PREMERA BLUE CROSS

PHARMACY / MEDICAL POLICY – 5.01.519

Increlex® (mecasermin); Recombinant Human Insulin-Like Growth Factor-1

Effective Date:	Dec. 1, 2018	RELATED MEDICAL POLICIES:
Last Revised:	Nov. 21, 2018	5.01.500 Growth Hormone Therapy
Replaces:	N/A	

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | CODING | RELATED INFORMATION
EVIDENCE REVIEW | REFERENCES | HISTORY

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Introduction

Insulin-like growth factor-1 (IGF-1) acts a bit like a go-between in the growth process is a IGF-1 is hormone that's naturally produced in the liver and certain other tissues. The pituitary gland, located in the brain, stimulates the production of growth hormone, which is then released into the blood. When growth hormone reaches the liver, it causes the liver to create IGF-1. Then, IGF-1 acts as the link between growth hormone that's in the blood and the growth processes inside cells. The levels of IGF-1 increase during childhood, peak during puberty, and then decline. Children whose bodies don't create enough IGF-1 are very short for their age. IGF-1 that is made in a lab may be used to help children grow when other causes of slow growth have been ruled out. This policy describes when IGF-1 may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Drug	Medical Necessity
Increlex® (mecasermin)	**Increlex® (mecasermin) may be considered medically necessary for its FDA-approved indication for the treatment of growth failure in children. (See Authorization Criteria below.)** **The use of Increlex® (mecasermin) for idiopathic short stature is considered not medically necessary.**

Drug	Investigational
Increlex® (mecasermin)	**Use of Increlex® (mecasermin) to treat all other indications is considered investigational, including but not limited to:** • Less severe forms of IGF-1 deficiency • Secondary forms of IGF-1 deficiency (GH deficiency, malnutrition, hypothyroidism, or chronic corticosteroid therapy) • Growth failure due to other identifiable causes (eg, Prader-Willi syndrome, Turner syndrome, Noonan syndrome) • Diabetes mellitus • AIDS-associated wasting • Women with anorexia nervosa • Obesity in postmenopausal women • Advanced chronic renal failure • Cystic fibrosis • Amyotrophic lateral sclerosis (ALS) • Severe head injury • Use in combination with GH

Authorization Criteria
Up to 12 months of coverage may be authorized for patients meeting ALL the following criteria: • Diagnosis of growth failure due to severe primary IGF-1 deficiency (growth hormone receptor mutations [eg, Laron syndrome], post-growth hormone receptor signaling pathway mutations, or IGF-1 gene defects) OR growth hormone (GH) gene deletion with neutralizing antibodies to GH • The patient's height is below the 3rd percentile on growth charts for their age and gender related height. (ie, height is greater than 2.25 standard deviations below the mean). • The patient's baseline IGF-1 concentration is ≥ 3 SD below normal (based on lab reference

Authorization Criteria
range for age and sex) • The patient's baseline growth hormone concentration is normal or elevated based on at least one stimulation test • Bone age is < 13 years for females or < 15 years for males **Coverage may be reauthorized for up to 12 months in patients previously receiving mecasermin if ALL the following criteria are met:** • Growth velocity is ≥ 2.5 cm / year **AND** • Bone age is ≤ 14 years for females or ≤ 16 years for males

Note: Policy and guidelines for the use of growth hormone (somatropin) are contained in a separate medical policy (see **Related Policies**).

Coding

Code	Description
HCPCS	
J2170	Injection, Mecasermin (Increlex™), 1 mg

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

Benefit Application

Enrollees receiving mecasermin should be reviewed on at least an annual basis to assure proper application of benefits.

Mecasermin may be covered under the drug or medical benefit.

Evidence Review

Description

Increlex® (mecasermin) is produced by recombinant DNA technology and has an identical amino acid sequence to endogenous human insulin-like growth factor-1 (IGF-1). Mecasermin is approved for the treatment of growth failure in children with severe primary IGF-1 deficiency (growth hormone receptor mutations, post-growth hormone receptor signaling pathway mutations, or IGF-1 gene defects) and in those with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH. It is estimated that 30,000 to 60,000 children in the US and Western Europe have primary IGF-1 deficiency. Of these individuals, approximately 20%, or 6,000 to 12,000, have severe primary IGF-1 deficiency.

