig deeper into timely critical business information:

- Important website updates
 - System changes
 - Fee Schedules
 - Medical policy updates
 - Claims and billing updates
-and much more

[Registration](#) is fast and easy. There is no limit to the number of subscribers who can register for Network Rapid Updates, so you can submit as many e-mail addresses as you like.

Network Leasing Arrangements

Anthem Blue Cross has network leasing arrangements with a variety of organizations, which we call *Other Payers*. Other payers and affiliates use the Anthem Blue Cross network.

Under the terms of your provider agreement, members of other payers and affiliates are treated like Anthem Blue Cross members. As such, they're entitled to the same Anthem Blue Cross billing considerations, including discounts and freedom from balance billing. You can obtain the *Other Payers* list on ProviderAccess®, which can be accessed through the Anthem Blue Cross website at www.anthem.com/ca. If you don't have internet access, please contact us at 855-238-0095 for assistance.

Health Care Reform Updates

Preventive Care Service Reminders

The Affordable Care Act (ACA) requires certain defined preventive care services to be covered with no member cost-sharing (copayments, deductibles, or coinsurance) when rendered by in-network providers. It is important to remember that not all benefit plans are subject to the preventive care coverage requirements under the ACA, so providers should verify eligibility and benefits when determining copayments or coinsurance due by members for services rendered. A list of services currently covered under preventive care can be viewed in [Changes in Preventive Care Benefits Due to Health Care Reform](#).

Preventive evaluation and management services are included in the defined preventive care services paid at 100%. To ensure your patients appropriately receive these benefits, we encourage physicians and other providers to use correct coding guidelines when reporting preventive evaluations. Specific preventive medicine service codes are indicated in the Preventive Medicine Services subsection of the CPT Professional Edition coding manual (e.g. 99381– 99387 and 99391-99397). Additionally, preventive evaluation HCPCS codes are provided in the HCPCS Level II reference manual (e.g. G0402, G0438, G0439). Both sets of codes can be separately reported for preventive evaluation services as long as documentation and criteria are met to support the use of these codes. Please review the most current versions of these coding books for additional information.

In the event that an abnormality is encountered or a pre-existing problem is significantly addressed during the process of performing a preventive exam, the CPT Professional Edition provides details on when and how to report a problem oriented evaluation and

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management code (e.g. 99201-99215) in conjunction with the preventive exam. We encourage familiarity with these guidelines to facilitate appropriate and accurate claim processing in accordance with the member's benefit plan.

What We've Implemented and Future Changes

There is a lot to know when it comes to health care reform. That's why we've created a summary with details about how we've implemented some of the most significant provisions impacting members and providers in 2010 and 2011. Except where indicated, these provisions were effective for members in non-grandfathered plans upon renewal on or after September 23, 2010. In some cases, we implemented provisions for grandfathered members as well, even though the provision did not require us to do so. Policy benefits vary based on grandfathered and non-grandfathered status, the size of the member's group, and other factors. *In order to know how benefits apply to a specific policy, please continue to verify eligibility and benefits for all patients.*

Provision	Details
Dependent coverage to age 26	For many plans, we implemented this provision early to avoid a coverage gap for spring 2010 graduates. Members with group plans were given the opportunity to enroll dependents younger than 26 at their first open enrollment after September 23, 2010. We implemented this provision for dependents to age 26 for most vision and dental plans as well, even though the health care reform law does not apply to these benefits.
No lifetime dollar limits/Restricted annual dollar limits on essential health benefits	We removed lifetime dollar limits from plans where required and provided a one-time open enrollment period for members who had reached their lifetime maximum limit. We implemented the annual limits provision, removing annual dollar limits. In some limited cases, employers could apply to the government for a waiver of this requirement. In order to understand how benefits apply to a specific policy, please continue to verify eligibility and benefits for all patients.
No member cost share for in-network preventive care/Preventive services expansion	We expanded our standard preventive care list and updated non-grandfathered plans to cover these services with no member cost share. We also chose to include this coverage in some grandfathered plans.
Patient protections	This provision gave members more flexibility in choosing a primary care doctor and accessing OB-GYN services without a pre-auth or referral. It also requires copays and coinsurance for out-of-network emergency medical care received in an ER to not exceed those required for in-network emergency care. We decided to include these provisions in all plans, even though they were not required for grandfathered plans.
Pre-existing conditions	Beginning with renewals after September 23, 2010, we provide coverage for members under the age of 19, regardless of pre-existing conditions.
Spending account changes	Effective January 1, 2011, prescriptions are required for spending account reimbursement of over-the-counter drugs other than insulin.
Revised appeals process and adverse benefit determinations	If it was not already in place, we created a standard appeal process for members to comply with health care reform, including providing certain information to members, and allowing members to review their file and present evidence during the review. We've also coordinated external review for self insured plans through three accredited independent review organizations. As we move forward, we will implement

