SELECT A HYPERLINK BELOW TO BE REDIRECTED TO THAT SECTION.

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

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Nulojix® (belatacept) is a drug that suppresses the immune system to prevent the body from rejecting a transplanted kidney. It can be used for both right at the time of transplantation (induction) and long-term as a maintenance therapy. It was shown to be safe and effective in two large studies that compared it to other drugs used to prevent rejection after kidney transplant. In the study and based on the recommendation of the drug manufacturer, the drug needs to be given with other medications: all basiliximab, mycophenolate mofetil (MMF), and corticosteroids.

Note: The Introduction section is for your general knowledge and is not to be construed 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

This policy does not apply to members who are currently admitted to an acute hospital setting.

We will review specific intravenous (IV) and injectable drugs for medical necessity for all ages.
For those age 13 and older, we also will review the site of service for medical necessity. Site of service is defined as the location where the drug is administered, such as a hospital-based outpatient setting, an infusion center, a physician's office, or at home.

**Drugs subject to site of service review addressed in this policy are:**

- Nulojix® (belatacept)

**Click on the links below to be directed to the related medical necessity criteria:**

<table>
<thead>
<tr>
<th>Epstein-Barr Virus (EBV) seronegative or unknown serostatus</th>
<th>Prophylaxis of organ rejection, organs other than kidney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prophylaxis of organ rejection, kidney</td>
<td>Site of Service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Site of Service Administration</strong></th>
<th><strong>Medical Necessity</strong></th>
</tr>
</thead>
</table>
| Medically necessary sites of service | IV infusion therapy of various medical or biologic agents will be covered in the most appropriate, safe and cost effective site:  
• These are the preferred medically necessary sites of service for specified drugs. |
| Hospital-based outpatient setting | IV infusion therapy of various medical or biologic agents will be covered in the most appropriate, safe and cost-effective site.  
This site is considered medically necessary for the first 90 days for the following:  
• The initial course of infusion of a pharmacologic or biologic agent  
OR  
• Re-initiation of an agent after 6 months or longer following |
### Site of Service Administration

<table>
<thead>
<tr>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>discontinuation of therapy*</td>
</tr>
</tbody>
</table>

*Note: This does not include when standard dosing between infusions is 6 months or longer

This site is considered medically necessary when there is no outpatient infusion center within 50 miles of the patient’s home and there is no contracted home infusion agency that will travel to their home, or a hospital is the only place that offers infusions of this drug.

This site is considered medically necessary only when the patient has a clinical condition which puts him or her at increased risk of complications for infusions, including any ONE of the following:

- Known cardiac condition (eg, symptomatic cardiac arrhythmia) or pulmonary condition (eg, significant respiratory disease, serious obstructive airway disease, %FVC ≤ 40%) that may increase the risk of an adverse reaction
- Unstable renal function which decreases the ability to respond to fluids
- Difficult or unstable vascular access
- Acute mental status changes or cognitive conditions that impact the safety of infusion therapy
- A known history of severe adverse drug reactions and/or anaphylaxis to prior treatment with a related or similar drug

### Hospital-based outpatient setting

- Outpatient hospital IV infusion department
- Hospital-based outpatient clinical level of care

These sites are considered not medically necessary for infusion and injectable therapy services of various medical and biologic agents when the site-of-service criteria in this policy are not met.

### Condition

<table>
<thead>
<tr>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prophylaxis of organ <strong>Nulojix® (belatacept) is subject to review for site of service</strong></td>
</tr>
<tr>
<td>Condition</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>rejection in adult patients receiving a kidney transplant</td>
</tr>
</tbody>
</table>
|                                                                           |   • Basiliximab induction  
|                                                                           |   • Mycophenolate Mofetil (MMF)  
|                                                                           |   • Corticosteroids  
|                                                                           | Patient must have seropositive test result for Epstein-Barr Virus (EBV).  
|                                                                           | Patients should be monitored for new or worsening neurological, cognitive, or behavioral signs and symptoms. |
| Prophylaxis of organ rejection in transplanted organs other than kidney   | Nulojix® (belatacept) is subject to review for site of service administration.  
|                                                                           | The use of Nulojix® (belatacept) is considered investigational.  
|                                                                           | Use in liver transplant patients is not recommended by the manufacturer due to increased risk of graft loss and death. |
| EBV seronegative or unknown serostatus                                   | Nulojix® (belatacept) is subject to review for site of service administration.  
|                                                                           | Nulojix® (belatacept) is contraindicated for use in patients who are EBV seronegative or with unknown serostatus because the risk of PTLD (post-transplant lymphoproliferative disorder) is particularly increased in patients who are EBV seronegative. |

