CELEBRATING 25 YEARS OF SERVICE AND PARTNERSHIP

This year, we at WellCare Health Plans, ‘Ohana Health Plan’s parent company, celebrate our silver anniversary. Over our first 25 years, we have touched many lives in many different and meaningful ways. Our success would not be possible without your steadfast commitment to the highest standards of service.

Our relationship with providers runs deep; WellCare was founded by a group of physicians. Since the beginning, we have provided quality, cost-effective managed health care solutions in partnership with you and the members, governments and communities we serve. Today, more than 2 million people count on us for their health care and prescription drug needs.

As we continue to focus our energies on enhancing our members’ wellness and quality of life, we remain dedicated to strengthening our partnership with you. We value and thank you for the quality care and services you provide, and look forward to a long and healthy future together.

‘OHANA CLAIMS INFORMATION

From time to time, ‘Ohana Health Plan reviews its reimbursement policies to maintain close alignment with industry standards and coding updates released by health care industry sources like the Centers for Medicare and Medicaid Services (CMS), as well as nationally recognized health and medical societies.

Please note that ‘Ohana publishes periodic reimbursement policy updates. To obtain a copy of our current policies, please visit the Provider Resources area of our Web site at www.ohanahealthplan.com, and select the Claims Updates link.

PROVIDER MATERIALS UPDATE

Since our last newsletter was published, the following correspondence was sent to providers via fax or was posted in the Provider Messages section of ‘Ohana Health Plan’s Web site:

- Provider Education Meetings Invite
- Outcomes RAPS Provider Letter
- ‘Ohana Medicaid Formulary Deletion Notice

You can find copies of all these correspondences when you visit www.ohanahealthplan.com. Click on the Provider tab and you will see Messages from ‘Ohana located on the right side of the page. Remember to check the messages regularly to receive new and updated information.

UPDATES ON THE WEB

For new and updated information, please visit our Web site, www.ohanahealthplan.com, and click on the Provider Resources link located directly below the For Providers tab. Here, you will find the following:

- Current Provider Manual with Member Rights and Responsibilities
- Clinical Coverage Guidelines
- Preventive Health Guidelines
PEOPLE STILL TRUST THEIR DOCTORS RATHER THAN THE INTERNET

The Internet has made vast amounts of health information available to the general public, but all that virtual “noise” has made people more likely than ever to trust their doctor with medical decisions, a new survey finds.

As the environment gets noisier, physicians will be needed more to help patients decipher the noise, explained Bradford W. Hesse, one of three researchers from the U.S. National Cancer Institute who produced the survey.

“Part of noise is there’s good information and there’s bad information,” Hesse said. “We have a hard time understanding which is which. But doctors are credible. They’ve gone through a lot of training, and they can help [people] sort the good information from the bad.”

Published in the March 4 issue of the New England Journal of Medicine, the survey of nearly 16,000 people over seven years found the following:

- People’s trust in physicians has increased with the ascent of the Internet, while their trust in Internet information has declined slightly over time. Simultaneously, their trust in other sources of health information such as television has plummeted.
- By a large margin, people take their health questions to the Internet first, performing their own research. They then take that information to their doctor for discussion.
- Increasing numbers of people are using e-mail to communicate directly with their physicians.

The study dovetails with previous research, showing that the Internet is not replacing the role of doctors in people’s health, believes Susannah Fox, an associate director of the Pew Research Center’s Internet & American Life Project.
Some people had been concerned that the Internet would supplant people’s need to visit the doctor, much as Web sites have replaced local travel agents and print newspapers for many, Hesse and Fox concurred.

This latest research reveals the opposite, in fact, is occurring.

“The doctor’s appointment is an institution that will not budge,” Fox said. “People still want someone to help guide them when they’re making decisions about an acute disease or managing a chronic illness.”

However, the study also shows that people are getting some use from Internet-provided medical information. They are using the Internet as a first source for health questions, for one thing.

“They use both channels,” Hesse said. “They go to the Internet first because it’s the easy thing to get to, but then they go to the doctor and follow up.”

People also are using Web sites to get answers for questions they feel are too minor to bring to their doctor, Fox added.

