Injectable Iron Products

Policy Number: MC/PC 022
Effective Date: June 1, 2026.

Instructions for Use

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Related Policies

- N/A

Coverage Rationale

This policy refers to the following injectable iron products:

- Feraheme® (ferumoxytol injection)
- Injectafer® (ferric carboxymaltose injection)
- Monoferric (ferric derisomaltose injection)

For initial coverage of Feraheme or Monoferric, the following will be required:

- Requested drug is being used for a Food and Drug Administration (FDA)-approved indication **and**
- One of the following:
  - Trial and failure of a minimum 30-day supply or intolerance to one oral iron therapy (e.g., ferrous sulfate, ferrous gluconate, ferrous fumarate) **or**
  - Attestation demonstrating a trial with oral iron therapies may be inappropriate

For initial coverage of Injectafer, the following will be required:

- Requested drug is being used for a Food and Drug Administration (FDA)-approved indication **and**
- One of the following:
  - Trial and failure of a minimum 30-day supply or intolerance to one oral iron therapy (e.g., ferrous sulfate, ferrous gluconate, ferrous fumarate)
  - Attestation demonstrating a trial with oral iron therapies may be inappropriate
  - Patient has New York Heart Association class II or III heart failure

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
J1437	Injection, ferric derisomaltose, 10 mg
J1439	Injection, ferric carboxymaltose, 1 mg
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use)
Q0139	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (for ESRD on dialysis)

ICD-10 Code	Description
D50.0	Iron deficiency anemia secondary to blood loss (chronic)
D50.1	Sideropenic dysphagia
D50.8	Other iron deficiency anemias
D50.9	Iron deficiency anemia, unspecified
D63.1	Anemia in chronic kidney disease
I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I13.10	Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I50.1	Left ventricular failure, unspecified
I50.20	Unspecified systolic (congestive) heart failure
I50.21	Acute systolic (congestive) heart failure
I50.22	Chronic systolic (congestive) heart failure
I50.23	Acute on chronic systolic (congestive) heart failure
I50.30	Unspecified diastolic (congestive) heart failure
I50.31	Acute diastolic (congestive) heart failure
I50.32	Chronic diastolic (congestive) heart failure
I50.33	Acute on chronic diastolic (congestive) heart failure
I50.40	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
I50.41	Acute combined systolic (congestive) and diastolic (congestive) heart failure
I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.43	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.810	Right heart failure, unspecified
I50.811	Acute right heart failure
I50.812	Chronic right heart failure
I50.813	Acute on chronic right heart failure
I50.814	Right heart failure due to left heart failure
I50.82	Biventricular heart failure
I50.83	High output heart failure
I50.84	End stage heart failure
I50.89	Other heart failure

ICD-10 Code	Description
I50.9	Heart failure, unspecified
N18.1	Chronic kidney disease, stage 1
N18.2	Chronic kidney disease, stage 2 (mild)
N18.30	Chronic kidney disease, stage 3 unspecified
N18.31	Chronic kidney disease, stage 3a
N18.32	Chronic kidney disease, stage 3b
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5

Background

It is estimated that a quarter of the world's population is anemic; about half of these cases are due to iron deficiency (ID) (Auerbach & DeLoughery 2026). It has been estimated that 10 million people in the United States (U.S.) have ID; 5 million of these cases are attributed to iron deficiency anemia (IDA). The major causes of ID are decreased dietary intake of iron, reduced absorption (e.g., due to celiac disease, *Helicobacter pylori*, gastritis, or bariatric surgery), and blood loss (Auerbach & DeLoughery 2026). The World Health Organization (WHO) defines anemia as a circulating hemoglobin (Hb) level of < 12 g/dL in non-pregnant women, < 13 g/dL in men, and < 11 g/dL in pregnant women (World Health Organization [WHO] Website).

Anemia is common among patients with chronic kidney disease (CKD), including those on dialysis; ID is the most common reversible cause (Berns 2025). Hemodialysis (HD) patients may experience repeated blood loss due to retention of blood in the dialyzer and blood lines. Other contributing causes in HD and other CKD patients include frequent blood sampling for laboratory testing, blood loss from surgical procedures (such as creation of vascular access), interference with iron absorption due to medications such as gastric acid inhibitors and phosphate binders, and reduced iron absorption due to inflammation (Kidney Disease Improving Global Outcomes [KDIGO] 2026).

