Tysabri (natalizumab) injection, for intravenous use

Policy Number: MC/PC 046
Effective Date: June 1, 2025

Instructions for Use

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- N/A

Coverage Rationale

Multiple Sclerosis (MS)

For initial coverage of Tysabri (natalizumab) for Multiple Sclerosis, the following will be required:

- All of the following:
  - Diagnosis of a relapsing form of multiple sclerosis (MS) (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions) **and**
  - Not used in combination with another disease-modifying therapy for MS **and**
  - Prescribed by or in consultation with a neurologist.

  OR
- All of the following:
  - For continuation of prior therapy **and**
  - Not used in combination with another disease-modifying therapy for MS **and**
  - Prescribed by or in consultation with a neurologist.

For reauthorization coverage of Tysabri (natalizumab) for Multiple Sclerosis, the following will be required:

- Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression) **and**
- Not used in combination with another disease-modifying therapy for MS **and**
- Prescribed by or in consultation with a neurologist.

Crohn's Disease (CD)

For initial coverage of Tysabri (natalizumab) for Crohn's Disease, the following will be required:

- Diagnosis of moderately to severely active Crohn's disease **and**
- Crohn's disease has evidence of inflammation (e.g., elevated C-reactive protein [CRP], elevated erythrocyte sedimentation rate, presence of fecal leukocytes) **and**
- Trial and failure, contraindication, or intolerance to one of the following conventional therapies:

    - corticosteroids (e.g., prednisone)
    - 6-mercaptopurine
    - Azathioprine
    - methotrexate **and**
- Trial and failure, contraindication, or intolerance to a tumor necrosis factor (TNF)-inhibitor (e.g., certolizumab pegol, adalimumab) **and**
- Not used in combination with a TNF inhibitor (e.g., adalimumab, certolizumab pegol) or immunosuppressants (e.g., 6-MP, azathioprine, cyclosporine, or methotrexate) **and**
- Prescribed by or in consultation with a gastroenterologist.

For reauthorization coverage of Tysabri (natalizumab) for Crohn's Disease, the following will be required:

- Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following:
    - Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline **or**
    - Reversal of high fecal output state **and**
- Not used in combination with TNF inhibitors (e.g., certolizumab pegol, adalimumab) or immunosuppressants (e.g., 6-MP, azathioprine, cyclosporine, or methotrexate)

Notes: Tysabri should be discontinued in patients with Crohn's disease who have not experienced therapeutic benefit by 12 weeks of induction therapy. For patients with Crohn's disease who start Tysabri while on chronic oral corticosteroids, steroid tapering should begin as soon as a therapeutic benefit of Tysabri has occurred. Tysabri should be discontinued if patients cannot be tapered off of oral corticosteroids within six months of starting Tysabri. Other than the initial six-month taper, prescribers should consider discontinuing Tysabri for patients who require additional steroid use that exceeds three months in a calendar year to control their Crohn's disease.

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
J2323	Injection, natalizumab, 1 mg

ICD-10 Code	Description
G35	Multiple Sclerosis
K50.00	Crohn's disease of small intestine without complications
K50.011	Crohn's disease of small intestine with rectal bleeding
K50.012	Crohn's disease of small intestine with intestinal obstruction
K50.013	Crohn's disease of small intestine with fistula
K50.014	Crohn's disease of small intestine with abscess
K50.018	Crohn's disease of small intestine with other complication
K50.019	Crohn's disease of small intestine with unspecified complications
K50.10	Crohn's disease of large intestine without complications
K50.111	Crohn's disease of large intestine with rectal bleeding

ICD-10 Code	Description
K50.112	Crohn's disease of large intestine with intestinal obstructi
K50.113	Crohn's disease of large intestine with fistula
K50.114	Crohn's disease of large intestine with abscess
K50.118	Crohn's disease of large intestine with other complication
K50.119	Crohn's disease of large intestine with unspecified complications
K50.80	Crohn's disease of both small and large intestine without complications
K50.811	Crohn's disease of both small and large intestine with rectal bleeding
K50.812	Crohn's disease of both small and large intestine with intestinal obstruction
K50.813	Crohn's disease of both small and large intestine with fistula
K50.814	Crohn's disease of both small and large intestine with abscess
K50.818	Crohn's disease of both small and large intestine with other complication
K50.819	Crohn's disease of both small and large intestine with unspecified complications
K50.90	Crohn's disease, unspecified, without complications
K50.911	Crohn's disease, unspecified, with rectal bleeding
K50.912	Crohn's disease, unspecified, with intestinal obstruction
K50.913	Crohn's disease, unspecified, with fistula
K50.914	Crohn's disease, unspecified, with abscess
K50.918	Crohn's disease, unspecified, with other complication
K50.919	Crohn's disease, unspecified, with unspecified complications

