SEPTEMBER 2026

BlueAlert℠

Mission driven FOR 80 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.

Keep Your Information Current

Please make sure your information is up to date in your **DataSpring** (formerly CAQH) account. This helps us reach you with important communications without delay.

INSIDE THIS ISSUE

Introducing Electronic Prior Authorization

Beginning in January 2027, you'll have a new way to submit and track prior authorization requests directly in your electronic health records (EHR). We're introducing electronic prior authorizations for all lines of business.

This new capability, powered through our partnership with 1upHealth, is designed to make the process easier by reducing phone calls, faxes and manual requests.

What this means for your practice: fewer manual steps, less back-and-forth and a more predictable workflow for prior authorizations.

Click here to learn more about how it works and how to prepare.

Provider Wait Time Surveys Coming Soon

If you haven't already, you'll soon receive our 2026 Provider Wait Time Survey. Please take a few minutes to complete it and share your feedback. Your input helps us improve how we support you.

Hospital Readmission Reduction Quality Programs Start Oct. 1, 2026

We're launching new Readmission Reduction Quality Programs for commercial medical and behavioral health inpatient admissions for all lines of business beginning Oct. 1, 2026.

What You Need to Know

- The programs focus on readmissions for the same or a similar diagnosis within 30 days of discharge.
- Readmissions within 48 hours may be considered part of the original admission and may not qualify for separate reimbursement.
- Readmissions occurring three to 30 days after discharge may be reimbursed at a reduced rate.
- The programs are reimbursement policies and aren't based on retrospective medical necessity reviews.

Exclusions

Several admission types are excluded, including but not limited to certain behavioral health services, observation stays, NICU admissions, phased treatments, active cancer and obstetrical treatments and those for members age 17 and younger. Refer to the Provider Administration Manual for full details.

Effective Date

The programs apply to inpatient admissions with index admission discharge dates on or after Oct. 1, 2026.
For commercial medical admissions, this program will replace the current 14-day readmission program. Existing medical readmission reduction programs for BlueCare Tennessee, Medicare Advantage and BlueCare Plus Tennessee products won't change.

Select the Correct ED Admission Category

When you submit an acute inpatient admission request in Cohere, be sure to select the correct admission category if the member entered the hospital through the emergency department (ED). Don't use ED categories for direct admissions from a provider's office.

Choosing the right category in Cohere may help lead to immediate approvals when the member meets all clinical requirements. Select Psychiatric Emergency (ED Admission) for behavioral health admissions. Select Medical Emergency (ED Admission) for medical/surgical admissions.

Benefits of selecting the correct category:

- Receive authorization decisions faster
- Reduce administrative work
- Confirm approval status sooner
- Improve efficiency for you and your patients

By selecting the correct ED admission category, you help us review requests more quickly and process authorizations as efficiently as possible.

ID Card Update – Suitcase Logo Removal

We're implementing a phased update to Member ID cards that removes the "suitcase" logo and replaces it with a product indicator (such as PPO or HMO).

This change won't require a full reissue of Member ID cards. Updated cards will be issued through normal business processes, including new enrollments, renewals and replacement card requests.

What to Expect

- Both current and updated ID card designs will remain in circulation during the transition period.
- The transition will occur gradually over the next several years.
- There's no impact to member benefits, eligibility or network access.
- Providers should continue to verify eligibility and benefits through their normal processes.

What's Changing

Exsisting Suitcase	New Product Indicatior	Applies To
PPO	PPO	Commercial
	TRAD	Commercial groups Quantum Health and Paramount Global
Blue HPN	BlueHPN	Commercial HPN groups
NetworkBlue PPO	PPO	Commercial groups with an alternate network
Blue Open Access POS PPO	PPO	Commercial groups with an alternate network
	EPO	On/off Marketplace
MA PPO MEDICARE ADVANTAGE	MA PPO	Medicare Advantage

Secure File Transfer Process (SFTP) Security Update: Action Needed

We're updating how data is securely sent to us. Password-based SFTP access will be replaced with Secure Shell (SSH) key authentication to better protect sensitive information.

