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Policy Number: C21554-A

Immunoglobulin (SCIg, IVIg) MHI

PRODUCTS AFFECTED

Alyglo (immune globulin (human)-stwk IV), Asceniv (immune globulin (human)-slra IV), Bivigam (immune globulin (human) IV), Cutaquig (immune globulin (human)-hipp subcutaneous), Cuvitru (immune globulin (human) subcutaneous), Flebogamma (immune globulin (human) IV), Gammagard S/D (immune globulin (human) IV), Gammagard (immune globulin (human) IV or subcutaneous), Gammaked (immune globulin (human) IV or subcutaneous), Gammaplex (immune globulin (human) IV), Gamunex-C (immune globulin (human) IV or subcutaneous), Hizentra (immune globulin (human) subcutaneous), Hyqvia (immune globulin (human) subcutaneous), Octagam (immune globulin (human) IV), Panzyga (immune globulin (human)-ifas IV), Privigen (immune globulin (human) IV), Xembify (immune globulin (human)-klhw subcutaneous), Yimmugo (immune globulin (human) IV)

COVERAGE POLICY

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This 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 Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:

Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:

Primary Immune Deficiency, Acute Immune Thrombocytopenia (ITP), Chronic Immune Thrombocytopenia (ITP), ITP In Pregnancy, Autoimmune Hemolytic Anemia, Autoimmune Mucocutaneous Blistering Diseases, B-Cell Chronic Lymphocytic Leukemia (CLL), Chronic Inflammatory Demyelinating Polyneuropathy, Dermatomyositis, Polymyositis, Fetal Alloimmune Thrombocytopenia, Natal Alloimmune Thrombocytopenia, Neonatal Hemochromatosis Prophylaxis, Guillain-Barre Syndrome, Pediatric HIV, Adult HIV Associated Thrombocytopenia, Kawasaki Disease, Lambert-Eaton Myasthenia Syndrome, Multiple Myeloma, Multifocal Motor Neuropathy, Myasthenia Gravis, Post-Transfusion Purpura, Pure Red Blood Cell Aplasia Secondary to Chronic Parvovirus, Opsoclonus Myoclonus Syndrome, Rasmussen Syndrome, Stiff-Person Syndrome, Staphylococcal Or Streptococcal Toxic Shock Syndrome, Transplant (Solid Organ, Allogeneic Bone Marrow Transplant)

REQUIRED MEDICAL INFORMATION:

This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

A. ALL INDICATIONS:

1. Prescriber attests to (or the clinical reviewer has found that) the member not having any FDA labeled contraindications that haven't been addressed by the prescriber within the documentation submitted for review [Contraindications to **Alyglo**, **Asceniv**, **Bivigam**, **Cutaquig**, **Cuvitru**, **Flebogamma**, **Gammagard**, **Gammagard S/D**, **Gammaked**, **Gammaplex**, **Gamunex-C**, **Octagam**, **Panzyga**, **Yimmugo** (immune globulin) include: History of anaphylactic or severe systemic reactions to human immunoglobulin, IgA deficient patients with antibodies against IgA and a history of hypersensitivity. Contraindications to **Hizentra** (immune globulin) include: Anaphylactic or severe systemic reaction to human immune globulin or inactive ingredients of Hizentra such as polysorbate 80, Hyperprolinemia Type I or II (Hizentra contains stabilizer L- proline), IgA-deficient patients with antibodies against IgA and a history of hypersensitivity. Contraindications to **Hyqvia** (immune globulin) include: History of anaphylactic or severe systemic hypersensitivity reactions to Immune Globulin (Human), IgA deficient patients with antibodies against IgA and a history of hypersensitivity, known systemic hypersensitivity to hyaluronidase including Recombinant Human Hyaluronidase of Hyqvia, known systemic hypersensitivity to human albumin (in the hyaluronidase solution). Contraindications to **Privigen** (immune globulin) include: History of anaphylactic or severe systemic reaction to human immune globulin, hyperprolinemia (Privigen contains the stabilizer L-proline), IgA-deficient patients with antibodies to IgA and a history of hypersensitivity. Contraindications to **Xembify** (immune globulin) include: Anaphylactic or severe systemic reaction to human immunoglobulin or inactive ingredients of Xembify such as polysorbate 80, IgA deficient patients with antibodies against IgA and a history of hypersensitivity.]
AND
2. Documentation of weight used for dosing (ideal body weight, actual body weight, adjusted body weight) or total grams or units prescribed/requested
MOLINA REVIEWER NOTE: If basis for dosing weight is not provided (ideal or actual or adjusted), calculate total approved dose/units based on ideal body weight [See Appendix]
AND
3. CONDITION SPECIFIC REQUIREMENTS [Listed Below]

B. PRIMARY IMMUNE DEFICIENCY [IVIG or SCIG]:

1. Documentation of a diagnosis of primary immune deficiency with supporting laboratory evidence of ONE of the following [DOCUMENTATION REQUIRED]:
 - a. Autosomal recessive agammaglobulinemia
 - b. Autosomal recessive hyperimmunoglobulin M syndrome (HIM)
 - c. Bruton's disease
 - d. Chronic mucocutaneous moniliasis (CMC) or Autoimmune polyendocrinopathy-candidiasis-ectodermal dystrophy (APCED)
 - e. Combined immunodeficiency disorder: Ataxia-telangiectasia, DiGeorge syndrome, Nuclear factor κB essential modifier deficiency (NEMO), Nijmegen breakage syndrome, WHIM (warts, hypogammaglobulinemia, immunodeficiency, and myelokathexis) syndrome, or Wiskott-Aldrich syndrome
 - f. Common variable immunodeficiency (CVID)

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- g. Congenital hypogammaglobulinemia late onset, ICOS impaired
- h. Congenital / X-linked agammaglobulinemia
- i. Good syndrome (immunodeficiency with thymoma)
- j. Hyperimmunoglobulinemia E syndrome
- k. Hypogammaglobulinemia
- l. ICF syndrome
- m. Polyendocrinopathy and enteropathy (IPEX)
- n. Selective IgG subclass deficiencies (persistent absence of IgG1, IgG2, and/or IgG3)
- o. Selective IgM deficiency
- p. Severe combined immunodeficiency
- q. Specific antibody deficiency
- r. Transient hypogammaglobulinemia of infancy, short-term treatment of recurrent severe bacterial infections
- s. X-linked immunodeficiency with hyperimmunoglobulin M
- t. X-linked agammaglobulinemia (congenital agammaglobulinemia)

AND

- 2. Laboratory documentation that members pre-treatment total serum IgG is below the lower limit of the age adjusted laboratory reference range, or more than two standard deviations below the age adjusted mean [DOCUMENTATION REQUIRED]