Background

Multiple sclerosis (MS) is a chronic, immune-mediated disease of the central nervous system (CNS) characterized by inflammation, demyelination, and axonal degeneration (*Olek & Howard 2024*). MS can lead to physical disability, cognitive impairment, and decreased quality of life (QOL) (*McGinley et al 2021*). The range of symptoms of MS includes sensory, motor, visual, and fatigue (*Giovannoni et al 2016*). An estimated 1 million adults in the United States (U.S.) are affected by MS. Most patients are diagnosed between the ages of 20 and 50; MS is approximately 3 times more common in women than men (National MS Society 2024). Pediatric-onset MS is rare, with the majority of cases demonstrating a relapsing-remitting course (Otallah et al 2018).

Ulcerative colitis (UC) and Crohn's disease (CD) are 2 forms of Inflammatory bowel disease (IBD) that differ in pathophysiology and presentation; as a result of these differences, the approach to the treatment of each condition often differs. CD can involve any part of the gastrointestinal tract and is characterized by transmural inflammation and "skip areas". Transmural inflammation may lead to fibrosis, strictures, sinus tracts, and fistulae (*Peppercorn and Kane 2024*).

Natalizumab, a humanized monoclonal antibody, is an alpha-4 integrin antagonist in a class of agents known as selective adhesion molecule inhibitors (*Clinical Pharmacology 2025*). It was the first FDA-approved alpha-4-integrin inhibitor. Natalizumab has a different mechanism of action and side-effect profile than other available therapies for multiple sclerosis (MS) and is indicated for adults with relapsing forms of multiple sclerosis. Natalizumab reduces MS relapse rates, decreases the appearance of brain lesions, and decreases the risk of disability progression; the drug also has been reported to improve quality of life for patients with MS. Tysabri (natalizumab) is approved for the induction and maintenance of clinical response and remission in moderate to severe Crohn's disease in adults, in addition to its approval for MS (*Tysabri prescribing information 2025*).

Clinical Evidence

Multiple Sclerosis (MS)
In a 2011 systematic review of 2 randomized controlled trials (RCTs) evaluating natalizumab for RRMS, pooled efficacy data from the AFFIRM and SENTINEL trials showed that natalizumab significantly reduced the risk for a relapse during 2 years of treatment (RR, 0.57, 95% CI, 0.47 to 0.69). In addition, natalizumab significantly reduced the risk for experiencing CDP-12 weeks over 2 years (RR, 0.74, 95% CI, 0.62 to 0.89) (*Pucci et al 2011*). The ongoing, 10-year, open-label, multicenter, Tysabri Observational Program (TOP) evaluated the long-term safety of natalizumab in 6148 patients with RRMS (*Butzkueven et al 2020[a]*). Median follow-up time was 5.2 years (range, 0 to 10.8). The most common serious adverse event was infection (incidence 4.1%). The most commonly reported infections were PML, pneumonia, UTIs, and herpes zoster. A total of 53 patients were diagnosed with PML after a median of 42 natalizumab doses. Thirty-six of the 53 PML cases occurred in patients receiving natalizumab for > 3 years, and 35 of these 36 patients (97.2%) had a positive anti-John Cunningham virus (JCV) antibody test in the 6 months prior to PML development. The overall PML incidence rate per 1000 PY was 2.034 (95% CI, 1.554 to 2.662).

Crohn's Disease (CD)
The efficacy and safety of natalizumab were evaluated in 3 RCTs in adults with moderate to severely active CD (Crohn's Disease Activity Index [CDAI] score between 220 and 450) (*Sandborn et al 2005, Tysabri prescribing information 2025*). Patients were randomized to either natalizumab 300 mg or placebo IV every 4 weeks. Concomitant TNF blockers were prohibited in the studies, while stable doses of 5-ASA, corticosteroids, and/or immunosuppressants (e.g., 6-MP, azathioprine, methotrexate) were allowed. While allowed in the clinical trials, natalizumab is not indicated to be used in combination with immunosuppressant therapy.

