



# Prior Authorization Criteria

Effective Date January 1, 2011

Updated July 15, 2011

- All items and services on this list require prior authorization, regardless of the service location or the provider’s participation status.
- This document is updated periodically, but may change at any time. Please refer to the version currently in effect by visiting our website at [www.HealthFirstHealthPlans.org](http://www.HealthFirstHealthPlans.org).
- To request authorization, submit the appropriate medical or pharmacy (drug) “Authorization Request” form or request authorization online through MyHFHP (go to [www.HealthFirstHealthPlans.org](http://www.HealthFirstHealthPlans.org) to log in). Include applicable codes, patient identification, and clinical information to support the request.
- Newly published/assigned codes and new/emerging therapy services not listed may require prior authorization to determine medical necessity.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
<b>Actimmune</b>	<ul style="list-style-type: none"> <li>• Chronic granulomatous disease: reduces the frequency/severity of associated serious infections.</li> <li>• Infantile malignant osteopetrosis (severe): delays the time to disease progression in patients with severe, malignant osteoporosis.</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	N/A	N/A	6 months
<b>Aldurazyme</b>	<ul style="list-style-type: none"> <li>• For the treatment of the Hurler and Hurler-Scheie forms of mucopolysaccharidosis I (MPS I) and the Scheie form of MPS I (moderate to severe symptoms only)</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Clinical diagnosis of MPS I	N/A	1 year
<b>Alinia</b>	<ul style="list-style-type: none"> <li>• Treatment of diarrhea caused by cryptosporidium parvum or giardia lamblia.</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Supporting clinical documentation	<b>Patient age</b> <ul style="list-style-type: none"> <li>• Oral suspension: Safety and efficacy have not been established in children under 1 year of age.</li> <li>• Tablet: Safety and efficacy have not been established in children under 12 years of age.</li> </ul>	10 days

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
<b>Antizol</b>	<ul style="list-style-type: none"> <li>• Antizol is indicated as an antidote for ethylene glycol (such as antifreeze) or methanol poisoning, or for use in suspected ethylene glycol or methanol ingestion, either alone or in combination with hemodialysis.</li> <li>• All FDA-approved indications not otherwise excluded from Part D</li> </ul>	<ul style="list-style-type: none"> <li>• Excluded for uses other than the indications described by and allowed by the FDA.</li> <li>• Should not be administered to patients with a documented serious hypersensitivity reaction to Antizol or other pyrazoles.</li> </ul>	Documentation of poisoning type.	<b>Other:</b> Hepatic enzymes and white blood cell counts should be monitored during treatment, as transient increases in serum transaminase concentrations and eosinophilia have been noted with repeated Antizol dosing.	10 days
<b>Apokyn</b>	<ul style="list-style-type: none"> <li>• All FDA-approved indications not otherwise excluded from Part D</li> </ul>	N/A	Clinical documentation of FDA-approved indication for treatment.	<b>Prescriber</b> must be neurologist for initial prescription	6 months initially. Continue 6–12 months if no progression.
<b>Arcalyst</b>	<ul style="list-style-type: none"> <li>• For the treatment of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-Inflammatory Syndrome (FCAS) and Muckle-Well Syndrome (MWS).</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Clinical documentation of FDA-approved indication for treatment.	<b>Patient age</b> must be 12 years and older	3 months initially. Continue 6 months if no progression.
<b>Arzerra</b>	<ul style="list-style-type: none"> <li>• Treatment of patients with chronic lymphocytic leukemia (CLL) refractory to fludarabine and alemtuzumab.</li> <li>• All FDA-approved indications not otherwise excluded from part D.</li> </ul>	Patients with no prior trial and failure of fludarabine and alemtuzumab.	N/A	<b>Patient age</b> must be 18 years or older <b>Prescriber</b> must be an oncologist.	3 months initially then 6 months thereafter if no progression.
<b>Buphenyl</b>	<ul style="list-style-type: none"> <li>• Indicated as adjunctive therapy in the chronic management of patients with urea cycle disorders involving deficiencies of carbamylphosphate synthetase (CPS), ornithinetranscarbamylase (OTC), or argininosuccinic acid synthetase (AS).</li> <li>• Indicated in all patients with neonatal-onset deficiency (complete enzymatic deficiency, presenting within the first 28 days of life).</li> <li>• Also indicated in patients with late-onset disease (partial enzymatic deficiency, presenting after the first month of life) who have a history of hyperammonemic encephalopathy.</li> <li>• All FDA-approved indications not otherwise</li> </ul>	N/A	N/A	N/A	Three months. Renewable with documentation of benefit.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
	excluded from Part D.				
<b>Campath</b>	<ul style="list-style-type: none"> <li>Indicated as a single agent for the treatment of B-cell chronic lymphocytic leukemia (B-CLL).</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	CBC count with differential shows absolute lymphocytosis with more than 5000 lymphocytes/microliter. Peripheral blood flow cytometry is the most valuable test to confirm CLL.	<b>Prescriber</b> must be an oncologist.	3 months. Clinical documentation of lack of disease progression required for continued approval.
<b>Cancidas</b>	<ul style="list-style-type: none"> <li>For the treatment of invasive aspergillosis in patients who are refractory to or intolerant of other antifungal therapies</li> <li>For the treatment of esophageal candidiasis with or without oropharyngeal candidiasis (thrush)</li> <li>For empirical therapy for presumed fungal infection in patients with febrile neutropenia</li> <li>For the treatment of candidemia and intra-abdominal abscesses, peritonitis, and pleural space infections due to Candida</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Cultures and sensitivities	<b>Patient age</b> must be 3 months or older	Maximum 30 days, then review required
<b>Ceredase</b>	<ul style="list-style-type: none"> <li>Indicated for use as a long-term enzyme replacement therapy for children, adolescents and adult patients with a confirmed diagnosis of Type I Gaucher disease. Aglucerase (Ceredase) is only available to patients who were treated with the product prior to the introduction of imiglucerase and who cannot tolerate imiglucerase therapy.</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	<ul style="list-style-type: none"> <li>Biochemical assay confirming Gaucher disease.</li> <li>Complete Blood Count.</li> </ul>	<b>Patient age</b> must be at least 2 years. Safety and efficacy in children less than 2 has not been established.	3 months, then clinical assessment of dose reduction required for continued approval.
<b>Cyklokapron</b>	<ul style="list-style-type: none"> <li>Indicated in patients with hemophilia for short term use (two to eight days) to reduce or prevent hemorrhage and reduce the need for replacement therapy during and following tooth extraction.</li> <li>Also approved for dysfunctional uterine bleeding.</li> <li>Prevention of hemorrhage following ocular trauma.</li> </ul>	N/A	Documentation of hemophilia diagnosis as appropriate.	<b>Note:</b> Tablets are no longer marketed in the US. For patients with the following serum creatinine levels, adjust dosage accordingly: <ul style="list-style-type: none"> <li>1.36–2.83 mg/dl: 10 mg/kg IV or 15 mg/kg PO 2 times per day.</li> </ul>	8 days

