

## Darzalex® (daratumumab) (Intravenous)

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### I. Length of Authorization <sup>1,16,17,19</sup>

Coverage will be provided for 6 months and may be renewed (unless otherwise specified).

- Use for newly diagnosed multiple myeloma in combination with bortezomib, thalidomide, and dexamethasone may not be renewed.
- Use for newly diagnosed multiple myeloma in combination with bortezomib, lenalidomide and dexamethasone may be renewed for up to a maximum of 2 years of maintenance therapy.
- Use for newly diagnosed or relapsed multiple myeloma in combination with cyclophosphamide, bortezomib and dexamethasone may be renewed for up to a maximum of 80 weeks (*32 weeks of induction therapy and 48 weeks of maintenance therapy*).
- Use for newly diagnosed multiple myeloma in combination with carfilzomib, lenalidomide, and dexamethasone may be renewed for up to a maximum of 32 weeks.
- Use for pediatric acute lymphoblastic leukemia may not be renewed.

### II. Dosing Limits

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

- Darzalex 100 mg single-dose vial for injection: Up to 3 vials per dose
  - *Weekly Weeks 1 to 8, then every two weeks Weeks 9-24, then every four weeks Week 25 onwards OR*
- Darzalex 400 mg single-dose vial for injection: Up to 4 vials per dose
  - *Weekly Weeks 1 to 8, then every two weeks Weeks 9-24, then every four weeks Week 25 onwards*

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

- Up to 180 billable units per dose

- *Weekly Week 1 to 8, then every two weeks Weeks 9-24, then every four weeks Week 25 onwards*

### III. Initial Approval Criteria <sup>1</sup>

Coverage is provided in the following conditions:

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

#### Universal Criteria

- Therapy will not be used in combination with other anti-CD38 therapies (i.e., daratumumab and hyaluronidase-fihj, isatuximab, etc.); **AND**

#### Multiple Myeloma † Φ <sup>1-11,13,14,16-19</sup>

- Used in the treatment of newly diagnosed disease in patients who are ineligible for autologous stem cell transplant (ASCT) in combination with ONE of the following regimens:
  - Lenalidomide and dexamethasone; **OR**
  - Bortezomib, melphalan, and prednisone; **OR**
  - Cyclophosphamide, bortezomib, and dexamethasone; **OR**
- Used in the treatment of newly diagnosed disease in patients who are eligible for autologous stem cell transplant (ASCT) in combination with ONE of the following regimens:
  - Bortezomib, lenalidomide, and dexamethasone; **OR**
  - Bortezomib, thalidomide, and dexamethasone (VTd); **OR**
  - Carfilzomib, lenalidomide, and dexamethasone; **OR**
  - Cyclophosphamide, bortezomib, and dexamethasone; **OR**
- Used for disease relapse after 6 months following primary induction therapy with the same regimen in combination with ONE of the following regimens:
  - Lenalidomide and dexamethasone for non-transplant candidates; **OR**
  - Cyclophosphamide, bortezomib, and dexamethasone; **OR**
- Used as subsequent therapy for relapsed or refractory/progressive disease in combination with dexamethasone and ONE of the following:
  - Lenalidomide; **OR**
  - Bortezomib; **OR**
  - Carfilzomib; **OR**
  - Cyclophosphamide and bortezomib; **OR**
  - Selinexor; **OR**
- Used in combination with pomalidomide and dexamethasone after prior therapy with lenalidomide and a proteasome inhibitor (bortezomib, carfilzomib, etc.); **OR**
- Used as single agent therapy; **AND**

- Patient received at least three prior lines of therapy including a proteasome inhibitor (e.g., bortezomib, carfilzomib, etc.) and an immunomodulatory agent (e.g., lenalidomide, pomalidomide, etc.); **OR**
- Patient is double-refractory to a proteasome inhibitor and an immunomodulatory agent; **OR**
- Used as maintenance therapy for symptomatic disease in transplant candidates; **AND**
  - Used as single agent therapy; **AND**
    - Used after response to primary myeloma therapy; **OR**
    - Used for response or stable disease following an autologous hematopoietic cell transplant (HCT); **OR**
    - Used for response or stable disease following a tandem autologous or allogeneic HCT for high risk\* patients

*\*High-risk as defined by the Revised International Staging System for Multiple Myeloma is the presence of del(17p) and/or translocation t(4;14) and/or translocation t(14;16). This is not an all-inclusive list. Refer to the NCCN Multiple Myeloma Guidelines for additional risk factors.*

#### **Systemic Light Chain Amyloidosis ‡<sup>2,12,15</sup>**

- Used as single agent therapy; **AND**
- Used for the treatment of relapsed/refractory disease