In Study 1 and Study 2, the induction of clinical response, defined as a ≥ 70-point decrease from baseline CDAI was evaluated. In Study 2, both clinical response, and remission, defined as a CDAI score of < 150, were required to be met at weeks 8 and 12. In Study 3, patients who achieved clinical response at both weeks 10 and 12 in Study 1 and 2 were re-randomized to natalizumab or placebo for an additional 6 and 12 months of treatment. Patients who did not lose clinical response at any study visit were considered responders.

In Study 1, clinical response was not significantly different between placebo and natalizumab groups at 10 weeks. In a post-hoc analysis of the 653 patients with high C-reactive protein (CRP); however, response was achieved in 57% of natalizumab patients compared to 45% of placebo patients (treatment difference, 12%; 95% CI, 3 to 22). Due to these findings, the second induction study, Study 2, assessed only patients with an elevated CRP. The cumulative clinical response for weeks 8 and 12 was improved with natalizumab vs placebo (48% vs 32%; $p < 0.005$). Cumulative clinical remission was also improved for weeks 8 and 12 with natalizumab vs placebo (26% vs 16%; $p < 0.005$).

In Study 3, the maintenance of clinical response assessed at month 9 was improved with natalizumab vs placebo treatment (61% vs 29%; $p < 0.005$). The maintenance of clinical remission at month 9 was also found to improve with natalizumab vs placebo (45% vs 26%; $p < 0.005$). Both response and remission at month 15 were improved with natalizumab vs placebo, however, were not considered significantly different. For patients in Study 3, the treatment effect was considered similar across groups based on inadequate response to prior therapies (e.g., corticosteroids, immunosuppressants, TNF blockers).

Place in therapy

Multiple Sclerosis
The American Academy of Neurology (AAN) performed a systematic review that included 20 Cochrane reviews and 73 additional articles in order to assess the available evidence on initiation, switching, and stopping DMTs in patients with MS (*Rae-Grant et al 2018*). The main recommendations were as follows:

- Starting DMT
  - Clinicians should discuss the benefits and risks of DMTs for people with [illegible] with 2 or more brain lesions that have imaging characteristics consistent with MS (Level B). After discussing the risks and benefits, clinicians should prescribe DMTs to people with a single clinical demyelinating event and 2 or more brain lesions characteristic of MS who decide they want this therapy. (Level B)
  - Clinicians should offer DMTs to people with relapsing forms of MS with recent clinical relapses or MRI activity. (Level B)
  - Clinicians should monitor the reproductive plans of women with MS and counsel regarding reproductive risks and use of birth control during DMT in women of childbearing potential who have MS. (Level B)
  - Clinicians should counsel men with MS on their reproductive plans regarding treatment implications before initiating treatment with teriflunomide. (Level B)
  - Because of the high frequency of severe adverse events, clinicians should not prescribe mitoxantrone to people with MS unless the potential therapeutic benefits greatly outweigh the risks. (Level B)
  - Clinicians should prescribe alemtuzumab, fingolimod, or natalizumab for people with highly active MS. (Level B)
  - Clinicians may initiate natalizumab treatment in people with MS with positive anti-John Cunningham virus (JCV) antibody indices above 0.9 only when there is a reasonable chance of benefit compared with the low but serious risk of PML. (Level C)
  - Clinicians should offer ocrelizumab to people with PPMS who are likely to benefit from this therapy unless there are risks of treatment that outweigh the benefits. (Level B)
- Switching DMTs
  - Clinicians should discuss switching from one DMT to another in people with MS who have been using a DMT long enough for the treatment to take full effect and are adherent to their therapy when they experience 1 or more relapses, 2 or more unequivocally new MRI-detected lesions, or increased disability on examination, over a 1-year period of using a DMT. (Level B)
  - Clinicians should evaluate the degree of disease activity, adherence, adverse event profiles, and mechanism of action of DMTs when switching DMTs in people with MS with breakthrough disease activity during DMT use. (Level B)
  - Clinicians should discuss a change to non-injectable or less frequently injected DMTs in people with MS who report intolerable discomfort with the injections or in those who report injection fatigue on injectable DMTs. (Level B)
  - Clinicians should inquire about medication adverse events with people with MS who are taking a DMT and attempt to manage these adverse events, as appropriate (Level B). Clinicians should discuss a medication switch with people with MS for whom these adverse events negatively influence adherence. (Level B)
  - Clinicians should monitor laboratory abnormalities found on requisite laboratory surveillance (as outlined in the medication's package insert) in people with MS who are using a DMT (Level B). Clinicians should discuss switching DMTs or reducing dosage or frequency (where there are data on different doses [e.g., interferons, teriflunomide]) when there are persistent laboratory abnormalities. (Level B)
  - Clinicians should counsel people with MS considering natalizumab, fingolimod, ocrelizumab, and dimethyl fumarate about the PML risk associated with these agents (Level B). Clinicians should discuss switching to a DMT with a lower PML risk with people with MS taking natalizumab who are or who become JCV antibody–positive, especially with an index of above 0.9 while on therapy. (Level B)
  - Clinicians should counsel that new DMTs without long-term safety data have an undefined risk of malignancy and infection for people with MS starting or using new DMTs (Level B). If a patient with MS develops a malignancy while using a DMT, clinicians should promptly discuss switching to an alternate DMT, especially for people with MS using fingolimod, teriflunomide, alemtuzumab, or dimethyl fumarate (Level B). People with MS with serious infections potentially linked to their DMTs should switch DMTs (does not pertain to PML management in people with MS using DMT). (Level B)
  - Clinicians should check for natalizumab antibodies in people with MS who have infusion reactions before subsequent infusions, or in people with MS who experience breakthrough disease activity with natalizumab use (Level B). Clinicians should switch DMTs in people with MS who have persistent natalizumab antibodies. (Level B)