“When these health questions pop up in people’s lives, often they do want to talk to a doctor,” she said. “But if it’s after office hours or a question that doesn’t necessarily need expert advice, there are decisions that can be made using information found on the Internet. On the big decisions, for example diagnosis and treatment decisions, people are still relying on health professionals to help them make those very high-stakes decisions.”

The increase in e-mail correspondence with physicians, along with a large decrease in people’s trust in other sources of information, point to an increasing role for the Internet in health care, even if that role will remain supplemental to a doctor’s authority, Fox said.

“They key is making sure we understand that as mobile devices and broadband proliferate, the conversation is increasingly happening online,” she added.

Hesse said that the findings also point to an emerging model of preventive medical care where a person’s family physician takes on the role of a “coach,” guiding self-motivated patients to better health through their advice and judgment.

“People don’t go away when there’s technology involved,” he said. “In this case, they might actually be more needed.”

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**UPDATED CLINICAL PRACTICE GUIDELINES**

‘Ohana strives to supply our providers with the most up-to-date clinical practice recommendations. The following Clinical Practice Guidelines were updated in early 2010:

- Adult preventive health (including updated immunization schedules)
- Pediatric preventive health (including updated immunization schedules)
- Asthma
- Chronic kidney disease
- Diabetes

Also, please remember that all Clinical Coverage Guidelines, detailing medical necessity criteria for several medical procedures, devices and tests, are available via the Provider Resources link at www.ohanahealthplan.com/Provider/CCGs.
CHILD HEALTH CHECKUP TIPS

‘Ohana members are entitled to receive a comprehensive package of preventive health care. Here are some questions and answers to help you conduct, document and bill for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

Question: How often is a well-child visit allowed for enhanced EPSDT payment?
Answer: EPSDT exams are part of well-child checkups. An enhanced EPSDT rate is payable at the following schedule:

- 14 days
- 2 months of age
- 6 months of age
- 12 months of age
- 18 months of age
- 3 years of age
- 5 years of age
- Even years up to age 20

Question: What must I do to perform an EPSDT exam?
Answer:
- An initial or interval history
- Measurements
- Sensory screening
- Developmental assessment, including autism, with validating screening tool
- TB risk assessments
- Lead risk assessment
- Psychosocial and behavioral assessment
- Alcohol and drug use assessment for adolescents
- STI and cervical dysplasia screening, as appropriate
- Complete physical exam
- Age-appropriate surveillance
- Immunizations
- Procedures like hemoglobin and lead level, as appropriate
- Referral to a dental home
- Referrals to state or specialty services
- Care coordination assistance, if needed
- Age-appropriate anticipatory guidance

Question: Are dental services part of EPSDT?
Answer: Regular Dental Preventive and Treatment Services, including screening examinations, prophylactic treatment (sealing and polishing), every 6 months from 12 months to 20 years of age.

Question: To ensure I get credit for doing an EPSDT exam, how should I document it in my patient’s record?
Answer: Documentation in the medical record must include a note indicating a visit with a primary care practitioner, the date the EPSDT visit occurred, and evidence of all of the required components listed above. Providers must use the 8015 or 8016 form to document completion of the service.

There are several forms available that can assist you in ensuring you have documented the service correctly. You may obtain these forms through the following means:

- In your ‘Ohana Provider Manual (Forms section)
- By calling ACS at 1-808-952-5570

Question: How do I bill for EPSDT exams?
Answer: Bill for an EPSDT exam using the following codes:

<table>
<thead>
<tr>
<th>Age of Child</th>
<th>New Patient</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–1 year of age</td>
<td>99391-EP</td>
<td>99391-EP</td>
</tr>
<tr>
<td>1–4 years of age</td>
<td>99382-EP</td>
<td>99392-EP</td>
</tr>
<tr>
<td>5–11 years of age</td>
<td>99383-EP</td>
<td>99393-EP</td>
</tr>
<tr>
<td>12–17 years of age</td>
<td>99384-EP</td>
<td>99394-EP</td>
</tr>
<tr>
<td>18–20 years of age</td>
<td>99385-EP</td>
<td>99395-EP</td>
</tr>
</tbody>
</table>

Billing for EPSDT should include a completed 8015 or 8016 form and be billed with an “EP” modifier.