#### **Pediatric Acute Lymphoblastic Leukemia (ALL) ‡<sup>2,20-21</sup>**

- Patient age ≥ 1 and ≤ 30 years; **AND**
- Patient has relapsed/refractory T-cell ALL; **AND**
- Used in combination with vincristine, pegaspargase/calaspargase, doxorubicin, and prednisone/dexamethasone

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

## **IV. Renewal Criteria<sup>1,2,16,17,19</sup>**

Coverage can be renewed based upon the following criteria:

- Patient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe infusion reactions including anaphylactic reactions, neutropenia, thrombocytopenia, etc.; **AND**

### **Multiple Myeloma**

- Use for newly diagnosed disease in combination with bortezomib, thalidomide, and dexamethasone may not be renewed.
- Use for newly diagnosed disease in combination with bortezomib, lenalidomide and dexamethasone may be renewed for up to a maximum of 2 years of maintenance therapy.
- Use for newly diagnosed or relapsed disease in combination with cyclophosphamide, bortezomib and dexamethasone may be renewed for up to a maximum of 80 weeks (*32 weeks of induction therapy and 48 weeks of maintenance therapy*).
- Use for newly diagnosed disease in combination with carfilzomib, lenalidomide, and dexamethasone may be renewed for up to a maximum of 32 weeks.

### Pediatric Acute Lymphoblastic Leukemia

- May not be renewed

## V. Dosage/Administration <sup>1,12,16-19, 21</sup>

| Indication       | Dose  |
|------------------|---|
| Multiple Myeloma | <u>Newly diagnosed disease in patients eligible for ASCT in combination with bortezomib, thalidomide and dexamethasone</u> <ul style="list-style-type: none"> <li>▪ 16 mg/kg body weight given as an intravenous infusion in a 4 week cycle: <ul style="list-style-type: none"> <li>▪ Induction – <ul style="list-style-type: none"> <li>– Weekly Weeks 1 to 8 (eight doses; cycles 1 and 2)</li> <li>– Every two weeks Weeks 9 to 16 (four doses; cycles 3 and 4)</li> </ul> <i>Stop for high dose chemotherapy and ASCT</i> </li> <li>▪ Consolidation – <ul style="list-style-type: none"> <li>– Every two weeks Weeks 1 to 8 (four doses; cycles 5 and 6)</li> </ul> </li> </ul> </li> </ul>   |
|                  | <u>Newly diagnosed disease in patients eligible for ASCT in combination with bortezomib, lenalidomide and dexamethasone</u> <ul style="list-style-type: none"> <li>▪ 16 mg/kg body weight given as an intravenous infusion as follows: <ul style="list-style-type: none"> <li>▪ Induction – <b>3 week cycle</b> <ul style="list-style-type: none"> <li>– Weekly Weeks 1 to 12 (twelve doses; cycles 1 to 4)</li> </ul> </li> <li>▪ Consolidation – (<i>after ASCT</i>) – <b>3 week cycle</b> <ul style="list-style-type: none"> <li>– Every 3 weeks Weeks 13 to 18 (two doses; cycles 5 and 6)</li> </ul> </li> <li>▪ Maintenance – <b>4 week cycle</b> <ul style="list-style-type: none"> <li>– Every 4 or 8 weeks Weeks 1 to 104 for a maximum of 2 years of maintenance treatment</li> </ul> </li> </ul> </li> </ul> |
|                  | <u>Newly diagnosed disease in patients eligible for ASCT in combination with carfilzomib, lenalidomide, and dexamethasone</u> <ul style="list-style-type: none"> <li>▪ 16 mg/kg body weight given as an intravenous infusion in a 4 week cycle: <ul style="list-style-type: none"> <li>– Weekly Weeks 1 to 8 (eight doses; cycles 1 and 2)</li> <li>– Every two weeks Weeks 9 to 24 (eight doses; cycles 3 to 6)</li> <li>– Every four weeks Week 25 to 32 (two doses; cycles 7 and 8)</li> </ul> </li> </ul>   |
|                  | <u>Newly diagnosed disease in patients ineligible for ASCT in combination with bortezomib, melphalan and prednisone</u> <ul style="list-style-type: none"> <li>▪ 16 mg/kg body weight given as an intravenous infusion in a 6 week cycle:</li> </ul>  |
|                  |   |