What to Know

- Deadline: **Jan. 31, 2027**
- SSH keys will replace passwords for SFTP access.

What You Need to Do

If you use SFTP with a password:

- Create an SSH key with your IT team or vendor.
- Email your SFTP username and public key to **IO_SecureFile_Transfer@bcbst.com**.

No Action Needed If

- You already use SSH keys.
- You use the web portal for file access.

Questions?

Contact **IO_SecureFile_Transfer@bcbst.com**.

Medical Record Submission Reminder

As a reminder, all contracted providers are required to cooperate with audit and medical record requests according to the terms of their provider agreement. This includes submitting complete and timely medical records when requested for Risk Adjustment Data Validation, requests from the Office of Inspector General and other regulatory or audit activities.

Failure to submit requested medical records may be considered non compliant with contractual obligations and may result in corrective action, including removal from our networks.

We encourage providers to adopt appropriate processes for responding to future record requests. If there are circumstances that could impact your ability to comply (such as practice closure or record transfers), please notify your Network Manager in advance.

Change of Ownership Reminder

If you're acquiring or being acquired by a provider facility or group, you must give us at least 60 days advance written 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 check your Provider Administration Manual (PAM). You can also find additional information in the FAQs document **here**.

Update Your Contact Preference in Availity®

To make sure you receive important provider enrollment and contracting information as soon as it's available, please update your contracting contact preference in Availity.

When you choose email as your Contracting contact preference, you'll receive email updates about contracts, fee schedules, PAMs, medical policies and annual performance ratings.

To update your preference, log in to BlueCross Payer Spaces in Availity. Open the **Contact Preferences & Communication Viewer** and select email for Contracting communications. Before saving your changes, be sure to add or confirm a contact name and email address.

If you need help, you can find a **Contact Preference Quick Reference Guide** under the **Payer Spaces Resources** tab. Please note, changes may not take effect right away, and you may still get some mail during the transition.

For extra help, contact eBusiness Technical Support at **423-535-5717, option 2**.

Inquiries, Reconsiderations and Appeals Must Be Submitted in Availity

Effective **April 1, 2026**, all providers must submit inquiries, reconsiderations and appeals through our claims dispute tool in Availity.

What you need to know:

- We no longer accept submissions by fax, mail or email.
- This applies to:
  - In-network providers.*
  - Out-of-network providers with a practicing address in Tennessee.**
- Forms are no longer required for reconsiderations or appeals submitted through Availity.
  - You must still enter the reason for your request in the appropriate Availity field.
  - Additionally, if you received a request to submit medical records, please follow the instructions included in the notification.
- If you identify an overpayment, submit it as a general inquiry in Availity.
  - Use this process until we announce a permanent overpayment submission option.
  - Previously, the "Think you have an overpayment" form was used.

For more information, please see our additional resources in our Payer Spaces in Availity or contact your **eBusiness Network Manager**.

*Please note, this doesn't apply to inquiries, reconsiderations or appeals for routine dental service claims performed by dental providers. It also doesn't apply to Utilization Management denials.

**Out-of-network providers who wish to submit an inquiry, reconsideration or appeal for review must still submit through Availity.

Updates to the Durable Medical Equipment Network

As of **March 6, 2026**, we've contracted with CareCentrix to manage our durable medical equipment (DME) network. This change supports our broader efforts to address rising health care costs while maintaining members' access to the DME services and products you currently order for your patients.

For DME items that don't require prior authorization, BlueCross participating providers should place orders through the DME Navigator portal, which Parachute Health manages. You can access the portal via a tile in Availity. Once in DME Navigator, you can select an in-network DME supplier.