Well-child visits occurring in between the EPSDT schedule can be counted as an EPSDT visit and billed at an enhanced rate as long as all the requirements of an EPSDT visit are fulfilled and a completed 8015 or 8016 form is included and billed with an “EP” modifier.
Motivational interviewing is a skill that clinicians can employ on a day-to-day basis to influence patient recovery. The practice helps a patient deal with his or her conscious and unconscious resistances to change through exploration, clarification and encouragement by the clinician during the medical visit.

As defined by Miller and Rollnick, motivational interviewing is a direct, client-centered counseling style for eliciting behavior change by helping patients explore and resolve ambivalence.

Principles of motivational interviewing are as follows:

- Motivation to change is elicited from the patient, not imposed by others.
- It is the patient’s task, not the clinician’s, to articulate and resolve his or her ambivalence.
- Direct persuasion is not an effective method for resolving ambivalence.
- The counseling style is usually quiet and eliciting.
- The counselor is direct in helping the patient examine and resolve ambivalence.
- Readiness to change is not a patient trait but a fluctuating product of interpersonal interaction.
- The therapeutic relationship is more like a partnership or companionship than expert and recipient roles.

In order to ensure that motivational interviewing is most effective, the clinician:

- Listens to what the patient has to say
- Respects and appreciates the patient’s individuality, independence and right to make the final decisions about his or her life and health care
- Seeks to understand the patient’s frame of reference, particularly via reflective listening
- Acknowledges the patient’s ambivalence
- Acts as a resource enabling the patient to identify the barriers to change and how to change
- Focuses on strengths but explores weaknesses shared by the patient
- Expresses encouragement, empathy, understanding, acceptance and affirmation
- Elicits and selectively reinforces the patient’s expressions of problem recognition, concern, desire and intention to change, and ability to change
- Monitors the patient’s degree of readiness to change and ensures that resistance is not generated by jumping ahead of the patient
- Affirms the patient’s freedom of choice and self-direction

The goal is to support self-efficacy and optimism, giving the patient hope that, in time, things can be better. All patients need hope. Even the most treatment-resistant patients need hope that things can improve.

In the time period from 1980 to 2020, the proportion of the population in Hawai'i over the age of 60 is expected to increase from 12 to 25 percent. The projection is that by 2020, Hawai'i will have more than 400,000 residents ages 60 or older, according to the Healthcare Association of Hawai'i. The reasons for this increase include migration into the state, the aging of the baby boomer generation, and the fact that Hawai'ians, who on average can expect to live to 80.8 years, enjoy the longest life expectancy in the United States.

With the aging of the population comes an array of chronic medical problems that plague older Americans, including diabetes, hypertension, heart disease, stroke, kidney disease, respiratory diseases and cancer. Many elderly people live with two, three and/or more chronic medical conditions. While these conditions can be controlled and improved with medication and life style adjustments, the reality is that patients age and, thus, develop multiple co-morbidities, functionality and quality of life concerns and issues.

As the goals of medical treatment for the chronically ill shift from curative to symptom management, palliative care as a system and philosophy of care should be a part of every treatment plan. The goal of palliative care is to prevent and relieve suffering, and to support the best possible quality of life for patients and families facing life-threatening or debilitating illness, regardless of the stage of disease or the need for other therapies. Palliative care focuses on quality of life issues, care versus cure, relief of suffering, pain and symptom management and (when the time comes) dying well.

Palliative care as a philosophy of patient management belongs in primary care, consultative care, hospital care, emergency departments, ICUs, nursing homes and care home cares, home care and Hospice care. It is initiated through the understanding of the need for its application by the provider, and starts with a conversation with the patient and family about “goals of care.” This conversation should usually include a frank discussion regarding the prognosis of medical conditions, and what the patient and family have as their health care and lifestyle goals. Are advance directives and Physician’s Orders for Life-Sustaining Treatment Paradigm (POLST) in place? Where would they like their care to take place? How do they envision the last chapter of life? What is their greatest desire and worst fear regarding end of life care? How is the family involved and how much assistance can they give?