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
	<ul style="list-style-type: none"> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>			<ul style="list-style-type: none"> <li>2.83–5.66 mg/dl: 10 mg/kg IV or 15 mg/kg PO once daily.</li> <li>5.66 mg/dl: 10 mg/kg IV or 15 mg/kg PO every 48 hours.</li> </ul>	
<b>Elitek</b>	<ul style="list-style-type: none"> <li>For the prevention of hyperuricemia and uric acid nephropathy in patients with leukemia, lymphoma, or solid tumor malignancies who are receiving anti-cancer therapy expected to result in tumor lysis.</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Clinically documented failure of allopurinol.	N/A	5 days
<b>Emcyt</b>	<ul style="list-style-type: none"> <li>Estramustine is an oral, nitrogen mustard antineoplastic agent that is used to treat prostate cancer.</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	N/A	<b>Prescriber</b> must be oncologist.	6 months
<b>Emsam</b>	<ul style="list-style-type: none"> <li>Treatment of major depressive disorder.</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Documented diagnosis of major depressive disorder.	<p><b>Pt. age</b> must be 18 years or older.  <b>Prescriber</b> must be licensed psychiatrist.  <b>Other:</b> EMSAM should not be used with oral selegiline or other MAO inhibitors (MAOIs e.g., isocarboxazid, phenelzine, and tranylcypromine). Carbamazepine and oxcarbazepine are contraindicated in patients taking selegiline.</p>	1 year
<b>Ethyol</b>	<ul style="list-style-type: none"> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	Patient must have FDA-approved indication for treatment. Ethyol is NOT covered for members if the patient has any of the following contraindications: <ul style="list-style-type: none"> <li>a. Dehydration</li> <li>b. exfoliative dermatitis</li> <li>c. hypotension</li> <li>d. mannitol hypersensitivity.</li> </ul>	Clinical documentation of FDA-approved indication for treatment.	<p><b>Pt. age</b> must be 12 years or older.  <b>Prescriber</b> must be oncologist or hematologist.</p>	6 months initially. Continue 6 months if no progression.
<b>Exjade</b>	<ul style="list-style-type: none"> <li>Exjade (deferasirox) is indicated for the treatment of chronic iron overload due to blood transfusions</li> </ul>	N/A	Serum ferritin levels	<b>Pt. age</b> must be at least 2 years or older.	As needed to correct iron

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
	<p>(transfusional hemosiderosis) in patients 2 years of age and older.</p> <ul style="list-style-type: none"> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>			<p><b>Hematologist</b> should be involved in patient care.</p>	<p>overload due to transfusional hemosiderosis</p>
<b>Gardasil</b>	<p>GARDASIL is a vaccine indicated in girls and women 9–26 years of age for the prevention of the following diseases caused by Human Papillomavirus (HPV) types 6, 11, 16, and 18:</p> <ul style="list-style-type: none"> <li>Cervical cancer</li> <li>Genital warts (condyloma acuminata)</li> <li>The following precancerous or dysplastic lesions: <ul style="list-style-type: none"> <li>Cervical adenocarcinoma in situ (AIS) Cervical intraepithelial neoplasia (CIN) grade 2 &amp; 3</li> <li>Vulvar intraepithelial neoplasia (VIN) grade 2 &amp; 3</li> <li>Vaginal intraepithelial neoplasia (VaIN) grade 2 &amp; 3</li> <li>Cervical intraepithelial neoplasia (CIN) grade 1.</li> </ul> </li> <li>All FDA-approved indications not otherwise excluded from part D.</li> </ul>	<p>Patient must meet age requirement as described by FDA—between the ages of 9 and 26 years</p>	<p>Patient age</p>	<p><b>Patient age</b> must be between 9 and 26 years.</p>	<p>1 year</p>
<b>Gemzar</b>	<ul style="list-style-type: none"> <li><b>Ovarian Cancer</b> — Gemzar in combination with carboplatin is indicated for the treatment of patients with advanced ovarian cancer that has relapsed at least 6 months after completion of platinum-based therapy.</li> <li><b>Breast Cancer</b> — Gemzar in combination with paclitaxel is indicated for the first-line treatment of patients with metastatic breast cancer after failure of prior anthracycline-containing adjuvant chemotherapy, unless anthracyclines were clinically contraindicated.</li> <li><b>Non-Small Cell Lung Cancer</b> — Gemzar is indicated in combination with cisplatin for the first-line treatment of patients with inoperable, locally advanced (Stage IIIA or IIIB), or metastatic (Stage IV) non-small cell lung cancer.</li> <li><b>Pancreatic Cancer</b> — Gemzar is indicated as first-</li> </ul>	<p>N/A</p>	<p>Previous chemotherapy regimen dates and dosing. Per the Prescribing Information, a complete blood count (CBC) should be done prior to each dose, including differential and platelet count.</p>	<p><b>Patient age:</b> Safe and effective use has not been established in children and adolescents.</p> <p><b>Must be prescribed and followed</b> by oncologist.</p>	<p>3 months, then renewable every 6 months for patients who continue to respond and have no disease progression.</p>