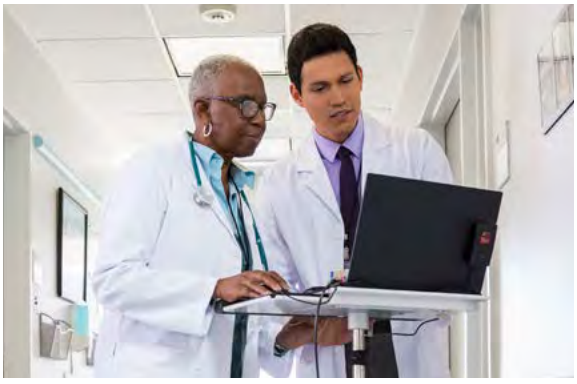
For DME requiring prior authorization, continue following the current BlueCross prior authorization process through Availity. Or, if you send an order directly to an in-network DME supplier, the supplier will initiate the prior authorization request.

We'll continue reviewing DME prior authorization requests in-house through the first half of 2027. After that, CareCentrix will begin reviewing and approving prior authorization requests for all networks. That process will start either in Availity or the DME Navigator portal. We'll share more information about that process once we have an implementation date for this transition.

If you have questions, please contact your Provider Network Manager.

Commercial

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



You May Soon Submit FEP and PSHB Prior Approvals and Pre-determinations Through Availity

You'll soon be able to submit prior approval and pre-determination requests for Federal Employee Program and Postal Service Health Benefits plan members in Availity. This change will simplify and streamline the prior approval and pre-determination request process so that we can provide faster, more efficient responses to requests. Watch for more information in an upcoming BlueAlert.

Understanding the Behavioral Health (BH) Comprehensive Network

Medical providers are typically contracted for specific, regional commercial networks.

BH providers are contracted into the BH Comprehensive Network, which automatically includes all commercial networks (P, S, L and E). These providers are considered in-network for any member with a commercial plan.

Multi-Specialty Group Practices

Some health care group practices include both medical and BH providers. While the BH provider may be in-network due to the BH Comprehensive Network, the medical provider in the same practice might not be in-network for the member's specific commercial plan.

Example 1:

- The member's policy uses Network S.
- The health care group practice is contracted only in Network P and the BH Comprehensive Network.
- The member would have in-network benefits with the BH provider, because the BH Comprehensive Network covers all networks.
- The medical providers in the group would be out-of-network for the member because they only participate in Network P.

Example 2:

- The member's policy uses Network S.
- The health care group practice is contracted in Network P and S and the BH Comprehensive Network.
- In this example, the member would have in-network benefits with the BH providers and medical providers, because the BH Comprehensive Network covers all networks, and the group is in the member's network.

Updates at a Glance: What's New and What's Coming

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 **Documents & Forms** page on **provider.bcbst.com**. Updates are located under **Code Edits/Code Updates** in the **News & Updates** 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**.

Commercial and Medicare Advantage

This information applies to all our commercial networks and Medicare Advantage.

New QR Code Requirement

Effective **July 31, 2026**, all exported PAF and CPAF assessments will include a required QR code on every page for Quality Care Rewards application uploads. Forms submitted after this date with missing QR codes will be rejected.

BlueCare Tennessee

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

Sickle Cell Awareness Month: Key Strategies to Improve Outcomes

Sickle cell disease (SCD) is a chronic condition associated with pain crises, organ damage and frequent ER visits. Providers can help improve outcomes by focusing on preventive care, disease-modifying therapy, routine screening and care coordination.

Prioritize Preventive Care

Patients with SCD are at increased risk for serious infections.

Recommended actions:

- Educate patients to seek immediate medical evaluation for fever ≥ 101.3°F (38.5°C).
- Keep vaccinations current.
- Review immunization status during routine visits.
- Educate patients and caregivers on the importance of preventive care.

Support Disease-Modifying Therapy

Hydroxyurea remains the cornerstone of SCD treatment and is recommended for many children and adults with SCD.

Benefits include:

- Fewer pain crises
- Reduced hospitalizations
- Improved anemia and clinical stability

At each visit:

- Assess medication adherence.
- Address barriers such as side effects, lab monitoring and access to medications.
- Engage care management and pharmacy resources when needed.