With the answers to these questions in place, the physician can initiate a treatment plan that focuses on disease management, symptom control, comfort measures and patient dignity. A multidisciplinary team can then be assembled to meet the patient’s needs. This team may include any of the following disciplines: nursing, social work, case management, home health, PT, nursing assistants, pharmacists, physical and occupational therapists, speech therapists, dietitians, psychologists, spiritual advisors, and other medical sub-specialties. With the expertise of multiple disciplines involved in the care of the chronically ill patient, there is hope for a much improved quality of life and the hope for a quality end to life—one achieved in comfortable surroundings with minimal pain and/or other distressing symptoms.
While incontinence supplies and absorbent products are covered benefits for the Medicaid population if medically necessary, here’s some data and observations from the field:

- 10 percent of the total population (approx. 2,000 members) use absorbent products.
- Reports from the field by the service coordinators that some members have an oversupply of diapers observed during the home visits.
- “Pull-up” diapers are being supplied by some providers to members who do not need this type. Pull-up diapers are double the cost of standard tab diapers.

Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For the purposes of this paragraph, cost-effective shall not necessarily mean lowest price.

So how does one go about determining medical necessity? This question has led to the development of a Clinical Coverage Guideline to assist and ensure consistency in the determination of need by the UM clinical team and service coordinators in the field. This guideline is based on generally accepted standards of practice, review of medical literature, and federal and state policies and laws applicable to Medicaid programs from other states.

The main points of the guideline are:

- Ensure that the root cause of the incontinence is being/was addressed by a qualified provider/specialist.
- All efforts have been exhausted to treat and resolve the cause of incontinence.
- If deemed incontinent, determine which modality is best for the member (i.e. disposable vs. usable incontinence pads, tab diapers or pull-ups – subject to benefit limitations).
- Determine how many supplies are needed and ensure that these supplies are fulfilled timely and accurately.
- If the condition changes, ensure that there is a mechanism for follow-up and follow-through.

To view the Clinical Coverage Guideline for Absorbent Products in its entirety, please visit www.ohanahealthplan.com/provider/resources.

As a reminder, please provide ‘Ohana with any updated information or changes that could affect your status with the Plan.

For example, be sure to inform ‘Ohana in writing within 24 hours of:

- Any revocation or suspension of your DEA number
- Suspension, limitation, or revocation of your license, certification or other legal credential authorizing you to practice in the state of Hawai‘i

In addition, please inform the Plan in writing immediately of changes to:

- Loss of liability insurance
- Tax identification numbers
- Status at participating hospitals
- Licensure status
- Telephone number
- Addresses

By keeping your information up to date, you are helping to improve member accessibility. You will also help to ensure all correspondence, claim payments and notifications the Plan sends will get to your correct location.
SUMMER 2010 PROVIDER FORMULARY UPDATE

GENERIC NEWS

The generic drugs listed below are now available to ‘Ohana Medicaid and Medicare members at the lowest co-payment (if applicable):

<table>
<thead>
<tr>
<th>BRAND NAME</th>
<th>GENERIC NAME</th>
<th>THERAPEUTIC CLASS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cozaar®</td>
<td>Losartan Potassium 25mg, 50mg, 100mg Tablets (ST: QL – 31 tablets/31 days – MEDICAID ONLY)</td>
<td>Angiotensin II Receptor Antagonists</td>
</tr>
<tr>
<td>Hyzaar®</td>
<td>Losartan Potassium &amp; Hydrochlorothiazide 50/12.5mg, 100/25mg Tablets (ST: QL – 31 tablets/31 days – MEDICAID ONLY)</td>
<td>Angiotensin II Receptor Antagonist/Diuretic Combinations</td>
</tr>
<tr>
<td>Mirapex®</td>
<td>Pramipexole Dihydrochloride 0.125mg, 0.25mg, 0.5mg, 1mg, 1.5mg Tablets</td>
<td>Antiparkinsonian Agents</td>
</tr>
<tr>
<td>Trileptal®</td>
<td>Oxcarbazepine 300mg/5mL Oral Suspension (MEDICAID ONLY – QL: 1500mL/31 days)</td>
<td>Anticonvulsants</td>
</tr>
</tbody>
</table>

QL = Quantity Limit  ST = Step Therapy

The generic drugs listed below are now available to ‘Ohana Medicare members only at the lowest cost-sharing benefit:

<table>
<thead>
<tr>
<th>BRAND NAME</th>
<th>GENERIC NAME</th>
<th>THERAPEUTIC CLASS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aldara® 5% Topical Cream</td>
<td>Imiquimod 5% Topical Cream (PA)</td>
<td>Topical Immunomodulator</td>
</tr>
<tr>
<td>Flomax® 0.4mg Capsules</td>
<td>Tamsulosin 0.4mg Capsules</td>
<td>Benign Prostatic Hyperplasia (BPH) Agents</td>
</tr>
</tbody>
</table>

The following changes have been made to ‘Ohana’s Medicaid Preferred Drug List:

<table>
<thead>
<tr>
<th>ADDITIONS</th>
<th>REMOVALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK-Pentolate™ 1% Ophthalmic Solution</td>
<td>A-200® Lice Control Spray</td>
</tr>
<tr>
<td>Anaplex DM Syrup</td>
<td>Acular® 0.5% Ophthalmic Solution</td>
</tr>
<tr>
<td>Baraclude 0.05mg/mL Solution (QL: 700mL/31 days)</td>
<td>Acular LS® 0.4% Ophthalmic Solution</td>
</tr>
<tr>
<td>Benzonatate 200mg Capsules</td>
<td>Alphagan® P 0.15% Ophthalmic Solution</td>
</tr>
<tr>
<td>Bromfed DM Syrup</td>
<td>Betaseron® for SC Injection</td>
</tr>
<tr>
<td>Budesonide 0.25mg/2mL, 0.5mg/2mL Suspension (AL: &lt;8 years old, QL: 120mL/31 days)</td>
<td>Exelon® 2mg/mL Oral Solution</td>
</tr>
<tr>
<td>ADDITIONS</td>
<td>REMOVALS</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
</tr>
<tr>
<td>Buprenorphine 2mg, 8 mg SL Tablets (PA)</td>
<td>Forteo™ 600mcg/2.4mL Injection</td>
</tr>
<tr>
<td>Claravis 10mg, 20mg, 30mg, 40mg Capsules (ST, AL: 12-20 years old ONLY, QL: 62 capsules/31 days)</td>
<td>Hyalgan® 20mg/2mL Solution for Injection</td>
</tr>
<tr>
<td>Exelon® Patch 4.6mg/24 hours, 9.5mg/24 hours</td>
<td>Loestrin® 24 Fe Tablets</td>
</tr>
<tr>
<td>Extavia® Kit</td>
<td>Migranal® 4mg/mL Nasal Spray</td>
</tr>
<tr>
<td>Fanapt™ 1mg, 2mg, 4mg, 6mg, 8mg, 10mg, 12 mg Tablets</td>
<td>Neocin Ophthalmic Ointment</td>
</tr>
<tr>
<td>Fanapt™ Titration Pack</td>
<td>Oxsoralen® 1% Lotion</td>
</tr>
<tr>
<td>Focalin XR® 30mg Capsule</td>
<td>Oxsoralen-Ultra® 10mg Capsules</td>
</tr>
<tr>
<td>Histadec DM Syrup</td>
<td>Oxycodone/APAP 2.5mg/325mg Tablets</td>
</tr>
<tr>
<td>Infergen® 9mcg/0.3mL, 15mcg/0.5mL vials</td>
<td>Pulmicort Respules® 0.25mg/2mL, 0.5mg/2mL</td>
</tr>
<tr>
<td>J-Tan D Suspension</td>
<td></td>
</tr>
<tr>
<td>Norvir® 100mg Tablets</td>
<td>Note that as of 3/15/2010, DESI (Drug Efficacy Study Implementation) drugs and drugs that are identical, related or similar to such drugs are no longer a covered benefit for ‘Ohana members.</td>
</tr>
<tr>
<td>Oxaliplatin 50mg, 100mg vials (PA)</td>
<td></td>
</tr>
<tr>
<td>Rebetol® 40mg/mL Solution (QL: 1000mL/31 days)</td>
<td></td>
</tr>
<tr>
<td>Ryna-12X Oral Suspension</td>
<td></td>
</tr>
<tr>
<td>Santyl® Ointment (PA)</td>
<td></td>
</tr>
<tr>
<td>Sildec PE-DM Drops</td>
<td></td>
</tr>
<tr>
<td>Supartz® 10mg/ml Syringe (PA)</td>
<td></td>
</tr>
<tr>
<td>Treximet® Tablets (PA)</td>
<td></td>
</tr>
<tr>
<td>Tyzeka® 600mg Tablets</td>
<td></td>
</tr>
<tr>
<td>Viracept® Powder</td>
<td></td>
</tr>
<tr>
<td>Zyprexa® Relprevv™ 210mg, 300mg, 405mg vials</td>
<td></td>
</tr>
</tbody>
</table>

