NOVEMBER 2025

BlueAlert℠

Mission driven FOR 75 Years

A monthly newsletter for our provider community, featuring important updates and reminders about our company's policies and procedures. All information is broken out by line of business.

BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise.

We Want to Hear From You!

We sent our 2025 Provider Wait Time Survey earlier this year to providers participating in certain BlueCross networks. If you got a survey and haven't completed it yet, please share your feedback with us as soon as possible to help us improve our services.

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About the Provider Exclusion Screening Process

To protect the health and safety of our members and your employees, please remember your contractual obligation to screen all employees, agents and contractors against the exclusion lists.

You also need to conduct criminal background checks and registry checks, as required by state law, to determine if any individuals are "ineligible persons," and therefore, excluded from participation in the Medicare or Medicaid programs. At minimum, registry checks should include the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, Social Security Death Master File, HHS-OIG List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM), and the Tennessee Terminated Providers List.

The screenings should be conducted prior to hiring employees or contracting with individuals and entities, and every month following. Providers are also required to have employees and contractors disclose if they're ineligible persons prior to providing any services on behalf of the provider.

If you have questions, please refer to the **Provider Networks – Federal Exclusion Screening Requirement** section of your **Provider Administration Manual**.

Troubleshooting Availity® Browser Issues

Some providers are experiencing issues loading Availity while using Google Chrome or Microsoft Edge. If you experience similar issues, follow these troubleshooting steps.

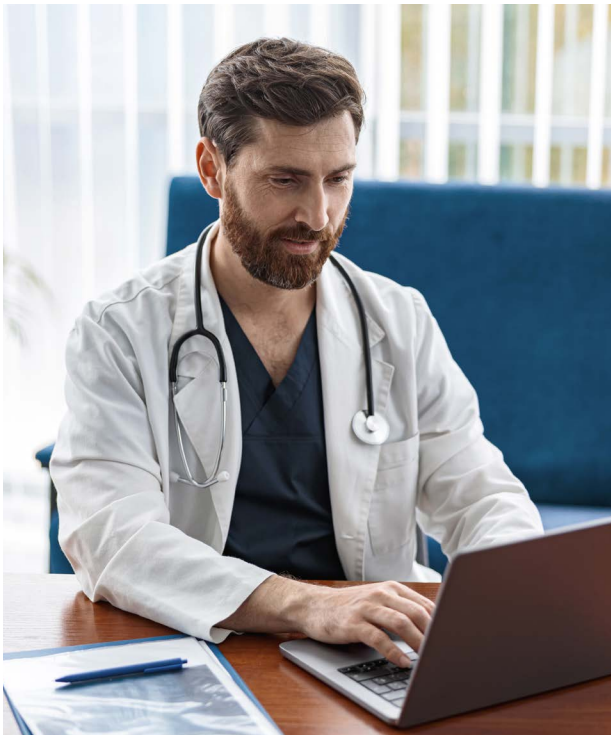
For problems with Availity while using Chrome:

1. Close all tabs within the browser.
2. Open a new tab and input **Ctrl + H** (Mac users **Command + H**).
3. Select **Delete browsing data**.
4. Select **All time**, then select **Clear Data**.
5. Open a new **Incognito tab** and go to **Availity.com** (do not use a bookmarked link).

For problems with Availity while using Edge:

1. Close all tabs within the browser.
2. Open a new tab and input **Ctrl + H** (Mac users **Command + H**).
3. Select the **trash can symbol**.
4. Select **All time**, then select **Clear Data**.
5. Open a new **InPrivate window** and go to **Availity.com** (do not use a bookmarked link).

If you still need help accessing Availity, please call **(423) 535-5717, option 2**, or contact your **eBusiness Regional Marketing Consultant**.



A Faster Way to Receive Important Communications From Us

You can receive contract-related communications – including fee schedule updates – up to three days faster by switching from mail to email. By selecting email and adding a contact name and email address, you can also request email for credentialing, network operations, network updates, quality and clinical information, and financial updates.

You can update your **Contact Preferences** through our **Payer Spaces** in **Availity**. Simply select email instead of mail for all types of communications and add a contact name and email address for each one.

