Corporate Medical Policy: Botulinum Toxin Injection

Restricted Product(s):

- ***abobotulinumtoxinA (Dysport®) intramuscular injection for administration by a healthcare professional
- ***incobotulinumtoxinA (Xeomin®) intramuscular or intraglandular injection for administration by a healthcare professional
- onabotulinumtoxinA (Botox®) intramuscular, intradetrusor, or intradermal injection for administration by a healthcare professional
- rimabotulinumtoxinB (Myobloc®) intramuscular or intraglandular injection for administration by a healthcare professional

***preferred agent(s)**

FDA Approved Use:

- AbobotulinumtoxinA (Dysport®)
  - For the treatment of cervical dystonia in adults
  - For the treatment of spasticity in patients 2 years or older
  - **For temporary improvement in the appearance of moderate to severe glabellar lines associated with procerus and corrugator muscle activity in patients 65 years or older

- IncobotulinumtoxinA (Xeomin®)
  - For the treatment of cervical dystonia in adults
  - For the treatment of upper limb spasticity in adults
  - For the treatment of upper limb spasticity in patients 2 to 17 years old, excluding spasticity caused by cerebral palsy
  - For the treatment of chronic sialorrhea in patients 2 years or older
  - For the treatment of blepharospasm in adults
  - **For temporary improvement in the appearance of moderate to severe glabellar lines associated with procerus and/or corrugator muscle activity in adults

- OnabotulinumtoxinA (Botox®)
  - For the treatment of cervical dystonia in adults to reduce the severity of abnormal head position and neck pain
  - For the treatment of spasticity in patients 2 years or older
    - Limitations of use: Not for improvement of upper extremity functional abilities or range of motion at a joint affected by a fixed contracture
  - For the prophylaxis of headaches in adults with chronic migraine (≥15 days per month with headache lasting 4 hours a day or longer)
    - Limitations of use: Not for prophylaxis of episodic migraine (≤14 headache days per month)

  - For the treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency, in adults who have an inadequate response to or are intolerant of an anticholinergic medication
  - For the treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis) in adults who have an inadequate response to or are intolerant of an anticholinergic medication
  - For the treatment of neurogenic detrusor overactivity in pediatric patients 5 years or older who have an inadequate response to or are intolerant of an anticholinergic medication
  - For the treatment of blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders, in patients 12 years or older
  - For the treatment of strabismus in patients 12 years or older
  - For the treatment of severe axillary hyperhidrosis in adults that is inadequately managed by topical agents
    - Limitations of use: Not for use in body areas other than axillary
  - **For temporary improvement in the appearance of moderate to severe glabellar lines associated with procerus and/or corrugator muscle activity, moderate to severe lateral canthal lines associated with orbicularis oculi activity, and moderate to severe forehead lines associated with frontalis muscle activity in adults

- RimabotulinumtoxinB (Myobloc®)
  - For the treatment of cervical dystonia to reduce the severity of abnormal head position and neck pain associated with cervical dystonia in adults
  - For the treatment of chronic sialorrhea in adults

**The restricted products within this policy may be FDA approved for temporary improvement of the appearance of glabellar (frown) lines in adults; however, use of these products for cosmetic purposes are considered a benefit exclusion and are not addressed in this medical policy. Please refer to the Member's Benefit Booklet for availability of benefits and for the definition of cosmetic and reconstructive services. Member's benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this medical policy.

Criteria for Medical Necessity:

The restricted product(s) may be considered medically necessary when the following criteria are met:

Initial Criteria for Approval:

Botulinum toxin may be considered medically necessary when the following criteria are met:

1. The patient will NOT be using the requested agent for cosmetic purposes (e.g., glabellar lines, wrinkles); **AND**
2. The patient has a diagnosis of **blepharospasm**; **AND**
    a. The patient is 12 years of age or older; **AND**
    b. If the requested agent is Botox or Myobloc AND the patient is 18 years of age or older, one of the following:
        i. The patient has tried and had an inadequate response with Xeomin **[medical record documentation required]**; **OR**
        ii. The patient has a clinical contraindication or intolerance to Xeomin **[medical record documentation required]**; **OR**
        iii. The patient's blepharospasm is associated with dystonia or facial nerve (VII) disorders (including benign essential blepharospasm and hemifacial spasm); **OR**