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
	<p>line treatment for patients with locally advanced (nonresectable Stage II or Stage III) or metastatic (Stage IV) adenocarcinoma of the pancreas. Gemzar is indicated for patients previously treated with 5-FU.</p> <ul style="list-style-type: none"> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>				
<b>Increlex</b>	<ul style="list-style-type: none"> <li>• INCRELEX (mecasermin [rDNA origin] injection) is indicated for the long-term treatment of growth failure in children with severe primary IGF-1 deficiency (Primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH. Severe Primary IGFD is defined by: height standard deviation score less than -3.0 and basal IGF-1 standard deviation score less than -3.0 and normal or elevated growth hormone (GH). Severe Primary IGFD includes patients with mutations in the GH receptor (GHR), post-GHR signaling pathway, and IGF-1 gene defects they are not GH deficient, and therefore, they cannot be expected to respond adequately to exogenous GH treatment. INCRELEX is not intended for use in subjects with secondary forms of IGF-1 deficiency, such as GH deficiency, malnutrition, hypothyroidism, or chronic treatment with pharmacologic doses of anti-inflammatory steroids. Thyroid and nutritional deficiencies should be corrected before initiating INCRELEX treatment. INCRELEX is not a substitute for GH treatment.</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Results of growth hormone stimulation tests. Height standard deviation scores. Basal IGF-1 results	<p><b>Patient age</b> as indicated by prescribing insert</p> <p><b>Prescriber</b> must be endocrinologist</p>	6 months to 1 year
<b>Iressa</b>	<ul style="list-style-type: none"> <li>• For the treatment of locally advanced or metastatic non-small cell lung cancer (NSCLC) after failure of both platinum- and docetaxel-based chemotherapies, in those patients showing benefit from current or past gefitinib.</li> </ul>	N/A	Documentation of failure of both platinum based and docetaxel chemotherapies, including dates and	<b>Prescriber</b> must be oncologist.	3 months initially, renewable in 6 month increments

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
	<ul style="list-style-type: none"> <li>All FDA-approved indication not otherwise excluded from Part D.</li> </ul>		duration of therapy.		
<b>Ixempra Kit</b>	<ul style="list-style-type: none"> <li>IXEMPRA (ixabepilone) is indicated in combination with capecitabine for the treatment of patients with metastatic or locally advanced breast cancer resistant to treatment with an anthracycline and a taxane, or whose cancer is taxane-resistant and for whom further anthracycline therapy is contraindicated. Anthracycline resistance is defined as progression while on therapy or within 6 months in the adjuvant setting or 3 months in the metastatic setting. Taxane resistance is defined as progression while on therapy or within 12 months in the adjuvant setting or 4 months in the metastatic setting. IXEMPRA is indicated as monotherapy for the treatment of metastatic or locally advanced breast cancer in patients whose tumors are resistant or refractory to anthracyclines, taxanes, and capecitabine.</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	<ul style="list-style-type: none"> <li>Patient must have documented prior use of anthracycline and taxane.</li> <li>Ixempra is not for use in the following patients: <ul style="list-style-type: none"> <li>Baseline neutrophil count below 1500 cells/mm<sup>3</sup> or a platelet count less than 100,000 cells/mm<sup>3</sup></li> <li>Patients with AST or ALT above 2.5 x ULN or bilirubin above 1 x ULN must not be treated with IXEMPRA (ixabepilone) in combination with capecitabine.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Documented metastatic or locally advanced breast cancer.</li> <li>Documentation of anthracycline and taxane use (dose, duration).</li> <li>Laboratory values for neutrophils.</li> <li>Liver function tests including AST, ALT, bilirubin.</li> </ul>	<b>Prescriber</b> must be oncologist	3 months. Continued approval based on lack of disease progression.
<b>Ketek</b>	<ul style="list-style-type: none"> <li>KETEK tablets are indicated for the treatment of community-acquired pneumonia (of mild to moderate severity) due to Streptococcus pneumoniae, (including multi-drug resistant isolates [MDRSP*]), Haemophilus influenzae, Moraxella catarrhalis, Chlamydia pneumoniae, or Mycoplasma pneumoniae, for patients 18 years old and above.*MDRSP, Multi-drug resistant Streptococcus pneumoniae includes isolates known as PRSP (penicillin-resistant Streptococcus pneumoniae), and are isolates resistant to two or more of the following antibiotics: penicillin, 2nd generation cephalosporins, e.g., cefuroxime, macrolides, tetracyclines and trimethoprim/sulfamethoxazole.</li> <li>All FDA-approved indications not otherwise</li> </ul>	KETEK is contraindicated in patients with previous history of hepatitis and/or jaundice associated with the use of KETEK tablets, or any macrolide antibiotic.	KETEK should be used only to treat infections that are proven or strongly suspected to be caused by susceptible bacteria. Cultures and sensitivities are requested to be provided.	<b>Patient age:</b> Ketek should not be used in patients less than 18 years of age.	10 days

