Blue Cross Blue Shield of North Dakota
Restricted Use List – Prior Approval

Restricted Use Drug -A Prescription Medication or Drug that may require Prior Approval and/or be subject to a limited dispensing amount.

Key Definitions		
CE	Coverage Exception	For Qualified Health Plans (QHP), this is a Non-Formulary drug excluded from coverage. If seeking coverage, a Coverage Exception Form must be submitted for review The coverage exception form can be found on the link below: https://www.myprime.com/content/dam/prime/memberportal/forms/2018/FullyQualified/Other/ALL/BCBSND/COMMERCIAL/NDIVLDRUG/ND_HIM_Coverage_Exception.pdf OR https://www.myprime.com/en/coverage-exception-form.html
F	Formulary Drug	A Brand Name or Generic Prescription Drug that has been determined to be safe, therapeutically effective, high quality, and cost-effective as determined by a committee of Physicians and Pharmacists based on current data.
MED	Medical Drug	For Qualified Health Plans (QHP), this drug is covered under the medical benefit and requires Prior Approval Prior authorization form for medical drugs can be found on the link below: https://www.bcbsnd.com/documents/10476/35335/outpatient-fillable.pdf/870cc1cd-8781-455e-bae1-e6dfbfcd182a
NF	Non-Formulary Drug	A Prescription Medication or Drug that is not a Formulary Drug
PA	Prior Approval	A drug that requires Prior Approval. Prior authorization form for pharmacy drugs can be found on the link below: https://www.myprime.com/en/forms/coverage-determination/prior-authorization.html
QHP	Qualified Health Plan	BlueCare, BlueDirect and BlueEssential/Simply Blue
*	n/a	Not all benefit plans cover Weight Loss medications. Please contact a Member Services representative for specific coverage information.

The following List of Drugs represents the drugs requiring Prior Approval (PA)

- This entire list applies to the commercial population.
- PA/CE prior authorization form for pharmacy drugs can be found on the link below:
  - https://www.myprime.com/en/forms/coverage-determination/prior-authorization.html
- MED prior authorization form for medical drugs can be found on the link below:
  - https://www.bcbsnd.com/documents/10476/35335/outpatient-fillable.pdf/870cc1cd-8781-455e-bae1-e6dfbfcd182a
- Specific criteria must be met before medication is covered under the pharmacy benefit. Unless otherwise noted, if a prior approval is granted, the drug will be allowed at the Formulary benefit level.
- Both brand name drugs and generic equivalents require Prior Approval. Please see separate documents for drugs requiring Prior Approval, due to a Utilization Management Quantity Limit or a Step Therapy edit.

CATEGORY	BRAND DRUG NAME	GENERIC DRUG NAME	QHP
TOPICAL ACNE & SKIN: Prior approval (PA) required for age >40	ATRALIN	TRETINOIN	CE
	AVITA	TRETINOIN	PA
	DIFFERIN	ADAPALENE	PA, CE (for Brand only)
	FABIOR	TAZAROTENE	CE
	RETIN-A, RETIN-A MICRO	TRETINOIN	CE