**Investigational**

The use of Nulojix® (belatacept) in patients under the age of 18 for any indication is considered investigational because there have been no studies to support use, safety, and efficacy in pediatric patients.
**Coding**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCPCS</td>
<td>Injection, belatacept (Nulojix®), 1 mg</td>
</tr>
</tbody>
</table>

**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**

Nulojix® (belatacept) inhibits T lymphocyte proliferation by binding to CD80 and CD86 on antigen-presenting cells, which blocks CD28 co-stimulation of the T cell. It also inhibits the production of interleukin-2&4, interferon-α, and TNF-α. Immunologic rejections are mostly mediated by activated T lymphocytes. In primate models, graft survival was extended and anti-donor antibodies were diminished. Nulojix® (belatacept) has also been studied and is considered off-label in islet cell transplantation in type 1 diabetic patients and liver transplant patients; the latter is warned against in labeling.

Nulojix® (belatacept) has the advantage of not requiring therapeutic drug monitoring, due to its predictable PK profile in trials among both healthy and kidney transplant patients. Bioavailability is 100%, the PK profile is linear and the exposure increased proportionately to doses of 1 to 20 mg/kg. In an extended phase 2 trial at 5 mg/kg, the measured Cmin was consistent from year 1 through 5 (Cmin range of 3.43-4.85 mcg/mL). A trend of higher clearance was found among patients with higher body weight. Subgroups determined to have no effect on clearance included age, gender, race, renal function, hepatic function, diabetes, and concomitant dialysis. Table 5 from the package insert (previous page) summarizes PK variability among healthy and post-transplant patients. The FDA approved dose is 10mg/kg on day 1, day 5, week 2, week 4, week 8, week 12, and 5 mg/kg every 4 weeks thereafter.

**Renal Transplantation**

Renal transplant is considered for most patients when the glomerular filtration rate (GFR) falls below 10 mL/min, while renal failure is considered permanent when the GFR reaches this level or
a serum creatinine exceeds 8 mg/dL. After transplantation, the survival of the graft and patient continues to be a challenge, and many therapies are targeted to help prevent rejection of the graft by the host’s immune system. Both dialysis and renal replacement therapy are options once the patient reaches end stage renal disease (ESRD). ESRD is most frequently caused by diabetes mellitus, with hypertension, glomerulonephritis, and renal cystic disease following in rank. After transplantation, the primary causes of death are heart disease, sepsis, and stroke (in this order). Compared to the general population, kidney transplant patients have an increased risk of atherosclerosis and ischemic heart disease and a 50-fold increase in the risk of mortality.

Approximately 360 per million people in the US begin renal replacement therapy each year. While the median age of a new patient is 64 years old, the prevalence and incidence is more pronounced in men and more pronounced among African-American, Hispanic, and Native American than Caucasian or Asian populations. The waiting list in the US for kidney transplantation is exceeds 80,000, while only 10,000 kidneys become available each year Among those on immunosuppressive drug regimens, it has been estimated that anywhere from 5 to 55% of patients do not take all of the medications as directed.

**Transplant Rejection**

Rejection of kidney grafts can be hyperacute, acute cellular, acute humoral, or chronic. Hyperacute rejection occurs within hours after transplantation and contains a marked accumulation of neutrophils within the capillaries, arterioles, and glomeruli, leading to thrombosis, necrosis, and requiring removal of the non-functional organ. Acute rejection occurs from days to years after transplantation, and involves humor or cellular immune mechanisms.

Acute cellular rejection appears clinically to resemble renal failure and histologically will show CD4+ and CD8+ T lymphocytes which express activated T cell markers. Tubular damage results from accumulation of mononuclear cells and T cells can also cause endothelitis in the vascular endothelial cells. This rejection can benefit from immunosuppressive therapies.