3. The patient has a diagnosis of **hemifacial spasm**; **OR**

4. The patient has a diagnosis of **cervical dystonia** (spasmodic torticollis; applicable whether congenital, due to child birth injury, or traumatic injury); **AND**
    a. The patient is 16 years of age or older; **AND**
    b. The patient's cervical dystonia is associated with sustained head tilt or abnormal posturing with limited range of motion in the neck; **AND**
    c. The patient has a history of recurrent involuntary contraction(s) of one or more of the muscles of the neck (e.g., sternocleidomastoid, splenius, trapezius, or posterior cervical muscles); **AND**
    d. If the requested agent is Botox or Myobloc, one of the following:
        i. The patient has tried and had an inadequate response with Xeomin AND Dysport **[medical record documentation required]**; **OR**
        ii. The patient has a clinical contraindication or intolerance to BOTH Xeomin AND Dysport **[medical record documentation required]**; **OR**

5. The patient has a diagnosis of **dystonia**; **AND**
    a. The patient is 18 years of age or older; **AND**
    b. The patient has at least ONE of the following focal dystonias:
        i. Focal upper-limb dystonia (e.g., organic writer's cramp);
        ii. Oromandibular dystonia (e.g., orofacial dyskinesia, Meige syndrome);
        iii. Laryngeal dystonia (e.g., adductor spasmodic dysphonia);
        iv. Idiopathic (primary or genetic) torsion dystonia;
        v. Symptomatic (acquired) torsion dystonia; **AND**

c. The patient's dystonia results in functional impairment (interference with joint function, mobility, communication, nutritional intake) with or without pain; **AND**
d. If the requested agent is Botox or Myobloc, one of the following:
    i. The patient has tried and had an inadequate response with Xeomin AND Dysport **[medical record documentation required]**; **OR**
    ii. The patient has a clinical contraindication or intolerance to BOTH Xeomin AND Dysport **[medical record documentation required]**; **OR**

6. The patient has a diagnosis of **spasticity**; **AND**
    a. The patient is 2 years of age or older; **AND**
    b. The patient has at least ONE of the following spastic conditions:
        i. Upper and/or lower limb spasticity;
        ii. Cerebral palsy;
        iii. Spasticity related to stroke;
        iv. Acquired spinal cord or brain injury;
        v. Hereditary spastic paraparesis;
        vi. Spastic hemiplegia;
        vii. Neuromyelitis optica;
        viii. Multiple sclerosis or Schilder's disease; **AND**
    c. The patient's spasticity results in functional impairment (interference with joint function, mobility, communication, nutritional intake) with or without pain; **AND**
    d. If the requested agent is Botox or Myobloc, one of the following:
        i. The patient has tried and had an inadequate response with Xeomin AND Dysport **[medical record documentation required]**; **OR**
        ii. The patient has a clinical contraindication or intolerance to BOTH Xeomin AND Dysport **[medical record documentation required]**; **OR**

7. The patient has a diagnosis of **chronic anal fissure**; **AND**
    a. The patient is 18 years of age or older; **AND**
    b. The patient has a tried and had an inadequate response to ONE of the following conventional therapies: topical nitrates or topical calcium channel blockers (e.g., diltiazem, nifedipine); **OR**
    c. The patient has a clinical contraindication or intolerance to ALL topical nitrates and topical calcium channel blockers (e.g., diltiazem, nifedipine); **OR**