Follow these steps in Availity:

1. Log in to **BlueCross Payer Spaces**.
2. Select the **Contact Preferences & Communication Viewer** tile.
3. Choose your **Contact Type**.
4. Select your **Organization** and **Tax ID**. (Tax ID is a newly added feature that lets you select a specific provider based on Tax ID. You can update contact information for all Tax IDs, including the primary Tax ID associated with the corresponding NPI.)
5. Pick a **Provider** from the drop-down list or by directly entering the provider's **NPI** and click **Submit**.
6. Follow the remaining cues and check the email **Opt In** box. Make sure email is the first option in the **Communication Preference** list on the right side. When finished, click **Save & Submit**. You can apply the same updates to other contact types by checking **Contact Type** boxes – or the **Select All** box, which automatically checks all contact types you have access to. In some cases, you may find it takes time to receive these messages through your newly specified email, and you may temporarily receive them as you did before.

If you don't see your name in the drop-down list, you can add it through the **Manage My Organization** dashboard. For the contracting contact, you may have multiple provider names in the left pane, so select the name(s) you want to update.

A **Contact Preference Quick Reference Guide** is available under the **Payer Spaces Resources** tab in Availity. If you have questions, please log in to Availity or contact eBusiness Technical Support at **(423) 535-5717, option 2**.

Coming Soon: New Inquiry, Reconsiderations and Appeals Tool in Availity

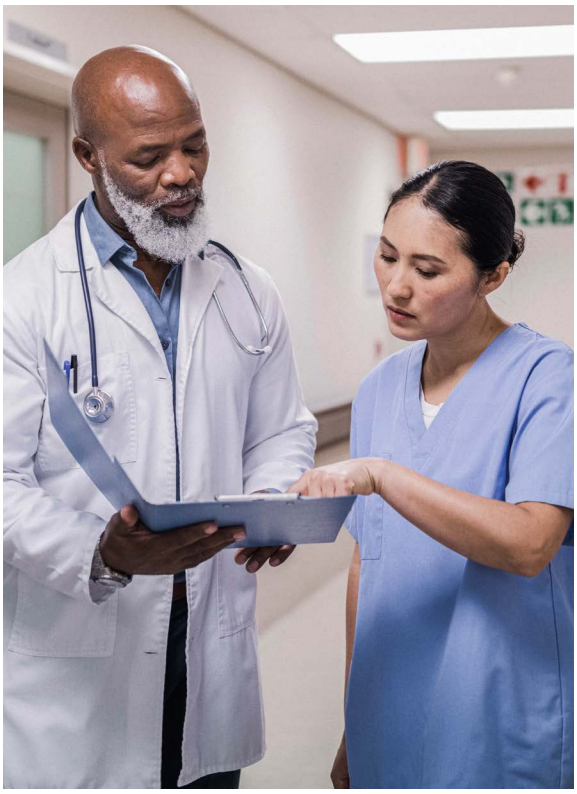
We're excited to announce our new online inquiry, reconsiderations and appeals tool in Availity is coming soon. Providers currently submit by phone, fax, mail and email. This new tool will streamline that process. For more information, please contact your **eBusiness Regional Marketing Consultant**.

Change of Ownership Reminder

If you are acquiring or being acquired by a provider facility or group, you must give us at least 60 days advance notice of change of ownership (CHOW). You also need to submit a CHOW notification using the **Provider Change of Ownership Notification Form**.

Once the transaction has closed, send us a copy of the executed bill of sale or purchase document (minus the purchase price) within five business days of closing. If you don't provide the required notice or documents, your payments could be impacted. For more details about CHOW requirements, please consult your BlueCross provider agreement or our PAM.

You can also find additional information in the Frequently Asked Questions document **here**.



Buprenorphine Medication Assisted Treatment (BMAT) Program Closure

We're ending the BMAT program and its related codes for our Commercial and Medicare Advantage lines of business. This will be a gradual process, and we don't have a set end date. Providers currently participating in the program can continue billing BMAT and other associated codes according to their provider agreement and within their scope of practice and licensure. But we aren't enrolling any new providers into the BMAT program.

We'll share more information as it's available in future issues of BlueAlert and in our Provider Administration Manuals. We'll also contact providers in the BMAT program when the codes are no longer available for use. If you have questions, please contact your Provider Network Manager.

Please note: This article only applies to our Commercial and Medicare Advantage networks. It doesn't affect our BlueCare Tennessee Buprenorphine Enhanced and Supportive Medication-Assisted Recovery and Treatment (BESMART) program for TennCare members.