AND

- 3. Documentation that member has clinically significant functional deficiency of humoral immunity as defined by ONE of the following:
 - a. Failure to produce antibodies to specific antigens (e.g., lack of or inadequate response to immunizations)
OR
 - b. History of significant recurrent or persistent bacterial infections (such as recurrent pneumonias, frequent episodes of bacterial infections such as sinusitis, otitis, bronchitis, skin structure infections, or infections of the gastrointestinal tract) or infections that fail to respond adequately to prophylactic antibiotic therapy
OR
 - c. FOR CVID OR UNSPECIFIED HYPOGAMMAGLOBULINEMIA: Impaired response to immunizations AND other causes have been excluded (if the above not met)

AND

- 4. Prescriber attestation that there is no evidence of renal (nephrotic syndrome) and gastrointestinal (for example, protein losing enteropathy) causes of hypogammaglobulinemia

AND

- 5. FOR SUBCUTANEOUS IMMUNOGLOBULIN (SCIG): Documentation that member has been receiving intravenous immune globulin treatment at regular intervals for at least 3 months, OR member is unable to be established on a dose with IVIG and requires a subcutaneous formulation [DOCUMENTATION REQUIRED]

AND

- 6. Prescriber Requirement: Prescribed by, or in consultation with an allergist, immunologist, otolaryngologist, or infectious disease specialist

AND

- 7. Quantity Limitation:
 - IVIG: 300-800 mg/kg every 3 to 4 weeks
 - SCIG HIZENTRA: Weekly dosing in accordance with FDA labeling for product (Note: Initial dosing based on previous IVIG dose)
 - SCIG HYQVIA: 300 mg/kg – 600 mg/kg every 3-4 weeks (after ramp up period)

C. CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP) OR POLYRADICULOPATHY [IVIG or Hizentra or Hyqvia SCIG ONLY]:

- 1. Documentation of a diagnosis of CIDP with symmetric or focal neurologic deficits with slowly progressive or relapsing course over 8 weeks or longer with neurophysiological abnormalities
AND

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2. Documentation of member's baseline strength and function using an objective clinical measuring tool (e.g., INCAT, MRC, 6- minute timed walking test, Rankin, Modified Rankin), which will be used to monitor member's response to therapy for reauthorization [DOCUMENTATION REQUIRED]
AND
 3. Documentation that member has met one of the following clinical/electro-diagnostic criteria [DOCUMENTATION REQUIRED]:
 - a. Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs, resulting in muscle weakness or sensory dysfunction confirmed by nerve conduction studies (NCS)
OR
 - b. Results of diagnostic testing meet a recognized set of diagnostic criteria as established by the American Academy of Neurology (AAN), Inflammatory Neuropathy Cause and Treatment (INCAT), or EFNS/PNS guidelineAND
 4. FOR HIZENTRA OR HYQVIA SUBCUTANEOUS IMMUNOGLOBULIN (SCIG): Documentation that member has been receiving intravenous immune globulin treatment at regular intervals for at least 3 months [DOCUMENTATION REQUIRED]
AND
 5. Prescriber Requirement: Prescribed by, or in consultation with a neurologist
AND
 6. Quantity limitation:
IVIG: Loading dose: 2,000 mg/kg in divided doses over 2 to 5 consecutive days (e.g., 400 mg/kg once daily for 5 days); Maintenance 1g/kg administered in 1 or 2 infusions on consecutive days every 3 weeks
SCIG HIZENTRA: 200 mg/kg – 400 mg/kg weekly (Note: Per package labeling, if CIDP symptoms worsen while on 400 mg/kg Hizentra weekly, consider re-initiating IVIG and discontinuing Hizentra.)
SCIG HYQVIA: Weekly dosing in accordance with FDA labeling for product (Note: Initial dosing based on previous IVIG dose)
AND
 7. Duration of Approval: Initial authorization: 3 months, Continuation of Therapy: 6 months
- D. ACUTE IMMUNE THROMBOCYTOPENIA (ITP) [IVIG ONLY]:
1. Documentation of a diagnosis of immune thrombocytopenia (ITP) with a duration of illness of less than 6 months
AND
 2. Documentation that member meets one of the following [DOCUMENTATION REQUIRED]:
 - a. Member has severe thrombocytopenia (platelet counts less than 20,000/mm³) and is considered to be at risk for intracerebral hemorrhage
OR
 - b. A rapid increase in platelet count is necessary to correct thrombocytopenia prior to major, invasive surgical procedures and platelet count is less than 100,000/mm³
OR
 - c. ADULTS ONLY: Platelet counts remain persistently at or below 30,000/mm³ despite prior treatment with corticosteroids or splenectomyAND
 3. Prescriber Requirement: Prescribed by, or in consultation with a hematologist
AND
 4. Quantity Limitations: 2000 mg/kg divided over 2-5 days; No reauthorization
MOLINA REVIEWER NOTE: NOTE: Rho(D) immune globulin is not necessarily recommended or preferred in place of IVIg; however, may be utilized instead in Rho(D) positive, non-splenectomized patients, with a negative direct antiglobulin test (DAT)
AND
 5. Duration of Approval: Initial authorization: One course of therapy, up to 5 days, Continuation of Therapy: N/A

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E. CHRONIC IMMUNE THROMBOCYTOPENIA (ITP) [IVIG ONLY]:

1. Documented diagnosis of chronic immune thrombocytopenia (ITP) with a duration of illness of *greater* than or equal to 6 months
AND
2. Documentation that member meets one of the following [DOCUMENTATION REQUIRED]:
 - a. Platelet count less than 20,000/mm³
OR
 - b. Platelet count less than 30,000/mm³ whose degree of thrombocytopenia and clinical condition(s) increase the risk of bleeding (e.g., hypertension, renal insufficiency, concomitant antiplatelet agents or anticoagulant medications, alcoholism, infections, undergoing a medical or dental procedure with blood loss anticipation, recent surgery, head trauma)
AND
3. Documentation that member has had a documented failure, serious side effects, or contraindication to ONE of the following: (i) corticosteroids [e.g., prednisone, dexamethasone] at immunosuppressive doses (See Appendix 2) OR (ii) splenectomy or is not a surgery candidate
AND
4. Prescriber Requirement: Prescribed By, Or In Consultation With A Hematologist Or Physician Specializing In The Treatment Of Thrombocytopenia In Patients With Chronic Immune Thrombocytopenia (ITP)
AND
5. Quantity Limitations: 2000 mg/kg divided over 2-5 days, every 2 to 6 weeks depending on platelet count.