The current somatomedin hypothesis of statural growth involves GH release by the anterior pituitary that is controlled in a stimulatory fashion by GH-releasing hormone and in an inhibitory fashion by somatostatin. Circulating GH then binds to GH receptors in the liver resulting in production of IGF-1, IGF binding proteins, and acid labile subunit. Virtually all circulating IGF-1 is bound to IGF binding proteins and acid labile subunit. This tertiary complex reduces extravascular passage and increases the half-life of IGF-1. Circulating IGF-1 then stimulates multiple processes leading to statural growth and metabolic changes that support this growth. GH also stimulates prechondrocyte differentiation and local production of IGF-1 (autocrine and paracrine) that in turn stimulate clonal expansion, maturation of chondrocytes, and growth. Approximately 15% to 20% of growth is thought to be the result of this local effect of GH versus that resulting from circulating hepatic IGF-1.

Mecasermin is not a substitute for GH treatment and is not indicated for the treatment of secondary IGF deficiency resulting from GH deficiency, malnutrition, hypothyroidism or chronic corticosteroid therapy.

Rationale

Severe primary IGF-1 deficiency or GH gene deletion with neutralizing antibodies to GH are rare disorders currently without therapeutic alternatives. A small quantity of low quality evidence consistently supports the efficacy and safety of Increlex® (mecasermin) for the treatment of children with these conditions to increase statural growth. According to the FDA review report

for mecasermin, approval was granted based on four small (n= 6 to 23) and one long-term clinical studies (4 open-label and 1 double-blind placebo-controlled). Because of the rarity of severe primary IGF-1 deficiency, the patients and data from the 4 smaller studies were "rolled into" the larger long-term study.

Chernausek et al. reported long-term efficacy and safety results from a multicenter, open-label, uncontrolled study in 76 children with severe IGF-1 deficiency associated with growth hormone insensitivity. It should be noted that the inclusion criteria used for the study were less stringent than defined by the FDA for identification of patients with severe deficiency. A total of 76 patients initially received mecasermin 0.04-0.08 mg/kg SC twice daily, and if the dose was tolerated for at least a week without hypoglycemic episodes it was titrated by 0.04 mg/kg/dose to 0.12 mg/kg twice daily. The primary study endpoint was change from baseline in height velocity. During the first year of treatment, height velocity increased from a mean baseline of 2.8 cm/yr to 8.0 cm/yr, in 59 evaluable patients (P<0.0001). Height velocity was lower in subsequent years, but remained above baseline for up to 8 years. Height velocity was dose dependent or fastest in those receiving the maximal dose (0.012 mg/kg twice daily). Bone age increased modestly an average of 5.8 yrs over 5.1 years (P=0.01).

A smaller (n=8) open-label uncontrolled study in which patients with severe primary IGF-1 deficiency were treated with mecasermin 0.08-0.12 mg/kg twice daily as tolerated for up to 7.5 years showed similar results. During the first year of treatment, height velocity increased from a mean baseline of 4.0 cm/yr to 9.3 cm/yr (mean height velocity SDS +3.8) and 6.2 cm/yr (mean height velocity SDS +0.5) in the second year of treatment. Mean change in height velocity SDS was +1.4 after 6-7 years of therapy.

The most commonly reported adverse events reported with use of mecasermin at recommended doses in children with severe primary IGF-1 deficiency were hypoglycemia, lymphoid tissue hypertrophy, and injection-site lipohypertrophy. Hypoglycemia was minimized by consumption of a meal or a snack within 20 minutes of administration of the drug, and lipohypertorphy was minimized by rotation of the injection site with each dose. Rarely, intracranial hypertension was also reported.

Labeled contraindications include closed epiphyses, suspected or active neoplasia, intravenous (IV) administration, and hypersensitivity to any component. Labeled warnings and precautions include that the product contains benzyl alcohol as a preservative, which has been associated with neurological toxicity in neonates; sensitivity reactions have been reported; treatment should be directed by physicians experienced in the diagnosis and management of patients with growth disorders; mecasermin should be administered shortly (± 20 min) before or after a meal or snack because mecasermin has insulin-like hypoglycemic effects; hypertrophy of lymphoid tissue with complications (eg, snoring, sleep apnea) has been observed; intracranial

hypertension has been reported; rapid growth may cause slipped capital femoral epiphysis or worsen scoliosis; and allergic reactions have been reported.

The recommended starting dose of mecasermin is 0.04-0.08 mg/kg subcutaneously twice daily. If well-tolerated (without hypoglycemia) for at least one week, the dose may be increased in 0.04 mg/kg/dose increments up to the maximum dose of 0.12 mg/kg SC twice daily. Doses greater than 0.12 mg/kg twice daily have not been studied in children with primary IGF-1 deficiency and should not be used to avoid potential hypoglycemia.

