

Soliris® (eculizumab) (Intravenous)

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I. Length of Authorization

- PNH and aHUS: Coverage will be provided for twelve (12) months and may be renewed.
- gMG and NMOSD: Initial coverage will be provided for six (6) months and may be renewed annually thereafter.

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

Loading Doses:

3 vials Days 1, 8, 15, & 22; then 4 vials Day 29

Maintenance Dose:

4 vials every 14 days

B. Max Units (per dose and over time) [HCPCS Unit]:

Indication	Loading Doses	Maintenance Dose
PNH	60 billable units Days 1, 8, 15, & 22; then 90 billable units Day 29	90 billable units every 14 days
aHUS, gMG, NMOSD	90 billable units Days 1, 8, 15, & 22; then 120 billable units Day 29	120 billable units every 14 days

III. Initial Approval Criteria ¹

Coverage is provided in the following conditions:

- Patient is at least 18 years of age (unless otherwise specified); **AND**

- Prescriber is enrolled in the Soliris Risk Evaluation and Mitigation Strategy (REMS) program; **AND**

Universal Criteria ¹

- Patient must be vaccinated against meningococcal disease at least two weeks prior to initiation of therapy and will continue to be revaccinated according to current medical guidelines for vaccine use (*If urgent Soliris therapy is indicated in an unvaccinated patient, administer meningococcal vaccine(s) as soon as possible and provide patients with two weeks of antibacterial drug prophylaxis*); **AND**
- Patient does not have an unresolved, serious systemic infection (e.g., *Neisseria meningitidis*, etc.); **AND**
- Will not be used in combination with other immunomodulatory biologic therapies (i.e., efgartigimod, ravulizumab, pegcetacoplan, satralizumab, inebilizumab, etc.) [*Note: a 4-week run-in period is allowed when transitioning from eculizumab to pegcetacoplan*]; **AND**

Paroxysmal Nocturnal Hemoglobinuria (PNH) † ⊕ ^{1,2-6,9,16,23}

- Diagnosis must be accompanied by detection of PNH clones of at least 10% by flow cytometry diagnostic testing; **AND**
 - Demonstrate the presence of at least 2 different glycosylphosphatidylinositol (GPI) protein deficiencies (e.g., CD55, CD59, etc.) within at least 2 different cell lines (e.g., granulocytes, monocytes, erythrocytes); **AND**
- Patient has laboratory evidence of significant intravascular hemolysis (i.e., LDH ≥ 1.5 x ULN) with symptomatic disease and at least one other indication for therapy from the following (regardless of transfusion dependence):
 - Patient has symptomatic anemia (i.e., hemoglobin < 7 g/dL or hemoglobin < 10 g/dL, in at least two independent measurements in a patient with cardiac symptoms)
 - Presence of a thrombotic event related to PNH
 - Presence of organ damage secondary to chronic hemolysis (i.e., renal insufficiency, pulmonary insufficiency/hypertension)
 - Patient is pregnant and potential benefit outweighs potential fetal risk
 - Patient has disabling fatigue
 - Patient has abdominal pain (requiring admission or opioid analgesia), dysphagia, or erectile dysfunction; **AND**
- Documented baseline values for one or more of the following (necessary for renewal): serum lactate dehydrogenase (LDH), hemoglobin level, packed RBC transfusion requirement, and history of thrombotic events; **AND**
- Patient had an inadequate response, contraindication, or intolerance to a trial of ravulizumab (Ultomiris®)

Atypical Hemolytic Uremic Syndrome (aHUS) † Φ 1,7,8,10,17

- Patient is at least 2 months of age; **AND**
- Patient shows signs of thrombotic microangiopathy (TMA) (e.g., changes in mental status, seizures, angina, dyspnea, thrombosis, increasing blood pressure, decreased platelet count, increased serum creatinine, increased LDH, etc.); **AND**
- Thrombotic Thrombocytopenic Purpura (TTP) has been ruled out by evaluating ADAMTS-13 level (i.e., ADAMTS-13 activity level $\geq 10\%$); **AND**
- Shiga toxin *E. coli* related hemolytic uremic syndrome (STEC-HUS) has been ruled out; **AND**
- Other causes have been ruled out such as coexisting diseases or conditions (e.g., bone marrow transplantation, solid organ transplantation, malignancy, autoimmune disorder, drug-induced, malignant hypertension, HIV infection, *Streptococcus pneumoniae* sepsis or known genetic defect in cobalamin C metabolism, etc); **AND**
- Documented baseline values for one or more of the following (necessary for renewal): serum lactate dehydrogenase (LDH), serum creatinine/eGFR, platelet count, and plasma exchange/infusion requirement; **AND**
- Patient had an inadequate response, contraindication, or intolerance to a trial of ravulizumab (Ultomiris®)

