Medical Benefit Drug Policy

Ultomiris (ravulizumab-cwvz) injection, for intravenous or subcutaneous use

Policy Number: MC/PC 047
Effective Date: May 1, 2025

Instructions for Use

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Related Policies

- n/a

Coverage Rationale

Atypical Hemolytic Uremic Syndrome

For initial coverage of Ultomiris (ravulizumab-cwvz) for Atypical Hemolytic Uremic Syndrome (aHUS), the following will be required:

- Diagnosis of atypical hemolytic uremic syndrome (aHUS) **and**
- Patient is one month of age and older **and**
- Prescribed by or in consultation with one of the following:
  - Hematologist
  - Nephrologist

For reauthorization coverage of Ultomiris (ravulizumab-cwvz) for Atypical Hemolytic Uremic Syndrome (aHUS), the following will be required:

- Patient demonstrates positive clinical response to therapy (e.g., normalization of platelet count, improvement in serum creatinine from baseline)

Generalized Myasthenia Gravis

For initial coverage of Ultomiris (ravulizumab-cwvz) for Generalized Myasthenia Gravis (gMG), the following will be required:

- Diagnosis of generalized myasthenia gravis (gMG) **and**
- Patient is anti-acetylcholine receptor (AChR) antibody positive **and**
- One of the following:
  - Trial and failure, contraindication, or intolerance to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus) **or**
  - Both of the following:

- Trial and failure, contraindication, or intolerance to on… glucocorticoids, azathioprine, cyclosporine, mycophen… …ius) **and**
- Trial and failure, contraindication, or intolerance to one of the following:
  - Chronic plasmapheresis or plasma exchange (PE)
  - Intravenous immunoglobulin (IVIG) **and**

- Prescribed by or in consultation with a neurologist

For reauthorization coverage of Ultomiris (ravulizumab-cwvz) for Generalized Myasthenia Gravis (gMG), the following will be required:

- Patient demonstrates positive clinical response to therapy

Neuromyelitis Optica Spectrum Disorder (NMOSD)

For initial coverage of Ultomiris (ravulizumab-cwvz) for Neuromyelitis Optica Spectrum Disorder (NMOSD), the following will be required:

- Diagnosis of Neuromyelitis Optica Spectrum Disorder (NMOSD) **and**
- Patient is anti-aquaporin-4 (AQP4) antibody positive **and**
- Prescribed by or in consultation with one of the following:
  - Neurologist
  - Ophthalmologist

For reauthorization coverage of Ultomiris (ravulizumab-cwvz) for Neuromyelitis Optica Spectrum Disorder (NMOSD), the following will be required:

- Patient demonstrates positive clinical response to therapy

Paroxysmal Nocturnal Hemoglobinuria

For initial coverage of Ultomiris (ravulizumab-cwvz) for Paroxysmal Nocturnal Hemoglobinuria (PNH), the following will be required:

- Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) **and**
- Patient is one month of age and older **and**
- Prescribed by or in consultation with a hematologist/oncologist.

For reauthorization coverage of Ultomiris (ravulizumab-cwvz) for Paroxysmal Nocturnal Hemoglobinuria (PNH), the following will be required:

- Patient demonstrates positive clinical response to therapy (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions)

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
J1303	Injection, ravulizumab-cwvz, 10 mg
C9052	Injection, ravulizumab-cwvz, 10 mg

ICD-10 Code	Description
D59.30	Hemolytic-uremic syndrome, unspecified
D59.32	Hereditary hemolytic-uremic syndrome
D59.39	Other hemolytic-uremic syndrome
D59.5	Paroxysmal nocturnal hemoglobinuria [Marchiafava-Micheli]
G36.0	Neuromyelitis optica [Devic]
G70.0	Myasthenia gravis
G70.00	Myasthenia gravis without (acute) exacerbation
G70.01	Myasthenia gravis with acute exacerbation

Background

Ravulizumab is a long-acting intravenous monoclonal antibody, which inhibits terminal complement-mediated intravascular hemolysis in patients with paroxysmal nocturnal hemoglobinuria and complement-mediated thrombotic microangiopathy (TMA) in patients with atypical hemolytic uremic syndrome. Ravulizumab binds to the complement protein C5 with high affinity, thereby inhibiting its cleavage to C5a (the proinflammatory anaphylatoxin) and C5b (the initiating subunit of the terminal complement complex [C5b-9]) and preventing the generation of the terminal complement complex C5b9. The presumed mechanism of action of ravulizumab in generalized myasthenia gravis is the reduction of the terminal complement complex C5b-9 deposition at the neuromuscular junction (*Clinical Pharmacology 2025*).