8. The patient has a diagnosis of **chronic migraine headache**; **AND**
    a. The patient is 18 years of age or older; **AND**
    b. The patient has ≥ 15 headache days per month for a minimum of 3 months; **AND**
    c. The patient ≥ 8 migraine headache days per month for a minimum of 3 months; **AND**
    d. The patient will be using the requested agent for chronic migraine prophylaxis; **AND**
    e. The patient has been evaluated for and does NOT have medication overuse headache; **AND**
    f. ONE of the following:
        i. The patient has tried and had an inadequate response to at least TWO agents from different migraine prophylaxis classes (anticonvulsants [i.e., divalproex, valproate, topiramate], beta blockers [i.e., atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [i.e., amitriptyline, venlafaxine], calcitonin gene-related peptide antagonists [i.e., fremanezumab, galcanezumab, erenumab, eptinezumab]) after an adequate trial as defined by BOTH of the following:
            1. The trial length was at least 6 weeks for each class at generally accepted doses; **AND**
            2. The patient was ≥ 80% adherent to the prophylaxis agent during the trial; **OR**
        ii. The patient has a clinical contraindication or intolerance to ALL anticonvulsants, beta blockers, antidepressants, AND prophylactic calcitonin gene-related peptide antagonists listed above; **AND**
    g. If the requested agent is Botox, one of the following:
        i. The patient has tried and had an inadequate response to at least one calcitonin gene-related peptide (CGRP) antagonist for chronic migraine headache prophylaxis (e.g., fremanezumab, galcanezumab, erenumab, or eptinezumab) **[medical record documentation required]**; **OR**
        ii. The patient has a clinical contraindication or intolerance to ALL calcitonin gene-related peptide (CGRP) antagonists (e.g., fremanezumab, galcanezumab, erenumab, or eptinezumab) **[medical record documentation required]**; **AND**
    h. The patient will NOT be using the requested agent in combination with a calcitonin gene-related peptide (CGRP) antagonist for chronic migraine headache prophylaxis (e.g., fremanezumab, galcanezumab, erenumab, or eptinezumab); **OR**

9. The patient has a diagnosis of **esophageal achalasia**; **AND**
    a. The patient has NOT responded to dilation therapy; **OR**
    b. The patient is considered a poor surgical candidate; **OR**

10. The patient has a diagnosis of **Hirschsprung disease**; **AND**
    a. The patient has developed obstructive symptoms after a pull-through operation; **OR**

11. The patient has a diagnosis of **overactive bladder (OAB)**; **AND**

a. The patient is 18 years of age or older; **AND**
b. The patient has symptoms of urge urinary incontinence, urgency, and frequency; **AND**
c. The patient has tried and had an inadequate response to ONE anticholinergic agent (e.g., oxybutynin, tolterodine, trospium, darifenacin, solifenacin or fesoterodine); **OR**
d. The patient has tried and had an inadequate response to a beta-3 adrenergic agonist (e.g., Myrbetriq [mirabegron]); **OR**
e. The patient has a clinical contraindication or intolerance to ALL anticholinergic agents AND beta-3 adrenergic agonists; **OR**

12. The patient has a diagnosis of **urinary incontinence** with detrusor muscle overactivity associated with neurogenic causes (e.g., spinal cord injury, multiple sclerosis); **AND**
    a. The patient is 18 years of age or older; **AND**
    b. The patient has tried and had an inadequate response to ONE anticholinergic agent (e.g., oxybutynin, tolterodine, trospium, darifenacin, solifenacin or fesoterodine); **OR**
    c. The patient has tried and had an inadequate response to a beta-3 adrenergic agonist (e.g., Myrbetriq [mirabegron]); **OR**
    d. The patient has a clinical contraindication or intolerance to ALL anticholinergic agents AND beta-3 adrenergic agonists; **OR**

13. The patient has a diagnosis of **neurogenic detrusor overactivity (NDO)**; **AND**
    a. The patient is 5 years of age or older; **AND**
    b. The patient has tried and had an inadequate response to ONE anticholinergic agent (e.g., oxybutynin, solifenacin); **OR**
    c. The patient has a clinical contraindication or intolerance to ALL anticholinergic agents; **OR**

14. The patient has a diagnosis of chronic **sialorrhea** (drooling); **AND**
    a. The patient is 18 years of age or older; **OR**
    b. If the requested agent is Xeomin, the patient is 2 years of age or older; **AND**
    c. The patient's diagnosis is associated with a neurological disorder (e.g., amyotrophic lateral sclerosis, atypical parkinsonian disorders, cerebral palsy, Parkinson disease, stroke, traumatic brain injury); **AND**
    d. The patient has experienced excessive salivation for ≥ 3 months; **AND**
    e. The patient has tried and had an inadequate response to at least 2 months continuous treatment with at least one conventional agent (e.g., anticholinergics, benztropine, oral hyoscyamine, glycopyrrolate); **OR**
    f. The patient has a clinical contraindication or intolerance to ALL conventional agents above; **AND**
    g. If the requested agent is Botox or Myobloc, one of the following:
        i. The patient has tried and had an inadequate response with Xeomin **[medical record documentation required]**; **OR**
        ii. The patient has a clinical contraindication or intolerance to Xeomin **[medical record documentation required]**; **OR**