Generalized Myasthenia Gravis (gMG) † Φ 1,11,12, 18-22

- Patient has Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II to IV disease §; **AND**
- Patient has a positive serologic test for anti-acetylcholine receptor (AChR) antibodies; **AND**
- Patient has had a thymectomy (*Note: Applicable only to patients with thymomas OR non-thymomatous patients who are 50 years of age or younger*); **AND**
- Physician has assessed objective signs of neurological weakness and fatiguability on a baseline neurological examination (e.g., including, but not limited to, the Quantitative Myasthenia Gravis (QMG) score, etc.); **AND**
- Patient has a MG-Activities of Daily Living (MG-ADL) total score of ≥ 6 ; **AND**
- Patient will avoid or use with caution medications known to worsen or exacerbate symptoms of MG (e.g., certain antibiotics, beta-blockers, botulinum toxins, hydroxychloroquine, etc.); **AND**
- Patient had an inadequate response after a minimum one-year trial with two (2) or more immunosuppressive therapies (e.g., corticosteroids plus an immunosuppressant such as azathioprine, cyclosporine, mycophenolate, etc.); **OR**
 - Patient required chronic treatment with plasmapheresis or plasma exchange (PE) or intravenous immunoglobulin (IVIG) in addition to immunosuppressant therapy; **AND**
- Patient had an inadequate response, contraindication, or intolerance to a trial of ravulizumab (Ultomiris®)

§ Myasthenia Gravis Foundation of America (MGFA) Disease Clinical Classification ¹⁹:

- **Class I:** Any ocular muscle weakness; may have weakness of eye closure. All other muscle strength is normal.
- **Class II:** Mild weakness affecting muscles other than ocular muscles; may also have ocular muscle weakness of any severity.
 - **IIa.** Predominantly affecting limb, axial muscles, or both. May also have lesser involvement of oropharyngeal muscles.
 - **IIb.** Predominantly affecting oropharyngeal, respiratory muscles, or both. May also have lesser or equal involvement of limb, axial muscles, or both.
- **Class III:** Moderate weakness affecting muscles other than ocular muscles; may also have ocular muscle weakness of any severity.
 - **IIIa.** Predominantly affecting limb, axial muscles, or both. May also have lesser involvement of oropharyngeal muscles.
 - **IIIb.** Predominantly affecting oropharyngeal, respiratory muscles, or both. May also have lesser or equal involvement of limb, axial muscles, or both.
- **Class IV:** Severe weakness affecting muscles other than ocular muscles; may also have ocular muscle weakness of any severity.
 - **IVa.** Predominantly affecting limb, axial muscles, or both. May also have lesser involvement of oropharyngeal muscles.
 - **IVb.** Predominantly affecting oropharyngeal, respiratory muscles, or both. May also have lesser or equal involvement of limb, axial muscles, or both.
- **Class V:** Defined as intubation, with or without mechanical ventilation, except when employed during routine postoperative management. The use of a feeding tube without intubation places the patient in class IVb.

Neuromyelitis Optica Spectrum Disorder (NMOSD) † Φ ^{1,13-15}

- Patient has a confirmed diagnosis based on the following:
 - Patient was found to be seropositive for aquaporin-4 (AQP4) IgG antibodies; **AND**
 - Patient has at least one core clinical characteristic §; **AND**
 - Alternative diagnoses have been excluded (e.g., multiple sclerosis, sarcoidosis, cancer, chronic infection, etc.); **AND**
- Patient has a history of at least 2 relapses in the last 12 months OR 3 relapses in the last 24 months, with at least 1 relapse in the last 12 months; **AND**
- Patient has an Expanded Disability Status Score (EDSS) of ≤ 7.0 (i.e., presence of at least limited ambulation with aid); **AND**
- Patient is receiving concurrent corticosteroid therapy of 20 mg per day or less and those receiving immunosuppressive therapy (e.g. azathioprine, glucocorticoids, mycophenolate, etc.) are on a stable dose regimen; **AND**
- Patient has not received therapy with rituximab or mitoxantrone in the last 3 months; **AND**
- Patient has not received intravenous immune globulin (IVIG) in the last 3 weeks; **AND**
- Patient had an inadequate response, or has a contraindication or intolerance, to rituximab OR inebilizumab; **AND**
- Patient will not concomitantly receive therapy with any of the following:
 - IL6-inhibitor (e.g., satralizumab); **AND**
 - Anti-CD20-directed antibody (e.g., rituximab); **AND**