For treatment of ID, the choice between oral and IV iron depends on several factors including the acuity of the anemia, costs and availability of different iron replacement products, and patient tolerability. Most patients are treated with oral iron because it is generally effective, readily available, inexpensive, and safe. IV administration of iron may be preferable to the oral route in patients with ongoing blood loss, a physiologic or anatomic abnormality that interferes with oral absorption or iron homeostasis, and intolerable gastrointestinal adverse effects (AEs) of oral iron (especially ferrous sulfate). In general, the various oral iron preparations are equally effective (Auerbach & DeLoughery 2026).

Clinical Evidence

Comparisons of IV iron with oral iron

Clevenger et al 2016 conducted a systematic review and meta-analysis of 65 randomized controlled trials (RCTs) (N = 9004) in adults with IDA without CKD. The primary outcome was mortality at 1 year.

- Only 1 study (comparing parenteral with oral iron) reported mortality at 1 year. Eight studies of oral iron vs inactive control, 19 studies of parenteral iron vs inactive control, and 13 studies of parenteral iron vs oral iron reported mortality. There were no statistically significant differences in mortality in any of the comparisons.
- Both oral and parenteral iron significantly reduced the proportion of patients requiring red blood cell (RBC) blood transfusion compared with control (risk ratio [RR] 0.66, 95% confidence interval [CI], 0.48 to 0.90; and RR 0.84, 95% CI, 0.73 to 0.97, respectively). Hb was increased more by both oral and parenteral iron compared with control (mean difference [MD] 0.91 g/dL, 95% CI, 0.48 to 1.35; and MD 1.04, 95% CI, 0.52 to 1.57, respectively), and parenteral iron demonstrated a greater increase when compared with oral iron (MD 0.53 g/dL; 95% CI, 0.31

to 0.75). In all comparisons, there were no differences in the results comparing patients with and without heart failure (HF).
- Six trials reported quality of life (QoL) with parenteral iron vs control and found higher QoL in the parenteral iron group. There was no significant difference in QoL with parenteral vs oral iron.
- There were no statistically significant differences in serious adverse effects (SAEs) between parenteral iron and control. No trials reported severe allergic reactions from parenteral iron. There was no statistically significant difference in SAEs with parenteral vs oral iron.

A Cochrane review of 39 RCTs (N = 3852) was conducted to compare IV iron with oral iron for anemia in adults and children with CKD stages 3 to 5 receiving HD or PD, not receiving dialysis, or post kidney transplant (O'Lone et al 2019). The primary outcomes were all-cause mortality, cardiovascular (CV) death, and QoL.
- There was insufficient evidence to determine whether all-cause death differed between IV iron and oral iron (absolute risk 33 vs 30 per 1000; RR 1.12; 95% CI, 0.64 to 1.94; I^2 = 0%, low certainty evidence). It was also uncertain whether CV death differed between IV and oral iron, (RR 1.71; 95% CI, 0.41 to 7.18; I^2 = 0%, very low certainty evidence).
- Compared with oral iron, IV iron increased the number of patients achieving target Hb (absolute benefit 542 vs 317 per 1000; RR 1.71; 95% CI, 1.43 to 2.04), increased Hb (MD 0.72 g/dL, 95% CI, 0.39 to 1.05); ferritin (MD 224.84 mcg/L; 95% CI, 165.85 to 283.83) and transferrin saturation (TSAT) (MD 7.69%; 95% CI, 5.10 to 10.28), and reduced the Erythropoiesis-stimulating agent (ESA) dose required (standardized mean difference [SMD] -0.72; 95% CI, -1.12 to -0.31). All analyses had low certainty evidence and moderate to high heterogeneity.
- Compared with oral iron, IV iron increased the numbers of patients who experienced allergic reactions or hypotension (RR 3.56; 95% CI, 1.88 to 6.74) but reduced the number with all GI AEs (RR 0.47; 95% CI, 0.33 to 0.66). The certainty of evidence was low. There was insufficient evidence to determine impact on QoL.

