Breyanzi® (lisocabtagene maraleucel)
(Intravenous)

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I. Length of Authorization

Coverage will be provided for one treatment course (1 dose of Breyanzi) and may not be renewed.

II. Dosing Limits

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

- 1 carton (1 to 4 vials) of up to 110 million autologous anti-cd19 CAR-positive viable T-cells

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

- 1 billable unit (1 infusion of up to 110 million autologous anti-cd19 CAR-positive viable T-cells)

III. Initial Approval Criteria [1]

Submission of medical records (chart notes) related to the medical necessity criteria is REQUIRED on all requests for authorizations. Records will be reviewed at the time of submission. Please provide documentation related to diagnosis, step therapy, and clinical markers (i.e. genetic and mutational testing) supporting initiation when applicable. Please provide documentation via direct upload through the PA web portal or by fax.

Coverage is provided in the following conditions:

- Patient is at least 18 years of age (unless otherwise specified); **AND**
- Patient does not have a clinically significant active systemic infection or inflammatory disorder; **AND**
- Patient has not received live vaccines within 6 weeks prior to the start of lymphodepleting chemotherapy, and will not receive live vaccines during lisocabtagene maraleucel treatment and until immune recovery following treatment; **AND**

- Patient has been screened for hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) in accordance with clinical guidelines prior to collection of cells (leukapheresis); **AND**
- Prophylaxis for infection will be followed according to standard institutional guidelines; **AND**
- Healthcare facility has enrolled in the BREYANZI REMS Program and training has been given to providers on the management of cytokine release syndrome (CRS) and neurological toxicities; **AND**
- Patient has not received prior CAR-T therapy; **AND**
- Patient has not received prior anti-CD19 therapy, (e.g., tafasitamab, etc.) OR patient previously received anti-CD19 therapy and re-biopsy indicates CD-19 positive disease; **AND**
- Used as single agent therapy (not applicable to lymphodepleting or bridging chemotherapy while awaiting manufacture); **AND**
- Patient does not have primary central nervous system lymphoma; **AND**

B-Cell Lymphomas † ‡ Φ [1,2,7-12]

- Patient has diffuse large B cell lymphoma (DLBCL), high-grade B-cell lymphoma, primary mediastinal B-cell lymphoma (PMBCL), AIDS-related B-cell lymphoma (e.g., diffuse large B-cell lymphoma, primary effusion lymphoma, and HHV8-positive diffuse large B-cell lymphoma, not otherwise specified), or monomorphic post-transplant lymphoproliferative disorder (PTLD) (B-cell type); **AND**
    - Used for primary refractory disease (partial response, no response, or progression) or relapsed disease within 12 months after completion of first-line therapy; **OR**
    - Used for relapsed or refractory disease after first-line chemoimmunotherapy in patients NOT eligible for hematopoietic stem cell transplantation (HSCT) *(Note: Excludes AIDS-related B-cell lymphoma and monomorphic PTLD)*; **AND**
        - Patient is ineligible for HSCT due to one of the following: age ≥ 70 years, adjusted diffusing capacity of the lung for carbon monoxide (DLCO) ≤ 60%, LVEF < 50%, CrCl < 60 mL/min, AST or ALT > 2 × ULN, or ECOG 2; **OR**
    - Used as additional therapy for relapsed or refractory disease >12 months after completion of first-line therapy in patients with intention to proceed to transplant who have a partial response following second-line therapy *(Note: Intention to proceed to transplant does NOT apply to monomorphic post-transplant lymphoproliferative disorder)*; **OR**
    - Used for treatment of disease that is in second or greater relapse in patients with partial response, no response, or progressive disease following therapy for relapsed or refractory disease; **OR**
- Patient has Richter's transformation of CLL to DLBCL; **AND**

- Patient received at least two (2) prior lines of chemoimmunotherapy which must have included an anthracycline or anthracenedione-based regimen, unless contraindicated; **OR**