Acute humoral rejection involves antidonor antibodies resulting in damaged blood vessels and can present as endothelial necrosis, neutrophil accumulation, deposition of immunoglobulins and fibrin, or thrombosis. B-Cell depleting agents are the typical therapy utilized. Chronic rejection is a large cause of graft loss and is seen with a progressive rise in serum creatinine over 4 to 6 months, often controlled with immunosuppressive therapy. It presents with interstitial fibrosis, tubular atrophy, and vascular changes including vascular lesions and resulting ischemia.
Treatment Alternatives

Immunosuppression involves a combination of targeted therapy. Cyclosporine, a calcineurin inhibitor (CNI) which blocks activation of cytokine transcription factors, was a foundation of therapy early in the last decade, but has fallen out of favor to tacrolimus in recent guidelines. Others include azathioprine (inhibits leukocyte development), steroids (block inflammation), rapamycin and mycophenylate mofetil (inhibit lymphocyte proliferation), monoclonal anti-T-cell antibodies, and drugs interrupting T-cell co-stimulatory signaling. While immunosuppression can further survival, patients become more susceptible to infections and carcinomas. CNIs and corticosteroids can contribute to weight gain, hypertension, and post-transplant diabetes, which can increase the risk of mortality and graft failure. CNIs also have an increased rate of renal function decline, which can further these risks and drug interactions involving CYP3A4 are concerning for this class as well.

Preferred Existing Therapy

For initial maintenance of immunosuppressive therapy, the 2009 Kidney Disease: Improving Global Outcomes (KDIGO) guideline recommends a combination including a CNI (with tacrolimus being first-line) and an anti-proliferative agent (mycophenolate being first-line), with or without corticosteroids (to be discontinued after one week in patients with low immunological risk). If an mTORi is chosen, it is recommended to be used after surgical wounds are healed and graft function is established. In long-term maintenance, if there has been no acute rejection, the lowest doses of immunosuppressive agents should be reached within 2-4 months. Also, CNIs should be continued and if prednisone is used beyond one week post-transplant, it should be continued as well.

Tacrolimus has been recommended over cyclosporine due to less acute rejection and better graft survival. While mortality, malignancy, infection, delayed onset of graft function, and blood pressure differences between the two agents are not significant, tacrolimus has less incidence of NODAT and lower non-HDL cholesterol. ACR occurrence is typically a top predictor of poor long-term graft survival, but in CNI studies, a decrease in ACR frequency did not increase graft or patient survival rates.
Consideration of Age

In relation to infusion place of service, the age described in this policy for medical necessity of select intravenous and injectable therapy services is 13 years of age or older. The age criteria are based on the following: Pediatric patients are not small adults. Pediatric patients differ physiologically, developmentally, cognitively, and emotionally from adult patients, and vary by age groups from infancy to teen. Children often require smaller doses than adults, lower infusion rates, appropriately sized equipment, the right venipuncture site determined by therapy and age, and behavioral management during administration of care. Specialty infusion training is therefore necessary for pediatric IV insertions and therapy. Due to pediatrics unique physiology and psychology, this policy is limited to patients above the age of 13.

Evidence Review

In renal transplant patients, Nulojix® (belatacept) was shown to be non-inferior to cyclosporine (CsA) for patient and graft survival and had significantly higher GFRs, a result which held up in long term studies as well. Incidences of acute rejection episodes, defined differently in each study, were often significantly higher in the Nulojix® (belatacept) patients, although without direct correlation to graft loss or death, and these events occurred early in therapy. Secondary outcomes were often focused on the common drawbacks to oral calcineurin inhibitors (CNIs), namely BP, lipid panels, and diabetic complications. For Nulojix® (belatacept), blood pressures and reductions in non-HDL cholesterol were significantly better, while fewer incidences of new-onset diabetes occurred with Nulojix® (belatacept) (significant to borderline significant depending on patient population), but long term follow up in one study extension showed these benefits were not preserved over time between agents. Some studies were complicated by patients being switched to tacrolimus, another more-favored CNI, yet were included in analysis, while other extensions were limited in size.