|  |  |
|--|--|
|  | <ul style="list-style-type: none"> <li>– Weekly Weeks 1 to 6 (six doses; cycle 1)</li> <li>– Every three weeks Weeks 7 to 54 (16 doses; cycles 2 to 9)</li> <li>– Every four weeks Week 55 onwards (cycle 10 and beyond)</li> </ul> <p><i>Treat until disease progression or unacceptable toxicity</i></p>   |
|  | <p><u>Newly diagnosed OR relapsed disease in combination with cyclophosphamide, bortezomib and dexamethasone</u></p> <p>Induction</p> <ul style="list-style-type: none"> <li>▪ 8 mg/kg body weight given as an intravenous infusion on days 1 and 2 (Week 1; total 2 doses)</li> <li>▪ Followed by 16 mg/kg body weight given as an intravenous infusion in a 4 week cycle: <ul style="list-style-type: none"> <li>– Weekly Weeks 2 to 8 (seven doses; cycles 1 and 2)</li> <li>– Every two weeks Weeks 9 to 24 (eight doses; cycles 3 to 6)</li> <li>– Every four weeks Week 25 to 32 (two doses; cycles 7 and 8)</li> </ul> </li> </ul> <p>Maintenance (<i>after ASCT</i>)</p> <ul style="list-style-type: none"> <li>▪ 16 mg/kg body weight given as an intravenous infusion every 4 weeks for up to 12 cycles (48 weeks)</li> </ul>  |
|  | <p><u>Treatment as one of the following:</u></p> <ul style="list-style-type: none"> <li>• Monotherapy for patients with relapsed/refractory multiple myeloma</li> <li>• Combination therapy with lenalidomide and low-dose dexamethasone for newly diagnosed patients ineligible for ASCT</li> <li>• Combination therapy with lenalidomide, pomalidomide, or selinexor AND low-dose dexamethasone in patients with relapsed or refractory/progressive disease</li> </ul> <ul style="list-style-type: none"> <li>▪ 16 mg/kg body weight given as an intravenous infusion in a 4 week cycle: <ul style="list-style-type: none"> <li>– Weekly Weeks 1 to 8 (eight doses; cycles 1 and 2)</li> <li>– Every two weeks Weeks 9 to 24 (eight doses; cycles 3 to 6)</li> <li>– Every four weeks Week 25 onwards (cycle 7 and beyond)</li> </ul> </li> </ul> <p><i>Treat until disease progression or unacceptable toxicity</i></p> |
|  | <p><u>Combination therapy with carfilzomib and dexamethasone for relapsed or refractory/progressive disease</u></p> <ul style="list-style-type: none"> <li>▪ 8 mg/kg body weight given as an intravenous infusion on days 1 and 2 (Week 1; total 2 doses)</li> <li>▪ Followed by 16 mg/kg body weight given as an intravenous infusion in a 4 week cycle: <ul style="list-style-type: none"> <li>– Weekly Weeks 2 to 8 (seven doses; cycles 1 and 2)</li> <li>– Every two weeks Weeks 9 to 24 (eight doses; cycles 3 to 6)</li> <li>– Every four weeks Week 25 onwards (cycle 7 and beyond)</li> </ul> </li> </ul> <p><i>Treat until disease progression or unacceptable toxicity</i></p>  |
|  | <p><u>Combination therapy with bortezomib and dexamethasone for relapsed or refractory/progressive disease</u></p> <ul style="list-style-type: none"> <li>▪ 16 mg/kg body weight given as an intravenous infusion in a 3 week cycle: <ul style="list-style-type: none"> <li>– Weekly Weeks 1 to 9 (nine doses; cycles 1 to 3)</li> <li>– Every three weeks Weeks 10 to 24 (five doses; cycles 4 to 8)</li> <li>– Every four weeks Week 25 onwards (cycle 9 and beyond)</li> </ul> </li> </ul> <p><i>Treat until disease progression or unacceptable toxicity</i></p>   |
|  | <p><u>Monotherapy as maintenance treatment for transplant candidates</u></p>   |

|   |   |
|---|---|
|   | <ul style="list-style-type: none"> <li>16 mg/kg body weight given as an intravenous infusion every 4 weeks until disease progression or unacceptable toxicity</li> </ul>  |
| Pediatric ALL   | <ul style="list-style-type: none"> <li>16 mg/kg body weight given as an intravenous infusion in a 4 week cycle: <ul style="list-style-type: none"> <li>Weekly Weeks 1 to 8 (eight doses; cycles 1 and 2)</li> </ul> </li> </ul>   |
| Systemic Light Chain Amyloidosis  | <ul style="list-style-type: none"> <li>16 mg/kg body weight given as an intravenous infusion: <ul style="list-style-type: none"> <li>Weekly Weeks 1 to 8 (eight doses)</li> <li>Every two weeks Weeks 9 to 24 (eight doses)</li> <li>Every four weeks Week 25 onwards until disease progression or unacceptable toxicity</li> </ul> </li> </ul> |
| <p><i>*To facilitate administration, the first prescribed 16 mg/kg dose at Week 1 may be split over two consecutive days (i.e., 8 mg/kg on Day 1 and Day 2 respectively).</i></p> |   |
| <p><i>Note: Initiate antiviral prophylaxis to prevent herpes zoster reactivation within 1 week after starting Darzalex and continue for 3 months following treatment.</i></p>     |   |