	<p>this review process for other plans as well.</p>
	<p>On 07/01/11, we began including the following information on all Adverse Benefit Determinations (member EOBs, letters to the member, etc.), if not already included:</p> <ul style="list-style-type: none"> • Date of service • Health care provider name • Claim amount (if applicable) • Statement that diagnosis code, treatment code and their meanings are available upon request • Denial rationale (include a discussion of the decision) • Any standards used denying the claim (e.g., medical policies, etc.) • The denial code and reason (this information is contained on the EOB) • Description of the internal appeals and external review procedures • Contact information for consumer assistance or Ombudsman program

Looking ahead, there are still many parts of health care reform that will impact providers, members, and the way we all work together. Here are some of the significant provisions which will be implemented through 2016. As we continue to navigate through the many upcoming phases of health care reform, we will share additional details about how these changes may impact the way we do business with you.

Provision	Details	Implementation Date
Revised appeals process and adverse benefit determinations	Appeals process – bypass internal: Claimants will have the right to bypass internal appeals and go to external appeal or litigation if the insurer or plan fails to comply with the rule (exceptions for minor violations that are not reflective of a pattern or practice of noncompliance).	Next plan year on or after January 1, 2012
	Language notifications: We will provide notices to certain members on how to request an adverse benefit determination in a language other than English.	Next plan year on or after July 1, 2012
Women's preventive services expanded	Approved women's preventive services will be added to the preventive care list to be covered at 100% with no patient cost sharing. We are unsure at this time if these services will be added at one time or upon renewal. More information will be provided as it is available.	August 1, 2012 or upon renewals starting August 1, 2012
Pre-existing Conditions	Pre-Existing conditions will no longer apply to non-grandfathered plan members (over the age of 19).	January 2014
Administrative simplification	This provision requires the HHS Secretary to adopt and regularly update the standard, implementation, specifications	January 2013 - 2016

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	and operating rules for electronic exchange and the use of health information for the purposes of financial and administrative transactions. Providers will need to continue to work with their clearinghouses to ensure that they are compliant with standards for electronic exchange.	
Health insurance exchanges	States will begin to operate health insurance exchanges, which are envisioned to be marketplaces for individuals and some employer groups to obtain private health insurance. Employers will also be able to purchase coverage outside of the exchanges.	Expected to be set up before 2014.
Coverage for clinical trials	Non-grandfathered plans must include coverage of routine patient costs for clinical trials of life-threatening diseases.	2014
Individual mandate	All U.S. Citizens and legal residents are required to have health care coverage. For citizens without health care coverage, a penalty will be phased in. Penalties are the greater of \$95 per year in 2014, phasing in to \$695 per year by 2016 or 1% of taxable income phasing in to 2.5% of taxable income by 2016. Some exemptions will be allowed for low-income individuals.	2014-2016

Current and past articles are available online under [Health Care Reform Updates and Notifications](#).

Guidelines

Clinical Practice and Preventive Health Guidelines Available on the Web

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health, and preventive health guidelines, which are available to providers on our website. The guidelines, which are used for our Quality programs, are based on reasonable medical evidence and are reviewed for content accuracy, current primary sources, the newest technologies advances and recent medical research. All guidelines are reviewed annually and updated as needed.

The current guidelines are available on our website at www.anthem.com/ca, select Providers>Enter> then choose the Health & Wellness tab, select [Practice Guidelines](#).

Medicare Advantage Updates

Formularies Changing for 2012 Medicare Part D Members

Some medications you have prescribed could be affected by recent formulary changes. As a result, your patients may request a prescription for a new, less expensive and/or equally therapeutic medication. Or, they may ask you for your help with medical necessity information for a prior authorization, or formulary or step therapy exceptions.

Please refer to your patient's 2012 formulary for a complete list of available drugs. The formulary also notes tier levels and any requirements for coverage. If you need to immediately initiate a prior authorization, tiering, formulary, or a step therapy exception request, please call **800-338-6180**.

Thank you for reviewing these changes. We want to provide your patients with access to effective and affordable medications, so your help is much appreciated.

Notice of Medicare Non-Coverage (NOMNC) Document Reminders

The Centers for Medicare & Medicaid Services (CMS) recently issued a clarification regarding proper use and delivery of the Notice of Medicare Non-Coverage (NOMNC).