New Prior Authorization Submission Process Expands to All Lines of Business

We recently began using Cohere Health technology to manage most prior authorizations for our Commercial members. In December, we're expanding the use of this technology to all lines of business. In addition to our Commercial plans, this will also apply to:

- BlueCare Tennessee
- BlueAdvantage (PPO)SM
- BlueCare Plus Tennessee

For your convenience, you'll continue to submit requests directly to us through Availity. To learn more about this update, join our webinar hosted by eBusiness (dates forthcoming).

If you have questions about using Availity, please call **(423) 535-5717, option 2**, or contact your **eBusiness Regional Marketing Consultant**.

Commercial

This information applies to Blue Network P℠, Blue Network S℠, Blue Network L℠ and Blue Network E℠ unless specifically identified below.

Authorizations for Out-of-State Members

Prior authorization requests for out-of-state members can be submitted electronically through Availity. To do this, simply:

- Log in to Availity.
- Select the **Authorization and Referrals** tile.
- Select **Payer** and **Request** type.
- Enter the ordering/requesting provider information and complete all necessary fields.
- The three-digit member prefix will single sign-on (SSO) over to the member's Home Plan to complete the authorization.

View the **InterPlan tool** for specific medical policy or prior authorization details based on the member's three-digit prefix. You can also reach out to your **eBusiness Regional Marketing Consultant**.

Future Updates: See the Latest and What Changes Are on the Way

Please review the table below to find the latest information from us and what changes are on the way. If you have questions, please contact your Provider Network Manager. If you're unsure who that is, go to **My BlueCross Contact**. For questions about medical policy updates, please send an email to **medical_policy@bcbst.com**.

Update Type	Availability	Where to Find It
Coding Updates	60 days before the effective date	Go to the **Coverage & Claims** page on **provider.bcbst.com**. Updates are located under Coding Updates in the Coding Information section.
Lab Testing Policies	60 days before the effective date	Go to the **Documents & Forms** page on **provider.bcbst.com**.
Upcoming Prior Authorization Changes	60 days before the effective date	Go to the **Documents & Forms** page on **provider.bcbst.com**. Updates are located under Upcoming Prior Authorization Changes in the News & Updates section.
Pharmacy Updates	Updated as needed	Download a summary of select upcoming drug prior authorization criteria changes **here**.
Medical Policy Updates	60 days before the effective date	Go to the Manuals, Policies & Guidelines page on **provider.bcbst.com**. Updates are located under **Coverage**.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids plans unless specifically identified below.

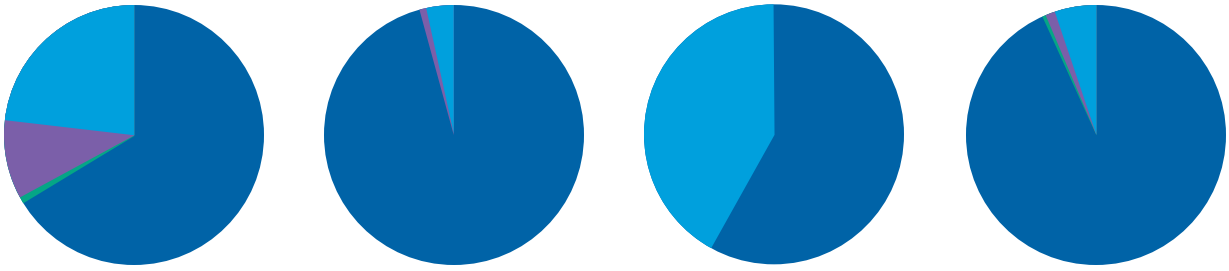
New Billing Requirement for CPT® Code 81420

Beginning **Dec. 1, 2025**, providers will only be able to bill one unit of CPT® code 81420 (fetal chromosomal aneuploidy genomic analysis panel, circulating cell-free fetal DNA in maternal blood, including analysis of chromosomes 13, 18 and 21) in a 10-month period. This code is used for one-time testing during pregnancy, so we'll deny claims for multiple units billed for the same patient within a 10-month period.

This change applies to all BlueCare Tennessee members. If you have questions, please call the Provider Service line for your patient's plan.