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
	excluded from Part D.				
<b>Kineret</b>	<ul style="list-style-type: none"> <li>• Kineret is indicated for reducing the signs and symptoms and slowing the progression of structural damage of moderately to severely active rheumatoid arthritis.</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	N/A	<b>Patient age:</b> Safety and efficacy has not been determined in children. Not recommended for use in those under the age of 18.	Three months initially. If treatment goals are achieved, additional authorization for 12 months.
<b>Leukine</b>	<ul style="list-style-type: none"> <li>• All FDA-approved indications not otherwise excluded from Part D</li> </ul>	N/A	<ul style="list-style-type: none"> <li>• Clinical documentation of FDA-approved indication for treatment.</li> <li>• Clinical documentation of current absolute neutrophil count, white blood cell count, and patient's percent neutrophils must be provided.</li> </ul>	<b>Prescriber</b> must be oncologist or hematologist.	3 months initially. Continue 6 months if no progression.
<b>Lotronex</b>	<ul style="list-style-type: none"> <li>• Lotronex s used for diarrhea associated with irritable bowel syndrome in women</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	N/A	<b>Patient age</b> must be at least 18 years or older. <b>Prescriber</b> must be specially trained gastrointestinal physician.	Six months per approval.
<b>Lovenox</b>	<ul style="list-style-type: none"> <li>• Abdominal surgery - postoperative deep vein thrombosis Prophylaxis</li> <li>• Arthroplasty of knee, total - postoperative deep vein thrombosis prophylaxis</li> <li>• Deep venous thrombosis, in combination with warfarin</li> <li>• Pulmonary embolism, in combination with warfarin</li> <li>• Deep venous thrombosis, in patients with restricted mobility from acute illness</li> <li>• Prophylaxis of deep venous thrombosis, without pulmonary embolism (in combination with warfarin)</li> <li>• Ischemia, in unstable angina or non-Q-wave MI</li> </ul>	N/A	N/A	N/A	Prophylaxis 30 days. Maintenance treatment 6 months, renewable every 6 months.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
	<ul style="list-style-type: none"> <li>• Prophylaxis of postoperative deep vein thrombosis, total replacement of hip</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>				
<b>Lupron</b>	<ul style="list-style-type: none"> <li>• Prostate cancer</li> <li>• Endometriosis</li> <li>• Central precocious puberty</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Laboratory tests which support the diagnosis. Imaging tests that confirm endometriosis.	<b>Prescriber</b> must be oncologist, endocrinologist, or gynecologist.	Initial approval 3 months. Renewable if it continues to provide clinical benefit.
<b>Naglazyme</b>	<ul style="list-style-type: none"> <li>• Naglazyme is used for the treatment of mucopolysaccharidosis VI (MPS VI Maroteaux-Lamy syndrome), an autosomal recessive disorder that results from the deficiency of N-acetylgalactosamine 4-sulfatase (or arylsulfatase B) activity.</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	Not approved if patient does not meet the following criteria: Clinically diagnosed mucopolysaccharidosis VI (MPS VI or (Maroteaux-Lamy syndrome).	N/A	N/A	1 year
<b>Neulasta</b>	<ul style="list-style-type: none"> <li>• Neulasta is indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Absolute neutrophil counts and chemotherapy regimen information.	<b>Must be prescribed and followed</b> by oncologist.	3 months and is renewable if it continues to provide clinical benefit
<b>Neumega</b>	<ul style="list-style-type: none"> <li>• All FDA-approved indications not otherwise excluded from Part D</li> </ul>	Neumega will be excluded from coverage for patients who do not have nonmyeloid malignancies AND have severe thrombocytopenia with a platelet count below 50,000 per microliter.	Patient must have: <ul style="list-style-type: none"> <li>• FDA-indicated diagnosis for use, <i>and</i></li> <li>• Laboratory values for platelets</li> </ul>	<b>Patient age</b> must be 18 years or older. <b>Prescriber</b> must be oncologist or hematologist	3 months initially. Continue 6 months if no progression.
<b>Nexavar</b>	<ul style="list-style-type: none"> <li>• For the treatment of advanced renal cell cancer</li> <li>• For the treatment of unresectable hepatocellular cancer (HCC)</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Staging and imaging studies at baseline for comparison purposes	<b>Prescriber</b> must be oncologist.	Initial approval 12 wks. Continue for 1 year with stable disease. Renewed until progression.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
<b>Novatrone</b>	<ul style="list-style-type: none"> <li>•NOVANTRONE in combination with corticosteroids is indicated as initial chemotherapy for the treatment of patients with pain related to advanced hormone-refractory prostate cancer.</li> <li>•NOVANTRONE in combination with other approved drug(s) is indicated in the initial therapy of acute nonlymphocytic leukemia (ANLL) in adults. This category includes myelogenous, promyelocytic, monocytic, and erythroid acute leukemias.</li> <li>•NOVANTRONE is indicated for reducing neurologic disability and/or the frequency of clinical relapses in patients with secondary (chronic) progressive, progressive relapsing, or worsening relapsing-remitting multiple sclerosis (i.e., patients whose neurologic status is significantly abnormal between relapses).</li> <li>•NOVANTRONE is not indicated in the treatment of patients with primary progressive multiple sclerosis.</li> <li>•All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Left ventricular ejection fraction (LVEF) must be evaluated by echocardiogram or MUGA prior to administration of the initial dose of NOVANTRONE and all subsequent doses. In addition, LVEF evaluations are recommended if signs or symptoms of congestive heart failure develop at any time during treatment with NOVANTRONE.	<b>Other:</b> NOVANTRONE is not be administered to multiple sclerosis patients with an LVEF 50%, with a clinically significant reduction in LVEF, or to those who have received a cumulative lifetime dose of 140 mg/m <sup>2</sup> . NOVANTRONE generally should not be administered to multiple sclerosis patients with neutrophil counts less than 1500 cells/mm <sup>3</sup> .	6 months initially, renewable for 1 year.
<b>Novarel</b>	<ul style="list-style-type: none"> <li>•Prepubertal cryptorchidism not due to anatomical obstruction. In general, HCG is thought to induce testicular descent in situations when descent would have occurred at puberty. HCG thus may help predict whether or not orchiopexy will be needed in the future. Although, in some cases, descent following HCG administration is permanent, in most cases, the response is temporary. Therapy is usually instituted between the ages 4 and 9.</li> <li>•Selected cases of hypogonadotropic hypogonadism (hypogonadism secondary to a pituitary deficiency) in males.</li> <li>•All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	<p>Novarel will not be covered unless prescribed for FDA-approved uses:</p> <ul style="list-style-type: none"> <li>•Prepubertal cryptorchidism not due to anatomical obstruction, usually in children ages 4 to 9 years</li> <li>•Hypogonadotropic hypogonadism in males (secondary to pituitary deficiency)</li> </ul> <p>CONTRAINDICATIONS to Novarel treatment:</p> <ul style="list-style-type: none"> <li>•Precocious puberty</li> <li>•Prostatic carcinoma or</li> </ul>	N/A	<b>Prescriber</b> must be endocrinologist.	Prepub cryptorchidism: 16 weeks Hypogonadotropic: 12 months