CATEGORY	BRAND DRUG NAME	GENERIC DRUG NAME	QHP
	TAZORAC	TAZAROTENE	PA
ANTIFUNGALS	CRESEMBA	ISAVUCONAZONIUM	PA
	NOXAFIL	POSACONAZOLE	PA
	VFEND	VORICONAZOLE	PA, CE (for Brand only)
AUTOIMMUNE INFLAMMATORY DISORDERS	ACTEMRA	TOCLIZUMAB	MED
	ARCALYST	RILONACEPT	PA
	CIMZIA	CERTOLIZUMAB	PA
	COSENTYX	SECUKINUMAB	PA
	ENBREL	ETANERCEPT	PA
	ENTYVIO	VEDOLIZUMAB	MED
	HUMIRA	ADALIMUMAB	PA
	ILARIS	CANAKINUMAB	PA
	INFLECTRA	INFLIXIMAB-DYYB	MED
	KEVZARA	SARILUMAB	CE
	KINERET	ANAKINRA	PA
	OLUMIANT	BARICITINIB	CE
	ORENCIA	ABATACEPT	PA
	ORENCIA IV	ABATACEPT	MED
	OTEZLA	APREMILAST	PA
	REMICADE	INFLIXIMAB	MED
	RENFLEXIS	INFLIXIMAB-ABDA	MED
	RITUXAN	RITUXIMAB	MED
	RITUXAN HYCELA	RITUXIMAB-HYALURONIDASE	MED
	SILIQ	BRODALUMAB	CE
	SIMPONI	GOLIMUMAB	PA
	SIMPONI ARIA	GOLIMUMAB	MED
	STELARA	USTEKINUMAB	PA
	STELARA IV	USTEKINUMAB	MED
	TALTZ	IXEKIZUMAB	PA
	TREMFYA	GUSELKUMAB	CE
	XELJANZ, XELJANZ XR	TOFACITINIB	PA
CANCER— ORALLY ADMINISTERED	AFINITOR/AFINITOR DISPERZ	EVEROLIMUS	PA
	ALECENSA	ALECTINIB	PA
	ALUNBRIG	BRIGATINIB	PA
	BOSULIF	BOSUTINIB	PA
	BRAFTOVI	ENCORAFENIB	PA

CATEGORY	BRAND DRUG NAME	GENERIC DRUG NAME	QHP
	CABOMETYX	CABOZANTINIB	PA
	CALQUENCE	ACALABRUTINIB	PA
	CAPRELSA	VANDETANIB	PA
	COMETRIQ	CABOZANTINIB S-MAL	PA
	COPIKTRA	DUVELSIB	CE
	COTELLIC	COBIMETINIB	PA
	DAURISMO	GLASDEGIB	CE
	ERIVEDGE	VISMODEGIB	PA
	ERLEADA	APALUTAMIDE	PA
	FARYDAK	PANOBINOSTAT LACTATE	PA
	GILOTRIF	AFATINIB DIMALEATE	PA
	GLEEVEC	IMATINIB MESYLATE	PA, CE (brand only)
	HEXALEN	ALTRETAMINE	PA
	HYCAMTIN	TOPOTECAN	PA
	IBRANCE	PALBOCICLIB	PA
	ICLUSIG	PONATINIB	PA
	IDHIFA	ENASIDENIB	PA
	IMBRUVICA	IBRUTINIB	PA
	INLYTA	AXITINIB	PA
	IRESSA	GEFITINIB	PA
	JAKAFI	RUXOLITINIB	PA
	KISQALI	RIBOCICLIB	PA
	KISQALI/FEMARA DOSE PAK	RIBOCICLIB/LETROZOLE	PA
	LENVIMA	LENVATINIB MESYLATE	PA
	LOBRENA	LORLATINIB	CE
	LONSURF	TRIFLURIDINE-TIPIRACIL	PA
	LYNPARZA	OLAPARIB	PA
	LYSODREN	MITOTANE	PA
	MATULANE	PROCARBAZINE	PA
	MEKINIST	TRAMETINIB	PA
	MEKTOVI	BINIMETINIB	PA
	NERLYNX	NERATINIB	PA
	NEXAVAR	SORAFENIB	PA
	NINLARO	IXAZOMIB	PA
	ODOMZO	SONIDEGIB	PA
	POMALYST	POMALIDOMIDE	PA