- Anti-CD19-directed antibody (e.g., inebilizumab)

§ Core Clinical Characteristics of NMOSD ¹⁵

- Optic neuritis
- Acute myelitis
- Area postrema syndrome: episode of otherwise unexplained hiccups or nausea and vomiting
- Acute brainstem syndrome
- Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
- Symptomatic cerebral syndrome with NMOSD-typical brain lesions

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); Ⓢ Orphan Drug

IV. Renewal Criteria ^{1-6,23}

Coverage may be renewed based upon the following criteria:

- Patient continues to meet the universal and other indication-specific relevant criteria identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: serious meningococcal infections (septicemia and/or meningitis), infusion reactions, serious infections, thrombotic microangiopathy complications (TMA), etc.; **AND**

Paroxysmal Nocturnal Hemoglobinuria (PNH)

- Patient has not developed severe bone marrow failure syndrome (i.e., aplastic anemia or myelodysplastic syndrome) OR experienced a spontaneous disease remission OR received curative allogeneic stem cell transplant; **AND**
- Disease response indicated by one or more of the following:
 - Decrease in serum LDH from pretreatment baseline Stabilization/improvement in hemoglobin level from pretreatment baseline
 - Decrease in packed RBC transfusion requirement from pretreatment baseline (i.e., reduction of at least 30%)
 - Reduction in thromboembolic events

Atypical Hemolytic Uremic Syndrome (aHUS)

- Disease response indicated by one or more of the following:
 - Decrease in serum LDH from pretreatment baseline
 - Stabilization/improvement in serum creatinine/eGFR from pretreatment baseline
 - Increase in platelet count from pretreatment baseline
 - Decrease in plasma exchange/infusion requirement from pretreatment baseline

Generalized Myasthenia Gravis (gMG)

- Patient experienced an improvement (i.e., reduction) of at least 3-points from baseline in the Myasthenia Gravis-Specific Activities of Daily Living scale (MG-ADL) total score; **OR**
- Patient experienced an improvement of at least 5-points from baseline in the Quantitative Myasthenia Gravis (QMG) total score

Neuromyelitis Optica Spectrum Disorder (NMOSD)

- Patient has stabilization and/or improvement of neurologic symptoms as evidenced by a decrease in acute relapses, EDSS, hospitalizations, or plasma exchange treatments

V. Dosage/Administration

Indication	Dose*
Paroxysmal nocturnal hemoglobinuria (PNH)	<u>Loading dose:</u> – 600 mg intravenously every 7 days for the first 4 weeks, followed by 900 mg intravenously for the fifth dose 7 days later <u>Maintenance dose:</u> – 900 mg intravenously every 14 days
Atypical hemolytic uremic syndrome (aHUS)	Adults <u>Loading dose:</u> – 900 mg intravenously every 7 days for the first 4 weeks, followed by 1,200 mg intravenously for the fifth dose 7 days later <u>Maintenance dose:</u> – 1200 mg intravenously every 14 days Patients < 18 years <u>5 kg - <10 kg:</u> – 300 mg weekly x 1 dose, 300 mg at week 2, then 300 mg every 3 weeks <u>10 kg - <20 kg:</u> – 600 mg weekly x 1 dose, 300 mg at week 2, then 300 mg every 2 weeks <u>20 kg - <30 kg:</u> – 600 mg weekly x 2 doses, 600 mg at week 3, then 600 mg every 2 weeks <u>30 kg - <40 kg:</u> – 600 mg weekly x 2 doses, 900 mg at week 3, then 900 mg every 2 weeks <u>≥ 40 kg:</u> – 900 mg weekly x 4 doses, 1200 mg at week 5, then 1200 mg every 2 weeks
Generalized Myasthenia Gravis (gMG) and Neuromyelitis Optica Spectrum Disorder (NMOSD)	<u>Loading dose:</u> – 900 mg intravenously every 7 days for the first 4 weeks, followed by 1,200 mg intravenously for the fifth dose 7 days later <u>Maintenance dose:</u> – 1200 mg intravenously every 14 days
Dose Adjustment for adult patients with aHUS (includes pediatric patients), gMG, and NMOSD in case of Plasmapheresis, Plasma Exchange or Fresh Frozen Plasma Infusion	
<u>Type of Plasma Intervention</u>	<u>Most Recent Soliris Dose</u> <u>Supplemental Soliris With Each Plasma Intervention</u> <u>Timing of Supplemental Soliris Dose</u>