Additional disease-modifying therapies may be appropriate for selected patients and should be individualized in consultation with a hematology specialist.

Advanced and Curative Therapies

For eligible patients with severe disease:

- Hematopoietic stem cell transplant remains an established curative option.
- Emerging gene therapies may reduce disease burden in carefully selected patients.

Consider a referral to specialty centers for multidisciplinary evaluation.

Note: Pre-pregnancy counseling is essential to optimize health, review medications, coordinate high-risk obstetric care and provide genetic counseling.

Screen for Complications Early

Routine monitoring can help identify complications before they progress.

Recommended screening includes:

- Stroke risk assessment (including transcranial Doppler when appropriate)
- Retinopathy screening
- Renal function monitoring
- Cardiopulmonary and vascular risk assessment

BlueCare Tennessee supports these services when provided in appropriate settings.

Coordinate Care Across the Continuum

A multidisciplinary approach is critical for long-term disease management.

Encourage patients to:

- Maintain regular follow-up visits.
- Stay hydrated.
- Avoid temperature extremes and hypoxia.
- Balance activity with rest.
- Practice infection prevention.
- Address behavioral health needs.

BlueCare Population Health Support

The BlueCare Population Health team can help with:

- Care coordination and specialist access
- Medication adherence support
- Transportation and social needs assistance
- Complex case management for high-risk members

How to Refer to BlueCare Population Health

- Call **888-416-3025**.
- Submit a referral in Availity.

Setting Up Standing Transportation

If a member has a standing appointment for three consecutive weeks or longer, Verida can set up rides for them on the same day at the same time each week. Examples include treatments such as chemotherapy, dialysis, behavioral health or physical therapy. To arrange this service, contact Verida's customer service team and complete the required form. Setting up a standing order means members don't need to call each time to schedule their non-emergency medical transportation.

- For BlueCare members, call **855-735-4660**.
- For TennCare*Select* members, call **866-473-7565**.
- Or fax **423-370-1422**.

How Teams Are Reaching 80% EPSDT Completion

Getting children in for annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) checkups can be challenging. Practices with strong screening rates often use simple processes that help families stay on track.

Make Every Visit Count

If a child is due for an EPSDT visit, look for chances to complete it during other appointments. When appropriate, a sick visit and a well-child visit can happen on the same day. This helps reduce missed opportunities and saves families an extra trip.

Consider these proven strategies:

1. Schedule all six visits during the first 15 months of life at the infant's first appointment.
2. Convert sports physicals to well-child exams when appropriate.
3. Combine a well-child visit with visits for other types of services, such as acute care.
4. Use electronic health/medical record tools to manage appointment scheduling and patient reminders.
5. Schedule the next EPSDT appointment at the end of each visit.

Keep Families Engaged

EPSDT completion rates often drop during the teen years. Regular reminders can help adolescents stay up to date on preventive care.

Many parents don't realize how important annual checkups are, especially when their child seems healthy. A quick conversation about the benefits of preventive care can encourage families to schedule and keep appointments.

Use Simple Office Workflows

Sometimes, adjusting office processes or hours can help promote EPSDT visits. Consider these suggestions:

- Designate specific staff members to perform and manage well-child care.
- Offer alternative or extended office hours.
- Hold a daily huddle to identify patients who are due for preventive services.
- Ask about care received from other providers during every visit.
- Use checklists, templates and electronic health record (EHR) prompts to help staff complete and document all required EPSDT services.

Note: This information applies to BlueCare Tennessee and TennCareSelect members. It doesn't apply to CoverKids.

Protecting Moms and Babies

Vaccines are a safe and important way to protect pregnant patients and their babies from serious illnesses. The CDC and American College of Obstetricians and Gynecologists recommend three key vaccines during pregnancy:

- **Flu vaccine** – Recommended during flu season.
- **Tdap vaccine** – Given between 27 and 36 weeks of pregnancy.
- **RSV vaccine** – Given between 32 and 36 weeks of pregnancy during RSV season (typically September through January).