As you know, a Medicare health provider must give a completed copy of the NOMNC to Medicare enrollees receiving skilled nursing, home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services, no later than two days before the termination of services.

Please keep the following in mind when delivering a NOMNC to a patient:

1. Providers must use the Notice of Medicare Non-Coverage (NOMNC) from the member's health plan. The form must include the CMS form number, the Office of Management and Budget (OMB) control number and the health plan specific Marketing Material Identification Number (MMID) and CMS approval date. That form <Anthem Blue Cross Medicare Advantage plans> can be found here:
 - [HMO NOMNC](#)
 - [RPPO NOMNC](#)
2. As stated in the NOMNC instructions, the provider **delivering** the NOMNC should be referenced in the header of the form. This must include your name and/or the name of your practice, address and telephone number; a Medicare registered logo also may be used.
3. Providers may fill in the enrollee's unique medical record or other identification number. Note that the enrollee's Health Insurance Claim (HIC) number must not be used.

Thank you for your attention to this matter.

Pharmacy

Generic Pipeline Quarterly Update

Our quarterly generic pipeline update provides you with a quick view of the brand name drugs potentially coming off patent and becoming available as a generic in the next three months. The table below reflects brand-name medications expected to lose patent protection during the fourth quarter of 2011.

Within the next four years, more than \$83 billion in annual U.S. sales of brand-name medications will be coming off patent. A one percent increase in generic utilization can result in approximately a one to two percent reduction in total drug spend. When appropriate for your patients, we encourage you to prescribe generic drugs to help reduce prescription drug costs.

For more information about our Drug List, including prior authorization, Drug List selection and drug alerts, log on to anthem.com/pharmacyinformation.

Source: Internal WellPoint data

Generic launch schedule 4Q 2011

Brand Name	Generic Name	Manufacturer	Therapeutic Class	Probability of Launch (Low, Medium, High)
Asacol (400 mg)	Mesalamine	Warner Chilcott	Inflammatory Bowel Agents	Very Low
Caduet (2.5/10, 2.5/20, 2.5/40, 10/40, 5/10, 5/20, 5/40, 10/10, 10/20, 10/80)	Amlodipine / Atorvastatin	Pfizer	Cardiovascular Agents Misc. – Combinations	Medium
Combivir	Lamivudine / Zidovudine	GSK	Antiretrovirals	High
Delsym	Dextromethorphan polistirex	Reckitt Benckiser	Antitussives	Low
Doryx (150mg)	Doxycycline Hyclate	Warner Chilcott	Tetracyclines	Medium
Hectorol (0.5 and 2.5 mcg capsules)	Doxercalciferol	Genzyme	Genzyme	Low
Hectorol 4mcg/2ml (injection)	Doxercalciferol	Genzyme	Metabolic Modifiers	Low
Lipitor	Atorvastatin	Pfizer	HMG CoA Reductase Inhibitors	High
Myfortic	Mycophenolic acid	Novartis	Immunosuppressive Agents	Low
Patanase	Olopatadine	Alcon	Nasal Antiallergy	Low
Perforomist	Formoterol fumarate	Dey	Sympathomimetics	Low
Ryzolt	Tramadol	Purdue	Opioid Agonists	High

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	hydrochloride			
Sanctura XR	Trospium	Allergan	Urinary Antispasmodics	Medium
Solodyn (45, 90 & 135 mg)	Minocycline	Medicis	Tetracyclines	High
Symbyax (3/25, 6/25, 6/50, 12/25, 12/50)	Olanzapine / Fluoxetine	Lilly	Combination Psychotherapeutics	High
Travatan	Travaprost	Alcon	Prostaglandins - Ophthalmic	Medium
Travatan Z	Travaprost	Alcon	Prostaglandins - Ophthalmic	Low
Vfend (injection)	Voriconazole	Pfizer	Imidazole-Related Antifungals	Low
Xyzal (oral solution)	Levocetirizine Dihydrochloride	UCB; Sanofi	Antihistamines - Non-Sedating	High
Zyprexa (2.5, 5, 7.5, 10, 15, 20 mg tablets)	Olanzapine	Lilly	Dibenzapines	High
Zyprexa Zydys (ODT)	Olanzapine	Lilly	Dibenzapines	High
Zyprexa 10 mg (injection)	Olanzapine	Lilly	Dibenzapines	Low

Anthem Drug List Updates

Visit <http://www.anthem.com/pharmacyinformation> for more information on copayment/coinsurance requirements and their applicable drug classes, Drug Lists and prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs.

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