F. ITP IN PREGNANCY [IVIG ONLY]:

1. Documentation that member is currently pregnant and meets one of the following [DOCUMENTATION REQUIRED]:
 - a. Platelet count less than 30,000/mm³ or clinically relevant bleeding is present
OR
 - b. Platelet count less than 50,000/mm³ prior to labor and delivery (36 weeks gestation or sooner if delivery is imminent)
OR
 - c. Previously delivered infants with autoimmune thrombocytopenia
OR
 - d. Past history of a splenectomy
AND
2. Prescriber Requirement: Prescribed by, or in consultation with a hematologist
AND
3. Quantity Limitations: 2000 mg/kg divided over 2-5 days, every 2 to 6 weeks until delivery
AND
4. Duration of Approval: Initial authorization: Until anticipated delivery date, Continuation of Therapy: N/A

G. AUTOIMMUNE HEMOLYTIC ANEMIA (AIHA) [IVIG ONLY]:

1. Documentation of a diagnosis of warm-type autoimmune hemolytic anemia confirmed by detection of antibody and/or complement components on the surface of the red blood cell, such as the **direct** antiglobulin (Coombs) test [DOCUMENTATION REQUIRED]
AND
2. Documentation of an inadequate response, serious side effects, or contraindication to both corticosteroids and rituximab.
AND
3. Prescriber Requirement: Prescribed by, or in consultation with a hematologist
AND
4. Quantity Limitation: 500 mg/kg once daily for 4-5 days or 1 g/kg once daily for 2 days

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H. AUTOIMMUNE MUCOCUTANEOUS BLISTERING DISEASES (AMBDs) [IVIG ONLY]:

1. Documentation of a diagnosis of one of the following autoimmune mucocutaneous blistering diseases (AMBDs) confirmed by biopsy [DOCUMENTATION REQUIRED]:
 - a. Bullous pemphigoid
 - b. Epidermolysis Bullosa Acquisita (EBA)
 - c. Mucous membrane pemphigoid (also referred to as Cicatrical Pemphigoid)
 - d. Pemphigus Foliaceus
 - e. Pemphigus VulgarisAND
2. Immunoglobulin has been prescribed for short term therapy only (not as long-term maintenance therapy).
NOTE: Regular use of repeated courses of IVIg for a continuous cycle of exacerbation and remission constitutes maintenance therapy. IVIg should be given with conventional treatment(s) and used only until conventional therapy can take effect.
AND
3. Documentation of ONE of the following [DOCUMENTATION REQUIRED]:
 - a. Inadequate response, serious side effect, or contraindication to both corticosteroids (i.e., prednisone, prednisolone, methylprednisolone) AND immunosuppressive agents (e.g., azathioprine, cyclophosphamide, methotrexate, or mycophenolate mofetil)
OR
 - b. Use of systemic corticosteroids and immunosuppressive agents are inappropriate due to rapid, debilitating or progressive disease severity
NOTE: Contraindications to systemic corticosteroids include existing diabetes, clinically significant osteoporosis, fractures, upper GI bleeding, posterior subcapsular cataracts, pseudotumor cerebri, bone marrow suppression, aplastic anemia, clinically significant psychological changes, steroid myopathy, glaucoma
NOTE: Contraindications to immunosuppressive agents include significant persistent anemia, clinically significant neutropenia, clinically significant abnormal hepatic function, clinically significant impaired renal function, hemorrhagic cystitis, clinically significant bone marrow suppression, history of malignancyAND
4. Prescriber Requirement: Prescribed by, or in consultation with a dermatologist
AND
5. Quantity Limitation: 2000 mg/kg in divided doses (2- 5 days) every 28-30 days
AND
6. Duration of Approval: Initial authorization: 3 months, Continuation of Therapy: N/A

I. B-CELL CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) [IVIG OR SCIG]:

1. Documentation that member has a diagnosis of B-cell Chronic Lymphocytic Leukemia (CLL)
AND
2. Documentation that member has hypogammaglobulinemia, with IgG level less than 500 mg/dL [DOCUMENTATION REQUIRED]
AND
3. Documentation that member has had recurrent (two) bacterial infections in the previous 12 months
OR one severe bacterial infection in the previous 6 months which were associated with B-cell CLL
AND
4. FOR SUBCUTANEOUS IMMUNOGLOBULIN (SCIG): Documentation that member has been receiving intravenous immune globulin treatment at regular intervals for at least 3 months, OR member is unable to be established on a dose with IVIG and requires a subcutaneous formulation [DOCUMENTATION REQUIRED]
AND
5. Prescriber Requirement: Prescribed by, or in consultation with a hematologist, oncologist, or infectious disease specialist
AND
6. Quantity Limitation: 400 mg/kg every 3 to 4 weeks or 300 mg/kg-500mg/kg monthly or SCIG

J. DERMATOMYOSITIS OR POLYMYOSITIS [IVIG ONLY]:

1. Documentation of a diagnosis of dermatomyositis or polymyositis confirmed by positive biopsy
AND
2. Documentation of ANY of the following: (i) severe active disease (e.g., dysphagia, diaphragmatic weakness, or weakness preventing activities of daily living), (ii) muscle weakness in all upper and/or lower limbs, (iii) cutaneous manifestations
AND
3. Documentation of member's baseline physical examination, including an objective measure, such as creatine kinase (CK) or electromyography (EMG), which can be used to assess objective response to therapy [DOCUMENTATION REQUIRED]
AND
4. Documentation of ONE of the following [DOCUMENTATION REQUIRED]:
 - a. Inadequate response, serious side effect, or contraindication to both corticosteroids (i.e., prednisone, prednisolone, methylprednisolone) AND immunosuppressive agents (e.g., azathioprine, cyclophosphamide, methotrexate, or mycophenolate mofetil)
OR
 - b. Use of systemic corticosteroids and immunosuppressive agents are inappropriate due to rapid progressive or potentially life-threatening muscular weakness refractory to prior therapyAND
5. Prescriber Requirement: Prescribed by, or in consultation with a neurologist, rheumatologist, or dermatologist
AND
6. Quantity Limitation: 2000 mg/kg in divided doses (2- 5 days) every 4 weeks
AND
7. Duration of Approval: Initial authorization: 3 months, Continuation of Therapy: 6 months