Clinical Evidence

Paroxysmal Nocturnal Hemoglobinuria (PNH)
The efficacy and safety of ravulizumab in adult PNH patients were evaluated in two 26-week, Phase 3, multi-center (MC), open-label (OL), active comparator (AC), noninferiority randomized control trials (RCTs) (*Kulasekararaj et al 2019, Lee et al 2019*). In CHAMPION-301, patients naïve to complement inhibitor therapy were randomized to receive weight-based ravulizumab induction therapy followed by maintenance therapy every 8 weeks (n = 125) or labeled dose eculizumab induction therapy followed by maintenance therapy every 2 weeks (n = 121). Ravulizumab demonstrated noninferiority to eculizumab for the coprimary endpoints of transfusion avoidance (73.6% vs 66.1%, respectively; treatment effect difference, 6.8%; 95% CI, -4.66 to 18.14) and lactate dehydrogenase (LDH) normalization (53.6% vs 49.4%, respectively; odds ratio [OR], 1.19; 95% CI, 0.80 to 1.77). The most commonly reported adverse event (AE) in both groups was headache (36.0% ravulizumab vs 33.1% eculizumab) (*Lee et al 2019*). In this open-label extension (OLE), 124 adults with PNH initially randomized to ravulizumab and 119 patients initially randomized to eculizumab received ravulizumab IV every 8 weeks in the 26-week OLE study. One patient randomized to ravulizumab and 2 patients randomized to eculizumab discontinued. At Week 52, LDH normalization was achieved in 43.5% in the ravulizumab-ravulizumab arm and 40.3% in the eculizumab-ravulizumab arm. Transfusion was avoided in 76.6% and 67.2% of the ravulizumab-ravulizumab and the eculizumab-ravulizumab arms, respectively. During the OLE, 4 patients in the ravulizumab-ravulizumab arm and 2 patients in the eculizumab-ravulizumab arm experienced breakthrough hemolysis compared with 5 and 13 patients in the initial 26-week treatment period, respectively. None of the breakthrough hemolysis events during the extension period were associated with free C5 levels ≥ 0.5 mcg/mL. LDH levels remained stable from the initial treatment period throughout the 26-week OLE period (*Schrezenmeier et al 2020*).

Atypical Hemolytic Uremic Syndrome (aHUS)
The efficacy and safety of ravulizumab for the treatment of aHUS were established in two Phase 3, single-arm, MC, OL trials in 58 adults and 21 children. In the 26-week trial, 53.6% of the complement inhibitor naïve adults with aHUS achieved a complete TMA response, defined as normalization of platelet count (≥ 150 x 109/L), LDH (≤ 246 U/L), and ≥ 25% improvement in SCr from baseline for ≥ 28 days apart. At the last follow-up, 60.7% of the adults maintained a

complete TMA response. The majority of patients achieved normalization of pl % of adults had ≥ 25% improvement in serum creatinine (SCr) (*Rondeau et al 2020*). complement inhibitor naïve children with aHUS, TMA response rate at Weeks 26 and 50 were 77.8% and 94.4%. Normalization of platelet count (94.4%), LDH (88.9%), ≥ 25% improvement in SCr (83.3%), and Hb (88.9%) were observed following ravulizumab for 26 weeks. Seventeen of eighteen (94.4%) children had normalization of these parameters at Week 50 (*Ariceta et al 2020*).

Generalized Myasthenia Gravis (gMG)
A 26-week, double blind (DB), placebo-controlled (PC), MC, RCT established the efficacy and safety of ravulizumab-cwvz in 175 adults with anti-AChR antibody positive gMG. Patients were randomized to ravulizumab-cwvz (n = 86) or placebo (n = 89) administered via IV administration and dosed based on body weight. Patients were also treated with acetylcholinesterase inhibitors (80%), corticosteroids (70%), and non-steroidal immunosuppressants (68%) at baseline and continued during the study. The primary endpoint, mean MG-ADL (Myasthenia Gravis Activities of Daily Living) change from baseline at Week 26 was significantly improved with ravulizumab-cwvz (difference, -1.6; 95% confidence interval [CI], -2.6 to -0.7; $p < 0.001$) compared to placebo. Ravulizumab-cwvz also significantly improved the key secondary endpoint, change from baseline in QMG (quantitative myasthenia gravis scores) (difference, -2.0; 95% CI, -3.2 to -0.8; $p < 0.001$). Serious adverse effects (AEs, i.e., infections, pneumonia) were reported in 23% of patients receiving ravulizumab-cwvz (*Ultomiris prescribing information 2024*).