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
		other androgen-dependent neoplasm, prior allergic reaction to HCG			
<b>Nuvigil</b>	<ul style="list-style-type: none"> <li>Improved wakefulness in patients with excessive daytime sleepiness associated with narcolepsy, obstructive sleep apnea (OSA), and shift work sleep disorder. For patients with OSA, Nuvigil is indicated as an adjunct to standard treatments for the underlying obstruction including continuous positive airway pressure (CPAP).</li> <li>All FDA-approved indications not otherwise excluded by Part D.</li> </ul>	N/A	Clinical documentation of narcolepsy, obstructive sleep apnea, or shift work sleep disorder.	<b>Patient age</b> must be 16 years or older.	1 year
<b>Ontak</b>	<ul style="list-style-type: none"> <li>ONTAK is indicated for the treatment of patients with persistent or recurrent cutaneous T-cell lymphoma whose malignant cells express the CD25 component of the IL-2 receptor. The safety and efficacy of Ontak in patients with CTCL whose malignant cells do not express the CD25 component of the IL-2 receptor have not been examined.</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Lab tests: Prior to administration of this product, the patient's malignant cells should be tested for CD25 expression. A testing service for the assay of CD25 on skin biopsy samples is available. For information on this service call 877-873-4724.	<b>Prescriber</b> must be oncologist or dermatologist.	Two months
<b>Procrit</b>	<ul style="list-style-type: none"> <li>Treatment of anemia of chronic renal failure patients</li> <li>Treatment of anemia in Zidovudine-treated HIV-infected patients</li> <li>Treatment of anemia in cancer patients on chemotherapy <ul style="list-style-type: none"> <li>with non-myeloid malignancies where anemia is due to the effect of concomitantly administered chemotherapy.</li> <li>to decrease the need for transfusions in patients who will be receiving concomitant chemotherapy for a minimum of 2 months.</li> </ul> </li> <li>Reduction of allogeneic blood transfusion in</li> </ul>	N/A	Current hematocrit and hemoglobin labs	N/A	CKD and CRF 6 months, renewable every 6 months. Cancer and all other indications, 3 months, renewable

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
	surgery patients. <ul style="list-style-type: none"> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>				
<b>Protopic</b>	<ul style="list-style-type: none"> <li>Tacrolimus (Protopic) is covered for the treatment of atopic dermatitis. On February 15, 2005, the FDA announced a new Black Box warning on the professional label for Protopic (tacrolimus topical), instructing prescribers to use only after failure of other eczema treatments due to a possible increased cancer risk.</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	N/A	<b>Patient age:</b> Protopic is not indicated for children younger than 2 years.	6 weeks
<b>Provigil</b>	<ul style="list-style-type: none"> <li>Narcolepsy</li> <li>Improve wakefulness in patients with excessive daytime sleepiness</li> <li>Obstructive sleep apnea</li> <li>Improve excessive sleepiness, as an adjunct to standard treatment(s) for the underlying obstruction such as C-PAP adjunct shift work sleep disorder</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Clinical documentation of narcolepsy, obstructive sleep apnea, or shift work sleep disorder.	<b>Patient age</b> must be 16 years or older.	One year
<b>Pulmozyme</b>	<ul style="list-style-type: none"> <li>Daily administration of Pulmozyme (dornase alpha) Inhalation Solution in conjunction with standard therapies is indicated in the management of cystic fibrosis patients to improve pulmonary function.</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Clinical documentation of cystic fibrosis diagnosis	<b>Patient age:</b> In patients younger than 5 years, its use should be considered only if there is a potential for benefit in pulmonary function or in risk of respiratory tract infection. <b>Other:</b> Pulmozyme should be used in conjunction with standard therapies for CF.	1st approval 6 months, and 12 months for subsequent approvals
<b>Regranex</b>	<ul style="list-style-type: none"> <li>REGANEX (becaplermin) Gel is indicated for the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply.</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Debridement and ulcer treatment notes documenting infection level and blood supply	N/A	3 months per approval
<b>Relistor</b>	<ul style="list-style-type: none"> <li>For the treatment of opioid-induced constipation in patients with advanced illness who are receiving</li> </ul>	Not approved in patients who: <ul style="list-style-type: none"> <li>do not have advanced</li> </ul>	Documentation of advanced illness /	<b>Patient age:</b> Safety and efficacy in pediatric population has not been	One year