PA = Prior Authorization Required  
QL = Quantity Limit  
AL = Age Limit  
ST = Step Therapy

The Utilization Management criteria have changed for the following medications as noted below:

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>CHANGE</th>
<th>PLAN</th>
</tr>
</thead>
</table>
| Ciclopirox 8% Topical Solution | Prior Authorization requirement removed | • ‘Ohana Medicaid  
• ‘Ohana Medicare |
| Namenda® 5mg, 10mg Tablets, Titration Pak, 10mg/5mL Solution | Step Therapy requirement removed | • ‘Ohana Medicaid |
| Zolpidem 5mg, 10mg Tablets | Step Therapy requirement removed | • ‘Ohana Medicaid |

continued on next page
The quantity limits associated with the following medications have been changed as noted below for the ‘Ohana Medicaid Preferred Drug List:

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>OLD QL</th>
<th>NEW QL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ondansetron 4mg/5ml Solution</td>
<td>No QL</td>
<td>300ml/31 days</td>
</tr>
<tr>
<td>Ondansetron 24mg Tablet</td>
<td>62 tablets/31 days</td>
<td>31 tablets/31 days</td>
</tr>
<tr>
<td>Ondansetron ODT 4mg, 8mg Tablets</td>
<td>12 tablets/31 days</td>
<td>62 tablets/31 days</td>
</tr>
</tbody>
</table>

The following additions have been made to the ‘Ohana Medicare Formulary:

<table>
<thead>
<tr>
<th>ADDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK-Con™ Ophthalmic Solution</td>
</tr>
<tr>
<td>Brimonidine Tartrate 0.15% Ophthalmic Solution</td>
</tr>
<tr>
<td>BioThrax® (Anthrax Vaccine Adsorbed) Suspension for Intramuscular Injection</td>
</tr>
<tr>
<td>Carac® 0.5% Topical Cream (PA)</td>
</tr>
<tr>
<td>Carimune® NF 6gm, 12gm Vials (PA)</td>
</tr>
<tr>
<td>Cyclosporine 50mg Soft Gelatin Capsules (PA)</td>
</tr>
<tr>
<td>Fanapt™ 1mg, 2mg, 4mg, 6mg, 8mg, 10mg, 12 mg Tablets (PA)</td>
</tr>
<tr>
<td>Fanapt™ Titration Pack (PA)</td>
</tr>
<tr>
<td>Fluconazole-NS 100mg/50ml Vial</td>
</tr>
<tr>
<td>Humira® 20mg/0.4mL Pediatric Pre-Filled Syringe (PA)</td>
</tr>
<tr>
<td>Menveo® Solution for Intramuscular Injection</td>
</tr>
</tbody>
</table>

PA = Prior Authorization Required      QL = Quantity Limit

PLANNED MARKET DRUG WITHDRAWAL:

<table>
<thead>
<tr>
<th>COMPANY NAME</th>
<th>DRUG NAME</th>
<th>DATE REMOVED</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endo Pharmaceuticals Inc.</td>
<td>Moban® (molindone HCl) Tablets</td>
<td>June 30, 2010</td>
<td>Endo has been unable to obtain an alternate supplier of molindone hydrochloride after the current supplier notified Endo of their intent to discontinue manufacturing molindone hydrochloride. Prescriptions will continue to adjudicate until supplies are exhausted.</td>
</tr>
</tbody>
</table>

Please visit www.ohanahealthplan.com to view the current Preferred Drug List and Formulary and pharmacy updates.
**BREASTFEEDING: THE NATURAL CHOICE FOR HEALTH**

SHOWS GREAT POTENTIAL TO ENHANCE MATERNAL AND CHILD WELLNESS

With few medical exceptions, the American Academy of Family Physicians recommends that most mothers breastfeed their babies exclusively for the first six months and in combination with other foods until at least 12 months. Breastfeeding is not recommended for women with HIV and certain other conditions.