CATEGORY	BRAND DRUG NAME	GENERIC DRUG NAME	QHP
	REVLIMID	LENALIDOMIDE	PA
	RUBRACA	RUCAPARIB	PA
	RYDAPT	MIDOSTAURIN	PA
	SPRYCEL	DASATINIB	PA
	STIVARGA	REGORAFENIB	PA
	SUTENT	SUNITINIB	PA
	TAFINLAR	DABRAFENIB	PA
	TAGRISSO	OSIMERTINIB	PA
	TALZENNA	TALAZOPARIB	CE
	TARCEVA	ERLOTINIB	PA
	TARGRETIN	BEXAROTENE	PA, CE (brand only)
	TASIGNA	NILOTINIB	PA
	TEMODAR	TEMOZOLOMIDE	PA
	THALOMID	THALIDOMIDE	PA
	TIBSOVO	IVOSIDENIB	PA
	TRETINOIN	TRETINOIN	PA
	TYKERB	LAPATINIB	PA
	VENCLEXTA	VENETOCLAX	PA
	VERZENIO	ABEMACICLIB	PA
	VIKTRAVI	LAROTRECTINIB	CE
	VIZIMPRO	DACOITINIB	CE
	VOTRIENT	PAZOPANIB	PA
	XALKORI	CRIZOTINIB	PA
	XELODA	CAPECITABINE	PA
	XOSPATA	GLITERITINIB	CE
	XTANDI	ENZALUTAMIDE	PA
	YONSA	ABIRATERONE	CE
	ZEJULA	NIRAPARIB	PA
	ZELBORAF	VEMURAFENIB	PA
	ZOLINZA	VORINOSTAT	PA
	ZYDELIG	IDELALISIB	PA
	ZYKADIA	CERITINIB	PA
	ZYTIGA	ABIRATERONE	PA
CANCER—INJECTABLE	AVASTIN	BEVACIZUMAB	MED
	HERCEPTIN	TRASTUZUMAB	MED
	KADCYLA	ADO-TRASTUZUMAB EMTANSINE	MED

CATEGORY	BRAND DRUG NAME	GENERIC DRUG NAME	QHP
	KYPROLIS	CARFILZOMIB	MED
	PERJETA	PERTUZUMAB	MED
	RITUXAN	RITUXIMAB	MED
	SYLATRON	PEGINTERFERON ALFA-2B	PA
	SYNRIBO	OMACETAXINE	MED
CYSTIC FIBROSIS	KALYDECO	IVACAFTOR	PA
	ORKAMBI	LUMACAFTOR-IVACAFTOR	PA
	SYMDEKO	TEZACAFTOR-IVACAFTOR	PA
ENZYME DEFICIENCIES	CARBAGLU	CARGLUMIC ACID	CE
	ELELYSO	TALIGLUCERASE ALFA	MED
	KUVAN	SAPROPTERIN	PA
	LUMIZYME	ALGLUCOSIDASE ALFA	MED
	STRENSIQ	ASFOTASE ALFA	PA
	VIMIZIM	ELOSULFASE ALFA	MED
	VPRIV	VELAGLUCERASE ALFA	MED
	ZAVESCA	MIGLUSTAT	PA
GROWTH HORMONES	GENOTROPIN	SOMATROPIN	CE
	HUMATROPE	SOMATROPIN	CE
	NORDITROPIN	SOMATROPIN	CE
	NUTROPIN/NUTROPIN AQ	SOMATROPIN	CE
	OMNITROPE	SOMATROPIN	PA
	SAIZEN	SOMATROPIN	CE
	SEROSTIM	SOMATROPIN	CE
	TEV-TROPIN	SOMATROPIN	CE
	ZOMACTON	SOMATROPIN	CE
	ZORBTIVE	SOMATROPIN	CE
HEPATITIS C	OLYSIO	SIMEPRIVIR	PA
	HARVONI	LEDIPASVIR-SOFOSBUVIR	PA
	SOVALDI	SOFOSBUVIR	PA
	EPCLUSA	SOFOSBUVIR-VELPATASVIR	PA
	MAVYRET	GLECAPREVIR-PIBRENTASVIR	PA
	VOSEVI	SOFOSBUVIR-VELPATASVIR-VOXILAPREVIR	PA
	ZEPATIER	ELBASVIR-GRAZOPREVIR	PA
HEREDITARY ANGIOEDEMA (HAE)	BERINERT	C1 ESTERASE INHIBITOR (HUMAN)	MED
	CINRYZE	C1 ESTERASE INHIBITOR (HUMAN)	MED
	FIRAZYR	ICATIBANT ACETATE	PA

