The following products are included in this PA program (formulary specific):

**Ideal:** Adasuve, aripiprazole, Aristada, Aristada Initio, chlorpromazine, clozapine (tablet, ODT 12.5mg, 25 mg and 100 mg), Fanapt, Fanapt Titration Pack, fluphenazine, Geodon injection, haloperidol (concentrate, injection, tablet), Invega Sustenna, Invega Trinza, Latuda, loxapine, molindone, olanzapine, paliperidone, perphenazine, Perseris, quetiapine, quetiapine ER, Rexulti, Risperdal Consta, risperidone, Saphris, thioridazine, thiothixene, trifluoperazine, Versacloz, Vraylar, ziprasidone, Zyprexa Relprevv

**Value/Value Stars:** Adasuve, aripiprazole, Aristada, Aristada Initio, chlorpromazine, clozapine (tablet, ODT 12.5mg, 25 mg and 100 mg), Fanapt, Fanapt Titration Pack, fluphenazine, Geodon injection, haloperidol (concentrate, injection, tablet), Invega Sustenna, Invega Trinza, Latuda, loxapine, molindone, olanzapine, paliperidone, perphenazine, Perseris, quetiapine, quetiapine ER, Rexulti, Risperdal Consta, risperidone, Saphris, thioridazine, thiothixene, trifluoperazine, Versacloz, Vraylar, ziprasidone, Zyprexa Relprevv

The following products are included in this Prior Authorization program:
Adasuve, aripiprazole, Aristada, Aristada Initio, chlorpromazine (injection, tablet), clozapine (tablet, ODT 12.5mg, 25 mg and 100 mg), Fanapt, Fanapt Titration Pack, fluphenazine (concentrate, elixir, injection, tablet), Geodon inj, haloperidol (concentrate, injection, tablet), Invega Sustenna, Invega Trinza, Latuda, loxapine capsule, molindone, olanzapine, paliperidone, perphenazine tablet, Perseris, quetiapine tablet, quetiapine ER (Ideal only), Rexulti, Risperdal Consta, risperidone, Saphris, thioridazine tablet, thiothixene, trifluoperazine, Versacloz, Vraylar, ziprasidone, Zyprexa Relprevv

The following products are included in this Quantity Limits program:
aripiprazole, Aristada, Aristada Initio, clozapine (tablet, ODT 12.5 mg, 25 mg and 100 mg), Fanapt, Geodon inj, Invega Sustenna, Invega Trinza, Latuda, olanzapine, paliperidone ER, Perseris, quetiapine tablet, quetiapine ER (Ideal only), Rexulti, Risperdal Consta, risperidone, Saphris, Versacloz, Vraylar, ziprasidone, Zyprexa Relprevv

**Criteria for approval for PATIENTS WHO ARE 65 YEARS OLD AND OVER**
(subject to prior authorization for **typical antipsychotic agents** and prior authorization with quantity limit for **atypical antipsychotic agents**):

**Formulary Typical or Atypical Antipsychotics** will be approved when ALL of the following are met:
1. The patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
   **AND**
2. **ONE** of the following:
   A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days
   **OR**
   B. The prescriber states the patient is currently using the requested agent
   **OR**
   C. **IF** dementia-related psychosis, BOTH of the following:
      i. Dementia-related psychosis is determined to be severe or the associated agitation, combativeness, or violent behavior puts the patient or others in danger
      **AND**
      ii. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient’s surrogate decision maker

Updated: 01/15/2019
AND
3. **IF** the requested medication is an atypical antipsychotic, ONE of the following:
   A. The requested quantity (dose) is NOT greater than the program quantity limit
   OR
   B. ALL of the following:
      i. The requested quantity (dose) is greater than the program quantity limit
      AND
      ii. The requested quantity (dose) is less than or equal to the FDA labeled dose
      AND
      iii. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does not exceed the limit
   OR
   C. ALL of the following:
      i. The requested quantity (dose) is greater than the program quantity limit
      AND
      ii. The requested quantity (dose) is greater than the FDA labeled dose
      AND
      iii. The prescriber has submitted documentation in support of therapy with a higher dose for the intended diagnosis

Length of approval: 12 months

Criteria for approval for **PATIENTS WHO ARE LESS THAN 65 YEARS OF AGE**
(subject only to quantity limit for atypical antipsychotic agents):

**Formulary Atypical Antipsychotics** will be approved for quantities above the program set limit when ONE of the following is met:
1. The requested quantity (dose) is NOT greater than the program quantity limit
   OR
2. ALL of the following:
   A. The requested quantity (dose) is greater than the program quantity limit
   AND
   B. The requested quantity (dose) is less than or equal to the FDA labeled dose
   AND
   C. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does not exceed the limit
   OR
3. ALL of the following:
   A. The requested quantity (dose) is greater than the program quantity limit
   AND
   B. The requested quantity (dose) is greater than the FDA labeled dose
   AND
   C. The prescriber has submitted documentation in support of therapy with a higher dose for the intended diagnosis

Length of approval: 12 months
MULTI-LANGUAGE INTERPRETER SERVICES

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call the Customer Services number on the back of your member ID card.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio de Atención al Cliente al número que figura al dorso de su tarjeta de identificación.

注意: 如果您講廣東話或普通話，您可以免費獲得語言援助服務。請撥打您會員卡背面的客服部電話號碼。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Dịch vụ khách hàng trên mặt sau thẻ thành viên ID của bạn.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 가입자 ID 카드 뒷면에 있는 고객 서비스 전화번호로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Téléphonez le Service clients au numéro qui figure au dos de votre carte de membre.

বিবেচনা করা হয়েছে: যদি আপনি স্প্রেন্সিয়াল ভাষা বলেন তাহলে আপনাকে মূল্যবান ভাষা সহায়তা উপলব্ধি করার মাধ্যমে সাহায্য করা হবে। সাধারণভাবে মূল্যবান ভাষা সহায়তার জন্য ক্লায়র মূল্যবান বিভাগ নম্বর উপর কল করুন।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie die Nummer des Kundenservice an, die auf der Rückseite Ihrer Mitglieds-ID-Karte angegeben ist.

PRECAUȚIE: Dacă vorbiți o altă limbă, există servicii de asistență lingvistică gratuite disponibile pentru dvs. Vă rugăm să vă contactați numărul Customer Service din spatele cardului de identitate al dvs.

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。メンバーIDカードの裏面のカスタマーサービス番号にお電話ください。

Blue Cross and Blue Shield of North Carolina is an HMO, PPO and PDP plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.

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Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified interpreters and/or written information in other formats (large print, accessible electronic formats, etc.)
- Free language services to people whose primary language is not English, such as: qualified interpreters and/or information written in other languages

If you need these services, contact:

Customer Service
Call the number on the back of your ID card

If you believe that Blue Cross NC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Cross NC, P.O. Box 2291, Durham, NC 27702
Attention: Civil Rights Coordinator-Privacy, Ethics & Corporate Policy Office
Call: 919-765-1663, 1-888-291-1783 (TTY)
Fax: 919-287-5613
E-mail: civilrightscoordinator@bcbsnc.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Coordinator-Privacy, Ethics & Corporate Policy Office is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

- Online: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
- Mail: U.S. Department of Health & Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building Washington, D.C. 20201
- Call: 1-800-368-1019, 1-800-537-7697 (TDD)
- Complaint forms are available online at: http://www.hhs.gov/civil-rights/filing-a-complaint/index.html

This notice and/or attachments may have important information about your application or coverage through Blue Cross NC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Contact:

Customer Service
Call the number on the back of your ID card

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