K. FETAL OR NATAL ALLOIMMUNE THROMBOCYTOPENIA (FAIT/NAIT) [IVIG ONLY]:

1. Documentation of a diagnosis of neonatal alloimmune thrombocytopenia (NAIT) or fetal alloimmune thrombocytopenia (FAIT)
AND
2. For fetal autoimmune thrombocytopenia (FAIT): Documentation the member (pregnant female) meets ONE of the following [DOCUMENTATION REQUIRED]:
 - a. Member has a history of previous pregnancy affected by FAIT (previously delivered infants with autoimmune thrombocytopenia)
OR
 - b. Member is 20 weeks gestation or later and cordocentesis reveals fetal platelets less than 20,000/ mm³; or screening reveals platelet alloantibodiesOR
3. For neonatal alloimmune thrombocytopenia (NAIT): Documentation that member (neonate) meets ALL of the following [DOCUMENTATION REQUIRED]:
 - a. Neonate is severely thrombocytopenic (i.e., platelet count less than 30,000/mm³) and/or symptomatic
AND
 - b. Neonate failed, has a contraindication to, or has serious side effects to platelet transfusionsAND
4. Prescriber Requirement: Prescribed by, or in consultation with a fetal medicine specialist, obstetrician/gynecologist, or hematologist
AND
5. Quantity Limitation: FAIT: 1000 mg/kg (starting) to 2000 mg/kg (max dose for refractory cases) weekly until delivery; NAIT: 1000 mg/kg per dose, for up to 2 doses
AND
6. Duration of Approval:

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FAIT: Initial authorization: Until delivery, Continuation of Therapy: N/A

NAIT: Initial authorization: up to 2 doses, Continuation of Therapy: N/A

L. GUILLAIN-BARRE SYNDROME (GBS) [IVIG ONLY]:

1. Documentation of a diagnosis of Guillain-Barré Syndrome (GBS) [also referred to as Acute Inflammatory Demyelinating Polyneuropathy (AIDP)] [DOCUMENTATION REQUIRED]
AND
2. Documentation that member has functional disability due to Severe GBS (defined as having significant weakness such as inability to walk or stand without aid, respiratory weakness or bulbar weakness) or Miller-Fisher Syndrome (MFS)
AND
3. IVIg will not be used concomitantly with plasmapheresis
AND
4. Documentation that IVIg therapy is being initiated within 2 weeks, and no longer than 4 weeks, of onset of neuropathic symptoms
AND
5. Prescriber Requirement: Prescribed by, or in consultation with a neurologist or specialist with experience in the diagnosis and treatment of GBS
AND
6. Quantity Limitation: 2000 mg/kg divided over 2 to 5 days
AND
7. Duration of Approval: Initial authorization: One course of therapy up to 5 days, Continuation of Therapy: N/A

M. PEDIATRIC HIV [IVIG ONLY]:

1. Documentation that member has a diagnosis of HIV
AND
2. Member is currently age 13 or younger
AND
3. Documentation member is currently using highly active antiretroviral therapy (HAART) for HIV
OR Request is for secondary prophylaxis in a member that has experienced frequent (at least 2) severe infections in the past year and is unable to take HAART
AND
4. Member meets ONE of the following [DOCUMENTATION REQUIRED]:
 - a. Member has hypogammaglobulinemia (pretreatment serum IgG less than 400 mg/dL) AND Recurrent serious bacterial infections defined as two (2) or more infections such as bacteremia, meningitis, or pneumonia in a 1-year period
OR
 - b. Member has failed to form antibodies to common antigens, such as measles, pneumococcal, and/or Haemophilus influenzae type b vaccine
OR
 - c. Member resides in areas where measles is highly prevalent and has not developed an antibody response after TWO doses of measles, mumps, and rubella virus vaccine OR
 - d. Member has chronic bronchiectasis that is sub-optimally responsive to antimicrobial and pulmonary therapy
OR
 - e. Request is for secondary prophylaxis and member has failed antibiotics
AND
5. Prescriber Requirement: Prescribed by, or in consultation with an infectious disease or HIV specialist
AND
6. Quantity Limitation: 400 mg/kg every 2 to 4 weeks

N. ADULT HIV ASSOCIATED THROMBOCYTOPENIA [IVIG ONLY]:

1. Documentation of a diagnosis of HIV

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- AND
- 2. Documentation that member has thrombocytopenia as evidenced by a platelet count less than 20,000/ μ L OR has clinically significant bleeding [DOCUMENTATION REQUIRED]
- AND
- 3. Member is currently using combination antiretroviral therapy for HIV
- AND
- 4. For Rh-positive members, documentation of a failure of RhIg
- AND
- 5. Prescriber Requirement: Prescribed by, or in consultation with an infectious disease or HIV specialist
- AND
- 6. Quantity Limitation: 1000 mg/kg daily for 2 days
- AND
- 7. Duration of Approval: Initial authorization: One course of therapy, Continuation of Therapy: N/A

O. KAWASAKI DISEASE (MUCOCUTANEOUS LYMPH NODE SYNDROME) [IVIG ONLY]:

- 1. (a) Documentation of a diagnosis of Kawasaki Disease defined as having FOUR of the following 5 symptoms [DOCUMENTATION REQUIRED]:
 - a. Mucous membrane changes such as strawberry tongue and dry fissured lips without discrete lesions
 - b. Changes in the extremities such as edema of the hands and feet
 - c. Enlarged lymph nodes in the neck
 - d. Diffuse red rash covering most of the body
 - e. Redness of the eyesOR
- (b) Documented diagnosis of Incomplete (Atypical) Kawasaki Disease as evidenced by 2-3 clinical criteria, lab abnormalities, and/or coronary artery abnormalities (AHA, 2024)
- AND
- 2. Documentation that member has had a fever which has persisted for at least 5 days
- AND
- 3. Prescriber attestation that treatment is being initiated within ten days of fever onset OR that member has been diagnosed after ten days of onset and the member continues to exhibit manifestations of inflammation or evolving coronary artery disease.
NOTE: The effectiveness of IVIg therapy is best established for patients treated within the first 7 to 10 days of illness. The AHA and AAP guidelines recommend that IVIg be administered to children with KD within the first 10 days of illness, and if possible, within the first seven days of illness.
- AND
- 4. Concomitant aspirin will be given with immune globulin
- AND
- 5. Prescriber attestation that other diseases with similar findings have been excluded including:
 - a. Viral infections (i.e., measles, adenovirus, enterovirus, Epstein-Barr virus)
 - b. Scarlet fever
 - c. Staphylococcal scalded skin syndrome
 - d. Toxic shock syndrome
 - e. Bacterial cervical lymphadenitis
 - f. Drug hypersensitivity reactions
 - g. Stevens-Johnson syndrome
 - h. Juvenile rheumatoid arthritis
 - i. Rocky Mountain spotted fever
 - j. Leptospirosis
 - k. Mercury hypersensitivity reaction (acrodynia)AND
- 6. Prescriber Requirement: Prescribed by, or in consultation with a cardiologist, allergist or rheumatologist