- Patient has follicular lymphoma grade 3B or histologic transformation of indolent lymphoma (follicular lymphoma or marginal zone lymphoma) to DLBCL; **AND**
  - Disease is refractory to first-line chemoimmunotherapy or has relapsed within 12 months of first-line chemoimmunotherapy; **AND**
    - Patient is a candidate for autologous hematopoietic stem cell transplant (HSCT); **OR**
  - Disease is relapsed or refractory after first-line chemoimmunotherapy and patient is NOT eligible for HSCT; **AND**
    - Patient is not eligible for HSCT due to one of the following: age ≥ 70 years, adjusted diffusing capacity of the lung for carbon monoxide (DLCO) ≤ 60%, LVEF < 50%, CrCl < 60 mL/min, AST or ALT > 2 × ULN, or ECOG 2; **OR**
  - Patient received at least two (2) prior lines of chemoimmunotherapy which must have included an anthracycline or anthracenedione-based regimen, unless contraindicated

Pediatric Aggressive Mature B-Cell Lymphomas ‡ [1,2,7,11,12]

- Patient is ≤ 18 years of age; **AND**
- Patient has primary mediastinal large B-Cell lymphoma; **AND**
- Disease is relapsed or refractory after use of ≥ 2 prior chemoimmunotherapy regimens and used as consolidation or additional therapy if partial response was achieved

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

IV. Renewal Criteria [1]

Coverage cannot be renewed.

V. Dosage/Administration [1]

Indication	Dose
All indications	<u>Lymphodepleting chemotherapy</u>: • Administer cyclophosphamide 300 mg/m² and fludarabine 30 mg/m² intravenously daily for three days. <u>Breyanzi infusion for relapsed/refractory disease after receiving at least ONE line of therapy:</u> • Infuse 2 to 7 days after completion of lymphodepleting chemotherapy. • A single dose of Breyanzi contains 90 to 110 × 10^6 CAR-positive viable T cells (consisting of 1:1 CAR-positive viable T cells of the CD8 and CD4 components), with each component supplied separately in one to four single-dose vials. <u>Breyanzi infusion for relapsed/refractory disease after receiving at least TWO lines of therapy:</u> • Infuse 2 to 7 days after completion of lymphodepleting chemotherapy.

	• A single dose of Breyanzi contains 50 to 110 × 10^6 CAR-positive viable T cells (consisting of 1:1 CAR-positive viable T cells of the CD8 and CD4 components), with each component supplied separately in one to four single-dose vials.

For autologous use only. For intravenous use only.

- Breyanzi is prepared from the patient's T-cells, which are obtained via a standard leukapheresis procedure.
- One treatment course consists of lymphodepleting chemotherapy followed by a single infusion of Breyanzi.
- Confirm Breyanzi availability prior to starting the lymphodepleting regimen.
- Confirm the patient's identity with the patient identifiers on the shipper and the respective Certificate of Release for Infusion (RFI Certificate) prior to infusion.
- Delay the infusion of BREYANZI if the patient has unresolved serious adverse events from preceding chemotherapies, active uncontrolled infection, or active graft-versus-host disease (GVHD).

Premedication:

- Premedicate with 650 mg acetaminophen and 25-50 mg diphenhydramine (or another H1-antihistamine) 30-60 minutes prior to infusion. Avoid prophylactic system corticosteroids which may interfere with Breyanzi activity.

Monitoring after infusion:

- Monitor patients daily at a certified healthcare facility during the first week following infusion for signs and symptoms of CRS and neurologic toxicities.
- Instruct patients to remain within proximity of the certified healthcare facility for at least 4 weeks following infusion.
- Instruct patients to refrain from driving or hazardous activities for 8 weeks following infusion.

- Store infusion bag in the vapor phase of liquid nitrogen (less than or equal to minus 130°C). Thaw prior to infusion.
- In case of manufacturing failure, a second manufacturing may be attempted.
- Additional bridging chemotherapy (not the lymphodepletion) may be necessary while the patient awaits the product.
- Ensure that 2 doses of tocilizumab and emergency equipment are available prior to infusion and during the recovery period.
- Breyanzi contains human blood cells that are genetically modified with replication incompetent self-inactivating lentiviral vector. Follow universal precautions and local biosafety guidelines for handling and disposal.

