IMMUNE GLOBULIN THERAPY

Non-Discrimination Statement and Multi-Language Interpreter Services information are located at the end of this document.

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Medical Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Medical Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as “Description” defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as “Criteria” defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Medical Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Medical Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

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DESCRIPTION:

Immune globulin (IG), also known as immune serum globulin or gamma globulin, is an antibody-containing solution taken from donated human blood. Immune globulin contains antibodies to over 10 million antigens. IG can be administered intramuscularly, intravenously or subcutaneously.

**Intravenous Immune Globulin (IVIG or IGIV):**

IVIG is used to correct immune deficiencies in individuals with inherited or acquired immunodeficiencies. IVIG has also been investigated in diseases thought to have an autoimmune origin. IVIG products include Bivigam™, Carimune NF®, Flebogamma DIF®, Gammagard Liquid®, Gammagard S/D®, Gammaplex®, Gamunex-C®, Gamunex-C®, Octagam® and Privigen®.

**Subcutaneous Immune Globulin (SCIG or IGSC):**

SCIG is used for the treatment of primary immune deficiency. SCIG products include Cuvitru®, Gammagard Liquid, Gammaked®, Gamunex-C®, Hizentra® and HyQvia®.

**Definitions:**

Multiple sclerosis, relapsing/remitting:
Mix of acute attacks and stable periods.
IMMUNE GLOBULIN THERAPY (cont.)

Criteria:

Effective 02/01/17: For site of service requirements for immune globulin therapy, see BCBSAZ Medical Coverage Guideline #O1008, “Site of Service Requirements for Certain Medications”.

Intravenous Immune Globulin (IGIV, IVIG):

Initial Course of Treatment:

Initial requests for immune globulin therapy will be reviewed by the clinical pharmacist and/or medical director(s) and/or clinical advisor(s) and, if approved, may be authorized for a maximum of 12 months.

➤ Initial course of intravenous immune globulin is considered medically necessary for ANY of the following indications:

1. Immunodeficiency states:
   - Primary immunodeficiencies
     - Agammaglobulinemia, congenital
     - Ataxia telangiectasia
     - Hypogammaglobulinemia
     - Common variable immunodeficiency (CVID)
     - Severe combined immunodeficiency (SCID)
     - Wiskott-Aldrich syndrome
     - X-linked agammaglobulinemia (Bruton agammaglobulinemia)
     - X-linked hyper-IgM syndrome
   - Individuals undergoing or have undergone hematopoietic cell transplantation and immunoglobulin G (IgG) levels less than 400 mg/dL
     - Prevention of graft-vs-host disease in bone marrow transplant
     - Prevention of infection in bone marrow transplant
   - Before solid organ transplant for treatment of an individual at high risk of antibody mediated rejection (AMR) including highly sensitized individuals and those receiving an ABO incompatible organ
   - After solid organ transplant for treatment of antibody mediated rejection (AMR)
IMMUNE GLOBULIN THERAPY (cont.)

Criteria: (cont.)

Intravenous Immune Globulin (IGIV, IVIG): (cont.)

Initial Course of Treatment: (cont.)

➢ Initial course of intravenous immune globulin is considered *medically necessary* for ANY of the following indications: (cont.)

2. Infections:
   - Chronic lymphocytic leukemia (CLL) in individuals with hypogammaglobulinemia (IgG level less than 400 mg/dL) and persistent bacterial infections
   - Individuals with Human Immunodeficiency Virus (HIV) and IgG levels less than 400 mg/dL to prevent opportunistic infections
   - Severe anemia associated with human parvovirus B19
   - Primary with defective antibody synthesis MPRM
   - Toxic shock syndrome
   - Prevention of infection in preterm (<37 weeks' gestational age) and/or low birth weight (<2500 g) neonates

3. Acute humoral rejection

4. Autoimmune and inflammatory disorders:
   - Severe, progressive autoimmune mucocutaneous blistering disease in individuals who have failed treatment with conventional agents (corticosteroids, azathioprine, cyclophosphamide, etc.)
   - Pemphigus
   - Pemphigoid
   - Pemphigus vulgaris
   - Pemphigus foliaceus
IMMUNE GLOBULIN THERAPY (cont.)

