2025

Prior Authorization Criteria

For FHCP's Medical

Pharmacy Formulary

abatacept (Orencia)

Products Affected

- **Orencia Intravenous**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Must be prescribed by a rheumatologist. Must fail Kevzara, Simponi Aria, Renflexis, adalimumab, and Enbrel for shared indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be prescribed by a rheumatologist
Coverage Duration	Up to 12 months
Other Criteria	Orencia is indicated to treat rheumatoid arthritis, JIA, and Psoriatic arthritis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

ado-trastuzumab emtansine (Kadcyla)

Products Affected

- **Kadcyla**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Oncology
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Coverage will be based on failure of prior taxane and Herceptin (trastuzumab).

aflibercept (Zaltrap)

Products Affected

- **Zaltrap**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Oncologist/Hematologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Coverage will be based on failure or intolerance of Avastin.

alpha 1-antitrypsin (Prolastin)

Products Affected

- **Prolastin-C Intravenous Solution Reconstituted 1000 MG**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	FDA labeled contraindications.
Required Medical Information	Medical notes, previous treatment history, and associated studies. Patient must have documented progressive COPD.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months
Other Criteria	Patient must be a non-smoker. Serum Concentration of Alpha-1 Antitrypsin must be less than 11micromoles/L. Must have a high-risk AAT deficiency phenotype (PiZZ, PiZ (null) or Pi (null)(null) or other phenotypes associated with serum AAT concentrations of less than 11 uM/L.). FEV1 between 35%-65% predicted. Must currently be using long acting bronchodilator AND oral or inhaled corticosteroids.

aminolevulinate (Levulan)

Products Affected

- **Levulan Kerastick**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Dermatologist or Plastic Surgeon
Coverage Duration	12 Months
Other Criteria	

aminolevulinic acid (Ameluz)

Products Affected

- **Ameluz**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

aprepitant (Emend)

Products Affected

- Aprepitant

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Patient must have failed Zofran. A pre-packaged three-day course of this medication will be approved per each co-pay incidental to a chemotherapy treatment cycle.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Medication will be approved through referrals when written by Oncology
Coverage Duration	12 months
Other Criteria	Emend is used as part of a three day regimen for chemotherapy induced nausea and vomiting (CINV) of moderate to highly emetogenic Chemotherapy treatments, and Post-Operative Nausea and Vomiting. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

aripiprazole (Abilify)

Products Affected

- **Abilify Maintena Intramuscular Suspension Reconstituted ER**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of oral aripiprazole and lurasidone.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Approved when written/ordered by a Psychiatrist or Neurologist through referrals for new starts.
Coverage Duration	12 months
Other Criteria	Aripiprazole is a psychotropic medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

arsenic trioxide (Trisenox)

Products Affected

- **Trisenox Intravenous Solution 10 MG/10ML**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

atezolizumab (Tecentriq)

Products Affected

- **Tecentriq Intravenous Solution 1200 MG/20ML**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications,progression on PD-1/PDL-1 in previous line of treatment
Required Medical Information	Medical notes, previous treatment history, and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Oncologist/Hematologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

avelumab (Bavencio)

Products Affected

- **Bavencio**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Adults and pediatric patients 12 years and older
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	BAVENCIO is a programmed death ligand-1 (PD-L1) blocking antibody indicated for the treatment of advanced or metastatic cancers.Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

belatacept (Nulojix)

Products Affected

- **Nulojix**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes and previous treatment history.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Nephrologist or Transplant specialist.
Coverage Duration	12 months
Other Criteria	Requires failure or intolerance to a calcineurin inhibitor.

belimumab (Benlysta)

Products Affected

- **Benlysta Intravenous**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

bevacizumab-bvzr (Zirabev)