VI. Billing Code/Availability Information

HCPCS Code:

- Q2054 – Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose

NDC:

- Breyanzi suspension for intravenous infusion [Each vial contains between 6.9 × 10^6 and 322 x 10^6 CAR-positive viable T cells in 4.6 mL cell suspension (between 1.5 × 10^6 and 70 x 10^6 CAR-positive viable T cells/mL)]: 73153-0900-xx

VII. References

1. Breyanzi [package insert]. Bothell, WA; Juno Therap., Inc., June 2022. Accessed October 2022.
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7. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) lisocabtagene maraleucel. National Comprehensive Cancer Network, 2022. 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 October 2022.
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10. Sehgal AR, Hildebrandt G, Ghosh N, et al. Lisocabtagene maraleucel (liso-cel) for treatment of second-line (2L) transplant noneligible (TNE) relapsed/refractory (R/R) aggressive large B-cell non-Hodgkin lymphoma (NHL): Updated results from the PILOT study. Journal of Clinical Oncology 2020 38:15_suppl, 8040-8040. DOI: 10.1200/JCO.2020.38.
11. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for B-Cell Lymphomas Version 5.2022. National Comprehensive Cancer Network, 2022. 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 October 2022.

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Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
C82.40	Follicular lymphoma grade IIIb, unspecified site
C82.41	Follicular lymphoma grade IIIb, lymph nodes of head, face, and neck
C82.42	Follicular lymphoma grade IIIb, intrathoracic lymph nodes
C82.43	Follicular lymphoma grade IIIb, intra-abdominal lymph nodes
C82.44	Follicular lymphoma grade IIIb, lymph nodes of axilla and upper limb
C82.45	Follicular lymphoma grade IIIb, lymph nodes of inguinal region and lower limb
C82.46	Follicular lymphoma grade IIIb, intrapelvic lymph nodes
C82.47	Follicular lymphoma grade IIIb, spleen
C82.48	Follicular lymphoma grade IIIb, lymph nodes of multiple sites
C82.49	Follicular lymphoma grade IIIb, extranodal and solid organ sites
C83.00	Small cell B-cell lymphoma, unspecified site
C83.01	Small cell B-cell lymphoma, lymph nodes of head, face and neck
C83.02	Small cell B-cell lymphoma, intrathoracic lymph nodes
C83.03	Small cell B-cell lymphoma, intra-abdominal lymph nodes
C83.04	Small cell B-cell lymphoma, lymph nodes of axilla and upper limb
C83.05	Small cell B-cell lymphoma, lymph nodes of inguinal region and lower limb
C83.06	Small cell B-cell lymphoma, intrapelvic lymph nodes
C83.07	Small cell B-cell lymphoma, spleen
C83.08	Small cell B-cell lymphoma, lymph nodes of multiple sites
C83.09	Small cell B-cell lymphoma, extranodal and solid organ sites
C83.30	Diffuse large B-cell lymphoma unspecified site
C83.31	Diffuse large B-cell lymphoma, lymph nodes of head, face, and neck
C83.32	Diffuse large B-cell lymphoma intrathoracic lymph nodes
C83.33	Diffuse large B-cell lymphoma intra-abdominal lymph nodes
C83.34	Diffuse large B-cell lymphoma lymph nodes of axilla and upper limb
C83.35	Diffuse large B-cell lymphoma, lymph nodes of inguinal region and lower limb
C83.36	Diffuse large B-cell lymphoma intrapelvic lymph nodes
C83.37	Diffuse large B-cell lymphoma, spleen