Providers play a key role in helping patients feel confident. Here's how:

- Speak clearly and confidently. For example, "You're 32 weeks pregnant and can get these vaccines today."
- Listen to concerns and answer questions with empathy.
- Share your own experience or that of other patients, when appropriate.
- Offer the vaccine in your office or refer patients to where they can get it.

Psychotropic Medication in Children and Young Adults

Psychotropic medications affect how the brain works and cause changes in mood, awareness, thoughts and feelings. They're typically prescribed to children and teens to manage conditions such as attention-deficit/hyperactivity disorder, anxiety, depression and mood disorders. Recently, increases in psychotropic medication use has led to concerns that some young patients are being misdiagnosed with psychiatric disorders and treated with inappropriate medications. Our goal is to help promote the safe and appropriate use of psychotropic medications in children with behavioral health disorders by sharing resources and best practices. If you have questions about psychotropic medication use, please call **800-367-3403** to speak with a board-certified psychiatrist or consult an expert about treatment.

Strategies for Successful Care

Consider these tips when treating young patients with psychotropic medications:

Develop a plan for short- and long-term monitoring. Consider the type of medication, side effect risks, the patient's need for ongoing psychosocial support and other factors when developing this plan. Keep in mind that children taking an antipsychotic medication need annual metabolic testing, including blood glucose and cholesterol testing.

Work with the Department of Children's Services (DCS) as needed. After performing an evaluation and proposing a treatment plan, educate families about the diagnosis, medication, expected benefits, potential side effects and alternatives to medication to ensure they can make an informed decision.

We're Here to Help

Short-term and long-term medication monitoring is medically necessary, and there are special considerations for children in DCS custody. The Tennessee Chapter of the American Academy of Pediatrics offers free training to help providers diagnose and manage patients with behavioral health needs. For more information about this training, visit **tnaap.org/programs/behip/behip-overview/**.

If your patient is in foster care, you must get consent from the child's regional nurse consultant before starting medication. Once treatment begins, DCS monitors the prescribing and drug use patterns of children in foster care to ensure these patients get safe, appropriate treatment. This may include working with DCS regional nurse consultants, the DCS chief medical officer or other personnel.

Medication Adherence for Children in DCS Custody and SSI

For children in DCS custody and those who receive Supplemental Security Income (SSI), taking medications as directed is an important part of staying healthy. Many of these children rely on medication to manage physical, behavioral or developmental health conditions.

When children take their medications regularly, they're less likely to have health crises, ER visits or hospital stays. They often have fewer behavior problems and experience fewer disruptions at home, in school and in their daily routines. Consistent medication use also helps providers see whether a treatment is working and make better care decisions.

Challenges to Medication Adherence

Children in DCS custody or receiving SSI may face challenges that make it harder to stay on track with medications. Changes in caregivers or living arrangements, transportation issues and limited understanding of why medications are needed can all lead to missed doses and worsening symptoms.

Providers can help by explaining medications in simple terms, keeping treatment plans as easy as possible, ensuring refills are available on time and working closely with caregivers and caseworkers. These steps can support better health and more stable outcomes.

The Importance of EPSDT Screenings

EPSDT screenings are an important part of care for children with intellectual and developmental disabilities (IDD) and those receiving SSI. EPSDT helps identify health concerns early and connects children to the services they need.

These screenings include physical, developmental, behavioral, dental, vision and hearing checkups. Because the needs of children with IDD or SSI can change quickly, regular screenings help providers identify concerns early and address them before they become larger problems.

The Provider's Role

Providers play a key role in helping children receive EPSDT services. Completing screenings on schedule, documenting results, and making referrals when needed helps reduce gaps in care and improves coordination with specialists, schools, and community resources.

Regular EPSDT screenings can help children maintain better health, participate more fully in school and daily activities, and gain access to services that support their growth, independence, and quality of life.