Products Affected

- **Mvasi**
- **Zirabev**

PA Criteria	Criteria Details
Covered Uses	Criteria for coverage (for oncology indications) as follows:FDA Approved Uses. Off-Label indications will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months or until disease progression
Other Criteria	Zirabev an anti-VEGF monoclonal antibody used to treat metastatic, recurrent, or locally advanced cancers. Ophthalmic uses such as wet AMD and macular edema will be covered without clinical review for Zirabev or Avastin.

bleomycin (Blenoxane)

Products Affected

- Bleomycin Sulfate Injection Solution Reconstituted 30 UNIT

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Oncologist
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

blinatumomab (Blincyto)

Products Affected

- **Blincyto**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

bortezomib (Velcade)

Products Affected

- **Velcade Injection**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

brentuximab vedotin (Adcetris)

Products Affected

- **Adcetris**

PA Criteria	Criteria Details
Covered Uses	•ADCETRIS is an antibody-drug conjugate FDA indicated to treat Hodgkin lymphoma and systemic anaplastic large cell lymphoma •Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.Criteria for coverage as follows:•FDA approved indications, off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

cabazitaxel (Jevtana)

Products Affected

- **Jevtana**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Oncology
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

carfilzomib (Kyprolis)

Products Affected

- **Kyprolis Intravenous Solution Reconstituted 30 MG, 60 MG**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Kyprolis is a proteasome inhibitor that is indicated in combination with dexamethasone or with lenalidomide plus dexamethasone for the treatment of patients with relapsed or refractory multiple myeloma who have received one to three lines of therapy one of which containing bortezomib.as a single agent for the treatment of patients with relapsed or refractory multiple myeloma who have received one or more lines of therapy. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

cetuximab (Erbitux)

Products Affected

- **Erbitux**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Oncology
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

daptomycin (Cubicin)

Products Affected

- DAPTOmycin Intravenous Solution Reconstituted 500 MG

PA Criteria	Criteria Details
Covered Uses	Daptomycin is an IV antibiotic indicated for the treatment of resistant gram + bacterial infections.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months
Other Criteria	Patient is identified as having an infection caused by VRE (Vancomycin Resistant Enterococcus) or VRSA (Vancomycin Resistant Staph Aureus) by culture and sensitivity; and Linezolid is not a therapeutic option OR patient has a skin or soft tissue infection caused by MRSA and resistant/allergic to other generically availably oral agents or combinations which may be used to treat MRSA (Sulfamethoxazole/TMP,?Rifampin, Clindamycin, Doxycycline) and patient is allergic to Vancomycin and Zyvox. OR patient has MRSA (non-skin/soft tissue) and is allergic to Vancomycin and oral Zyvox is not a therapeutic option.

daratumumab (Darzalex)

Products Affected

- **Darzalex**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Indicated in combination with lenalidomide and dexamethasone, or bortezomib and dexamethasone, for the treatment of patients with multiple myeloma who have received at least one prior therapy. Indicated in combination with pomalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received at least two prior therapies including lenalidomide and a proteasome inhibitor as monotherapy, for the treatment of patients with multiple myeloma who have received at least three prior lines of therapy including a proteasome inhibitor (PI) and an immunomodulatory agent or who are double refractory.

degarelix (Firmagon)

Products Affected

- **Firmagon**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Limited to two per month.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Written by oncology or urology
Coverage Duration	12 months
Other Criteria	Firmagon is indicated to treat advanced prostate cancer. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

denosumab (Prolia)

Products Affected

- **Prolia Subcutaneous Solution**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications Intolerance or contraindication to injectable bisphosphonate required for coverage of Prolia.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Prolia is a RANK-L ligand antagonist indicated for treatment of osteoporosis and prevention of osteoporosis for patients taking aromatase inhibitors. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

denosumab (Xgeva)

Products Affected

- **Xgeva**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Must have failed or a contraindication to an intravenous bisphosphonate.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or endocrinologist
Coverage Duration	12 months
Other Criteria	Xgeva is a RANKL ligand antagonist indicated to treat osteolytic cancers. Medical history and studies are reviewed in Referrals and if approved will notify the physician.