Criteria: (cont.)

Intravenous Immune Globulin (IGIV, IVIG): (cont.)

Initial Course of Treatment: (cont.)

- Initial course of intravenous immune globulin is considered **medically necessary** for **ANY** of the following indications: (cont.)

4. Autoimmune and inflammatory disorders: (cont.)

- Idiopathic Thrombocytopenic Purpura (ITP), acute, severe
- ITP, chronic of at least 6 months duration with persistent thrombocytopenia (platelet count less than 20,000 per microliter (adult) or 30,000 per microliter (child)) despite treatment with corticosteroids and splenectomy
- Guillain-Barre syndrome as an equivalent alternative to plasma exchange
- Kawasaki syndrome
- Wegener granulomatosis
- Chronic inflammatory demyelinating polyneuropathy (CIDP) with progressive symptoms for at least two months
- Multifocal motor neuropathy
- Eaton-Lambert myasthenic syndrome not responsive to anticholinesterase medications and/or corticosteroids
- Neuromyelitis optica as alternative for individuals with contraindication or lack of response to steroids or plasma exchange
- Myasthenia gravis, refractory, in individuals with chronic debilitating disease despite treatment with cholinesterase inhibitors, or complications from or failure of immunosuppressants, corticosteroids and/or azathioprine
- Myasthenic exacerbation (i.e., an acute episode of respiratory muscle weakness) in individuals with contraindications to plasma exchange
- Dermatomyositis or polymyositis refractory to treatment with corticosteroids; in combination with other immunosuppressive agents
- Warm antibody autoimmune hemolytic anemia refractory to corticosteroids and immunosuppressive agents
- Anti-phospholipid syndrome
IMMUNE GLOBULIN THERAPY (cont.)

Criteria: (cont.)

Intravenous Immune Globulin (IGIV, IVIG): (cont.)

Initial Course of Treatment: (cont.)

- Initial course of intravenous immune globulin is considered medically necessary for ANY of the following indications: (cont.)

5. Alloimmune processes:
   - Neonatal alloimmune thrombocytopenia
   - Hemolytic disease of the fetus and newborn (erythroblastosis fetalis)

6. Miscellaneous:
   - Stiff person syndrome not controlled by other therapies

7. Multiple sclerosis, relapsing/remitting in individuals who fail or are intolerant to standard immunomodulatory therapies or standard immunomodulatory therapies are not clinically indicated
IMMUNE GLOBULIN THERAPY (cont.)

Criteria: (cont.)

Intravenous Immune Globulin (IGIV, IVIG): (cont.)

Initial Course of Treatment: (cont.)

- Initial course of intravenous immune globulin for all other indications not previously listed or if above criteria not met is considered experimental or investigational based upon:
  1. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
  2. Insufficient evidence to support improvement of the net health outcome.

These indications include, but are not limited to:
- Abortion, recurrent spontaneous
- Acquired factor VIII inhibitors
- Acute lymphoblastic leukemia
- Acute myocarditis
- Adrenoleukodystrophy
- Alzheimer’s disease
- Aplastic anemia
- Asthma
- Autism spectrum disorder
- Behcet syndrome
- Birdshot retinopathy
- Chronic fatigue syndrome
- Chronic sinusitis
- Complex regional pain syndrome (CRPS)
- Crohn disease
- Cystic fibrosis
- Immune optic neuritis
- Paraproteinemic neuropathy
- Diabetes mellitus
- Diamond-Blackfan anemia
- Epidermolysis bullosa acquisita
- Epilepsy
- Fisher syndrome
- Hemolytic uremic syndrome
- Hemophagocytic syndrome i.e., hemophagocytic lymphohistiocytosis
- IGG subclass deficiency
- Immune-mediated neutropenia
IMMUNE GLOBULIN THERAPY (cont.)