Neuromyelitis optica spectrum disorder (NMOSD)
NMOSD is a rare inflammatory, demyelinating autoimmune disorder of the central nervous system (CNS). Previously known as neuromyelitis optica (NMO) or Devic's Disease, NMOSD presents as acute attacks or relapses in which patients experience inflammation of the optic nerve (optic neuritis), spinal cord (transverse myelitis), or brainstem (*Glisson 2025*). Optic neuritis may lead to severe visual loss. Transverse myelitis may lead to limb weakness, sensory loss, and bladder dysfunction. Brainstem symptoms of nausea and vomiting or hiccups may occur. NMOSD typically has a relapsing course with attacks occurring over days with variable degrees of recovery over weeks to months. The prevalence of NMOSD is from 0.37 to 10 per 100,000. The incidence of NMOSD in females is up to 10 times higher than males, and the median age of onset is 32 to 41 years (*Glisson 2025*). NMOSD may also present in children and older adults (*Glisson 2025*). Asians and those of African ancestry are at increased risk of NMOSD, with high mortality rates reported in the latter (*Huda et al 2019*).

Diagnosis of NMOSD is based on core clinical characteristics, aquaporin-4 (AQP4)-antibody status, and lesions observed on magnetic resonance imaging (MRI) (*Glisson 2025*). AQP4 is a membrane-bound water transporter in cells in the CNS that is highly expressed in the optic nerves, spinal cord, and area postrema of the brainstem (*Glisson 2025*). A positive assay for anti-AQP4 antibodies is not required for diagnosis although anti-AQP4 antibodies are present in 80% of patients with NMOSD (*Uplizna FDA Summary Review 2020*). Patients who are seronegative for the AQP4-antibody meet criteria for NMOSD if they have 2 core clinical characteristics, exclusion of other diagnoses, which may include multiple sclerosis, and may have anti-myelin oligodendrocyte glycoprotein (MOG) antibodies or other autoantibodies (*Glisson 2025*).

The treatment goals of NMOSD are to treat acute relapses, prevent relapses, and provide symptom management. NMOSD relapses can lead to permanent disability, poor prognosis, and overall high risk of mortality due to neurogenic respiratory failure (*Glisson 2024*). Acute relapses should be treated with corticosteroids; in corticosteroid-refractory cases, PLEX may be considered (*Sellner et al 2010*). Historically, the prevention of NMOSD relapses has consisted of off-label use of immunosuppressants including azathioprine, mycophenolate mofetil, tocilizumab, and rituximab (*Glisson 2024*, *Sellner et al 2010*). Since 2019, the FDA has approved Soliris (eculizumab), Uplizna (inebilizumab-cdon), and Enspryng (satralizumab- mwge), each with a unique mechanism of action for the treatment of adults with NMOSD.

The efficacy and safety of ULTOMIRIS in adult patients with anti-AQP4 antibody positive NMOSD was assessed in an open-label multicenter study, Study ALXN1210-NMO-307 (NCT04291262). Patients participating in Study ALXN1210-NMO-307 received ULTOMIRIS intravenously in the Primary Treatment Period that ended when the last enrolled patient completed (or discontinued prior to) 50 weeks on study, representing a median study duration of 73.5 weeks (minimum

13.7, maximum 117.7). Efficacy assessments were based on a comparison of p with an external placebo control group from another study (Study ECU-NMO-301, N able population of adult patients with anti-AQP4 antibody positive NMOSD.

Study ALXN1210-NMO-307 enrolled 58 adult patients with NMOSD who had a positive serologic test for anti-AQP4 antibodies, at least 1 relapse in the last 12 months prior to the Screening Period, and an Expanded Disability Status Scale (EDSS) score ≤ 7. In the external placebo control group, eligibility criteria were similar except patients were required to have at least 2 relapses in last 12 months or 3 relapses in the last 24 months with at least 1 relapse in the 12 months prior to screening. Prior treatment with immunosuppressant therapies (ISTs) was not required for enrollment. However, patients on selected ISTs (i.e., corticosteroids, azathioprine, mycophenolate mofetil, methotrexate, and tacrolimus) were permitted to continue on therapy, with a requirement for stable dosing until they reached Week 106 in the Study. Similar IST use was permitted in the external placebo control group.

The demographics were similar between the ULTOMIRIS treatment group from Study ALXN1210-NMO-307 and the placebo treatment group from Study ECU-NMO-301 (including age [median of 46.0 years for ULTOMIRIS versus 44.0 years for placebo] and sex [89.7% female for ULTOMIRIS versus 89.4% female for placebo]). The majority of patients were White or Asian. The median time from diagnosis to first dose was 0.9 years for ULTOMIRIS and 2.0 years for placebo. The median annualized relapse rate (ARR) in the last 24 months was 1.4 for ULTOMIRIS versus 1.9 for placebo, and the median number of historical relapses was 2 for ULTOMIRIS versus 4 for placebo. The median baseline EDSS score was 3.3 for ULTOMIRIS versus 4.0 for placebo. At baseline, 48% of patients in the ULTOMIRIS group received concomitant IST, including corticosteroids, versus 72% of subjects in the placebo group.