diabetic test strips (other than Ascensia products)

Products Affected

- **Accu-Chek Aviva Plus In Vitro**
- **FreeStyle Lite Test**
- **FreeStyle Test**
- **Nova Max Glucose Test**
- **OneTouch Ultra Blue**
- **OneTouch Verio In Vitro Strip**
- **Prodigy No Coding Blood Gluc In Vitro**

PA Criteria	Criteria Details
Covered Uses	Test strips other than Ascensia products are covered only when incompatible with an insulin pump, or if patient has a severe visual impairment.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

doxorubicin (Doxil/Lipodox)

Products Affected

- DOXOrubicin HCl Liposomal Intravenous Injectable

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. DOXIL is an anthracycline topoisomerase II inhibitor indicated for Ovarian cancer After failure of platinum-based chemotherapy.AIDS-related Kaposi SarcomaAfter failure of prior systemic chemotherapy or intolerance to such therapy.Multiple Myeloma In combination with bortezomib in patients who have not previously received bortezomib and have received at least one prior therapy Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.FDA approved indications, off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

durvalumab (Imfinzi)

Products Affected

- **Imfinzi**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications, progression on PD-1/PDL-1 in previous line of treatment
Required Medical Information	Medical notes, previous treatment history and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

edaravone (Radicava)

Products Affected

- **Radicava**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

elaprase (Elaprase)

Products Affected

- **Elaprase**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Limited to specialist trained in management of prescribed condition.
Coverage Duration	Up to 12 months
Other Criteria	Coverage will be based on medical history/status, response to previous treatments, and the consideration of other therapeutic options.

elotuzumab (Empliciti)

Products Affected

- **Empliciti**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

epoprostenol (Flolan)

Products Affected

- Epoprostenol Sodium

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Pulmonary hypertension must be diagnosed by heart catheterization, Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral. Patient must be a WHO class III or IV and fail combination ambrisentan and tadalafil.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Must be written by a pulmonologist or cardiologist.
Coverage Duration	12 Months
Other Criteria	epoprostinil is a prostacyclin analog indicated to treat primary pulmonary arterial hypertension. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

eribulin (Halaven)

Products Affected

- **Halaven**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Oncologist
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Prior therapy should have included an anthracycline and a taxane in either the adjuvant or metastatic setting.

Filgrastim

Products Affected

- **Leukine Injection Solution**
- **Leukine Intravenous**
- **Nivestym**
- **Zarxio**
- **Ziextenzo**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Off label use must be supported by NCCN category 2a or greater

imiglucerase (Cerezyme)

Products Affected

- **Cerezyme Intravenous Solution Reconstituted 400 UNIT**

PA Criteria	Criteria Details
Covered Uses	Indicated for the treatment of a patient with Type 1 Gaucher?s disease with anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months
Other Criteria	

immunoglobulin G (Gammagard)

Products Affected

- **Gammagard**

PA Criteria	Criteria Details
Covered Uses	Approval will be based on compliance with most current Medicare NCD or LCD coverage criteria for IVIG.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months
Other Criteria	

immunoglobulin G (Gamunex)

Products Affected

- **Gamunex-C**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months
Other Criteria	Approval will be based on compliance with most current Medicare NCD or LCD coverage criteria for IVIG.

incobotulinumtoxinA (Xeomin)

Products Affected

- **Xeomin**

PA Criteria	Criteria Details
Covered Uses	FHCP covers this medication only for medically necessary purposes, like cervical dystonia, not responsive to physical therapy, blepharospasm that interferes significantly with vision, and headache not responsive to preventive and acute therapy by Neurology for at least 16 weeks.
Exclusion Criteria	FDA labeled contraindications OR cosmetic conditions
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

infliximab (Remicade)