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
	<p>palliative care when response to laxative therapy has not been sufficient.</p> <ul style="list-style-type: none"> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	<p>illness and are also receiving palliative care</p> <ul style="list-style-type: none"> <li>have not tried at least two other laxative therapies</li> </ul>	<p>palliative care. Documentation of at least two (2) previous laxative trials and reason for failures.</p>	<p>established.</p>	
<b>Remicade</b>	<ul style="list-style-type: none"> <li>Ankylosing spondylitis</li> <li>Crohn's disease,</li> <li>Fistulizing Crohn's disease (moderate to severe)</li> <li>Psoriasis with arthropathy</li> <li>Rheumatoid arthritis, in combination with methotrexate</li> <li>Ulcerative colitis, treatment-refractory</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	N/A	<p><b>Initial diagnosis and prescription</b> should be made by rheumatologist, GI specialist, or dermatologist.</p>	1 year
<b>Sabril</b>	<ul style="list-style-type: none"> <li>Adjunctive therapy in patients with refractory complex partial seizures (CPS) who have responded inadequately to several alternative treatments and for whom the potential benefits outweigh the risk of vision loss, —OR—</li> <li>Monotherapy for pediatric patients one month to two years of age with infantile spasms (IS) for whom the potential benefits outweigh the potential risk of vision loss.</li> <li>All FDA-approved indications not otherwise excluded for Part D.</li> </ul>	N/A	<p>Documentation of diagnosis of refractory complex partial seizures or infantile spasms.</p>	<p><b>Patient age:</b> 18 years and older for CPS diagnosis. Children aged one month to two years old for IS. <b>Other:</b> Only prescribers and pharmacies registered with SHARE may prescribe and distribute SABRIL.</p>	1 year
<b>Samsca</b>	<ul style="list-style-type: none"> <li>Treatment of clinically significant hypervolemic and euvolemic hyponatremia, defined as a serum sodium less than 125 mEq/L or marked hyponatremia that is symptomatic and has resisted correction with fluid restriction, including patients with heart failure, cirrhosis, and Syndrome of Inappropriate Antidiuretic Hormone (SIADH).</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	<ul style="list-style-type: none"> <li>Patients with sodium serum levels above 125 mEq/L who are asymptomatic</li> <li>As an intervention to raise serum sodium urgently to prevent or to treat serious neurological symptoms.</li> </ul>	<p>Serum sodium levels</p> <p>Documentation of trial and failure of fluid restriction required.</p>	<p><b>Other:</b> Cannot be initiated or re-initiated outside of a hospital setting.</p>	6 months
<b>Sandostatin</b>	<ul style="list-style-type: none"> <li>Acromegaly carcinoid syndrome</li> <li>Associated flushing and diarrhea</li> <li>Diarrhea - Vasoactive intestinal peptide-secreting</li> </ul>	N/A	<p>Clinical documentation of diagnosis and any applicable and</p>	<p><b>Prescribers:</b></p> <ul style="list-style-type: none"> <li>Acromegaly treatment should be initiated by an endocrinologist.</li> </ul>	6 months to 1 year

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
	tumor <ul style="list-style-type: none"> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>		supporting laboratory values.	<ul style="list-style-type: none"> <li>Carcinoid tumors treatment should be initiated by an oncologist.</li> <li>VIPomas - use must be recommended by oncologist.</li> </ul> <b>Other:</b> For coverage in other disease states, the guidelines set forth by CMS regarding off-label coverage of medications will be used. The diagnosis for use must be listed in the Medicare recognized compendia (AHFS, USP-DI, or DrugDex) for consideration of coverage. Medical Director will review evidence as stated in compendia to determine if coverage for rare disease states is appropriate.	
<b>Serostim</b>	<ul style="list-style-type: none"> <li>Serostim is a human growth hormone and the only therapy for HIV-wasting</li> <li>FDA-approved to increase weight and lean body mass (LBM), and improve physical endurance.</li> <li>It is indicated for the treatment of HIV wasting in patients receiving antiretroviral therapy.</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	<ul style="list-style-type: none"> <li>Clear HIV diagnosis</li> <li>Record of weight changes</li> <li>Amylase levels</li> </ul>	N/A	3 months initially, renewable every 3 months.
<b>Skelaxin</b>	<ul style="list-style-type: none"> <li>Skelaxin is an oral CNS depressant used as adjunct therapy for acute, painful musculoskeletal conditions.</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	Patient must have tried and failed on at least two other formulary muscle relaxants (such as methocarbamol, cyclobenzaprine).	N/A	<b>Patient age:</b> Should not be used in children younger than 12 years.	6 months
<b>Somatuline</b>	<ul style="list-style-type: none"> <li>Treatment of acromegaly in patients who have failed or are not candidates for surgery or radiation.</li> <li>All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	Patient must have FDA-approved indication for treatment.	<ul style="list-style-type: none"> <li>Clinical documentation verifying patient has failed or has contraindication to surgery or radiation.</li> </ul>	<b>Patient age:</b> 18 years of age and older. <b>Prescriber</b> must be endocrinologist.	3 months initially. Continue 6 months if no progression.
<b>Sutent</b>	<ul style="list-style-type: none"> <li>Treatment of gastrointestinal stromal tumor (GIST) after disease progression or intolerance to imatinib mesylate.</li> </ul>	N/A	Staging information and imaging studies required at baseline and	<b>Patient age</b> must be at least 18 years. <b>Prescriber</b> must be oncologist. <b>Other:</b> For coverage in other disease	3 months initially, then renewable in 6-month