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- AND
- 7. Quantity Limitation: 1000 or 2000 mg/kg as a single dose, or 400 mg/kg/day for 4 days
- AND
- 8. Duration of Approval: Initial authorization: One course of therapy up to 5 days, Continuation of Therapy: N/A

P. LAMBERT-EATON MYASTHENIA SYNDROME (LEMS) [IVIG ONLY]:

- 1. Documentation of a diagnosis of Lambert-Eaton Myasthenia Syndrome (LEMS) which has been confirmed by electro-physiologic studies
- AND
- 2. Documentation that member has impaired function (e.g., inability to stand or walk without an aid) which has been measured by a standard clinical scale (e.g., Activities of Daily Living Score, quantitative muscle scores, or Medical Research Council Muscle Assessment) or objective findings based on initial therapy [DOCUMENTATION REQUIRED]
NOTE: Improvement in objective muscle function/strength is required for reauthorization.
- AND
- 3. Documentation that member has had a trial with lack of response or has a contraindication or serious side effects to ALL of the following:
 - a. Acetylcholinesterase inhibitors (e.g., Mestinon [pyridostigmine])
 - b. Immunosuppressants (e.g., corticosteroids, azathioprine)
 - c. Dalfampridine or Amifampridine (Firdapse)
- AND
- 4. Provider attestation that immune globulin is needed as an alternative to plasma exchange due to severe weakness or difficulty with venous access for plasmapheresis
- AND
- 5. Prescriber Requirement: Prescribed by, or in consultation with a neurologist
- AND
- 6. Quantity Limitation: 2000 mg/kg, which may be administered over 2 to 5 days every 4 to 8 weeks

Q. MULTIPLE MYELOMA [IVIG ONLY]:

- 1. Documented diagnosis of multiple myeloma
- AND
- 2. Documentation member is at high risk for recurrent infections as defined by ONE of the following [DOCUMENTATION REQUIRED]:
 - a. IgG less than 400 mg/dL and recurrent serious infections OR
 - b. Member failed to mount an appropriate IgG humoral immune response on challenge with pneumococcal vaccine
 - OR
 - c. IgG level less than 600 mg/dL and two (2) or more bacterial infections in the preceding year requiring IV antibiotic infusion therapy in the home or in the hospital
 - OR
 - d. IgG level less than 600 mg/dL and member has had a life-threatening, laboratory proven bacterial infection in the previous 6 months
 - OR
 - e. Member has received CAR-T therapy or is currently receiving bispecific antibody therapy
- AND
- 3. Prescriber Requirement: Prescribed by, or in consultation with a hematologist, oncologist, or infectious disease specialist
- AND
- 4. Quantity Limitation: 200-400 mg/kg, administered every 4 to 6 weeks
- AND
- 5. Duration of Approval: Initial authorization: 3 months, Continuation of Therapy: 3 months

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R. MYASTHENIA GRAVIS, ACUTE [IVIG ONLY] (MYASTHENIC CRISIS, MYASTHENIC EXACERBATION):

1. Documented diagnosis of myasthenia gravis
AND
2. Documentation diagnosis was confirmed by positive serologic test for anti- acetylcholine receptor (AChR) antibodies OR anti-muscle-specific tyrosine kinase (MuSK) antibodies
[DOCUMENTATION REQUIRED]
AND
3. Documentation that IVIg has been prescribed for the treatment of an ACUTE myasthenic crisis in member experiencing disease exacerbation and/or decompensation (e.g., difficulty swallowing, acute respiratory failure, major functional disability responsible for the discontinuation of physical activity; of physical activity, disabling weakness requiring hospital admission) or preoperatively, before thymectomy or other surgery [DOCUMENTATION REQUIRED]
AND
4. Documentation that member meets ONE of the following:
 - a. Member is currently receiving immunomodulator therapy (e.g., azathioprine, mycophenolate mofetil, cyclosporine) for long-term management of myasthenia gravis OR
 - b. i. Member has had a trial and failure of, or contraindication to, plasma exchange AND
ii. Prescriber attests to initiating immunomodulator therapy (e.g., corticosteroids, azathioprine, cyclosporine, methotrexate, mycophenolate mofetil, cyclophosphamide)
AND
5. Prescriber Requirement: Prescribed by, or in consultation with an immunologist, neurologist, or rheumatologist
AND
6. Quantity Limitation: 2000 mg/kg divided over 2 to 5 days (one course), One course per month for up to 3 months
AND
7. Duration of Approval: Initial authorization: 3 months, Continuation of Therapy: 3 months

S. MULTIFOCAL MOTOR NEUROPATHY (MMN) [IVIG ONLY]:

1. Documentation of a diagnosis of **progressive, symptomatic** multifocal motor neuropathy (as characterized by limb weakness or motor involvement having a motor nerve distribution in at least two nerves)
AND
2. Prescriber attestation that electrophysiological findings have ruled out other possible conditions that may not respond to IVIg
AND
3. Documentation of member's baseline strength and function using an objective clinical measuring tool (e.g., INCAT, MRC, 6-minute timed walking test, Rankin, Modified Rankin). NOTE: Improvement in objective strength or function is required for reauthorization. [DOCUMENTATION REQUIRED]
AND
4. Prescriber Requirement: Prescribed by, or in consultation with a neurologist
AND
5. Quantity Limitation: 2000 mg/kg once monthly, which may be administered over 2 to 5 days

T. NEONATAL HEMOCHROMATOSIS, PROPHYLAXIS [IVIG ONLY]:

1. Documentation that member is pregnant and has a history of a pregnancy ending with neonatal hemochromatosis [DOCUMENTATION REQUIRED]
AND
2. Prescriber Requirement: Prescribed by, or in consultation with a maternal/fetal medicine specialist, hepatologist, gastroenterologist, or hematologist
AND
3. Quantity Limitation: 1000 mg/kg weekly until delivery (usually from the 18th week until the end of gestation)

Drug and Biologic Coverage Criteria

AND

4. Duration of Approval: Initial authorization: Until delivery (usually from the 18th week until the end of gestation), Continuation of Therapy: N/A

U. POST-TRANSFUSION PURPURA (PTP)[IVIG ONLY]:

1. Documentation of a diagnosis of post-transfusion purpura
AND
2. Laboratory documentation of decreased platelet count (generally less than 20,000/mm³)
[DOCUMENTATION REQUIRED]
AND
3. Documentation that member is 2 to 14 days post-transfusion with bleeding due to thrombocytopenia
AND
4. Prescriber Requirement: Prescribed by, or in consultation with a hematologist
AND
5. Quantity limit: 500 mg/kg divided for 2 to 5 days (one course) OR 1000 mg/kg daily for 2 days
AND
6. Duration of Approval: Initial authorization: One course of therapy up to 5 days, Continuation of Therapy: N/A