Nulojix® (belatacept) was introduced as an infused alternative to oral CNIs, which can contribute to weight gain, hypertension, post-transplant diabetes (increasing the risk of mortality and graft failure), and a decline in renal function. Belatacept was primarily compared to CsA in studies, as that was the predominant CNI used at the time of most trials’ instigation. CsA has fallen out of favor compared to tacrolimus in guidelines, due to greater graft survival and less acute rejection but there is limited evidence available (one small trial) comparing these two agents.
Nulojix® (belatacept) has a black box warning concerning post-transplant lymphoproliferative disorder (PTLD), which occurred in belatacept patients who were Epstein-Barr virus (EBV) negative or previously used T-cell depleting therapies. The warning also contains cautions of malignancies, which can be opportunistic due to immunosuppression, and progressive multifocal leukoencephalopathy (PML), which was rare, but reported in studies. While general and serious AEs were similar compared to both CsA and tacrolimus, with more discontinuation of study drug with the latter, malignancies were varied in nature and fairly balanced across all arms in the pivotal studies. Non-life or graft-threatening infusion-related reactions occurred among belatacept patients, and while infections in general were higher in likelihood among all agents compared, fungal infections tended to be higher in belatacept patients when compared to tacrolimus.

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.

In 2-year follow up from a Phase II RCT of belatacept vs. calcineurin inhibitors cyclosporine or tacrolimus (CNI), year 2 data showed a mean cGFR of 62.0 ml/min (belatacept) vs. 55.4 ml/min (CNI). The mean change in cGFR from baseline was +8.8 ml/min (belatacept) and +0.3 ml/min (CNI). Higher cGFR was observed in patients switched from either cyclosporine (+7.8 ml/min) or tacrolimus (+8.9 ml/min). The frequency of acute rejection in the LTE cohort was comparable between the belatacept and CNI groups by Year 2. All acute rejection episodes occurred during Year 1 in the belatacept patients and during Year 2 in the CNI group. There were more non-serious mucocutaneous fungal infections in the belatacept group. Switching to a belatacept-based regimen from a CNI-based regimen resulted in a continued trend toward improved renal function at 2 years after switching. The results support the previous hypothesis of a prolonged renal-sparing effect of belatacept, since it avoids some of the toxicities commonly observed with CNI.

Similarly, in the 3-year extension of the Phase III BENEFIT-EXT trial in patients receiving extended donor criteria kidneys (ECD) where poorer outcomes are normally expected, patient survival with a functioning graft was comparable between groups (80% in MI, 82% in LI, 80% in cyclosporine). Mean calculated GFR (cGFR) was 11 mL/min higher in Nulojix® (belatacept)-treated versus cyclosporine-treated patients (42.7 in MI, 42.2 in LI, 31.5 mL/min in cyclosporine). More cyclosporine-treated patients (44%) progressed to GFR <30 mL/min (chronic kidney disease [CKD] stage 4/5) than Nulojix® (belatacept)-treated patients (27-30%). Acute rejection rates
were similar between groups. Posttransplant lymphoproliferative disorder (PTLD) occurrence was higher in belatacept-treated patients (two in MI, three in LI), most of which occurred during the first 18 months; four additional cases (3 in LI, 1 in cyclosporine) occurred after 3 years. Tuberculosis was reported in two MI, four LI and no cyclosporine patients. In conclusion, at 3 years after transplantation, immunosuppression with belatacept resulted in similar patient survival, graft survival and acute rejection, with better renal function compared with cyclosporine. As previously reported, PTLD and tuberculosis were the principal safety findings associated with belatacept in this study population.

2014 Update

A literature search conducted from 1/1/13 through 12/31/13 did not reveal new evidence that would require changes to this policy.

2017 Update

A literature search conducted from 1/1/14 through 9/30/17 did not reveal new evidence that would require changes to this policy. In 2016 Vincenti, et al. reported results of a 7 year follow up study of renal transplant patients maintained on Nulojix® (belatacept). The authors concluded that patient and graft survival and the mean eGFR were significantly higher with than with cyclosporine in the comparator arm of the study.