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
	<ul style="list-style-type: none"> <li>• Also indicated for advanced renal cell carcinoma.</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>		at intervals for documentation of disease status and progression.	states, the guidelines set forth by CMS regarding off-label coverage of medications will be used. The diagnosis for use must be listed in the Medicare recognized compendia (AHFS, USP-DI, or DrugDex) for consideration of coverage. Medical Director will review evidence as stated in compendia to determine if coverage for rare disease states is appropriate.	increments.
<b>Tasigna</b>	<ul style="list-style-type: none"> <li>• Nilotinib (Tasigna) is a tyrosine kinase inhibitor that is FDA-approved for the treatment of chronic phase and accelerated phase Philadelphia chromosome positive chronic myelogenous leukemia (Ph+ CML) in adult patients resistant to or intolerant to prior therapy that included imatinib.</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	<ul style="list-style-type: none"> <li>• Cytology reports supporting Philadelphia positive chromosome</li> <li>• CML diagnosis</li> <li>• Baseline ECG</li> <li>• Baseline electrolyte values if appropriate</li> </ul>	<b>Patient age:</b> Safe and effective use not established in children. <b>Prescriber</b> must be oncologist.	12 weeks. Renewable in 6-month increments when patient continues to benefit and clinical assessment supports continuation.
<b>Trisenox</b>	<ul style="list-style-type: none"> <li>• Trisenox is covered for FDA orphan drug designations including the treatment of APL, chronic and acute myeloid leukemias, multiple myeloma, and myelodysplastic syndromes.</li> <li>• The FDA-approved Trisenox for relapsed or refractory APL in September 2000.</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Patient's APL must be characterized by the t(15:17) translocation or PML/RAR-alpha gene expression. Verification of translocation must be provided with request for coverage.	<b>Patient age:</b> Safety and efficacy have not been established in children less than 5 years of age. <b>Prescriber</b> must be oncologist.	14 weeks, includes induction and consolidation treatment.
<b>Tykerb</b>	<ul style="list-style-type: none"> <li>• For patients with advanced or metastatic breast cancer whose tumors over-express HER2 and who have received prior therapy including an anthracycline, a taxane, and trastuzumab, for use in combination with capecitabine.</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Staging of disease, clinical progress notes, and available diagnostic imaging due at baseline and with subsequent renewal requests.	<b>Prescriber:</b> Oncologist must prescribe and monitor treatment.	3 months first approval, then approvable every 6 months.
<b>Vancocin</b>	<ul style="list-style-type: none"> <li>• Treatment of patients with infections caused by staphylococcal species and streptococcal species.</li> <li>• Used orally for staphylococcal enterocolitis or for</li> </ul>	N/A	Cultures and sensitivities.	N/A	10-14 days

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
	antibiotic-associated pseudomembranous colitis produced by <i>C. difficile</i> . • All FDA-approved indications not otherwise excluded from Part D.				
<b>Vectical</b>	• Topical treatment of mild to moderate plaque psoriasis. • All FDA-approved indications not otherwise excluded from part D.	N/A	N/A	<b>Patient age</b> must be 18 years or older. <b>Prescriber</b> must be dermatologist. <b>Other:</b> Per manufacturer, dosing not to exceed 200 g weekly.	6 months
<b>Velcade</b>	VELCADE is a proteasome inhibitor indicated for: • treatment of patients with multiple myeloma who have received at least 1 prior therapy • treatment of patients with mantle cell lymphoma who have received at least 1 prior therapy • All FDA-approved indications not otherwise excluded from Part D.	N/A	Laboratory values to support diagnosis of either multiple myeloma or mantle cell lymphoma.	<b>Patient age:</b> Safe and effective use not established for adolescents or children. <b>Prescriber</b> must be oncologist.	3 months. Renewable for six months in situations where treatment continues to provide clinical benefit.
<b>Vidaza</b>	• For the treatment of myelodysplastic syndrome (MDS), specifically refractory anemia or refractory anemia with ringed sideroblasts (if accompanied by neutropenia or thrombocytopenia or requiring transfusions), refractory anemia with excess blasts, refractory anemia with excess blasts in transformation, and chronic myelomonocytic leukemia • All FDA-approved indications not otherwise excluded from Part D.	N/A	Laboratory values for • Baseline WBC (should be greater than or equal to 3000/mm <sup>3</sup> ) • Absolute neutrophil count (ANC) • Nadir greater than or equal to 1500/mm <sup>3</sup> • Platelet count greater than or equal to 75,000/mm <sup>3</sup> prior to beginning treatment.	<b>Prescriber</b> must be hematologist or oncologist.	Initial approval 4 months. Continued approval based on response.
<b>Votrient</b>	• Treatment of patients with advanced renal cell carcinoma. • All FDA-approved indications not otherwise excluded from part D.	N/A	Patient must have the following clinically documented: • Diagnosis of advanced renal cell carcinoma. • Failed trial or contraindication to Sutent or Nexavar.	<b>Patient age</b> must be 18 years or older. <b>Prescriber</b> must be oncologist	3 months initially then 6 months thereafter if no progression