Criteria: (cont.)

Intravenous Immune Globulin (IGIV, IVIG): (cont.)

Initial Course of Treatment: (cont.)

- Initial course of intravenous immune globulin for all other indications not previously listed or if above criteria not met is considered experimental or investigational based upon: (cont.)
  1. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
  2. Insufficient evidence to support improvement of the net health outcome.

These indications include, but are not limited to: (cont.)

- Inclusion-body myositis
- Morphea
- Multiple myeloma
- Myasthenia gravis in individuals responsive to immunosuppressive treatment
- Necrotizing fasciitis
- Nonimmune thrombocytopenia
- Opsoclonus-myoclonus
- Organ transplant rejection
- Other vasculitides besides Kawasaki disease, including polyarteritis nodosa, Goodpasture syndrome, and vasculitis associated with other connective tissue diseases
- Paraneoplastic syndromes
- Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS)
- Polyradiculoneuropathy other than chronic inflammatory demyelinating polyneuropathy (CIDP)
- Recent onset dilated cardiomyopathy MPRM removed.
- Refractory recurrent pericarditis
- Post-polio syndrome
- Recurrent otitis media
- Red cell aplasia
- Refractory rheumatoid arthritis
- Scleroderma
- Sepsis including neonatal sepsis
- Stevens-Johnson syndrome and toxic epidermal necrolysis (TEN)
- Systemic lupus erythematosus
- Thrombotic thrombocytopenic purpura
- Uveitis
IMMUNE GLOBULIN THERAPY (cont.)

Criteria: (cont.)

Intravenous Immune Globulin (IGIV, IVIG): (cont.)

Continuing and Repeat Courses of Treatment:

Requests for continuing or repeat courses will be reviewed annually to determine if intravenous immune globulin therapy continues to be medically necessary and, if approved, may be authorized for a maximum of 12 months per request. Requests not meeting criteria below will be reviewed by the clinical pharmacist and/or medical director(s) and/or clinical advisor(s).

- Continuing or repeat course of intravenous immune globulin is considered medically necessary with documentation that the individual has been compliant and historical clinical records include documentation of clinical improvement or stability, the individual has been titrated to the minimum dosage and frequency to achieve sustained clinical effect and applicable concomitant therapy (e.g., immune modulator therapy when applicable) is used in treatment.

- Continuing or repeat course of intravenous immune globulin for all other indications not previously listed or if above criteria not met is considered experimental or investigational based upon:
  1. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
  2. Insufficient evidence to support improvement of the net health outcome.

Subcutaneous Immune Globulin (SCIG, IGSC):

Initial Course of Treatment:

- Initial course of subcutaneous immune globulin is considered medically necessary for primary immunodeficiency to include, but not limited to:
  1. Congenital agammaglobulinemia
  2. Common variable immunodeficiency (CVID)
  3. Hypogammaglobulinemia
  4. Severe combined immunodeficiencies (SCID)
  5. Wiskott-Aldrich syndrome
  6. X-linked agammaglobulinemia (XLA)
IMMUNE GLOBULIN THERAPY (cont.)

Criteria: (cont.)

Subcutaneous Immune Globulin (SCIG, IGSC): (cont.)

Initial Course of Treatment: (cont.)

- Initial course of subcutaneous immune globulin for all other indications not previously listed or if above criteria not met is considered experimental or investigational based upon:

  1. Lack of final approval from the Food and Drug Administration, and
  2. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
  3. Insufficient evidence to support improvement of the net health outcome, and
  4. Insufficient evidence to support improvement of the net health outcome as much as, or more than, established alternatives, and
  5. Insufficient evidence to support improvement outside the investigational setting.

These indications include, but are not limited to:

- Chronic inflammatory demyelinating polyneuropathy (CIDP)

Continuing and Repeat Courses of Treatment:

Requests for continuing or repeat courses will be reviewed annually to determine if subcutaneous immune globulin therapy continues to be medically necessary and, if approved, may be authorized for a maximum of 12 months per request. Requests not meeting criteria below will be reviewed by the clinical pharmacist and/or medical director(s) and/or clinical advisor(s).