SOLIRIS® (eculizumab) Prior Auth Criteria

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Plasmapheresis or plasma exchange (PE)	300 mg	300 mg per each plasmapheresis or PE	Within 60 minutes after each plasmapheresis or PE
	≥ 600 mg	600 mg per each plasmapheresis or PE	
Fresh frozen plasma infusion (FFP)	≥ 300 mg	300 mg per each infusion of FFP	60 minutes prior to each infusion of FFP

**Doses should be administered at the above intervals, or within two days of these time points.*

VI. Billing Code/Availability Information

HCPCS Code:

- J1300 – Injection, eculizumab, 10 mg; 1 billable unit = 10 mg

NDC:

- Soliris 300 mg/30 mL single-dose vials for injection: 25682-0001-xx

VII. References

1. Soliris [package insert]. Boston, MA; Alexion Pharmaceuticals, Inc; November 2020. Accessed May 2022.
2. Guidelines for the diagnosis and monitoring of paroxysmal nocturnal hemoglobinuria and related disorders by flow cytometry. Borowitz MJ, Craig FE, DiGiuseppe JA, Illingworth AJ, Rosse W, Sutherland DR, Wittwer CT, Richards SJ. Cytometry B Clin Cytom. 2010 Jul;78(4):211-30. doi: 10.1002/cyto.b.20525.
3. Effect of eculizumab on hemolysis and transfusion requirements in patients with paroxysmal nocturnal hemoglobinuria. Hillmen P; Hall C; Marsh JC; Elebute M; Bombara MP; Petro BE; Cullen MJ; Richards SJ; Rollins SA; Mojcik CF; Rother RP. N Engl J Med 2004 Feb 5;350(6):552-9.
4. The complement inhibitor eculizumab in paroxysmal nocturnal hemoglobinuria. Hillmen P; Young NS; Schubert J; Brodsky RA; Socie G; Muus P; Roth A; Szer J; Elebute MO; Nakamura R; Browne P; Risitano AM; Hill A; Schrezenmeier H; Fu CL; Maciejewski J; Rollins SA; Mojcik CF; Rother RP; Luzzatto L. N Engl J Med. 2006 Sep 21;355(12):1233-43.
5. Multicenter phase 3 study of the complement inhibitor eculizumab for the treatment of patients with paroxysmal nocturnal hemoglobinuria. Brodsky RA; Young NS; Antonioli E; Risitano AM; Schrezenmeier H; Schubert J; Gaya A; Coyle L; de Castro C; Fu CL; Maciejewski JP; Bessler M; Kroon HA; Rother RP; Hillmen P. Blood. 2008 Feb 15;111(4):1840-7. Epub 2007 Nov 30.
6. Parker C, Omine M, Richards S, et al. Diagnosis and management of paroxysmal nocturnal hemoglobinuria. Blood. 2005 Dec 1. 106(12):3699-709.
7. Loirat C, Fakhouri F, Ariceta G, et al. An international consensus approach to the management of atypical hemolytic uremic syndrome in children. Pediatr Nephrol. 2016 Jan;31(1):15-39.