2018 Update

A literature search conducted from 10/1/17 through 9/28/18 did not reveal new evidence that would require changes to this policy.

References


### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/13/13</td>
<td>Replace policy. Policy updated with literature review; no change in policy statements. HCPCS code J0485 added (new code 1/1/13); C9286 deleted effective 12/31/12.</td>
</tr>
<tr>
<td>03/25/14</td>
<td>Replace policy. Policy updated with literature review; no change to policy statement.</td>
</tr>
<tr>
<td>08/11/15</td>
<td>Annual Review. A literature search was conducted from 3/1/14-6/30/15. No new studies were found that would require changes to this policy. One new reference added. HCPCS codes J3490, J3590 and J7599 removed; these are non-specific codes – the specific code J0485 remains on the policy.</td>
</tr>
<tr>
<td>06/01/16</td>
<td>Annual Review, approved May 10, 2016. Inclusion of the “Site of Service” criteria to the existing policy. Format of the “Policy” section re-structured to include tabulated view of the medical necessity criteria.</td>
</tr>
<tr>
<td>08/19/16</td>
<td>Converted to new policy format; no changes in content or coverage.</td>
</tr>
<tr>
<td>11/01/16</td>
<td>Interim Review, approved October 11, 2016. Clarified age criteria language indicating that site of service review is applicable to only those age 13 and older; drug criteria review applies to all ages.</td>
</tr>
<tr>
<td>01/01/17</td>
<td>Interim Review, approved December 13, 2016. Added Consideration of Age Requirements to policy.</td>
</tr>
<tr>
<td>07/01/17</td>
<td>Formatting update; added hyperlinks to medical necessity criteria sections.</td>
</tr>
<tr>
<td>09/25/17</td>
<td>Interim Review, approved September 22, 2017, effective September 25, 2017. Policy statement added to indicate that Nulojix® (belatacept) beis investigational for use in pediatric patients because there have been no studies to support use in this group.</td>
</tr>
</tbody>
</table>
| 11/01/17   | Annual Review, approved October 3, 2017. Clarified site of service exception criterion related to access: There is no outpatient infusion center within 50 miles of the patient's
home and there is no contracted home infusion agency that will travel to their home, or a hospital is the only place that offers infusions of this drug. Added 7-year results of a long term follow up study.

02/14/18 | Interim Review, approved February 13, 2018. Update hospital based outpatient coverage from 30 days to 90 days.

11/01/18 | Annual Review, approved October 26, 2018. No changes to policy statement. References added.

**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.
Discrimination Is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:
- 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 the Civil Rights Coordinator.

If you believe that Premera 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 - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5952. TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

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, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

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).

Arabic (Amharic):
لا يوجد هذا الإشعار المعلوماتية. قد يوجد هذا الإشعار المعلوماتية مهمة بخصوص طلك أو طلبك. Premera Blue Cross. يتوافق هذا الإشعار المعلوماتية مع بداية المدة حسب ما هو محدد في الشريعة. يتوفر عليه بتأكيد التغطية. 800-722-1471 (TTY: 800-842-5357) خدمة العملاء

中文 (Chinese):
本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357).

Oromo (Cushite):

Français (French):

Kreyòl ayisyen (Creole):
Avi sila a gen Enfòmasyon Empòtan lidann. Avi sila a kapab genyen enfòmasyon empòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou prean kòk aksyon avan sèten atik pou ka nankal ak ouvèt ka sosòt av ou ka ede w akav desans yon. Se dwa yon res eva enfòmasyon a sa a le w ak a yon lan lang ou paale a, san ou pa gen pou peye pou sa. Rate nan 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):

Hmoob (Hmong):

Ilokano (Ilocano):
Daytoy a Pakdaak ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaak mabalini nga adda ket naglaon iti napateg nga impormasion maipanggepp iit aplikasyonnoch wongen coverage babaen iti Premera Blue Cross. Daytoy ket mabalini dagiti importante a petsa iti daytoy a pakdaak. Mabalini nga adda rumbeng nga aramideny nga adda saskay dagiti pabaiti a naitiing nga aldaw napatap mapagtalaineyad nga coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tuong iti bukodyo a pagasasao nga awan ti bayadayo. Tumawag ti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):