- Continuing or repeat course of subcutaneous immune globulin is considered medically necessary with documentation that the individual has been compliant and historical clinical records include documentation of clinical improvement or stability, the individual has been titrated to the minimum dosage and frequency to achieve sustained clinical effect and applicable concomitant therapy (e.g., immune modulator therapy when applicable) is used in treatment.

- Continuing or repeat course of subcutaneous immune globulin for all other indications not previously listed or if above criteria not met is considered experimental or investigational based upon:

  1. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
  2. Insufficient evidence to support improvement of the net health outcome.
Resources:

Literature reviewed 03/28/17. We do not include marketing materials, poster boards and non-published literature in our review.

The BCBS Association Medical Policy Reference Manual (MPRM) policy is included in our guideline review. References cited in the MPRM policy are not duplicated on this guideline.

Resources prior to 01/13/2015 may be requested from the BCBSAZ Medical Policy and Technology Research Department.


Resources: (cont.)


Bivigam Package Insert:

- FDA-approved indication: For the treatment of patients with primary humoral immunodeficiency (PI). This includes, but is not limited to, the humoral immune defect in common variable immunodeficiency (CVID), X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome and severe combined immunodeficiencies.

Carimune NF Package Insert:

- FDA-approved indication: For the maintenance treatment of patients with primary immunodeficiencies (PI), e.g., common variable immunodeficiency, X-linked agammaglobulinemia, severe combined immunodeficiency.

Cuvitru Package Insert:

- FDA-approved indication: Replacement therapy for primary humoral immunodeficiency (PI) in adult and pediatric patients two years of age and older. This includes, but is not limited to, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.
IMMUNE GLOBULIN THERAPY (cont.)

Resources: (cont.)

Flebogamma DIF 5% Package Insert:

- FDA-approved indication: Flebogamma 5% DIF is indicated in adults and pediatric patients 2 years of age and older for the treatment of primary immunodeficiency (PI), including the humoral immune defects in common variable immunodeficiency, x-linked agammaglobulinemia, severe combined immunodeficiency, and Wiskott-Aldrich syndrome.

Flebogamma DIF 10% Package Insert:

- FDA-approved indication: Flebogamma 10% DIF is indicated for the treatment of Primary Immunodeficiency (PI) including the humoral immune defect in common variable immunodeficiency, x-linked agammaglobulinemia, severe combined immunodeficiency, and Wiskott-Aldrich syndrome. Also, Flebogamma 10% DIF is indicated for the treatment of patients 2 years of age and older with chronic primary immune thrombocytopenia to raise platelet count.

Gammagard S/D Package Insert:

- FDA-approved indication: For replacement therapy for primary humoral immunodeficiency (PI) in adult and pediatric patients two years of age or older. This includes, but is not limited to, common variable immunodeficiency (CVID), congenital agammaglobulinemia, Wiskott-Aldrich syndrome and severe combined immunodeficiencies.

For prevention of bacterial infections in patients with hypogammaglobulinemia and/or recurrent bacterial infections associated with B-cell Chronic Lymphocytic Leukemia (CLL).

For the treatment of adult Chronic Idiopathic Thrombocytopenic Purpura to increase platelet count and to prevent and/or to control bleeding.

For the prevention of coronary artery aneurysms associated with Kawasaki syndrome in pediatric patients.
IMMUNE GLOBULIN THERAPY (cont.)

Resources: (cont.)

Gammagard Liquid Package Insert:

- FDA-approved indication: For replacement therapy for primary humoral immunodeficiency in adults and pediatric patients 2 years of age or older. This includes, but is not limited to, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome and severe combined immunodeficiencies.

For maintenance therapy to improve muscle strength and disability in adult patients with Multifocal Motor Neuropathy (MMN).