C83.38	Diffuse large B-cell lymphoma lymph nodes of multiple sites
C83.39	Diffuse large B-cell lymphoma extranodal and solid organ sites
C83.80	Other non-follicular lymphoma, unspecified site
C83.81	Other non-follicular lymphoma, lymph nodes of head, face and neck
C83.82	Other non-follicular lymphoma, intrathoracic lymph nodes
C83.83	Other non-follicular lymphoma, intra-abdominal lymph nodes
C83.84	Other non-follicular lymphoma, lymph nodes of axilla and upper limb
C83.85	Other non-follicular lymphoma, lymph nodes of inguinal region and lower limb
C83.86	Other non-follicular lymphoma, intrapelvic lymph nodes
C83.87	Other non-follicular lymphoma, spleen
C83.88	Other non-follicular lymphoma, lymph nodes of multiple sites
C83.89	Other non-follicular lymphoma, extranodal and solid organ sites
C83.90	Non-follicular (diffuse) lymphoma, unspecified site
C83.91	Non-follicular (diffuse) lymphoma, unspecified lymph nodes of head, face, and neck
C83.92	Non-follicular (diffuse) lymphoma, unspecified intrathoracic lymph nodes
C83.93	Non-follicular (diffuse) lymphoma, unspecified intra-abdominal lymph nodes
C83.94	Non-follicular (diffuse) lymphoma, unspecified lymph nodes of axilla and upper limb
C83.95	Non-follicular (diffuse) lymphoma, unspecified lymph nodes of inguinal region and lower limb
C83.96	Non-follicular (diffuse) lymphoma, unspecified intrapelvic lymph nodes
C83.97	Non-follicular (diffuse) lymphoma, unspecified spleen
C83.98	Non-follicular (diffuse) lymphoma, unspecified lymph nodes of multiple sites
C83.99	Non-follicular (diffuse) lymphoma, unspecified extranodal and solid organ sites
C85.10	Unspecified B-cell lymphoma, unspecified site
C85.11	Unspecified B-cell lymphoma, lymph nodes of head, face, and neck
C85.12	Unspecified B-cell lymphoma, intrathoracic lymph nodes
C85.13	Unspecified B-cell lymphoma, intra-abdominal lymph nodes
C85.14	Unspecified B-cell lymphoma, lymph nodes of axilla and upper limb
C85.15	Unspecified B-cell lymphoma, lymph nodes of inguinal region and lower limb
C85.16	Unspecified B-cell lymphoma, intrapelvic lymph nodes
C85.17	Unspecified B-cell lymphoma, spleen
C85.18	Unspecified B-cell lymphoma, lymph nodes of multiple sites
C85.19	Unspecified B-cell lymphoma, extranodal and solid organ sites
C85.20	Mediastinal (thymic) large B-cell lymphoma, unspecified site
C85.21	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of head, face and neck
C85.22	Mediastinal (thymic) large B-cell lymphoma, intrathoracic lymph nodes
C85.23	Mediastinal (thymic) large B-cell lymphoma, intra-abdominal lymph nodes

C85.24	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of axilla and upper limb
C85.25	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of inguinal region and lower limb
C85.26	Mediastinal (thymic) large B-cell lymphoma, intrapelvic lymph nodes
C85.27	Mediastinal (thymic) large B-cell lymphoma, spleen
C85.28	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of multiple sites
C85.29	Mediastinal (thymic) large B-cell lymphoma, extranodal and solid organ sites
C85.80	Other specified types of non-Hodgkin lymphoma, unspecified site
C85.81	Other specified types of non-Hodgkin lymphoma, lymph nodes of head, face and neck
C85.82	Other specified types of non-Hodgkin lymphoma, intrathoracic lymph nodes
C85.83	Other specified types of non-Hodgkin lymphoma, intra-abdominal lymph nodes
C85.84	Other specified types of non-Hodgkin lymphoma, lymph nodes of axilla and upper limb
C85.85	Other specified types of non-Hodgkin lymphoma, lymph nodes of inguinal region of lower limb
C85.86	Other specified types of non-Hodgkin lymphoma, intrapelvic lymph nodes
C85.87	Other specified types of non-Hodgkin lymphoma, spleen
C85.88	Other specified types of non-Hodgkin lymphoma, lymph nodes of multiple sites
C85.89	Other specified types of non-Hodgkin lymphoma, extranodal and solid organ sites
C91.10	Chronic lymphocytic leukemia of B-cell type not having achieved remission
C91.12	Chronic lymphocytic leukemia of B-cell type in relapse
D47.Z1	Post-transplant lymphoproliferative disorder (PTLD)

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 Articles (LCAs), and Local Coverage Determinations (LCDs) 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/LCA/LCD): 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.

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
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

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- 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

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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

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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.

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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).

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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

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, 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).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.800.940.5049 (TTY: 763.847.4013).

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

ဟသူဉ်ဟ်သး– နမ့ါကတိၤ ကညီ ကျိာ်အယိ, နမၤန့ါ ကျိာ်အတ၊်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. 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 ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ 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.

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