Products Affected

- **Renflexis**

PA Criteria	Criteria Details
Covered Uses	Renflexis is indicated for the treatment of Crohn's Disease and Rheumatoid Arthritis, Ulcerative Colitis, Ankylosing Spondylitis, Psoriatic Arthritis, Plaque Psoriasis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. Criteria for coverage as follows: For use in RA must fail adequate trial of MTX in combination with a DMARD If MTX contraindicated, must try combination of 2-nonbiologic DMARDS (3month trial in past 6 months). For use in Ankylosing Spondylitis PT must fail MTX or sulfasalazine and 2 NSAIDS within past 6 months. For use in Plaque Psoriasis must fail MTX or Soriatane and topical therapy. For Psoriatic Arthritis must fail adequate trial of MTX or LEF in past 6 months. For with Crohn's disease and ulcerative colitis must be written by a gastroenterologist and had recent failure of an immunosuppressant (Azathioprine, 6-mp or Methotrexate) and an anti-inflammatory (5-asa, sulfasalazine, balsalazide, mesalamine)
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	see covered uses
Coverage Duration	Up to 12 months
Other Criteria	

ipilimumab (Yervoy)

Products Affected

- **Yervoy**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications, and not covered in combinations unsupported by the NCCN evidence 2a or greater (i.e. Vemurafenib).
Required Medical Information	Medical notes, previous treatment history, and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Doses exceeding 3 mg/kg will only be approved in adjuvant treatment setting.

ixabepilone (Ixempra)

Products Affected

- **Ixempra Kit**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Oncology
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

lanreotide (Somatuline)

Products Affected

- **Somatuline Depot**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of octreotide.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescriber must be an endocrinologist.
Coverage Duration	12 months
Other Criteria	This medication is used to treat Acromegaly. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

natalizumab (Tysabri)

Products Affected

- **Tysabri**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Neurologist/Gastroenterologist
Coverage Duration	Up to 12 months
Other Criteria	Requires failure of a TNF-antagonist for Crohns disease. Requires failure of a first line DMT for multiple sclerosis

nivolumab (Opdivo)

Products Affected

- **Opdivo Intravenous Solution 100 MG/10ML, 40 MG/4ML**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications, progression on PD-1/PDL-1 in previous line of treatment
Required Medical Information	Medical notes, previous treatment history, and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Oncologist/Hematologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

obinutuzumab (Gazyva)

Products Affected

- **Gazyva**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

ocrelizumab (Ocrevus)

Products Affected

- **Ocrevus**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. For Relapsing Remitting Multiple Sclerosis must have failed Dimethyl Fumarate or Glatiramer
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be prescribed by a neurologist.
Coverage Duration	12 months
Other Criteria	Ocrevus is a CD20-directed cytolytic antibody indicated for the treatment of relapsing remitting or primary progressive forms of multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

octreotide (Sandostatin)

Products Affected

- **SandoSTATIN LAR Depot**

PA Criteria	Criteria Details
Covered Uses	Sandostatin is indicated for acromegaly and severe diarrhea associated carcinoid syndrome or VIP secreting tumors. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Requires failure of recent 2 month trial of octreotide (non LAR) in past 3 months

ofatumumab (Arzerra)

Products Affected

- **Arzerra**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Failure of rituximab.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Oncologist
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

omalizumab (Xolair)

Products Affected

- **Xolair Subcutaneous Solution Reconstituted**

PA Criteria	Criteria Details
Covered Uses	•Xolair is an anti-IgE monoclonal antibody indicated for patients 12 years and older with moderate to severe persistent asthma who have a positive skin test or in-vitro reactivity to an aeroallergen and chronic idiopathic urticaria. Xolair was not studied in patients who smoke. •Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.•Nasal Polyp indication is covered only by exception and will be based on all available treatment options including nebulized sinus treatments and devices The following criteria must be met for coverage for severe asthma:•Prescriber must be a pulmonologist or allergist.•Patient must have baseline IGE levels within indicated range for Xolair labeling.•Patient must test positive to an aeroallergen (either skin test or blood test).•Patient must fail 3 months of therapy on maximal indicated doses of Trelegy.•Patient must have failed leukotriene receptor antagonist The following criteria must be met for coverage for chronic idiopathic urticaria:•Prescribed by an allergist, immunologist, or dermatologist•Patient must have a diagnosis of chronic idiopathic urticaria (at least a 6 week history)•Patient must have tried, for a minimum of 2 weeks and failed 2 of the following antihistamines at maximal doses used to treat CIU: cetirizine(40mg/day), levocetirizine (20mg/day), desloratadine(20mg/day), fexofenadine (540mg/day), loratadine (40mg/day) with MONTELUKAST AND trial Dicyclomine or Hydroxyzine
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

