

## 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

- Darzalex [package insert]. Horsham, PA; Janssen Biotech, Inc; January 2023. Accessed August 2023.
- 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

## PreferredOne Community Health Plan Nondiscrimination Notice

PreferredOne Community Health Plan (“PCHP”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PCHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PCHP:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact a Grievance Specialist.

If you believe that PCHP 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:

Grievance Specialist  
PreferredOne Community Health Plan  
PO Box 59052  
Minneapolis, MN 55459-0052  
Phone: 1.800.940.5049 (TTY: 763.847.4013)  
Fax: 763.847.4010  
[customerservice@preferredone.com](mailto:customerservice@preferredone.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Assistance Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1.800.940.5049 (TTY: 763.847.4013).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.940.5049 (TTY: 763.847.4013).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.800.940.5049 (TTY: 763.847.4013).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, taiaajiila qarqaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1.800.940.5049 (TTY: 763.847.4013).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.800.940.5049 (TTY: 763.847.4013).

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 1.800.940.5049 (TTY: 763.847.4013)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.800.940.5049 (телетайп: 763.847.4013).

ໂບດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.800.940.5049 (TTY: 763.847.4013).

ማስታወሻ፡ የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፡ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1.800.940.5049 (መስማት ለተሳናቸው፡ 763.847.4013 ) .

ဟ်သ့ဟ်သး- နမၤကတိၤ ကသီၤ ကျိၣ်အယိၤ, နမၤန့ၣ် ကျိၣ်အတၢ်မၤစၢၤလၢ တလၢၣ်ဘျဉ်လၢၣ်စၢၤ နီၣ်တမံၤဘၣ်သ့န့ၣ်လီၤ. ကိး 1.800.940.5049 (TTY: 763.847.4013).

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.800.940.5049 (TTY: 763.847.4013).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្បួល គឺអាចមានសំរាប់បំរើអ្នក។ ចរ ទូរស័ព្ទ 1.800.940.5049 (TTY: 763.847.4013)។

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.800.940.5049 (رقم هاتف الصم والبكم: 763.847.4013).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.800.940.5049 (TTY: 763.847.4013).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.800.940.5049 (TTY: 763.847.4013), 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.800.940.5049 (TTY: 763.847.4013).

## PreferredOne Insurance Company Nondiscrimination Notice

PreferredOne Insurance Company ("PIC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PIC:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact a Grievance Specialist.

If you believe that PIC 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:

Grievance Specialist  
PreferredOne Insurance Company  
PO Box 59212  
Minneapolis, MN 55459-0212  
Phone: 1.800.940.5049 (TTY: 763.847.4013)  
Fax: 763.847.4010  
[customerservice@preferredone.com](mailto:customerservice@preferredone.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Assistance Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1.800.940.5049 (TTY: 763.847.4013).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.940.5049 (TTY: 763.847.4013).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.800.940.5049 (TTY: 763.847.4013).

XIYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1.800.940.5049 (TTY: 763.847.4013).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.800.940.5049 (TTY: 763.847.4013).

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 1.800.940.5049 (TTY: 763.847.4013)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.800.940.5049 (телетайп: 763.847.4013).

បំពេញ: ប្រសិនបើ អ្នកមិននិយាយភាសាអង់គ្លេស ទេ, សេវាជំនួយភាសា គឺអាចមានសេរីសេរី ដោយឥតគិតថ្លៃ។ ហៅ 1.800.940.5049 (TTY: 763.847.4013)។

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች፡ በነጻ ሊያገኙበት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1.800.940.5049 (ማስማት ለተሳናቸው: 763.847.4013)፡፡

ဟံသာဝတီ: နမူနာတို့ ကညီ ကျိအသိ, နမူနာ ကျိအတိအကျတို့ တလက်တလက်စွာ နှိမ့်တံ့သည့်လို့လိ။ ကိ: 1.800.940.5049 (TTY: 763.847.4013).

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ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភាសា គឺអាចមានសេរីសេរី ដោយឥតគិតថ្លៃ។ ហៅ 1.800.940.5049 (TTY: 763.847.4013)។

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