- Physicians must counsel people with MS considering natalizumab disc risk of MS relapse or MRI-detected disease activity within 6 months of disc people with MS choosing to switch from natalizumab to fingolimod should initiate treatment within 8 to 12 weeks after natalizumab discontinuation (for reasons other than pregnancy or pregnancy planning) to diminish the return of disease activity. (Level B)
- Clinicians should counsel women to stop their DMT before conception for planned pregnancies unless the risk of MS activity during pregnancy outweighs the risk associated with the specific DMT during pregnancy (Level B). Clinicians should discontinue DMTs during pregnancy if accidental exposure occurs, unless the risk of MS activity during pregnancy outweighs the risk associated with the specific DMT during pregnancy (Level B). Clinicians should not initiate DMTs during pregnancy unless the risk of MS activity during pregnancy outweighs the risk associated with the specific DMT during pregnancy. (Level B)

- Stopping DMTs
  - In people with RRMS who are stable on DMT and want to discontinue therapy, clinicians should counsel people regarding the need for ongoing follow-up and periodic reevaluation of the decision to discontinue DMT (Level B). Clinicians should advocate that people with MS who are stable (that is, those with no relapses, no disability progression, and stable imaging) on DMT should continue their current DMT unless the patient and physician decide a trial off therapy is warranted. (Level B)
  - Clinicians should assess the likelihood of future relapse in individuals with SPMS by assessing patient age, disease duration, relapse history, and MRI-detected activity (eg, frequency, severity, time since most recent relapse or Gd-enhanced lesion) (Level B). Clinicians may advise discontinuation of DMT in people with SPMS who do not have ongoing relapses (or Gd-enhanced lesions on MRI activity) and have not been ambulatory (EDSS 7 or greater) for at least 2 years. (Level C)
  - Clinicians should review the associated risks of continuing DMTs vs those of stopping DMTs in people with CIS using DMTs who have not been diagnosed with MS. (Level B)