V. PURE RED BLOOD CELL APLASIA (PRCA) Secondary to Chronic (persistent) Parvovirus B19 Infection [IVIG ONLY]:

1. Documentation of a diagnosis of Pure Red Blood Cell Aplasia (PRCA) secondary to parvovirus B19 infection
AND
2. Laboratory documentation of severe anemia (Hemoglobin less than 10 or Hematocrit less than 30) associated with bone marrow suppression due to CHRONIC parvovirus [DOCUMENTATION REQUIRED]
AND
3. Documentation that member has a CHRONIC immunodeficient condition (e.g., HIV infection, solid organ transplants [e.g., renal, liver], chemotherapy for hematologic malignancy) NOTE: Chronic parvovirus infection with anemia usually occurs in immunocompromised patients. If the immunodeficiency improves, the parvovirus and anemia may spontaneously resolve.
AND
4. Prescriber Requirement: Prescribed by, or in consultation with an infectious disease specialist, immunologist, hematologist, or transplant specialist
AND
5. Quantity Limitation: Initial: 2000-4000 mg/kg divided over up to 10 days, Maintenance: 400 mg/kg every 4 weeks

W. OPSOCLONUS-MYOCLOONUS-ATAXIA SYNDROME (OMAS) [IVIG ONLY]:

1. Documented diagnosis of opsoclonus-myoelonus-ataxia syndrome (OMAS), or opsoclonus-myoelonus
AND
2. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal (e.g., symptoms, disability) [DOCUMENTATION REQUIRED]
AND
3. Documentation of inadequate response, serious side effects or clinical contraindication to glucocorticoids
AND
4. Prescriber Requirement: Prescribed by, or in consultation with a neurologist
AND
5. Quantity Limitation: 2000 mg/kg over two to five days followed by 1000 to 2000 mg/kg every four weeks

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X. RASMUSSEN SYNDROME (RS); CHRONIC FOCAL ENCEPHALITIS [IVIG ONLY]:

1. Documented diagnosis of Rasmussen Syndrome, which is also known as Rasmussen Encephalitis (RE) or Chronic Focal Encephalitis [DOCUMENTATION REQUIRED]
AND
2. Documentation that member has had intractable focal motor seizures and progressive neurologic deterioration (dementia, hemiparesis)
AND
3. Documentation of a trial and failure of or contraindication to both antiepileptic drugs and corticosteroids
AND
4. IVIg is prescribed for short-term amelioration of encephalitis prior to definitive surgical therapy
NOTE: IVIg is not recommended for long-term therapy for Rasmussen's encephalitis as surgical treatment is the current standard of care. Requests for continuation of therapy beyond 6 months requires review and determination by a Clinical Pharmacist or Medical Director.
AND
5. Prescriber Requirement: Prescribed by, or in consultation with a neurologist or neurosurgeon
AND
6. Quantity Limitation: 2000 mg/kg once monthly, which may be administered over 2 to 5 days
AND
7. Duration of Approval: Initial authorization: 6 months, Continuation of Therapy: N/A

Y. STIFF-PERSON SYNDROME (MOERSCH-WOLTMANN SYNDROME) [IVIG ONLY]:

1. Documentation of a diagnosis of Stiff-Person Syndrome (Moersch-Woltmann Syndrome)
AND
2. Documentation diagnosis was made by supportive testing including EMG findings, anti- glutamic acid decarboxylase antibodies, and/or anti-amphiphysin antibodies [DOCUMENTATION REQUIRED]
AND
3. Documentation of a history of failure, contraindication or serious side effects to conventional therapy with at least TWO of the following treatments: benzodiazepines, baclofen, phenytoin, clonidine and/or tizanidine
AND
4. Prescriber Requirement: Prescribed by, or in consultation with a neurologist
AND
5. Quantity Limitation: 2000 mg/kg once which may be administered over 2 to 5 days, followed by 2000 mg/kg every two weeks for up to six doses, if needed
AND
6. Duration of Approval: Initial authorization: 6 months, Continuation of Therapy: N/A

Z. STAPHYLOCOCCAL OR STREPTOCOCCAL TOXIC SHOCK SYNDROME (TSS) [IVIG ONLY]:

1. Documentation that member has a severe, life-threatening case of streptococcal or staphylococcal TSS [DOCUMENTATION REQUIRED]
AND
2. Documentation that member has failed to achieve rapid improvement with antibiotic therapy and other supportive measures (fluids, inotropes, vasopressors)
AND
3. Documentation that member meets ONE of the following:
 - a. Member has an infection that is refractory to several hours of aggressive therapy OR
 - b. Member has an undrainable focus OR
 - c. Member has persistent oliguria with pulmonary edema
AND
4. Prescriber Requirement: Prescribed by, or in consultation with an infectious disease specialist, obstetrician/gynecologist, or physician experienced in the management of TSS
AND

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5. Quantity Limitation: 2000 mg/kg administered in divided doses over 5 days
AND
6. Duration of Approval: Initial authorization: Once course of therapy up to 5 days, Continuation of Therapy: N/A

AA. SOLID ORGAN TRANSPLANT [IVIG ONLY]:

NOTE: For Cytogam see Cytogam (cytomegalovirus immune globulin) MHI Policy Number C9970-A

1. Documentation that member has had or has a planned solid organ transplant
AND
2. Documentation the request is for ONE of the following [DOCUMENTATION REQUIRED]:
 - a. IVIg is prescribed PRIOR to solid organ transplant for prevention of acute rejection (pre- and peri-operative): for prevention of antibody-mediated rejection prior to solid organ transplant, or in the peri-operative period, for patients at high-risk for antibody-mediated rejection (including highly sensitized patients, and those receiving an ABO-incompatible organ)
OR
 - b. IVIg is prescribed POST solid-organ transplant for the treatment of antibody-mediated (humoral) rejection following solid organ transplant confirmed by either biopsy or presence of panel reactive antibodies (PRAs), if used in combination with plasmapheresis

AND

3. Documentation of date of solid-organ transplant or anticipated transplant date
AND
4. FOR POST SOLID-ORGAN TRANSPLANT THAT ARE 100 DAYS OR MORE POST-TRANSPLANT: Documentation of an IgG value less than 400 mg/dL or a documented CMV, EBV or RSV infection [DOCUMENTATION REQUIRED]
AND
5. FOR REQUESTS PRIOR TO KIDNEY TRANSPLANT ONLY: Documentation that IVIg is prescribed for member with high levels of "anti-donor" antibodies (i.e., patients highly sensitized to the tissue of the majority of living or cadaveric donors because of "non-self" human leukocyte antigen (HLA) or ABO incompatibility).