Member Demographics

To deliver culturally competent care, promote health equity and reduce health disparities, it's important to understand the demographics of our BlueCare Tennessee membership. As of **Dec. 31, 2024**, we had 585,361 members. Below is a breakdown of our population by race, ethnicity, gender and language:



Race

- **66.3%** White
- **23.2%** Black
- **9.8%** Other
- **0.8%** Unknown

Ethnicity

- **95.8%** Non-Hispanic
- **3.4%** Hispanic
- **0.8%** Unknown

Gender

- **58.1%** Female
- **41.9%** Male

Language*

- **93.1%** English
- **5.2%** Spanish
- **0.4%** Arabic
- **1.1%** Other

*Primary language information was missing for 0.2% of the population surveyed.

Coming Soon: School-Based Services Provider Webinar

We're hosting a virtual meeting about school-based medical services for providers and school systems on **Nov. 12, 2025**, from **1 to 2 p.m. CT** (2 to 3 p.m. ET).

During the webinar, we'll cover key updates and guidelines for Medicaid reimbursement, as well as tips for accurate documentation and coding. We'll also set aside time to answer your questions.

We encourage all school nurses, nurse practitioners, physicians, special education directors and administrators involved in school-based health care delivery to join us. Complete our **registration form** to save your spot.

Important Reminder for Filing Electronic Claims

To help us correctly identify whether a claim is a crossover (cost share) or secondary claim (including Medicare non-covered services), please follow these guidelines:

- Use the correct insurance indicator and policy number.
- Crossover (cost share) claims are identified by the 2000B Loop (Subscriber Info) section of your electronic claim. Use "16" in SBR09 to show the claim is secondary to Medicare, a Dual Special Needs Plan or a Medicare Advantage plan.
- For all secondary claims, the 2320 Loop (Other Subscriber Info) includes the patient's other insurance. Continue using MA, MB, OF or 16 in SBR09 for Medicare or the appropriate Commercial indicator (e.g., 12, BL, CI, HM) depending on the primary insurance type — just like you do today. You can view a full list of indicators **here**.

Using the correct indicators helps prevent claim denials, avoid payment delays and ensure accurate coordination of benefits.

Gestational Diabetes Awareness

November is American Diabetes Awareness Month, so now's a good time to talk with your patients and their families about gestational diabetes. According to March of Dimes, 6% of pregnant people in the United States will develop it.

Most people with gestational diabetes don't have symptoms. So it's important to check with your patients during their visits.

You can encourage patients to lower their risk by:

- Maintaining a healthy weight (if they're not pregnant yet).
- Gaining a healthy amount of weight (if they're already pregnant).
- Doing physical activity.
- Eating a healthy diet.

Gestational diabetes usually goes away after the baby is born. But it's important to be aware that it can increase the mother's risk of developing type 2 diabetes later.

Keep an eye on your patients and work with them closely. This can help them maintain their health.

EPSDT Documentation and Claims Tips

Document All Seven Components of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Exams

When a patient visits your office for their well-child checkup, please document all seven required parts of the EPSDT exam, as well as assessments of their nutrition and physical activity. Each exam should include documentation of:

- Comprehensive health (physical and mental) and developmental history
- Initial and interval history
- Developmental/behavioral assessment
- Comprehensive, unclothed physical exam
- Vision screening
- Hearing screening
- Lab tests
- Immunizations
- Health education/anticipatory guidance

Claims submitted for EPSDT visits must match your patients' medical records and include codes for all required components. Additionally, your patients' medical records should match the EPSDT record you send us and include all care given during the exam.

If you're unable to complete a checkup because a patient is uncooperative, deferred or refused any part of the exam, please include this information in the patient's medical record.

For more information, view our **Partners in Prevention booklet** for providers.

Review the Health Care for Adults with Intellectual and Developmental Disabilities (IDD) Tool Kit

Remember to use this helpful resource for providing primary care to adults with IDD.

Developed for primary care providers (PCPs) by Vanderbilt University Medical Center and the Vanderbilt Kennedy Center, the **Health Care for Adults with IDD Toolkit** offers best-practice tools and information about specific medical and behavioral health concerns, including resources for patients and families. While the toolkit is geared toward adult patients, it contains useful information for all PCPs, including those caring for children and young adults.

We've also launched an IDD resource toolkit for BlueCare Tennessee members on our website. These resources can help guide members and their families through a diagnosis and connect them with resources and the IDD community. **Click here** to view the member toolkit.