Crohn's Disease

A 2018 American College of Gastroenterology (ACG) guideline on the management of CD in adults states that TNF inhibitors adalimumab, certolizumab, and infliximab are effective in the treatment of moderate to severely active CD in patients who are resistant to corticosteroids or are refractory to thiopurines or methotrexate. These agents can be considered for treating perianal fistulas, and infliximab can also treat enterocutaneous and rectovaginal fistulas in CD. Adalimumab, certolizumab, and infliximab are effective for the maintenance of TNF inhibitor induced remission; due to the potential for immunogenicity and loss of response, combination with azathioprine/6-MP or methotrexate should be considered. The combination of infliximab with an immunomodulator (thiopurine) is more effective than monotherapy with individual agents in patients with moderate to severe CD and who are naïve to both agents. Infliximab can also treat fuliminant CD. Vedolizumab with or without an immunomodulator can be used for induction and maintenance of remission in patients with moderate to severe CD. Patients are candidates for ustekinumab therapy, including for the maintenance of remission, if they have moderate to severe CD and have failed corticosteroids, thiopurines, methotrexate, or TNF inhibitors. The guideline acknowledges the effectiveness of biosimilar infliximab and biosimilar adalimumab for the management of moderate to severe CD (*Lichtenstein et al 2018*).

A 2021 American Gastroenterological Association (AGA) guideline on the medical management of moderate to severe CD (CDAI of > 220) strongly recommends the use of biologic monotherapy over thiopurine monotherapy for the induction of remission in adult outpatients and recommends TNF inhibitors or ustekinumab over no treatment for induction and maintenance of remission. In patients who are naïve to biologic drugs, infliximab, adalimumab, or ustekinumab are recommended over certolizumab pegol for the induction of remission and vedolizumab is suggested over certolizumab pegol. In patients who never responded to TNF inhibitors, the use of ustekinumab is recommended and the use of vedolizumab is suggested over no treatment for the induction of remission. In patients who previously responded to infliximab, the use of adalimumab or ustekinumab is recommended and the use of vedolizumab is suggested over no treatment for the induction of remission. The AGA recommends against the use of 5-ASA or sulfasalazine over no treatment for the induction or maintenance of remission. In patients with CD and active perianal

fistula, infliximab is recommended over no treatment for the induction and ma ients with CD and active perianal fistula without perianal abscess, the use of biologi iotic over a biologic drug alone is recommended for the induction of fistula remissio...

In adult outpatients, the AGA recommends against the use of natalizumab over no treatment for the induction and maintenance of clinical remission. This recommendation, the AGA states, is due to the availability of other agents and the evidence of harm due to PML in post-marketing data. Patients who will adhere to ongoing monitoring for the JCV and put a high value on the potential benefits of therapy vs the risks of PML, can consider using natalizumab (*Feuerstein et al 2021*).

The 2024 ECCO guideline on medical treatment in CD recommends the use of infliximab, adalimumab, ustekinumab, risankizumab, vedolizumab, and upadacitinib to induce remission and maintenance of remission in patients with moderate-to-severe CD (*Gordon et al 2024*). Other immunomodulator-related recommendations within the guideline include:

- Recommending combination therapy with infliximab and thiopurines when starting infliximab as induction therapy in patients with moderate-to-severe CD and recommending combination therapy for a minimum of 6 to 12 months.
- Suggesting against the combination of adalimumab and thiopurines over adalimumab alone to achieve clinical remission and response.
- Suggesting certolizumab can be used as induction therapy and maintenance therapy in moderate-to-severe CD.
- Suggesting adalimumab or ustekinumab are equally effective as induction and maintenance therapy in biologic-naïve patients with moderate-to-severe CD.

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.

Tysabri is an integrin receptor antagonist indicated for treatment of:

- Multiple Sclerosis (MS): Tysabri is indicated as monotherapy for the treatment of relapsing forms of multiple sclerosis, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults. Tysabri increases the risk of PML. When initiating and continuing treatment with Tysabri, physicians should consider whether the expected benefit of Tysabri is sufficient to offset this risk.
- Crohn's Disease (CD): Tysabri is indicated for inducing and maintaining clinical response and remission in adult patients with moderately to severely active Crohn's disease with evidence of inflammation who have had an inadequate response to, or are unable to tolerate, conventional CD therapies and inhibitors of TNF-α.

Important Limitations: In CD, Tysabri should not be used in combination with immunosuppressants or inhibitors of TNF-α.

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Policy History/Revision Information

Date	Summary of Changes
12/13/2023	Approved by OptumRx P&T Committee
5/16/2024	Annual review. Updated references.
5/15/2025	Annual review. Added reauthorization criteria to CD indication. Updated background section 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.

Archived Policy Versions (Internal Only)

Effective Date	Policy Number	Policy Title
mm/dd/yyyy – mm/dd/yyyy	######	Title of Policy Hyperlinked to KL or Other Internal Location

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).