8. Taylor CM, Machin S, Wigmore SJ, et al. Clinical practice guidelines for the management of atypical haemolytic uraemic syndrome in the United Kingdom. *Br J Haematol*. 2010 Jan;148(1):37-47.
9. Sahin F, Akay OM, Ayer M, et al. Pessg PNH diagnosis, follow-up and treatment guidelines. *Am J Blood Res*. 2016;6(2): 19-27.
10. Cheong HI, Kyung Jo S, Yoon SS, et al. Clinical Practice Guidelines for the Management of Atypical Hemolytic Uremic Syndrome in Korea. *J Korean Med Sci*. 2016 Oct;31(10):1516-1528.
11. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidance for management of myasthenia gravis-Executive Summary. *Neurology*. 2016 Jul 26; 87(4): 419-25.
12. Howard JF Jr, Utsugisawa K, Benatar M, et al. Safety and efficacy of eculizumab in anti-acetylcholine receptor antibody-positive refractory generalised myasthenia gravis (REGAIN): a phase 3, randomised, double-blind, placebo-controlled, multicentre study. *Lancet Neurol*. 2017 Dec;16(12):976-986.
13. Trebst C, Jarius S, Berthele A, et al. Update on the diagnosis and treatment of neuromyelitis optica: recommendations of the Neuromyelitis Optica Study Group (NEMOS). *J Neurol* 2014; 261:1.
14. Pittock SJ, Berthele A, Fujihara K, et al. Eculizumab in Aquaporin-4-Positive Neuromyelitis Optica Spectrum Disorder. *N Engl J Med* 2019.
15. Wingerchuk DM, Banwell B, Bennett JL, et al. International consensus diagnostic criteria for neuromyelitis optica spectrum disorders. *Neurology*. 2015 Jul;85(2):177-89. Epub 2015 Jun 19.
16. Patriquin CJ, Kiss T, Caplan S, et al. How we treat paroxysmal nocturnal hemoglobinuria: A consensus statement of the Canadian PNH Network and review of the national registry. *Eur J Haematol*. 2019;102(1):36. Epub 2018 Oct 25.
17. Lee H, Kang E, Kang HG, et al. Consensus regarding diagnosis and management of atypical hemolytic uremic syndrome. *Korean J Intern Med*. 2020;35(1):25-40. doi:10.3904/kjim.2019.388.
18. Narayanaswami P, Sanders D, Wolfe G, Benatar M, et al. International consensus guidance for management of myasthenia gravis, 2020 update. *Neurology®* 2021;96:114-122. doi:10.1212/WNL.0000000000001124.
19. Jayam-Trouth A, Dabi A, Solieman N, Kurukumbi M, Kalyanam J. Myasthenia gravis: a review. *Autoimmune Dis*. 2012;2012:874680. doi:10.1155/2012/874680
20. Gronseth GS, Barohn R, Narayanaswami P. Practice advisory: Thymectomy for myasthenia gravis (practice parameter update): Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. *Neurology*. 2020;94(16):705. Epub 2020 Mar 25.
21. Sussman J, Farrugia ME, Maddison P, et al. Myasthenia gravis: Association of British Neurologists' management guidelines. *Pract Neurol* 2015; 15: 199-206.
22. Institute for Clinical and Economic Review. Eculizumab and Efgartigimod for the Treatment of Myasthenia Gravis: Effectiveness and Value. Draft evidence report. July 22, 2021.

https://icer.org/wp-content/uploads/2021/03/ICER_Myasthenia-Gravis_Draft-Evidence-Report_072221.pdf. Accessed December 22, 2021.

23. Cançado RD, Araújo AdS, Sandes AF, et al. Consensus statement for diagnosis and treatment of paroxysmal nocturnal haemoglobinuria. *Hematology, Transfusion and Cell Therapy*, v43, Iss3, 2021, 341-348. ISSN 2531-1379, <https://doi.org/10.1016/j.htct.2020.06.006>.

24. National Government Services, Inc. Local Coverage Article: Billing and Coding: Eculizumab (A54548). Centers for Medicare & Medicaid Services, Inc. Updated 06/25/2021 with effective dates 07/01/2021. Accessed May 2022.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
D59.3	Hemolytic-uremic syndrome
D59.5	Paroxysmal nocturnal hemoglobinuria [Marchiafava-Micheli]
G36.0	Neuromyelitis optica [Devic]
G70.00	Myasthenia gravis without (acute) exacerbation
G70.01	Myasthenia gravis with (acute) exacerbation

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Articles (LCAs), and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at:

<https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCA/LCD):

Jurisdiction(s): 6; K		NCD/LCA/LCD Document (s): A54548
https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=54548&ver=20&bc=0		
Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC

Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. We do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:

Provide 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)

Provide 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 us at the phone number shown on the inside cover of this contract, your id card, or aspirushealthplan.com.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1062
Minneapolis, MN 55440
Phone: 1.866.631.5404 (TTY: 711)
Fax: 763.847.4010
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Nondiscrimination Grievance 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>.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.866.631.5404 (TTY: 711).

Arabic: تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلی رقم الهاتف 1.866.631.5404 (رقم هاتف الصم والبك : 711)

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

Hindi: _यान द_ : य_द आप िहंदी बोलते ह_ तो आपके िलए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_। 1.866.631.5404 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.866.631.5404 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

Traditional Chinese: 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 1.866.631.5404 (TTY: 711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

Lao: ໄປດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.866.631.5404 (TTY: 711).