A systematic review and meta-analysis of 75 RCTs (N = 10,605) evaluated the efficacy (change in Hb concentration and proportion of patients requiring allogeneic RBC transfusion) and safety (all-cause infection) of IV iron compared with oral iron or no iron (Litton et al 2013). IV iron was associated with a significant increase in standardized mean Hb (6.5 g/L; 95% CI, 5.1 g/L to 7.9 g/L; I^2 = 87.7%, p < 0.01) and a significant reduction in risk of blood transfusion (RR 0.74; 95% CI, 0.62 to 0.88; I^2 = 9%, p = 0.3). There was no significant difference in mortality (RR 1.1; 95% CI, 0.8 to 1.5) or SAEs (RR 1.1; 95% CI, 0.9 to 1.2) with IV iron therapy compared with oral iron or no iron. IV iron was associated with a significant increase in the risk of infection compared with either oral iron or no iron (RR 1.33; 95% CI, 1.10 to 1.64; I^2 = 22.7%, p = 0.2).

Comparative trials of IV iron products

Multiple trials and meta-analyses comparing various IV iron products have generally found similar efficacy and safety among agents.
- A systematic review and network meta-analysis of 21 RCTs comparing the efficacy and safety of ferric carboxymaltose (Injectafer) with other iron formulations in patients with iron deficiency (ID) found that all IV iron preparations appeared to be safe and effective, but ferric carboxymaltose seemed to provide a better and quicker correction of Hb and serum ferritin levels in patients with ID (Rognoni et al 2016). The mean difference (MD) in Hb over the study period was significantly larger for ferric carboxymaltose compared to ferric gluconate (Ferrlecit) (delta 0.6; 95% CI, 0.2 to 0.9). Ferric carboxymaltose was superior to iron sucrose (Venofer) with a delta of 1.1 (95% CI, to 1.8 to 3.9) but without statistical significance. All IV iron products were well tolerated, with no anaphylactic reactions reported.
- A systematic review and meta-analysis of 9 RCTs (N = 5691) was conducted to compare the safety and efficacy of ferumoxytol (Feraheme) in the treatment of ID (with or without anemia) to other IV iron formulations, oral iron, or placebo (Abdulrehman et al 2019). The results indicated little to no difference in treatment emergent adverse events (TEAEs) (RR 0.88; 95% CI, 0.80 to 0.97), treatment-related adverse events (TRAEs) (RR 0.73; 95% CI, 0.61 to 0.88), serious adverse events (SAEs) (RR 1.13; 95% CI, 0.77 to 1.67), related serious adverse events (RSAEs) (RR 0.55; 95% CI, 0.05 to 6.16), hypotension or hypersensitivity reactions (HSRs) (RR 0.58; 95% CI, 0.31 to 1.09), or composite cardiovascular (CV) outcomes (RR 0.56; 95% CI, 0.24 to 1.29) when comparing ferumoxytol to other IV iron products; there was also little to no difference in the number of patients achieving an increase in

Hb of ≥ 1 g/dL (RR 1.04; 95% CI, 0.96 to 1.12). Ferumoxytol was associated with fewer TEAEs compared to oral iron (RR 0.78; 95% CI, 0.61 to 0.98), but more compared to placebo (RR 1.62; 95% CI, 1.01 to 2.61).