CATEGORY	BRAND DRUG NAME	GENERIC DRUG NAME	QHP
	HAEGARDA	C1 ESTERASE INHIBITOR	CE
	KALBITOR	ECALLANTIDE	MED
	RUCONEST	C1 ESTERASE INHIBITOR (RECOMBINANT)	MED
	TAKHZYRO	LANADELUMAB	CE
IDIOPATHIC IMMUNE THROMBOCYTOPENIC PURPURA (ITP)	MULPLETA	LUSUTROMBOPG	CE
	NPLATE	ROMIPLOSTIM	PA/MED
	PROMACTA	ELTROMBOPAG	PA
	TAVALISSE	FOSTAMATINIB	CE
INSULIN	AFREZZA	INSULIN, INHALED	PA
	APIDRA	INSULIN GLULISINE	PA
	HUMALOG 50/50	INSULIN LISPRO	PA
	HUMALOG 75/25	INSULIN LISPRO	PA
	HUMALOG	INSULIN LISPRO	PA
	HUMULIN 70/30	REGULAR INSULIN; ISOPHANE INSULIN (NPH)	PA
	HUMULIN N	ISOPHANE INSULIN (NPH)	PA
	HUMULIN R	REGULAR INSULIN	PA
	HUMULIN R U-500	REGULAR INSULIN	PA
LUNG DISORDERS	ARALAST NP, PROLASTIN-C, ZEMAIRA	ALPHA1-PROTEINASE INHIBITOR	MED
	CINQAIR	RESLIZUMAB	MED
	ESBRIET	PIRFENIDONE	PA
	FASENRA	BENRALIZUMAB	MED
	GLASSIA	ALPHA1-PROTEINASE INHIBITOR	MED
	NUCALA	MEPOLIZUMAB	MED
	OFEV	NINTEDANIB	PA
	XOLAIR	OMALIZUMAB	MED
MULTIPLE SCLEROSIS	AUBAGIO	TERIFLUNOMIDE	PA
	AVONEX	INTERFERON β-1a	PA
	BETASERON	INTERFERON β-1b	PA
	COPAXONE	GLATIRAMER	PA
	EXTAVIA	INTERFERON β-1b	CE
	GILENYA	FINGOLIMOD	PA
	GLATOPA	GLATIRAMER	PA
	LEMTRADA	ALEMTUZUMAB	MED
	OCREVUS	OCRELIZUMAB	MED
	PLEGRIDY	PEGINTERFERON BETA-1A	PA

CATEGORY	BRAND DRUG NAME	GENERIC DRUG NAME	QHP
	REBIF	INTERFERON β-1a	PA
	TECFIDERA	DIMETHYL FUMARATE	PA
	TYSABRI	NATALIZUMAB	MED
	ZINBRYTA	DACLIZUMAB	CE
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS (PCSK9S)	PRALUENT	ALIROCUMAB	PA
	REPATHA	EVOLOCUMAB	PA
PULMONARY HYPERTENSION	ADCIRCA	TADALAFIL	PA
	ADEMPAS	RIOCIGUAT	PA
	FLOLAN	EPOPROSTENOL	MED
	LETAIRIS	AMBRISENTAN	PA
	OPSUMIT	MACITENTAN	PA
	ORENITRAM	TREPROSTINIL	PA
	REMODULIN	TREPROSTINIL	MED
	REVATIO	SILDENAFIL	PA, CE (brand only)
	TRACLEER	BOSENTAN	PA
	TYVASO	TREPOSTINOL	PA
	UPTRAVI	SELEXIPAG	PA
	VELETRI	EPOPROSTENOL	MED
	VENTAVIS	ILOPROST	PA
OTHERS	AIMOVIG	ERENUMAB	CE
	AJOVY	FREMANEZUMAB	CE
	AUSTEDO	DEUTETRABENAZINE	PA
	BENLYSTA	BELIMUMAB	MED
	BRINEURA	CERLIPONASE ALFA	MED
	CERDELGA	ELIGLUSTAT TARTRATE	PA
	CEREZYME	IMIGLUCERASE	MED
	DUPIXENT	DUPILUMAB	PA
	EMFLAZA	DEFLAZACORT	CE
	EMGALITY	GALCANEZUMAB	CE
	ENDARI	GLUTAMINE	CE
	FORTEO	TERIPARATIDE	PA
	GRASTEK	TIMOTHY GRASS POLLEN ALLERGEN EXTRACT	CE