15. The patient has a diagnosis of **strabismus**; **AND**
    a. The patient is 12 years of age or older; **OR**

16. The patient has a diagnosis of **severe primary axillary or palmar hyperhidrosis**; **AND**
    a. The patient is 18 years of age or older; **AND**
    b. The patient has focal, visible, excessive sweating of at least 6 months duration without apparent cause with at least TWO of the following characteristics:
        i. Bilateral and relatively symmetric;
        ii. Impairs daily activities;
        iii. Frequency of at least one episode per week;
        iv. Age of onset is less than 25 years;
        v. Positive family history;
        vi. Cessation of focal sweating during sleep; **AND**
    c. The patient has one of the following associated medical conditions:
        i. Acrocyanosis of the hands;
        ii. History of recurrent skin maceration with bacterial or fungal infections;
        iii. History of recurrent secondary infections;
        iv. History of persistent eczematous dermatitis despite medical treatments with topical dermatologic or systemic anticholinergic agents; **OR**
    d. The patient's hyperhidrosis causes functional impairment (e.g., inability to perform activities of daily living and/or manual tasks in a professional setting); **AND**
    e. Potential causes of secondary hyperhidrosis have been ruled out (e.g., hyperthyroidism); **AND**
    f. The patient has tried and had an inadequate response with topical agents (e.g., aluminum chloride 20% solution); **OR**
    g. The patient has a clinical contraindication or intolerance to ALL topical agents; **OR**

17. The patient has another diagnosis that is an FDA approved indication for botulinum toxins; **AND**
18. The patient will NOT be receiving botulinum toxin more frequently than every 12 weeks, regardless of diagnosis; **AND**
19. The requested quantity does NOT exceed the maximum units/visits allowed for the duration of approval (see table below).

Duration of Approval:

Migraine: 180 days (6 months)
All other indications: 365 days (1 year)

Continuation Criteria for Approval:

Botulinum toxin may be considered medically necessary when the following criteria are met:

1. The patient will NOT be using the requested agent for cosmetic purposes (e.g., glabellar lines, wrinkles); **AND**
2. The patient was approved through Blue Cross NC initial criteria for approval (above) or would have met initial criteria for approval upon the start of therapy; **AND**
3. The patient has a diagnosis of **chronic migraine headache**; **AND**
    a. The patient's migraine headache frequency has been reduced by at least 7 days per month compared to pre-treatment frequency; **OR**
    b. The patient's migraine headache duration has been reduced by at least 100 hours per month compared to pre-treatment duration; **AND**
    c. The patient NOT be using the requested agent in combination with a calcitonin gene-related peptide (CGRP) antagonist for chronic migraine headache prophylaxis (e.g., fremanezumab, galcanezumab, erenumab, or eptinezumab); **OR**
4. The patient is continuing botulinum toxin therapy for one of the indications listed in the initial coverage criteria; **AND**
    a. The patient has had a positive clinical response to botulinum toxin therapy; **AND**
5. The patient will NOT be receiving botulinum toxin more frequently than every 12 weeks, regardless of diagnosis; **AND**
6. The requested quantity does NOT exceed the maximum units/visits allowed for the duration of approval (see table below).

Duration of Approval: 365 days (1 year)

FDA Label Reference				
Medication	**Indication**	**Dosing**	**HCPCS**	**Maximum Units***
abobotulinumtoxinA (Dysport®) intramuscular (IM) injection	Cervical dystonia in adults	Initial: 500 units IM divided among affected muscles, titrate by 250 units (up to 1000 units) according to patient response Retreatment no sooner than every 12 weeks	J0586	4 visits (2 visits for migraine initial)

	Spasticity in patients ≥2 years old	Adults: • Upper limb: 500 to 1000 units divided among affected muscles • Lower limb: Up to 1500 units divided among affected muscles Max dose upper/lower combined: 1500 units Retreatment no sooner than every 12 weeks		