TennCare Dental Benefit Manager Change

As of **Nov. 1, 2025**, Renaissance is the new dental benefit manager for BlueCare Tennessee members. Member benefits will stay the same, and your patients can still get dental cleanings, X-rays and other dental care with limits. If your patients have questions about their dental benefits, please tell them to call Renaissance at **1-866-864-2526**. For more information about your patients' dental benefits, visit TennCare's **Dental Services** page.

New Behavioral Health Same Day Notice (SDN) Forms

TennCare recently supplied SDN forms in English and Spanish for provider use. Behavioral Health providers are required to review the form with all members age 21 and older and have them sign it before discharging them from the following levels of care:

- Inpatient psych/dual
- Inpatient rehab
- Residential treatment
- Inpatient detox
- Subacute

You can view and download these forms on the **Documents and Forms** page of **bluecare.bcbst.com/providers**. Select **Behavioral Health** and click **Forms** to expand the drop-down menu.

Coming Soon: Abortion, Sterilization or Hysterectomy (ASH) Claims Review

We're reviewing BlueCare, TennCare*Select* and CoverKids claims that include an ASH code submitted with a date of service between July 1, 2024, and June 30, 2025. The retrospective ASH review includes an in-depth look at documents that may not have been required at the time claims were submitted. If you submitted a claim with an ASH code between these dates, we may contact you for additional records. **Note:** We may recover payment if we don't receive records within the requested time frame.

If you have questions about ASH review or ASH claims guidelines, please see the **BlueCare Tennessee Provider Administration Manual** or contact your Provider Network Manager.

Your Source for Division of TennCare Announcements

You can view announcements from TennCare in the **News and Updates** section of **bluecare.bcbst.com/providers**. These announcements replace the TennCare Provider Experience newsletter. We'll update them quarterly, so check back frequently for news you need.

BlueCare Plus Tennessee and Medicare Advantage

This information applies to our Medicare Advantage and BlueCare Plus Tennessee plans unless specifically identified below.

New Post-Acute Care Partnership with tango and WellSky®

Effective **Feb. 1, 2026**, we'll begin working with tango and WellSky to manage skilled home health and post-acute facility services for Medicare and Medicaid dual-eligible special needs plans.

tango

Skilled home health services – nursing, therapy, aid, and social work

WellSky

Post-acute facility services – skilled nursing facilities, inpatient rehab facilities, and long-term acute care hospitals

We'll work with tango and WellSky to help manage:

- Referral coordination
- Prior authorization and continued stay reviews
- Transition of care support
- Provider and member experience oversight

If you have questions, please contact one of the options below:

- Home Health – **contractmanagement@tangocare.com**
- Post-acute – **PACSupport@WellSky.com**
- Phone – **1-888-224-1409**
- Web – **providerresourcecenter.com/bcbstn**

BlueCare Plus Tennessee

This information applies to our Medicare and Medicaid dual-eligible special needs plans unless specifically identified below.

Upcoming Changes for BlueCare Plus Tennessee Dual Eligible Members

Starting **Jan. 1, 2026**, we'll be making important updates to improve care for members with both Medicare and Medicaid. These changes will help make getting care easier and more coordinated for members. This will also simplify the claims process for providers.

What's changing?

Members who have BlueCare Plus and BlueCare Medicaid will be moved to one of the BlueCare Plus Fully Integrated Dual Eligible (FIDE) plans. This change only affects people who are dually eligible and currently enrolled in BlueCare Medicaid.

What does this mean for members?

These members will have their Medicare and Medicaid services managed under one plan. Members will get one ID card for both Medicare and Medicaid services, and the card will show the BlueCare Plus Tennessee plan name and policy number.

What does this mean for providers?

You'll send all claims (Medicare and Medicaid) to BlueCare Plus Tennessee. You won't need to submit a separate claim to BlueCare Medicaid. This will help make billing simpler and reduce delays.

Prior authorization requests for services will also go to BlueCare Plus Tennessee, using the member's BlueCare Plus ID number (usually starts with ZEUY or ZEU9).

What are self-service options for providers?