CATEGORY	BRAND DRUG NAME	GENERIC DRUG NAME	QHP
	HEMLIBRA	EMICIZUMAB-KXWH	PA
	HETLIOZ	TASIMELTEON	PA
	INGREZZA	VALBENAZINE	PA
	JUXTAPID	LOMITAPIDE	PA
	KYNAMRO	MIPOMIRSEN	PA
	MOVANTIK	NALOXEGOL	PA
	MYALEPT	METRELEPTIN	PA
	NATPARA	PARATHYROID HORMONE	CE
	NORTHERA	DROXIDOPA	CE
	OCALIVA	OBETICHOLIC ACID	PA
	ODACTRA	DUST MITE MIXED EXTRACT	CE
	ORALAIR	MIXED GRASS POLLENS ALLERGEN EXTRACT	CE
	ORILISSA	ELAGOLIX	PA
	PALYNZIQ	PEGVALIASE-PQPZ	PA
	H P ACTHAR GEL	CORTICOTROPIN INJ GEL	PA
	RADICAVA	EDAVARONE	MED
	RAGWITEK	SHORT RAGWEED POLLEN ALLERGEN EXTRACT	CE
	RELISTOR	METHYLNALTREXONE	PA
	SAMSCA	TOLVAPTAN	PA
	SENSIPAR	CINACALCET	PA
	SOLIRIS	ECULIZUMAB	MED
	SPINRAZA	NUSINERSEN	MED
	SMYPROIC	NALDEMEDINE	CE
	SYNAGIS	PALIVIZUMAB IM SOLUTION	MED
	SUPPRELIN LA	HISTRELIN ACETATE	MED
	TRIPTODUR	TRIPTORELIN	MED
	TYMLOS	ABALOPARATIDE	PA
	XENAZINE	TETRABENAZINE	PA, CE (brand only)
	XERMELO	TELOTRISTAT	PA
	XIAFLEX	COLLAGENASE	MED

Blue Cross Blue Shield of North Dakota
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CATEGORY	BRAND DRUG NAME	GENERIC DRUG NAME	QHP 2017	QHP 2018
WEIGHT LOSS* Not all benefit plans cover Weight Loss medications. Please contact a Member Services representative for specific coverage information.	ADIPEX-P	PHENTERMINE	BENEFIT EXCLUSION	BENEFIT EXCLUSION
	BELVIQ	LORCASERIN	BENEFIT EXCLUSION	BENEFIT EXCLUSION
	BELVIQ XR	LOCAXERIN ER	BENEFIT EXCLUSION	BENEFIT EXCLUSION
	BONTRIL PDM	PHENDIMETRAZINE	BENEFIT EXCLUSION	BENEFIT EXCLUSION
	BONTRIL SLOW RELEASE	PHENDIMETRAZINE	BENEFIT EXCLUSION	BENEFIT EXCLUSION
	CONTRAVE	NALTREXONE/BUPROPION	BENEFIT EXCLUSION	BENEFIT EXCLUSION
	DIDREX	BENZPHETAMINE	BENEFIT EXCLUSION	BENEFIT EXCLUSION
	DIETHYLPROPION	DIETHYLPROPION	BENEFIT EXCLUSION	BENEFIT EXCLUSION
	LOMAIRA	PHENTERMINE	BENEFIT EXCLUSION	BENEFIT EXCLUSION
	QSYMIA	PHENTERMINE/TOPIRAMATE	BENEFIT EXCLUSION	BENEFIT EXCLUSION
	REGIMEX	BENZPHENTAMINE	BENEFIT EXCLUSION	BENEFIT EXCLUSION
	SAXENDA	LIRAGLUTIDE	BENEFIT EXCLUSION	BENEFIT EXCLUSION
	SUPRENZA	PHENTERMINE	BENEFIT EXCLUSION	BENEFIT EXCLUSION
	XENICAL	ORLISTAT	BENEFIT EXCLUSION	BENEFIT EXCLUSION

Drugs with Benefit Quantity Limits: The following list represents the drugs subject to a limited dispensing amount.