- A systematic literature review of RCTs indirectly compared the efficacy of iron isomaltoside (Monoferric) and ferric carboxymaltose (Injectafer) in patients with IDA (Pollock & Muduma 2019). The indirect treatment comparison (ITC) using comparative trials of iron sucrose (Venofer) vs iron isomaltoside and iron sucrose vs ferric carboxymaltose resulted in a significantly larger increase from baseline in Hb with iron isomaltoside relative to ferric carboxymaltose (MD of +0.249 g/dL), but there was no significant difference in the proportion of patients with a clinically relevant response.
- A 5-week, Phase 3, double-blind (DB), multicenter (MC), RCT compared the safety and efficacy of ferumoxytol (Feraheme) with ferric carboxymaltose (Injectafer) in 1997 adults with IDA (Adkinson et al 2018). For the primary endpoint of the composite incidences of moderate-to-severe HSRs, including anaphylaxis, or moderate-to-severe hypotension, ferumoxytol and ferric carboxymaltose were shown to be noninferior (0.6% and 0.7%, respectively). No anaphylaxis was reported in either group. Least-squares (LS) mean changes in Hb were 1.4 and 1.6 g/dL in the ferumoxytol and ferric carboxymaltose groups, meeting the criteria for noninferiority. Hypophosphatemia occurred in 0.4% in the ferumoxytol group and 38.7% in the ferric carboxymaltose group; however, no clinical sequelae related to hypophosphatemia were seen in either group.
- Two identically designed, 35-day, OL, MC, randomized trials (PHOSPHARE) compared the risk of hypophosphatemia and effects on biomarkers of mineral and bone homeostasis of IV ferric derisomaltose (Monoferric) vs ferric carboxymaltose (Injectafer) in 245 adults with IDA and a history of intolerance or unresponsiveness to oral iron (Wolf et al 2020). The incidence of hypophosphatemia at any time between baseline and day 35 was significantly lower among patients treated with ferric derisomaltose than with ferric carboxymaltose (trial A: 7.9% vs 75.0% [adjusted rate difference, -67.0% {95% CI, -77.4% to -51.5%}], $p < 0.001$; trial B: 8.1% vs 73.7% [adjusted rate difference, -65.8% {95% CI, -76.6% to -49.8%}], $p < 0.001$. The clinical relevance of this difference has not been established and clinical outcomes were not assessed. In the pooled analysis, the change in Hb level per g of iron infused on day 35 was 2.2 vs 2.0 g/dL for ferric derisomaltose vs ferric carboxymaltose ($p = 0.02$). Hb level (exploratory endpoint) was 11.9 vs 12.4 g/dL, respectively; $p < 0.001$.

Heart failure (HF)

A systematic review and meta-analysis evaluated the efficacy and safety of IV iron supplementation in patients with heart failure (HF) and ID (5 RCTs, N = 907) (Qian et al 2016).

- The primary outcomes were hospitalization for HF, all-cause mortality, and a combined endpoint of hospitalization for HF and death. Ferric carboxymaltose (Injectafer) and iron sucrose (Venofer) were used in 2 trials each vs control and 1 trial used both vs control. There was a significantly reduced rate of hospitalization for HF among patients receiving iron compared with the non-iron treatment group (OR 0.28; 95% CI, 0.16 to 0.49; $p < 0.001$). There was no significant difference in all-cause mortality between the iron and non-iron groups (OR 0.81; 95% CI, 0.42 to 1.57; $p = 0.53$).
- The iron group had a significant decrease in the risk of the composite of hospitalization for HF and death (OR 0.47; 95% CI, 0.29 to 0.76; $p = 0.002$). The iron group had a statistically lower rate of SAEs than the control group (OR 0.50; 95% CI, 0.34 to 0.75; $p = 0.001$). Of the AEs reported in the included studies, such as CV, nervous system, GI, and vascular disorders, none was observed to occur more frequently in the iron group. In addition, no severe allergic reactions related to IV iron were reported in any of included trials.

Place in Therapy

Several clinical guidelines have been published addressing ID and IDA in various patient populations. None of these guidelines express a preference for any specific iron preparation over another.

The Kidney Disease Improving Global Outcomes (KDIGO) guidelines for anemia of CKD (KDIGO 2026) make the following recommendations with regard to iron supplementation:

- In people with anemia and CKD G5 receiving hemodialysis (CKD G5HD), they recommend initiating iron therapy if ferritin is ≤ 500 ng/mL and transferrin saturation (TSAT) is ≤ 30%.
- In people with anemia and CKD G5HD who are initiating iron therapy, they suggest using intravenous (IV) iron rather than oral iron.