To support these changes, providers should continue to use Availity to:

- Check member eligibility
- View claim status
- Submit prior authorization requests or check the status

Note: BlueCare Plus Tennessee offers three plans. This update applies **only** to members with **BlueCare Plus (HMO D-SNP)℠** and **BlueCare Plus Choice (HMO D-SNP)℠** plans who are also enrolled in BlueCare Medicaid.

Reminder: Complete the 2025 Special Needs Plan Model of Care (MOC) Training

Providers participating in BlueCare Plus Tennessee special needs plans are contractually required to complete our MOC training after initial contracting, then every year afterward. This training promotes quality of care and cost effectiveness through coordinated care for our members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by **clicking here**.

Medicare Advantage

This information applies to our Medicare plans unless specifically identified below.

Exciting News: New C-SNP Launching in 2026 for Members with Diabetes and Heart Disease

We are excited to announce the launch of a new Chronic Special Needs Plan (C-SNP) beginning in 2026. This innovative plan is specifically designed to provide tailored benefits and enhanced care coordination for individuals living with diabetes and/or heart disease. This plan reflects our ongoing commitment to improving the outcomes for these members with chronic conditions.

Healthcare providers play a crucial role in the success of this plan. During the enrollment process, providers will be requested to attest that their patients have the necessary underlying conditions to qualify for the C-SNP. Proper completion of this attestation will enable us to deliver personalized, high-quality care that meets the unique needs of this population.

For more information about the upcoming C-SNP or any questions, please contact your Provider Outreach or Network Representative.

Quality Care Initiatives

This information applies to all lines of business unless specifically identified below.

Helping Your Patients Manage Diabetes

November is American Diabetes Awareness Month, so now's a good time to schedule screenings and talk with your patients and their families about diabetes and the importance of preventive screenings. Help your patients understand the role of chronically elevated insulin levels in elevated glucose, HgbA1c and the complications of diabetes. In addition, be aware that patients may have normal fasting blood glucose and HgbA1c and still have severe metabolic dysfunction secondary to hyperinsulinemia.

Diabetes is the most common chronic condition in Tennessee, and it can lead to many other long-term diseases and complications. Diabetes also has unique features that make management difficult. Diabetic patients are at risk of developing serious complications like kidney disease, visual impairment, poor wound healing, heart attack, stroke and depression. In addition to these common complications, hyperinsulinemia may be associated with an increased risk of cancer, auto-immune disease and vascular disease. That's why it's important for providers to educate patients about the importance of screenings.

HEDIS® Diabetes measures include:

- **Blood Pressure Control for Patients with Diabetes (BPD):** Patients 18-75 years old identified with diabetes (types 1 or 2) should have a controlled blood pressure of less than 140/90 as their most recent documented result during the measurement year.
- **Eye Exam for Patients with Diabetes (EED):** Patients 18-75 years old identified with diabetes (types 1 or 2) should have a retinal or dilated eye exam by an eye care professional or interpreted by an eye care professional during the measurement year.
- **Glycemic Status Assessment for Patients with Diabetes <8.0:** Patients 18-75 years old identified with diabetes (types 1 or 2) should have their most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) reading during the measurement year documented as <8.0
- **Statin Therapy for Patients with Diabetes - Received Statin Therapy (SPD):** Patients 40-75 years old identified with diabetes (types 1 or 2) that do not have clinical atherosclerotic cardiovascular disease (ASCVD) should be placed on a statin medication of any intensity during the measurement year.
- **Statin Adherence 80% (SPD):** Patients 40-75 years old identified with diabetes (types 1 or 2) that do not have clinical ASCVD should remain on their statin medication for at least 80% of their treatment period during the measurement year.
- **Kidney Health Evaluation for Patients with Diabetes (KED):** Patients 18-85 years old identified with diabetes (types 1 or 2) should have an estimated glomerular filtration rate (eGFR) AND a urine albumin-creatinine ratio (uACR) during the measurement year.

THCII Episodes of Care Quarterly Report Release

New quarterly reports for Medicaid and Commercial Episodes of Care quarterbacks will be available **Nov. 20, 2025**. If you're a quarterback having trouble accessing your quarterly report, please call **(423) 535-5717, option 2**, or email **eBusiness_Service@bcbst.com**.