		2-17 years old: • Upper limb: 8-16 units/kg per limb; not to exceed 640 units • Lower limb: 10-15 units/kg per limb; not to exceed 1000 units Max total dose in one treatment session is 30 units/kg or 1000 units (whichever is lower) in a 3-month interval Retreatment no sooner than every 12 weeks		
incobotulinumtoxinA (Xeomin®) intramuscular or intraglandular injection	Cervical dystonia in adults	Initial: 120 units per treatment session; retreatment no sooner than every 12 weeks Max cumulative dose for any indication not to exceed 400 units per treatment session	J0588	4 visits (2 visits for migraine initial)
	Upper limb spasticity in adults	Total dose is up to 400 units divided among affected muscles; retreatment no sooner than every 12 weeks Max cumulative dose for any indication not to exceed 400 units per treatment session		

	Upper limb spasticity in patients 2-17 years old	Total dose is 8 units/kg (max 200 units) per single upper limb or 16 units/kg (max 400 units) in both upper limbs, divided among affected muscles Max cumulative dose for any indication not to exceed 400 units per treatment session		
	Chronic sialorrhea in patients ≥2 years old	Adults: • 100 units per treatment session; retreatment no sooner than every 16 weeks 2-17 years old: • Weight-based dosing in 3:2 dose ratio parotid:submandibular glands for patients ≥12 kg; retreatment no sooner than every 16 weeks Max cumulative dose for any indication not to exceed 400 units per treatment session		
	Blepharospasm in adults	Previously treated with botulinum toxin: past dose, response, duration of effect, and adverse event history		

		should be considered in dose determination Botulinum toxin naïve: 50 units (25 units per eye) Dose per session not to exceed 100 units (50 units per eye) and retreatment no sooner than every 12 weeks Max cumulative dose for any indication not to exceed 400 units per treatment session		
onabotulinumtoxinA (Botox®) intramuscular, intradetrusor, or intradermal injection	Cervical dystonia in adults	Dosing based on head and neck position, localization of pain, muscle hypertrophy, response, and adverse event history; use lower initial dose in botulinum toxin naïve patients No more than 50 units per site up to a total dose of 400 units divided among affected muscles Maximum cumulative dose not to exceed 400 units in a 3-month interval in patients treated for one or more indication	J0585	4 visits (2 visits for migraine initial)

	Spasticity in patients ≥2 years	Dosing based on affected muscles, severity of muscle activity, prior treatment response, and adverse event history Adults: • Upper limb: Doses ranging from 75 to 400 units, divided among selected muscles • Lower limb: Total dose of 300 to 400 units, divided across ankle and toe muscles Maximum cumulative dose not to exceed 400 units in a 3-month interval in patients treated for one or more indication Retreatment no sooner than every 12 weeks		
		Dosing based on affected muscles, severity of muscle activity, prior treatment response, and adverse event history 2-17 years old:		

		• Upper limb: Total dose of 3-6 units/kg (max 200 units), divided among affected muscles • Lower limb: Total dose of 4-8 units/kg (max 300 units), divided among affected muscles Maximum cumulative dose not to exceed the lower of 10 units/kg or 340 units in a 3-month interval in patients treated for one or more indication		
	Chronic migraine prophylaxis in adults	Total dose 155 units, as 5-unit (0.1 mL) injections per each site, divided across 7 head/neck muscles Maximum cumulative dose not to exceed 400 units in a 3-month interval in patients treated for one or more indication Retreatment no sooner than every 12 weeks		

	OAB in adults	Total dose 100 units, as 5-unit (0.5 mL) injections across 20 sites into the detrusor Dose per session not to exceed 100 units Maximum cumulative dose not to exceed 400 units in a 3-month interval in patients treated for one or more indication Retreatment no sooner than every 12 weeks		
	Urinary incontinence due to detrusor overactivity in adults	Total dose 200 units, as ~6.7-unit (1 mL) injections across 30 sites into the detrusor Dose per session not to exceed 200 units Maximum cumulative dose not to exceed 400 units in a 3-month interval in patients treated for one or more indication Retreatment no sooner than every 12 weeks		