Important Reminders for Filing Crossover Claims

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

- Use the correct insurance indicator and policy number.
- Crossover claims are identified by the claim filing indicator located in the 2000B Loop (Subscriber Info) section of your electronic claim.
- Use "16" in SBR09 to show the claim is secondary to Medicare, a Dual Eligible Special Needs Plan (D-SNP) or a Medicare Advantage plan. For all secondary non-crossover claims, do not use "16" in the SBR09 for the 2000B Loop.
- 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.

Deadlines for Submitting Crossover Claims

Crossover claims should be limited to certain situations and should only occur after they've allowed at least 60 days for Medicare or D-SNP to cross the claim to BlueCare Tennessee.

Providers have 365 days from the date of service or 180 days from the paid date on the Medicare MSN-D-SNP Explanation of Benefits (EOB), whichever is greater, to submit a claim for cost-share reimbursement.

After the initial filing (within those timeframes), if BlueCare Tennessee rejects, returns or denies the claim, providers must resubmit the corrected claim within six months from the rejected, returned or denied date.

Telehealth Guidance for IECMH Service Delivery

We support the use of clinical best practices in service delivery. Please see below for updates about the delivery of Infant and Early Childhood Mental Health (IECMH) services.

Qualified Provider Requirements

An independently licensed clinician or a master's-level therapist working under the direct supervision of a licensed provider must complete assessments. This aligns with Tennessee Code Annotated § 33-1-101. The supervising entity must also be contracted with BlueCare.

Assessment Modality Expectations

In-person remains the preferred modality for the assessment components of this service. Telehealth may complement in-person care or serve as an alternative when clinically appropriate. Audiovisual telehealth with a visual connection is preferred over audio-only delivery.

Telehealth Assessment Documentation

For assessments completed through telehealth, documentation should include the clinical rationale for telehealth delivery, efforts made to provide the assessment in person, and any agency requirements for supervisor or program director approval.

Please note, all documentation remains subject to review for medical necessity and appropriateness of care. We'll incorporate this guidance into the joint **IECMH Program Description**.

BlueCare Plus Tennessee and Medicare Advantage

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

Coming Soon: New Radiation Oncology Partnership with CVS Caremark

Starting in October 2026, we're partnering with CVS Caremark Radiation Oncology to help manage radiation treatment services for members with cancer. Together, we'll work to improve care, support treatment decisions based on proven medical guidelines, and make the care experience easier for members.

How CVS Caremark Radiation Oncology Can Help

CVS Caremark Radiation Oncology will provide support for:

- Radiation treatment services and care management
- Prior authorization reviews
- Treatment plans that follow nationally recognized medical guidelines
- Care coordination and member support

What This Partnership Means

We'll work together to:

- Make prior authorization reviews more efficient.
- Support coordinated, evidence-based care.
- Strengthen collaboration with providers.
- Help ensure members receive the right care at the right time.

Important Submission Information

- Continue submitting medical radiation treatment requests to us through your current process.
- Submit oncology-related requests to CVS Caremark Radiation Oncology.
- Online authorizations are available through single sign-on.

Phone Numbers

- BlueCare Plus Tennessee: **800-299-1407**
- Medicare Advantage: **888-258-3864**

BlueCare Plus Tennessee

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

Complete the 2026 Special Needs Plans 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**.

Pharmacy

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

Using Disease-Modifying Therapies to Treat Multiple Sclerosis

According to the 2018 American Academy of Neurology, the European Committee for Treatment and Research of Multiple Sclerosis and the European Academy of Neurology, adherence to disease-modifying therapies (DMTs) is essential for effectively treating multiple sclerosis (MS). Improving adherence through proactive conversations and supportive strategies before beginning treatment may lead to better outcomes.

Comorbid conditions are common among patients with MS. Depression, anxiety, vascular risk factors, and behaviors like drinking and smoking are all associated with poorer clinical and functional outcomes in MS. Addressing these conditions before starting DMT may improve long term adherence.