onabotulinumtoxinA (Botox)

Products Affected

- **Botox**

PA Criteria	Criteria Details
Covered Uses	Non-Cosmetic FDA approved indications
Exclusion Criteria	FDA labeled contraindications, and excluded for cosmetic conditions
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	FHCP covers this medication only for medically necessary purposes, like cervical dystonia, not responsive to physical therapy, blepharospasm that interferes significantly with vision, and headache not responsive to preventive and acute therapy by Neurology for at least 16 weeks

paclitaxel (Abraxane)

Products Affected

- **Abraxane**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

palivizumab (Synagis)

Products Affected

- **Synagis**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Based on current AAP guidelines.
Other Criteria	Coverage will be based on current AAP guidelines for use of Palivizumab (Synagis). Physician must complete Synagis request form from the referrals department.

panitumumab (Vectibix)

Products Affected

- **Vectibix**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

PegFilgrastim

Products Affected

- **Fulphila**
- **Udenyca Subcutaneous Solution Prefilled Syringe**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	All FDA approved uses, Off-Label uses must be NCCN supported with a grade 2a recommendation or greater.

pembrolizumab (Keytruda)

Products Affected

- **Keytruda**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications, progression on PD-1/PDL-1 in previous line of treatment
Required Medical Information	Medical notes, previous treatment history and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Oncologist/Hematologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

pemetrexed (Alimta)

Products Affected

- **Alimta**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

pertuzumab (Perjeta)

Products Affected

- **Perjeta**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Oncology
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

plerixafor (Mozobil)

Products Affected

- **Mozobil**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

radium-223 (Xofigo)

Products Affected

- **Xofigo**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

ramucirumab (Cyramza)

Products Affected

- **Cyramza**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Hematologists/Oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

rituximab-abbs (Truxima)

Products Affected

- **Truxima**

PA Criteria	Criteria Details
Covered Uses	Truxima is a CD-20 targeted B-cell depleting biologic. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. Rituxan Hycela is not covered. Criteria for coverage (for treatment of malignancies) as follows:FDA approved indications, off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater. Criteria for coverage (for treatment of Rheumatoid Arthritis) as follows:Patient has failed 2 or more Anti-TNF agents. Coverage will be for 1000mg x 2 treatments separated by 2 weeks. Retreatment will not be covered sooner than 24 weeks post initial infusion. Patient must be on Methotrexate.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

rituximab-pvvr (Ruxience)

Products Affected

- **Ruxience**

PA Criteria	Criteria Details
Covered Uses	Ruxience is a CD-20 targeted B-cell depleting biologic. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.Rituxan Hycela is not covered. Criteria for coverage (for treatment of malignancies) as follows:FDA approved indications, off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.Criteria for coverage (for treatment of Rheumatoid Arthritis) as follows:Patient has failed 2 or more Anti-TNF agents. Coverage will be for 1000mg x 2 treatments separated by 2 weeks. Retreatment will not be covered sooner than 24 weeks post initial infusion. Patient must be on Methotrexate.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

Satralizumab (Enspryng)