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
<b>Xenazine</b>	<ul style="list-style-type: none"> <li>• For the treatment of chorea associated with Huntington’s Disease.</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	<p>Xenazine is contraindicated in patients</p> <ul style="list-style-type: none"> <li>• who are actively suicidal and in patients with untreated or inadequately treated depression.</li> <li>• with impaired hepatic function.</li> <li>• are taking MAO inhibitors</li> <li>• are taking reserpine</li> </ul>	<ul style="list-style-type: none"> <li>• Diagnosis of chorea associated with Huntington’s Disease.</li> <li>• Proof of REMS participation by physician.</li> </ul>	N/A	Six months.
<b>Xifaxin</b>	<ul style="list-style-type: none"> <li>• Traveler’s diarrhea caused by noninvasive strains of E. coli.</li> <li>• All FDA-approved indications not otherwise excluded from part D.</li> </ul>	N/A	Clinical documentation of an FDA covered indication	<p><b>Patient age</b> must be 12 years or older  <b>Other:</b> Medical Director to review case-by-case for diagnosis of Hepatic Encephalopathy. Special considerations:</p> <ul style="list-style-type: none"> <li>• Clinical trials data shows similar efficacy between Xifaxin and lactulose for the treatment of hepatic encephalopathy.</li> <li>• Clinical trials data shows similar efficacy between Xifaxin and ciprofloxacin for the treatment of traveler’s diarrhea.</li> <li>• Adverse effects profile of Xifaxin has shown to be preferable to other first-line therapies for each indication.</li> </ul>	<p>30 days for traveler’s diarrhea.</p> <p>Six months for hepatic encephalopathy.</p>
<b>Xolair</b>	<ul style="list-style-type: none"> <li>• Xolair is indicated for adults 12 years and older with moderate to severe persistent asthma: <ul style="list-style-type: none"> <li>– who have a positive skin test or in vitro reactivity to a perennial aeroallergen and</li> <li>– whose symptoms are inadequately controlled with inhaled corticosteroids.</li> </ul> </li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Positive skin test or in vitro testing (i.e., a blood test for allergen-specific IgE antibodies such as the RAST) for one or more perennial aeroallergens.	<p><b>Patient age</b> must be 12 years or older.  <b>Prescriber</b> must be allergist or pulmonologist for initial order.  <b>Other:</b> Note that total IgE levels are elevated during treatment and remain elevated for up to one year after discontinuing treatment. Therefore, re-testing of IgE levels during treatment cannot be used as a guide for dose determination. Dose determination</p>	Six months per approval.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Restrictions (Prescriber/patient age/other)	Coverage Duration
				after treatment interruptions lasting less than 1 year should be based on serum IgE levels obtained at the initial dose determination.	
<b>Zavesca</b>	<ul style="list-style-type: none"> <li>• Zavesca is used for the treatment of type 1 Gaucher disease. Zavesca was approved by the FDA for patients with mild to moderate type 1 Gaucher's disease in whom enzyme replacement therapy is not an option.</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Documentation that hemoglobin is greater than 9g/dL and platelet count is greater than 50/mm <sup>3</sup> . Creatinine clearance results	<b>Patient age:</b> Safe and effective use has not been established for adolescents and children. <b>Other:</b> Written consultation with trained specialists (either a geneticist or hematologist) required.	1 year
<b>Zometa</b>	<ul style="list-style-type: none"> <li>• Prevention of skeletal-related events (pathological fractures, spinal compression, radiation or surgery to bone, or tumour-induced hypercalcaemia) in patients with advanced malignancies involving bone. Treatment of hypercalcemia of malignancy (HCM).</li> <li>• Multiple myeloma.</li> <li>• All FDA-approved indications not otherwise excluded from Part D.</li> </ul>	N/A	Albumin-corrected serum calcium of 12 mg/dL or greater	N/A	1 year
<b>Cyclosporine</b> <b>Cyclophosphamide</b> <b>Azathioprine</b> <b>Methotrexate</b> <b>Etoposide</b> <b>Prograf</b> <b>Cellcept</b> <b>Rapamune</b> <b>Emend</b>	<ul style="list-style-type: none"> <li>• These drugs may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of these drugs to make the determination.</li> </ul>	N/A	N/A	N/A	N/A

A Medicare Advantage organization with a Medicare contract. The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information contact the plan. Benefits, formulary, pharmacy network, premium and/or co-payments/co-insurance may change on January 1, 2012. You must use network pharmacies to access your prescription drug benefit, except under non-

routine circumstances when you cannot reasonably use a network pharmacy. Quantity limitations, copayments, and restrictions may apply. This document may be available in alternate formats or languages by contacting our Customer Service Department at the number listed below.

**More information** For more information on authorizations, eligibility, enrollment, pharmacies, prescriptions, or any other

benefits, please contact Health First Health Plans Customer Service: Call any day of the week from 8 am to 8 pm: 321-434-5665, toll-free 1-800-716-7737, or through TDD relay 1-800-955-8771. • Visit our office Monday through Friday 8 am to 5 pm or write to us at 6450 US Highway 1, Rockledge, FL 32955. • Visit our web site at [www.HealthFirstHealthPlans.org](http://www.HealthFirstHealthPlans.org).