2009 Update

A literature search of the MEDLINE database conducted from August 2008 through June 2009 did not identify any additional published studies that would prompt reconsideration of the policy statements.

2010 Update

A literature search of the MEDLINE database conducted from July 2009 through April 2010 did not identify any additional published studies that would prompt reconsideration of the policy statements.

2011 Update

A literature search of the MEDLINE database conducted from May 2010 through January 2011 did not identify any additional published studies that would prompt reconsideration of the policy statements.

2012 Update

A literature search of the MEDLINE database conducted from January 2011 through February 2012 did not identify any additional published studies that would prompt reconsideration of the policy statements.

2013 Update

A literature search of the MEDLINE database conducted from January through December 2012 did not identify any additional published studies that would prompt reconsideration of the policy statements.

2014 Update

A literature search conducted from January 2013 through February 2014 and no new evidence was found that would change this policy.

2015 Update

A literature search conducted from January 2014 through March 2015 and no new evidence was found that would change this policy.

2016 Update

A literature search conducted from July 1, 2015, through December 5, 2016, and no new evidence was found that would change this policy.

2017 Update

A literature search conducted from October 1, 2016, through November 1, 2017, and no new evidence was found that would change this policy.

2018 Update

A literature search conducted from November 1, 2017, through October 31, 2018, and no new evidence was found that would change this policy.

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History

Date	Comments
08/12/08	Add to Prescription Drug Section - New PR Policy.
07/14/09	Replace Policy - Policy updated with literature search, no change to the policy statement.
06/08/10	Replace Policy - Policy updated with literature search, no change to the policy statement.
03/08/11	Replace Policy - Policy updated with literature review; no change in policy statement. Policy guidelines updated for improved clarity and administrative simplicity.
04/25/12	Replace policy. Policy updated with literature review; policy statements unchanged. Reference 15 added.
04/16/13	Replace policy. Policy updated with literature review; policy statements unchanged.
05/05/14	Annual Review. Policy updated with literature review; policy statements unchanged.
05/27/15	Annual Review. Policy updated with literature review, policy statements unchanged. Notation added that this policy is managed and administered through the pharmacy benefit.
10/28/16	Formatting update. Coding table reformatted and moved to Policy Guidelines section.
01/01/17	Annual Review, approved December 13, 2016. Policy updated with literature review, policy statements unchanged.
12/01/17	Annual Review, approved November 21, 2017. No new evidence was found, and policy statements unchanged.
12/01/18	Annual Review, approved November 21, 2018. No new evidence was found, and policy statements unchanged.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2018 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to

the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.

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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.

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200 Independence Avenue SW, Room 509F, HHH Building
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Complaint forms are available at
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Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. 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 800-722-1471 (TTY: 800-842-5357).

አማሪኛ (Amharic):
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት።በስልክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

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この通知には重要な情報が含まれています。この通知には、Premera Blue Cross の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-722-1471 (TTY: 800-842-5357)までお電話ください。

한국어 (Korean):
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ (Lao):
ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-722-1471 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព ដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):
ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ਼ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

فارسی (Farsi):
این اعلامیه حاوی اطلاعات مهم میباشد .این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق Premera Blue Cross باشد. به تاریخ های مهم در این اعلامیه توجه نمایید .شما ممکن است برای حقظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید .شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471 (کاربران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

Polskie (Polish):
To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross. Prosimy zwrócić uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-722-1471 (TTY: 800-842-5357).

Português (Portuguese):
Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

Română (Romanian):
Prezenta notificare conține informații importante. Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin Premera Blue Cross. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-722-1471 (TTY: 800-842-5357).

Русский (Russian):
Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

Fa’asamoa (Samoan):
Atonu ua iai i lenei fa’asilasilaga ni fa’amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa’asilasilaga o se fesoasoani e fa’amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross, ua e tau fia maua atu i ai. Fa’amolemole, ia e iloilo fa’alelei i aso fa’apitoa olo’o iai i lenei fa’asilasilaga taua. Masalo o le’a iai ni feau e tatau ona e faia ao le’i aulia le aso ua ta’ua i lenei fa’asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo’o e iai i ai. Olo’o iai iate oe le aia tatau e maua atu i lenei fa’asilasilaga ma lenei fa’matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-722-1471 (TTY: 800-842-5357).

Español (Spanish):
Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog):
Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).

ไทย (Thai):
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

Український (Ukrainian):
Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-722-1471 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).