Products Affected

- **Enspryng**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. •Enspryng is a monoclonal antibody indicated to treat neuromyelitis optica spectrum disorder•Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.Criteria for coverage as follows:a. Member meets ALL of the following - documentation must be provided: i. Anti-aquaporin-4 (AQP4) antibody positive disease ii. ONE of the following: 1. Member has a history of at least 2 relapses in the past 12 months 2. Member has a history of at least 3 relapses in the past 24 months with at least 1 relapse in the previous 12 months iii. Member has an Expanded Disability Status Scale (EDSS) score less than or equal to 7 iv. Member had an inadequate response or contraindication to corticosteroids IVANDa. ONE of the following: 1. Member had an inadequate response to an adequate trial of ONE or more of the following: a. azathioprine b. mycophenolate mofetil c. methotrexate ANDb . Member had an inadequate response to rituximabANDc. Treatment is prescribed by or in consultation with a neurologist INITIAL Approval duration: 60 days for all indications ,continuation based on clinical improvement.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL Approval duration: 60 days for all indications, continuation based on clinical improvement.

PA Criteria	Criteria Details
Other Criteria	

siltuximab (Sylvant)

Products Affected

- **Sylvant**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Oncologist
Coverage Duration	Up to 12 months
Other Criteria	

talimogene laherparepvec (Imlygic)

Products Affected

- **Imlygic**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	

teprotumumab (Tepezza)

Products Affected

- **Tepezza**

PA Criteria	Criteria Details
Covered Uses	Tepezza is a medication indicated for Thyroid Eye Disease (TED). Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. Criteria for coverage as follows. Coverage will be provided for 6 months (max total of 8 infusions) and may not be renewed. Patient is at least 18 years old AND Must be prescribed by, or in consultation with, a specialist in ophthalmology, endocrinology, oculoplastic surgery or neuro-ophthalmology AND Patient is euthyroid [Note: mild hypo- or hyperthyroidism is permitted which is defined as free thyroxine (FT4) and free triiodothyronine (FT3) levels less than 50% above or below the normal limits (every effort should be made to correct the mild hypo- or hyperthyroidism promptly)] AND Patient does not have corneal decompensation that is unresponsive to medical management AND Member has not had a decrease in best corrected visual acuity (BVCA) due to optic neuropathy within the previous six months (i.e., decrease in vision of 2 lines on the Snellen chart, new visual field defect, or color defect secondary to optic nerve involvement) Patient does not have poorly controlled diabetes OR inflammatory bowel disease AND Must be used as single agent therapy AND Patient has a clinical diagnosis of active TED that is related to Graves' Disease (i.e., Graves' orbitopathy) AND Patient has a baseline clinical activity score (CAS) of at least 4 AND Patient has active phase TED that is non-sight threatening but has a significant impact on daily living by one or more of the following features- lid retraction greater than or equal to 2 mm, OR moderate or severe soft tissue involvement, OR exophthalmos greater than or equal to 3 mm above normal for race and gender, OR inconstant or constant diplopia AND Patient's onset of TED symptoms occurred within the previous 9 months AND Patient had an inadequate response or intolerance, to high-dose intravenous glucocorticoids OR Rituxumab AND Patient is a non-smoker or has recently stopped smoking for at least 6 months.
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

thyrotropin (Thyrogen)

Products Affected

- **Thyrogen Intramuscular Solution Reconstituted 1.1 MG**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Approved when written by Oncology or Endocrinology.
Coverage Duration	12 Months
Other Criteria	Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

tocilizumab (Actemra)

Products Affected

- **Actemra Intravenous**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Rheumatologist
Coverage Duration	Up to 12 months
Other Criteria	Must fail Kevzara, Adalimumab, Enbrel, Renflexis for overlapping indications

treprostinil (Remodulin)

Products Affected

- Treprostinil Sodium

PA Criteria	Criteria Details
Covered Uses	Pulmonary hypertension must be diagnosed by heart catheterization, Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral.Patient must be a WHO class III or IV and fail combination ambrisentan and tadalafil.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Pulmonologist/Cardiologist
Coverage Duration	12 months
Other Criteria	Remodulin is a prostacyclin analog indicated to treat primary pulmonary arterial hypertension. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

ustekinumab (Stelara)