Gamunex-C Package Insert:

- FDA-approved indication: For replacement therapy of primary humoral immunodeficiency in patients 2 years of age and older. This includes, but is not limited to congenital agammaglobulinemia, common variable immunodeficiency, X-linked agammaglobulinemia, Wiskott-Aldrich syndrome and severe combined immunodeficiencies.

For the treatment of patients with Idiopathic Thrombocytopenic Purpura to raise platelet counts to prevent bleeding or to allow a patient with ITP to undergo surgery.

For the treatment of CIDP to improve neuromuscular disability and impairment and for maintenance therapy to prevent relapse.

Gammaplex Package Insert:

- FDA-approved indication: For replacement therapy in adults with primary humoral immunodeficiency in patients 2 years of age and older. This includes, but is not limited to, the humoral immune defect in common variable immunodeficiency, X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.

For the treatment of adults with chronic immune thrombocytopenic purpura (ITP) to raise platelet counts.
IMMUNE GLOBULIN THERAPY (cont.)

Resources: (cont.)

Hizentra Package Insert:
- FDA-approved indication: As replacement therapy for primary humoral immunodeficiency (PI) in adults and pediatric patients 2 years of age and older. This includes, but is not limited to, the humoral immune defect in congenital agammaglobulinemia, common variable immunodeficiency, X-linked agammaglobulinemia, Wiskott-Aldrich syndrome and severe combined immunodeficiencies.

HyQvia Package Insert:
- FDA-approved indication: For the treatment of primary immunodeficiency (PI) in adults. This includes, but is not limited to, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.

Safety and efficacy of chronic use of recombinant human hyaluronidase in HyQvia have not been established in conditions other than PI.

Octagam Package Insert:
- FDA-approved indication: For the treatment of chronic immune thrombocytopenic purpura (ITP) in adults.

Privigen Package Insert:
- FDA-approved indication: For replacement therapy for primary humoral immunodeficiency (PI). This includes, but is not limited to, the humoral immune defect in congenital agammaglobulinemia, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, Wiskott-Aldrich syndrome and severe combined immunodeficiencies.

For the treatment of patients with chronic immune thrombocytopenic purpura (ITP) to raise platelet counts.
IMMUNE GLOBULIN THERAPY (cont.)

Non-Discrimination Statement:

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call (602) 864-4884 for Spanish and (877) 475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ 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: BCBSAZ’s Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance BCBSAZ’s 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, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Multi-Language Interpreter Services:

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe’é atah nílínígíí Blue Cross Blue Shield of Arizona haada yit’éego bíná’idílkipé éí doodago Háida bítá aniyee ééítógíí tá’doo lo ée yína’idílkipé beehaz’aání hólo fíí díí t’áá hizaid’ehjí háká a’doo wholgo beehaz’a doo baq á ilínígóó. Ata’ halné’ééitójí kójí bichí’jí hódííñih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thợ dịch việt, xin gọi 877-475-4799.

Arabic: إن كان لديك أو أدى شخص تساعدك أسللة بخصوص Blue Cross Blue Shield of Arizona الضرورية يُنصحك من دون اية تكلفة للتحدث مع متجر التلفة ب 877-475-4799.
IMMUNE GLOBULIN THERAPY (cont.)

Multi-Language Interpreter Services: (cont.)

Tagalog: Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatang na mag lugar at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagsalas, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona에 관해서 질문이 있다면 귀하의 그러한 도움과 정보를 귀하의 언어로 이용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеет право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799までお電話ください。

Farsi: 

أگر شما یا کسی که شما به او کمک می‌کنید، سوال‌های مورد اطلاعات به زبان خود را به طور رایگان دریافت کنید. نمایندگان شما می‌توانند به شما کمک کنند.

Assyrian: 

Blue Cross Blue Shield of Arizona

Serbo-Croatian: Ukoiko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijate pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคุณ มีคำถามเกี่ยวกับการป้องกันภัยคุณภาพจาก Blue Cross Blue Shield of Arizona คุณสามารถขอความช่วยเหลือและข้อมูลทางภาษาของคุณได้โดยโทรศัพท์โทร 877-475-4799.