NOTE: To reduce the risk of acute antibody-mediated rejection, IVIg is recommended for kidney transplant patients who have donor-specific antibodies preoperatively. IVIg is not recommended for kidney transplant patients who do not have donor-specific antibodies. (The National Advisory Committee on Blood and Blood Products and Canadian Blood Services, 2010)

AND

6. Prescriber Requirement: Prescribed by, or in consultation with a transplant medicine specialist or provider affiliated with a transplant center
AND
7. Quantity Limitations:
Post-Transplant Acute Rejection: 2000 mg/kg (up to 140 grams in a single dose); One dose per rejection episode, 14 days
Prior to Transplant, prevention: 100-500 mg/kg; Four doses prior to and four doses following transplant, maximum of 8 total doses (2000 mg/kg total per 8-week period). If used with plasma exchange: Total maximum dose of 2000 mg/kg per 4-week period, which may be given in divided doses.
8. Duration of Approval: Initial authorization: Acute Rejection: 14 days, Prophylaxis: 8 months, Continuation of Therapy: N/A

BB. ALLOGENEIC BONE MARROW TRANSPLANT (BMT)/ HEMATOPOIETIC STEM CELL TRANSPLANTATION (HSCT) [IVIG ONLY]:

NOTE: For Cytogam see Cytogam (cytomegalovirus immune globulin) MHI Policy Number C9970-A

1. Documentation that member has had **ALLOGENEIC** (not autologous) Bone Marrow Transplant (BMT)/Hematopoietic Stem Cell Transplantation (HSCT)

NOTE: Routine use of IVIg among autologous recipients is not recommended, according to the Centers for Disease Control and Prevention.

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- AND
- 2. Documentation that IVIg is prescribed for prophylaxis of acute graft vs. host disease (GVHD) OR prophylaxis treatment against infection (i.e., cytomegalovirus)
- AND
- 3. Documentation that member meets ONE of the following [DOCUMENTATION REQUIRED]:
 - a. Member in within the first 100 days post- transplant OR
 - b. Member is greater than 100 days post-transplant AND has a pre-treatment serum IgG less than 400mg/dL
- AND
- 4. Prescriber Requirement: Prescribed by, or in consultation with a hematologist, oncologist, or infectious disease specialist
- AND
- 5. Quantity limitation:
 - Less than 100 days post-transplant: 500 - 600 mg/kg/week until member reaches 90 days post-transplant
 - Greater than 100 days: 500 mg/kg/month until member reaches 360 days post-transplant

CONTINUATION OF THERAPY:

- A. ALL LISTED INDICATIONS: PRIMARY IMMUNE DEFICIENCY, ALLOGENEIC BONE MARROW TRANSPLANT (BMT)/ HEMATOPOIETIC STEM CELL TRANSPLANTATION (HSCT), AUTOIMMUNE HEMOLYTIC ANEMIA CHRONIC ITP, B-CELL CHRONIC LYMPHOCYTIC LEUKEMIA, CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY, DERMATOMYOSITIS/POLYMYOSITIS, HIV-PEDIATRIC, LAMBERT- EATON MYASTHENIA SYNDROME, MULTIPLE MYELOMA, MULTIFOCAL MOTOR NEUROPATHY, MYASTHENIA GRAVIS, OPSOCLONUS MYOCLONUS SYNDROME, PURE RED BLOOD CELL APLASIA (PRCA)/PARVOVIRUS:
 - 1. Prescriber attests to or clinical reviewer has found no evidence intolerable adverse effects or drug toxicity
 - AND
 - 2. Documentation of positive clinical response as demonstrated by low disease activity and/or improvements in the condition's signs and symptoms and clinical endpoints
 - AND
 - 3. Documentation of annual clinical review and/or immunological evaluation
 - AND
 - 4. Prescriber attestation that the dose and frequency of immunoglobulin treatment have been titrated to the minimum dose and/or frequency to maintain the appropriate clinical outcome
 - AND
 - 5. After 12 months of therapy and annually thereafter, prescriber attests that cessation of IVIg has been attempted and caused the condition to worsen, or that cessation of therapy is medically contraindicated, or cessation of therapy is not appropriate for the disease state
 - AND
 - 6. Documentation of weight used for dosing (ideal body weight, actual body weight, adjusted body weight) or total grams or units prescribed/requested
 - MOLINA REVIEWER NOTE: If basis for dosing weight is not provided (ideal or actual or adjusted), calculate total approved dose/units based on ideal body weight [See Appendix] AND
 - 7. CONDITION SPECIFIC REQUIREMENTS [Listed Below]
- B. PRIMARY IMMUNE DEFICIENCY [IVIG or SCIG]:
 - 1. Documentation of current IgG levels that are in the low to normal range and evidence of clinical improvement, such as reduction of the number and severity of clinical infections [DOCUMENTATION REQUIRED]
 - AND
 - 2. Prescriber Requirement: Prescribed by, or in consultation with an allergist, immunologist, otolaryngologist, or infectious disease specialist

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- C. ALLOGENEIC BONE MARROW TRANSPLANT (BMT)/ HEMATOPOIETIC STEM CELL TRANSPLANTATION (HSCT) [IVIG ONLY]:
1. Documentation the member is 100 days or greater post-transplant and has a pre-treatment IgG less than 400 mg/dL [DOCUMENTATION REQUIRED]
AND
 2. Documentation that member is within 360 days post-transplant
AND
 3. Prescriber Requirement: Prescribed by, or in consultation with a hematologist, oncologist, or infectious disease specialist
- D. AUTOIMMUNE HEMOLYTIC ANEMIA (AIHA) [IVIG ONLY]:
1. Documentation of initial response and recurrence of clinically significant, symptomatic anemia [DOCUMENTATION REQUIRED]
AND
 2. Prescriber Requirement: Prescribed by, or in consultation with a hematologist
- E. B-CELL CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) [IVIG OR SCIG]:
1. Documentation of positive clinical response as demonstrated by a reduction in the frequency of bacterial infections since the initiation of IVIG therapy [DOCUMENTATION REQUIRED]
AND
 2. Prescriber Requirement: Prescribed by, or in consultation with a hematologist, oncologist, or infectious disease specialist
- F. CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP) OR POLYRADICULOPATHY [IVIG or Hizentra or Hyqvia SCIG ONLY]:
1. Documentation of a positive response to therapy as measured by an objective clinical measuring tool, compared to baseline: INCAT, MRC, 6-minute timed walking test, Rankin, or Modified Rankin [DOCUMENTATION REQUIRED]
AND
 2. Prescriber Requirement: Prescribed by, or in consultation with a neurologist
AND
 3. Duration of Approval: Continuation of Therapy: 6 months
- G. CHRONIC ITP [IVIG ONLY]:
1. Documentation of positive clinical response to therapy as evidenced by increase in platelet count to a level sufficient to avoid clinically important bleeding, OR increase or achievement of platelet count to at least 50,000/mm³ [DOCUMENTATION REQUIRED]
AND
 2. Prescriber Requirement: Prescribed by, or in consultation with a hematologist or physician specializing in the treatment of thrombocytopenia in patients with chronic immune thrombocytopenia
- H. DERMATOMYOSITIS OR POLYMYOSITIS [IVIG]:
1. Documentation of improvement in ONE objective measure, compared to baseline: serum creatine kinase (ck) levels, muscle strength, electromyography testing (EMG), and/or improvement in rash (for dermatomyositis indication) [DOCUMENTATION REQUIRED]
AND
 2. Prescriber Requirement: Prescribed by, or in consultation with a neurologist, rheumatologist, or dermatologist
AND
 3. Duration of Approval: Continuation of Therapy: 6 months
- I. LAMBERT-EATON MYASTHENIA SYNDROME (LEMS) [IVIG ONLY]:
1. Documentation of improvement or stabilization in muscle function/strength as demonstrated by