Products Affected

- **Stelara Subcutaneous Solution 45 MG/0.5ML**
- **Stelara Subcutaneous Solution Prefilled Syringe**

PA Criteria	Criteria Details
Covered Uses	Stelara is indicated for treatment of moderate to severe plaque psoriasis and psoriatic arthritis and Crohn's disease. Medical history and studies are reviewed in Referrals and if approved will notify the physician.Criteria for coverage as follows:•FDA approved indications only at FDA approved doses•Prescribed by a dermatologist or Rheumatologist.•Only covered as a medical benefit.•Notes supporting moderate to severe Plaque psoriasis or Psoriatic arthritis•For Plaque Psoriasis, recent failure (in past 6 months) of Renflexis, and Enbrel in combination with topical treatment following conventional therapy.•For Psoriatric Arthritis failure of adalimumab, Renflexis, Enbrel, Xeljanz,. •For Crohns Disease must fail conventional agents AND adalimumab, Renflexis, Entyvio, , AND TNF in combination with a conventional immunosuppressant (when clinically appropriate) with 5-ASA anti-inflammatory.•For Ulcerative Colitis must fail conventional agents AND adalimumab, Renflexis, Entyvio, Xeljanz, AND TNF in combination with a conventional immunosuppressant (when clinically appropriate) with 5-ASA anti-inflammatory.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Up to 12 months
Other Criteria	

vedolizumab (Entyvio)

Products Affected

- **Entyvio Intravenous**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Gastroenterologist
Coverage Duration	Up to 12 months
Other Criteria	Criteria for coverage as follows:•Must be written by a gastroenterologist and had recent failure of an immunosuppressant (Azathioprine, 6-mp or Methotrexate) and an anti-inflammatory (5-asa, sulfasalazine, balsalazide, mesalamine) And Renflexis and Adalimumab (if TNF naive or previous TNF responder). Requires a 3 month trial in past 6 months

verteporfin (Visudyne)

Products Affected

- **Visudyne**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

ziprasidone (Geodon) injection

Products Affected

- **Geodon Intramuscular**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Approved when written/ordered by a Psychiatrist or Neurologist through referrals for new starts.
Coverage Duration	12 months
Other Criteria	Geodon is a psychotropic medication. Prior authorization only applies to existing members who are new starts on the drug. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Index

Florida Health Care Plans®
An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

Florida Health Care Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Florida Health Care Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Health Care Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified Interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Health Care Plans : 1-877-615-4022

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

Florida Health Care Plans
Civil Rights Coordinator
PO Box 9910,
Daytona Beach, FL 32120-9910.
Phone: 1-844-219-6137,
TTY: 1-800-955-8770
Fax: 386-676-7149,
Email: rights@fhcp.com.

You can file grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Florida Health Care Plans

An Independent Licensee of the Blue Cross and Blue Shield Association

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-615-4022. (TTY: 1-800-955-8770)**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-615-4022** (TTY: **1-800-955-8770**).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-615-4022 (TTY: 1-800-955-8770).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-615-4022 (TTY: 1-800-955-8770).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-615-4022 (TTY: 1-800-955-8770).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-615-4022
（TTY：1-800-955-8770）

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-615-4022 (ATS : 1-800-955-8770).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-615-4022 (TTY: 1-800-955-8770).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-615-4022 (телетайп: 1-800-955-8770).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-615-4022 (رقم هاتف الصم والبكم: 1-800-955-8770).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-615-4022 (TTY: 1-800-955-8770).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-615-4022 (TTY: 1-800-955-8770).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-615-4022 (TTY: 1-800-955-8770)번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-615-4022 (TTY: 1-800-955-8770).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-615-4022 (TTY: 1-800-955-8770).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-615-4022 (TTY: 1-800-955-8770).

10104-U65 0718