## VI. Billing Code/Availability Information

### HCPCS Code:

- J9145 – Injection, daratumumab, 10 mg; 1 billable unit = 10 mg

### NDC(s):

- Darzalex 100 mg/5 mL single-dose vial: 57894-0502-xx
- Darzalex 100 mg/5mL single-dose vial: 57894-0505-xx
- Darzalex 400 mg/20 mL single-dose vial: 57894-0502-xx
- Darzalex 400 mg/20 mL single-dose vial: 57894-0505-xx

## VII. References

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- Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) for daratumumab. National Comprehensive Cancer Network, 2023. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed August 2023.
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15. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Systemic Light Chain Amyloidosis 2.2023. National Comprehensive Cancer Network, 2023. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Guidelines, go online to NCCN.org. Accessed August 2023.

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## Appendix 1 – Covered Diagnosis Codes

| ICD-10 | ICD-10 Description   |
|--------|--|
| C90.00 | Multiple myeloma not having achieved remission             |
| C90.02 | Multiple myeloma, in relapse                               |
| C90.10 | Plasma cell leukemia not having achieved remission         |
| C90.12 | Plasma cell leukemia in relapse                            |
| C90.20 | Extramedullary plasmacytoma not having achieved remission  |
| C90.22 | Extramedullary plasmacytoma in relapse                     |
| C90.30 | Solitary plasmacytoma not having achieved remission        |
| C90.32 | Solitary plasmacytoma in relapse                           |
| C91.00 | Acute lymphoblastic leukemia not having achieved remission |
| C91.02 | Acute lymphoblastic leukemia, in relapse                   |
| E85.3  | Secondary systemic amyloidosis                             |
| E85.4  | Organ-limited amyloidosis                                  |



| ICD-10 | ICD-10 Description   |
|--------|--|
| E85.81 | Light chain (AL) amyloidosis   |
| E85.89 | Other amyloidosis  |
| E85.9  | Amyloidosis, unspecified   |
| Z85.79 | Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues |

## 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 Determinations (LCDs), and Local Coverage Articles (LCAs) 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/LCD/LCA): N/A

| 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.                 |
| 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



Discrimination is Against the Law. 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, or sex, (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation, gender identity and sex stereotypes), consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2). Aspirus Health Plan, Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aspirus Health Plan, Inc.:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:

- Qualified interpreters.
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Nondiscrimination Grievance Coordinator at the address, phone number, fax number, or email address below.

If you believe that Aspirus Health Plan, Inc. 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:

Nondiscrimination Grievance Coordinator  
Aspirus Health Plan, Inc.  
PO Box 1890  
Southampton, PA 18966-9998  
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>. This notice is available at Aspirus Health Plan, Inc.'s website: [https://aspirushealthplan.com/webdocs/70021-AHP-NonDiscrim\\_Lang-Assist-Notice.pdf](https://aspirushealthplan.com/webdocs/70021-AHP-NonDiscrim_Lang-Assist-Notice.pdf).

## Language Assistance Services

**Albanian:** KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-332-6501 (TTY: 711).

**Arabic:** تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن أعلى رقم الهاتف 1-800-332-6501 (رقم هاتف الصم والبك : 711)

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-332-6501 (ATS: 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-332-6501 (TTY: 711).

**Hindi:** यान द : य द आप िहंदी बोलते ह तो आपके िलए मु त म भाषा सहायता सेवाएं उपल थ ह 1-800-332-6501 (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 1-800-332-6501 (TTY: 711).

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-6501 (TTY: 711) 번으로 전화해 주십시오.

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-6501 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-332-6501 (телетайп: 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-332-6501 (TTY: 711).

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1-800-332-6501 (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 1-800-332-6501 (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 1-800-332-6501 (TTY: 711).

**Pennsylvania Dutch:** Wann du Deutsch (Pennsylvania German / Dutch) schwetzscht, kannst du mitaue Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-332-6501 (TTY: 711).

**Lao:** ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-332-6501 (TTY: 711).