Understanding ADHD and the ADD HEDIS® Measure

Attention-Deficit/Hyperactivity Disorder (ADHD) is one of the most common neurodevelopmental disorders diagnosed in children. Effective treatment often includes medication, behavioral therapy and regular follow-up care. To ensure quality and consistency in care, the Healthcare Effectiveness Data and Information Set (HEDIS) includes a specific measure for ADHD medication management—known as the ADD measure. This measure evaluates whether children newly prescribed ADHD medication receive appropriate follow-up care, which is critical for monitoring effectiveness, side effects and adherence.

ADD HEDIS Measure Overview

The ADD HEDIS measure tracks the percentage of children ages 6–12 who are newly prescribed ADHD medication and receive timely follow-up care. It includes two key phases:

- **Initiation Phase:** The percentage of children who had one follow-up visit with a practitioner with prescribing authority within 30 days of the first ADHD medication being dispensed.
- **Continuation and Maintenance (C&M) Phase:** The percentage of children who remained on ADHD medication for at least 210 days and, in addition to the initiation visit, had at least two follow-up visits with a practitioner within the subsequent 270 days (9 months).

Practical Tips for Providers

To improve performance on the ADD HEDIS measure and ensure high-quality care for children with ADHD, providers can adopt the following strategies:

- **Educate all staff:** Make sure that everyone in your practice is aware of the importance of follow-up visits and committed to the scheduling protocol. Consider making this a priority during annual reviews.
- **Link prescriptions to appointments:** Require a follow-up appointment for additional prescriptions. Prescribe only enough medication to last until the next recommended visit.
- **Schedule before patients leave:** Put systems in place that prompt staff to schedule follow-up appointments before the current visit ends.
- **Make appointments convenient:** When possible, combine medication follow-ups with therapy sessions to reduce the burden on families.
- **Expand access:** If staffing is limited, consider offering evening and weekend clinic hours to accommodate more patients.
- **Use telehealth:** Offer virtual visits when appropriate to improve access and reduce missed appointments.
- **Send reminders:** Use text, email or phone reminders to reduce no-show rates and keep families engaged in care.

Pharmacy

This information applies to all lines of business unless specifically identified below.

BlueCare Tennessee Prescription Limit

As of **Aug. 1, 2025**, the Division of TennCare lifted prescription limits on generic drugs for adult TennCare members. Previously, members aged 21 and older were limited to five prescription drug fills and refills each month. Now, members may fill as many generic prescriptions as they need.

Please note: TennCare still has a monthly limit on brand-name prescriptions. TennCare members are limited to two brand-name prescription fills and refills monthly, unless the brand-name medication is on the **Auto-Exempt and Attestation Drug List**.

If your patients have questions about their prescription drug coverage, please ask them to call their pharmacy benefit manager at **1-888-816-1680**.

2026 Drug List Changes

Each year, we review our drug lists and make changes based on a drug's safety, effectiveness and affordability. Although many of these changes happen at the beginning of the year, they may occur at any time because of market changes. These can include, but aren't limited to:

- Release of new drugs to the market after FDA approval
- Removal of drugs from the market by the FDA
- Release of new generic drugs to the market

Please visit the following links on the Pharmacy Resources & Forms page to view the 2026 drug list changes:

- To see the 2026 Preferred Formulary and 2026 Essential Formulary changes, click **here**.
- To see the 2026 BlueAdvantage Formulary and 2026 BlueAdvantage Extra (PPO)℠ formulary, click **here**.
- To see the 2026 BlueCare Plus Formulary, click **here**.

Biosimilar Drugs

Effective **Jan. 1, 2026**, we're removing Humira (adalimumab) from our Essential and Essential Plus Formularies. We'll cover these biosimilars instead:

- Simlandi
- Adalimumab-adaz
- Hadlima

Additionally, we'll be removing Stelara from the Preferred, Essential, and Essential Plus Formularies. We'll cover these biosimilars instead:

- Selarsdi
- Imuldosa
- Yesintek

We wanted to prepare you so you can:

- Proactively update members' prescriptions.
- Be prepared to answer questions about the preferred options.

We'll be mailing members to notify them of the change. We'll also send providers a letter with a list of impacted members. We're loading new prior authorizations for the biosimilars to make sure members have a smooth transtion with no additional prior authorization requests required.

If you have any questions, please reach out to the provider support team. We appreciate the care you provide to our members.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

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BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
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CHOICES	1-888-747-8955
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Phone: Select Option 2 at	(423) 535-5717
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Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice or facility:

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