There are four clinical subtypes of MS:

- Relapsing-remitting MS (RRMS), which is characterized by acute attacks followed by partial or full recovery. This is the most common form of MS, accounting for an estimated 85% to 90% of cases.
- Secondary progressive MS (SPMS) begins as RRMS, followed by gradual worsening, which may be accompanied by occasional relapses, remissions and plateaus. Transition to SPMS from RRMS usually occurs after 10 to 20 years.
- Primary progressive MS (PPMS) occurs in approximately 10% of patients with MS. Patients have a continuous and gradual decline in function without evidence of acute attacks.
- Clinically isolated syndrome (CIS) refers to the first episode of neurologic symptoms that lasts at least 24 hours and is caused by inflammation or demyelination in the CNS. Patients who experience a CIS may or may not develop MS.

Indications: Multiple Sclerosis Agents

Indication	MS, to improve walking	Relapsing forms of MS, to include CIS, RRMS, and active SPMS in adults	Relapsing forms of MS, to include RRMS and active in adults	PPMS in adults	SPMS, progressive relapsing, or RRMS to reduce neurologic disability and/or relapse frequency in adults
Ampyra (dalfampridine)	✓				
Aubagio (teriflunomide)		✓			
Avonex (interferon ß-1a)		✓			
Bafiertam (monomethyl fumarate)		✓			
Betaseron (interferon ß-1b)		✓			
Briumvi (ublituximab-xiiy)		✓			
Copaxone, Glatopa (glatiramer acetate)		✓			
Gilenya (fingolimod)		✓			
Kesimpta (ofatumumab)		✓			
Lemtrada (alemtuzumab)			✓		
Mavenclad (cladribine)			✓		
Mayzent (siponimod)		✓			
mitoxantrone					✓
Ocrevus (ocrelizumab)		✓		✓	
Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq)		✓		✓	
Plegridy		✓			
(peginterferon ß-1a)		✓			
Ponvory (ponesimod)		✓			
Rebif (interferon ß-1a)		✓			
Tascenso ODT (fingolimod)		✓			
Tecfidera (dimethyl fumarate)		✓			
Tysabri (natalizumab)		✓			
Vumerity (diroximel fumarate)		✓			
Zeposia (ozanimod)					

Common side effects of DMTs include:

- Influenza-like symptoms including musculoskeletal pain, fatigue, headache and thrombotic microangiopathy
- Chest pain, palpitations, tachycardia, anxiety, dyspnea, constriction of the throat or urticaria immediately following the injection (glatiramer)
- Headache, liver transaminase elevation, diarrhea, cough, influenza, sinusitis, back pain, abdominal pain and pain in extremities
- Increased risk of cutaneous malignancies, life-threatening and fatal infections, significant hepatic injury, and macular edema

Updates to Medical Policies for Select Specialty Medications

BlueCare Tennessee is updating medical policies that apply to the following medications:

- Vyepti®
- Tepezza®
- Exondys 51®

The updated policies are available under the Specialty Care tab on the **provider tools and resources page**.

These policy changes will take effect on **Sept. 30, 2026**.

What This Means for You

BlueCare Tennessee medical policies may differ from those in the broader Medical Policy Manual. When reviewing coverage criteria:

- Policies labeled "Applies to BlueCare Only" are specific to BlueCare Tennessee members.
- Policies labeled "Does Not Apply to BlueCare" apply to other lines of business.

To ensure accurate coverage determinations, please review the appropriate policy and label when prescribing or requesting authorization for these medications.

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 **800-468-9698** for BlueCare, **888-325-8386** for CoverKids or **800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **888-418-0008**.

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Federal Employee Program	800-572-1003
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BlueCare	800-468-9736
TennCare*Select*	800-276-1978
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CHOICES	888-747-8955
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Monday–Friday, 8 a.m. to 6 p.m. ET	
BlueCare Plus℠	800-299-1407
Seven days/week, 8 a.m. to 6 p.m. ET	
***Select* Community**	800-292-8196
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BlueAdvantage	800-924-7141
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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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