	Blepharospasm in patients ≥12 years old	1.25 to 2.5 units into each of 3 sites per affected eye Maximum cumulative dose in a 30-day period not to exceed 200 units Maximum cumulative dose not to exceed 400 units in a 3-month interval in patients treated for one or more indication		
	Strabismus in patients ≥12 years old	Dose based on prism diopter correction or previous response to Botox treatment Initial doses range from 1.25 to 5 units per muscle, subsequent doses at a max dose of 25 units per muscle Adults: Maximum cumulative dose not to exceed 400 units in a 3-month interval in patients treated for one or more indication Pediatrics: Maximum cumulative dose not to exceed the lower of 10 units/kg or 340 units in a 3-month interval in		

		patients treated for one or more indication		
	Severe axillary hyperhidrosis in adults	50 units per axilla Maximum cumulative dose not to exceed 400 units in a 3-month interval in patients treated for one or more indication		
rimabotulinumtoxinB (Myobloc®) intramuscular or intraglandular injection	Cervical dystonia in adults	Previously tolerating botulinum toxin: 2500 to 5000 units divided among affected muscles Botulinum toxin naïve: lower initial dosage Retreatment no sooner than every 12 weeks	J0587	4 visits (2 visits for migraine initial)
	Chronic sialorrhea in adults	1500 to 3500 units divided among parotid and submandibular glands Retreatment no sooner than every 12 weeks		

***Maximum units/visits allowed for duration of approval**

References: all information referenced is from FDA package insert unless otherwise noted below.

Policy Implementation/Update Information:

November 2021: Criteria change: Added hemifacial spasm as a covered indication; updated criteria for blepharospasm to include blepharospasm associated with dystonia or facial nerve (VII) disorders (including benign essential blepharospasm and hemifacial spasm) separately without step therapy requirement.
April 2021: Criteria change: Added specific age requirements according to indication where appropriate; Chronic anal fissure: added requirement of trial and failure of one conventional therapy; Chronic migraine: added criteria that patient has been evaluated for and does not have medication overuse headache; Sialorrhea: added requirement that patient has experienced excessive salivation for ≥3 months, and added trial and failure of at least one convention agent, added requirement of trial and failure of preferred Xeomin for Botox/Myobloc requests; OAB/urinary incontinence: added option of trial and failure of a beta-3 adrenergic agonist (Myrbetriq); combined coverage criteria for severe axillary or palmar hyperhidrosis into this policy; added maximum units/visits; medical policy formatting change. **Policy notification given 2/26/2021 for effective date 4/28/2021**.
*Further historical criteria changes and updates available upon request from Medical Policy and/or Corporate Pharmacy.

Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina ("Blue Cross NC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- Blue Cross NC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

  Blue Cross NC:

  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified 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 Customer Service **1-888-206-4697**, TTY and TDD, call **1-800-442-7028**.

- If you believe that Blue Cross NC 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:
  - Blue Cross NC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone **919-765-1663**, Fax **919-287-5613**, TTY **1-888-291-1783** civilrightscoordinator@bcbsnc.com

- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office 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 and/or attachments may have important information about your application or coverage through Blue Cross NC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service **1-888-206-4697**.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-206-4697 (TTY: 1-800-442-7028).

注意：如果您講廣東話或普通話， 您可以免費獲得語言援助服務。請致電 1-888-206-4697 (TTY：1-800-442-7028）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-206-4697 (TTY: 1-800-442-7028).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-888-206-4697 (TTY: 1- 800-442-7028)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-206-4697 (ATS : 1-800-442-7028).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
1-888-206-4697. المبرقة الكاتبة: 1-800-442-7028.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau
1-888-206-4697 (TTY: 1-800-442-7028).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-206-4697 (телетайп: 1-800-442-7028).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-206-4697 (TTY: 1-800-442-7028).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:સુલ્કુ ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો
1-888-206-4697 (TTY: 1-800-442-7028).

ចំណាំ៖ ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមទំនាក់ទំនងតាមរយៈលេខ៖ 1-888-206-4697 (TTY: 1-800-442-7028)។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-206-4697 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-206-4697 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-206-4697 (TTY: 1-800-442-7028).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697（TTY: 1-800-442-7028）まで、お電話にてご連絡ください。