MULTIPLE SCLEROSIS			
BRAND NAME	**GENERIC NAME**	**FORMULARY STATUS**	**Quantity Limit**
AMPYRA*	DALFAMPRIDINE	NF	2 tabs/day

ERECTILE DYSFUNCTION, ORAL**		**Daily and as-needed use prescriptions are not allowed concomitantly**		
BRAND NAME	**GENERIC NAME**	**FORMULARY STATUS**	**Quantity Limit**	
CIALIS 10 mg, 20 mg	TADALAFIL	NF	**A Combined Total of 18 tablets per 90 Days**	A member can receive **up to** a combined total of 18 tablets per 90 days. The claims system **will not allow** any quantity >18 in **any** 90-day claims period.
LEVITRA	VARDENAFIL	NF		
STAXYN	VARDENAFIL	NF		
STENDRA	AVANAFIL	NF		
VIAGRA	SILDENAFIL	NF		
CIALIS Once-Daily Use 2.5 mg, 5 mg**	TADALAFIL	NF	1 tab/day	

***Ampyra is Tier 4 on the QHP formulary**

****Medications used to treat erectile dysfunction are a benefit exclusion under Qualified Health Plans. Cialis Once-Daily 5mg may be eligible for a Coverage Exception under Qualified Health Plans to treat benign prostatic hypertrophy (BPH).**

In accordance with federal regulations, Blue Cross Blue Shield of North Dakota is required to provide you the following disclosure:

Blue Cross Blue Shield of North Dakota 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 Blue Shield of North Dakota does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross Blue Shield of North Dakota:

- 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, please call Member Services at 1-800-342-4718 (toll-free) or through the North Dakota Relay at 1-800-366-6888 or 711.

If you believe that Blue Cross Blue Shield of North Dakota 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:

Civil Rights Coordinator

4510 13th Ave S

Fargo, ND 58121

701-297-1638 or North Dakota Relay at 800-366-6888 or 711

701-282-1804 (fax)

CivilRightsCoordinator@bcbsnd.com (email)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights 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, DC 20201

800-368-1019 or 800-537-7697 (TDD)

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

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-342-4718 (TTY: 1-800-366-6888 o 711).

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-342-4718 (TTY: 1-800-366-6888 oder 711).

繁體中文 (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 1-800-342-4718（TTY：1-800-366-6888 或 711）。

Oroomiffa (Oromo)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-342-4718 (TTY: 1-800-366-6888 ykn 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-800-342-4718 (TTY: 1-800-366-6888 hoặc 711).

Ikirundi (Bantu – Kirundi)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu.
Woterefona 1-800-342-4718 (TTY: 1-800-366-6888 canke 711).

(Arabic) العربية

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-342-4718 (رقم هاتف الصم والبكم: 1-800-366-6888 أو711).

Kiswahili (Swahili)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo.
Piga simu 1-800-342-4718 (TTY: 1-800-366-6888 au 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-800-342-4718 (телетайп: 1-800-366-6888 или 711).

日本語 (Japanese)

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。1-800-342-4718
（TTY: 1-800-366-6888 または 711）まで、お電話にてご連絡ください。

नेपाली (Nepali)

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-342-4718 (टिटिवाइ: 1-800-366-6888 वा 711) ।

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-800-342-4718 (ATS : 1-800-366-6888 ou 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-342-4718
(TTY: 1-800-366-6888 또는 711)번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-342-4718 (TTY: 1-800-366-6888 o 711).

Norsk (Norwegian)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-342-4718 (TTY: 1-800-366-6888 eller 711).

Diné Bizaad (Navajo)

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-342-4718 (TTY: 1-800-366-6888 éí doodagó 711.)