Promotion and support of breastfeeding should begin in prenatal care and continue after delivery and during pediatric care. Unless medical contraindications exist, babies should be put to their mother’s breast within the first hour after birth.

The American Academy of Pediatrics recommends a schedule of supplementing breastfeeding with Vitamin D drops until the infant begins to consume at least 500 ml of commercial formula. Pediatric providers should be able to refer families to local lactation consultants and support services. Structured educational programs are more effective than written materials alone. Refer to the resources listed below for more information.

**FOR PROVIDERS:**
- Breastfeeding policies and resources: [www.aafp.org](http://www.aafp.org), [www.acog.org](http://www.acog.org), [www.aap.org](http://www.aap.org) and [www.apha.org](http://www.apha.org)
- Safety of maternal medications during breastfeeding: [www.perinatology.com/exposures/druglist.htm](http://www.perinatology.com/exposures/druglist.htm)
- International Lactation Consultant Association: [www.ilca.org](http://www.ilca.org)
- Academy of Breastfeeding Medicine: [www.bfmed.org](http://www.bfmed.org)

**FOR FAMILIES:**
- The National Women’s Health Information Center: [www.4women.gov/breastfeeding](http://www.4women.gov/breastfeeding) or 1-800-994-9662

*Source: American Academy of Family Physicians; American Academy of Pediatrics*

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**REGULAR CERVICAL CANCER TESTING CAN SAVE LIVES**

‘Ohana invites its physicians to help reinforce the importance of cervical cancer screening to our female members. Our Pap test recommendations are as follows:

- Females should receive an initial Pap test within three years of first sexual activity or at age 21—whichever comes first.
- Cervical cancer screenings should occur once every three years until age 65.
- Women older than 65 should discontinue Pap testing only after they have had several negative tests and are not otherwise at risk for cervical cancer.
- Women living with HIV/AIDS should have a Pap test twice in the first year and, if the tests are normal, Pap tests should continue at least every year.

- A woman who has had a total hysterectomy (in which the cervix was removed) no longer needs Pap tests, unless the surgery was done as a treatment for cervical abnormalities or cancer.

Health care providers should encourage patients who may be less likely to get Pap tests to be screened regularly.

- All primary care providers, not just gynecologists, should check if women need to have a Pap test and, if so, either perform the test or refer appropriately.
- Targeted outreach toward older, foreign-born, low-income and uninsured women is recommended.
- All women 21 and older should be screened at least every three years, regardless of sexual activity.

*Sources: National Cancer Institute; U.S. Department of Health and Human Services; American Cancer Society*
INFLUENZA: WHAT’S NEW IN 2010

Now that influenza season has arrived, we’re encouraging providers to ensure that each of their patients receives a flu vaccine. Here are some important things to remember as you encourage your patients to fight off the flu bug this upcoming season:

- Vaccination recommendations for adults have been expanded to include all adults beginning in the 2010–11 influenza season. Therefore, it is important that all people age 6 months and older receive the annual influenza vaccination.
- This year’s vaccines, which will also provide protection against H1N1, include the same strain that was in the pandemic influenza A (H1N1) 2009 monovalent vaccines.
- Finally, a higher-dose formulation of an inactivated seasonal influenza vaccine, Fluzone® High-Dose*, will be available in the 2010–11 influenza season for use in people age 65 years and older. Fluzone High-Dose, which contains four times the amount of influenza antigen compared with other inactivated seasonal influenza vaccines, produced higher antibody levels. Studies are under way to assess the relative effectiveness of Fluzone High-Dose compared with the standard-dose inactivated influenza vaccine, but results from those studies will not be available before the 2010–11 influenza season. The ACIP has not expressed a preference for Fluzone High-Dose or any other licensed inactivated influenza vaccine for use in people age 65 and older.

‘Ohana offers FREE flu vaccinations for its members. Please encourage our members to receive the flu vaccine either in your office or have them call the Customer Service number located on the back of their Member ID card. They can also visit www.ohanahealthplan.com to locate a network provider near them to receive a FREE flu vaccination!

* ‘Ohana will not pay for the Fluzone High-Dose vaccine.

Source: Centers for Disease Control and Prevention