- In people with anemia and CKD not receiving dialysis or CKD G5 receiving peritoneal dialysis (CKD G5PD), they suggest initiating iron if:
    - Ferritin <100 ng/ml (<100 mg/l) and TSAT <40% or
    - Ferritin ≥100 ng/ml (≥100 mg/l) and <300 ng/ml (<300 mg/l), and TSAT <25%
- In people with anemia and CKD not receiving hemodialysis (HD) in whom iron is initiated, they suggest using either oral iron or IV iron based on the person's values and preferences, the degree of anemia and iron deficiency, and the relative efficacy, tolerability, availability, and cost of each.
- The guidelines state that in people with CKD treated with oral iron, the choice between different formulations and dosing schedules is guided by cost, individual patient preference, tolerability, and efficacy.
- They recommend switching from oral to IV iron if there is an insufficient effect of an optimal oral regimen after 1–3 months or if tolerability is poor.

The U.S. Preventive Services Task Force (USPSTF) Screening for IDA and Iron Supplementation in Pregnant Women to Improve Maternal Health and Birth Outcomes recommendation statement (Nicholson 2024) summary of recommendations state that:

- The current evidence is insufficient to assess the balance of benefits and harms of screening for iron deficiency and iron deficiency anemia in pregnant persons to prevent adverse maternal and infant health outcomes.
- The current evidence is insufficient to assess the balance of benefits and harms of routine supplementation for iron deficiency and iron deficiency anemia in pregnant persons to prevent adverse maternal and infant health outcomes.
- They note that in the absence of evidence, clinicians should use their clinical judgement regarding whether to screen for ID or IDA and whether to provide routine iron supplementation during pregnancy.

The American College of Cardiology/American Heart Association/Heart Failure Society of America (ACC/AHA/HFSA) Guideline for the Management of HF (Yancy et al 2022) provides a recommendation regarding IDA in patients with HF. Anemia is independently associated with HF disease severity, and ID appears to be uniquely associated with reduced exercise capacity. IV repletion of iron, especially in the setting of concomitant hepcidin deficiency in HF, may improve exercise capacity and QoL. There is an uncertain evidence base for oral iron repletion in the setting of anemia associated with HF. In patients with New York Heart Association (NYHA) class II and III HF and ID (ferritin < 100 ng/mL or 100 to 300 ng/mL if TSAT is < 20%), IV iron has been shown to improve exercise capacity and QoL (Class of recommendation [COR] IIa [moderate], level of evidence [LOE] B-R [moderate-quality evidence from 1 or more RCTs or meta-analyses of moderate-quality RCTs]).

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

FERAHEME (ferumoxytol injection) is an iron replacement product indicated for the treatment of iron deficiency anemia (IDA) in adult patients:

- who have intolerance to oral iron or have had unsatisfactory response to oral iron or
- who have chronic kidney disease (CKD).

INJECTAFER (ferric carboxymaltose injection) is an iron replacement product indicated for the treatment of:

- iron deficiency anemia (IDA) in:
    - adult and pediatric patients 1 year of age and older who have either intolerance or an unsatisfactory response to oral iron.
    - adult patients who have non-dialysis dependent chronic kidney disease.
- iron deficiency in adult patients with heart failure and New York Heart Association class II/III to improve exercise capacity.

MONOFERRIC (ferric derisomaltose) injection is an iron replacement product indicated for the treatment of iron deficiency anemia in adult patients:

- who have intolerance to oral iron or have had unsatisfactory response to oral iron.
- who have non-hemodialysis dependent chronic kidney disease (NDD-CKD).

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Policy History/Revision Information

Date	Summary of Changes
12/13/2023	Approved by OptumRx P&T Committee
4/17/2024	Annual Review. Updated references.
4/16/2025	Annual Review. Updated references.
5/14/2026	Annual Review. Updates to coverage rationale to allow for attestation for when trial with oral iron therapies may be inappropriate. Updated background, place in therapy, and references.

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. The insurance reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

OptumRx may also use tools developed by third parties to assist us in administering health benefits. OptumRx Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

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.

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 اعلى رقم الهاتف1-800-332-6501(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 zurVerfügung. 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_ध 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 numer1-800-332-6501 (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 al1-800-332-6501 (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 Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-332-6501 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-332-6501 (TTY: 711).