The primary endpoint of Study ALXN1210-NMO-307 was the time to first adjudicated ontrial relapse as determined by an independent adjudication committee. No adjudicated on-trial relapses were observed in ULTOMIRIS-treated patients during the Primary Treatment Period, representing a statistically significant difference between the ULTOMIRIS and placebo treatment arms in time to first adjudicated on-trial relapse ($p < 0.0001$). The hazard ratio (95% confidence interval [CI]) for ULTOMIRIS compared with placebo was 0.014 (0.000, 0.103), representing a 98.6% reduction in the risk of relapse. ULTOMIRIS-treated patients experienced similar improvement in time to first adjudicated on-trial relapse with or without concomitant treatment. (*Ultomiris prescribing information 2024*).

Place in therapy

PNH: Although there are currently no U.S. consensus guidelines for the treatment of PNH, ravulizumab is preferred over eculizumab based on greater convenience and fewer episodes of pharmacokinetic breakthrough hemolysis, but otherwise, these agents have comparable efficacy and toxicity for patients with significant disease manifestations due to hemolysis. Allogeneic HCT is the only curative therapy for PNH and may be pursued for patients with severe cytopenias, patients with suboptimal disease response to complement inhibition, and patients who do not have access to a complement inhibitor (*Brodsky 2024*).

aHUS: Based on international consensus recommendations, all patients with a clinical diagnosis of aHUS should be treated with eculizumab as first-line therapy. Plasma therapy may be used if eculizumab is unavailable. Depending on patient and disease characteristics, immunosuppressant therapy with corticosteroids, cyclophosphamide, mycophenolate mofetil, and/or rituximab may be utilized. Certain patients may be candidates for kidney transplantation (*Goodship et al 2017, Loirat et al 2016*). Ravulizumab was FDA-approved in 2018 after these aHUS guidelines were released.

MG: International consensus guidance for the management of MG recommends pyridostigmine as initial symptomatic treatment in most patients with MG. Corticosteroids and/or other immunosuppressive therapy (e.g., azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus) may be used in patients who have not met treatment goals after an adequate trial of pyridostigmine. Patients with refractory MG may require chronic IVIG or PE, cyclophosphamide, or rituximab; complement inhibition with eculizumab should be considered in severe refractory MG (*Narayanaswami et al 2020*).

NMOSD: No U.S. based guidelines for NMOSD are available, and no guidelines n therapy for the 3 agents in this review. NMO acute relapses are treated with high-dose corticosteroids followed by an oral prednisone taper over several months (*Kimbrough et al 2012, Sellner et al 2010, Kumpfel et al 2024*).

The Neuromyelitis Optica Study Group (NEMOS) recently updated their guideline to include the monoclonal antibodies. This guideline recommends eculizumab, ravulizumab, inebilizumab, rituximab, or satralizumab for first-line treatment and azathioprine, mycophenolate mofetil, or tocilizumab for second-line treatment. Third-line therapy may include a combination of a monoclonal antibody plus a classical immunosuppressive therapy (eg, azathioprine or mycophenolate mofetil) (*Kumpfel et al 2024)*.

The European Federation of Neurological Societies (EFNS) guideline for the prevention of NMO relapses recommends oral azathioprine plus prednisone or rituximab as first-line therapy (*Sellner et al 2010*). Other groups recommend mycophenolate mofetil plus prednisone as an additional first-line choice. Other treatment options include oral methotrexate, mitoxantrone, IV cyclophosphamide, IVIG, or PLEX (*Kimbrough et al 2012, Sellner et al 2010).*

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.

Ultomiris is a complement inhibitor indicated for:

- The treatment of adult and pediatric patients one month of age and older with paroxysmal nocturnal hemoglobinuria (PNH).
- The treatment of adult and pediatric patients one month of age and older with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy (TMA).
- The treatment of adult patients with generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR) antibody-positive.
- The treatment of adult patients with neuromyelitis optica spectrum disorder (NMOSD) who are antiaquaporin-4 (AQP4) antibody-positive.

Limitations of Use: Ultomiris is not indicated for the treatment of patients with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS).

References

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Policy History/Revision Information

Date	Summary of Changes
10/18/2023	Approved by OptumRx P&T Committee
3/20/2024	Annual Review. Updated references. Change wording for reauthorization criteria.
4/16/2025	Annual Review. Updated references. Addition of Neuromyelitis Optica Spectrum Disorder (NMOSD) indication, ICD-10 code, and clinical evidence to policy.

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).