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one of the following standard clinical scales: Functional scores of Activities of Daily Living (ADL)

HIGH RISK ALERT

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or Quantitative Muscle Scores or Medical Research Council (MRC) muscle assessment
[DOCUMENTATION REQUIRED]

AND

2. Prescriber Requirement: Prescribed by, or in consultation with a neurologist

J. MULTIFOCAL MOTOR NEUROPATHY (MMN) [IVIG ONLY]:

1. Documentation of clinical improvement in strength and function within three weeks of the start of the infusion period as measured by an objective clinical measuring tool (e.g. INCAT, MRC, 6-minute timed walking test, Rankin, Modified Rankin) [DOCUMENTATION REQUIRED]
AND
2. Documentation that based on neurology evaluation that IVIg at the requested dose and interval are medically necessary and that attempts to reduce the dose, or the interval, has resulted in worsening of symptoms.
AND
3. Prescriber Requirement: Prescribed by, or in consultation with a neurologist

K. MYASTHENIA GRAVIS, ACUTE [IVIG ONLY] (MYASTHENIC CRISIS, MYASTHENIC EXACERBATION):

1. Documentation that member has had a myasthenic exacerbation as evidenced by at least one of the following symptoms within the recent 30 days: difficulty swallowing, acute respiratory failure, major functional disability responsible for the discontinuation of physical activity; of physical activity, disabling weakness requiring hospital admission (not an all-inclusive list) [DOCUMENTATION REQUIRED]
 - *Maintenance IVIg or plasma exchange: Periodic administration of IVIg or plasma exchange is sometimes used to maintain remission in patients with MG that is not well controlled despite the use of chronic immunomodulating drugs. There are no studies comparing this strategy with other options for refractory disease, however, maintenance IVIg has been noted as necessary and useful in some patients when other strategies have failed (Bird, SJ. 2019).*
 - *There are no data from RCTs regarding the value of IVIg as maintenance therapy in MG, either alone or as add-on therapy to IS agents. IVIg has been used chronically as maintenance therapy in individual cases. (Sanders DB, et al. 2016).*

AND

2. Prescriber Requirement: Prescribed by, or in consultation with an immunologist, neurologist, or rheumatologist
AND
3. Duration of Approval: Continuation of Therapy: 3 months

L. OPSOCLONUS-MYOCLONUS-ATAXIA SYNDROME (OMAS) [IVIG ONLY]:

1. Documentation of positive clinical response as demonstrated by stability or improvement in symptoms or disability [DOCUMENTATION REQUIRED]
AND
2. Prescriber Requirement: Prescribed by, or in consultation with a neurologist

M. PURE RED BLOOD CELL APLASIA (PRCA) Secondary to Chronic (persistent) Parvovirus B19 Infection [IVIG ONLY]:

1. Documentation that member has had an initial response to treatment, with persistent chronic parvovirus infection and recurrence of significant anemia [DOCUMENTATION REQUIRED]
AND
2. Prescriber Requirement: Prescribed by, or in consultation with an infectious disease specialist, immunologist, hematologist, or transplant specialist

N. PEDIATRIC HIV [IVIG ONLY]:

1. Documentation of current IgG levels that are in the low to normal range and evidence of clinical improvement, such as reduction of the number and severity of clinical infections

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[DOCUMENTATION REQUIRED]

AND

2. Prescriber Requirement: Prescribed by, or in consultation with an infectious disease or HIV specialist

DURATION OF APPROVAL:

Initial authorization: 6 months if not specified in the Required Medical Information, Continuation of Therapy:
6 months if not specified in the Required Medical Information

MOLINA REVIEWER NOTE: For Illinois Marketplace, Kentucky Marketplace, Mississippi Marketplace, Ohio Marketplace, Kentucky Medicaid, and Mississippi Medicaid, please see Appendix.

PRESCRIBER REQUIREMENTS:

Prescribed by, or in consultation with, a board-certified specialist, or physician experienced in the treatment of in the management of the condition being treated as specified in the Required Medical Information. [If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

AGE RESTRICTIONS: [AS LISTED IN FDA LABELING]

ALYGLO [IV]: PID: 18 years and older

ASCENIV [IV]: PID: 12 years and older

BIVIGAM [IV]: PID: 2 years and older

CUTAQUIG [SC]: PID: 2 years of age and older

CUVITRU [SC]: PID: 2 years and older

FLEBOGAMMA DIF [IV]: PID: 2 years and older

GAMMAGARD LIQUID [IV, SC]: PID: 2 years and older; MMN, CIDP [IV ONLY]: 18 years and older

GAMMAGARD S/D [IV]: PID, CLL: 2 years and older; ITP: 18 years and older; Kawasaki: No restriction

GAMMAKED: PID [SC, IV], ITP [IV ONLY]: 2 years and older; CIDP [IV]: 18 years and older

GAMMAPLEX [IV]: 5%, PID, ITP: 2 years and older; 10%, PID: 2 years and older, ITP: 18 years and older

GAMUNEX-C: PID [SC, IV], ITP [IV ONLY]: 2 years and older; CIDP [IV]: 18 years and older

HIZENTRA [SC]: PID: 2 years and older; CIDP: 18 years and older

HYQVIA [SC]: PID: 2 years and older, CIDP: 18 years and older

OCTAGAM 10% [IV]: ITP, DM: 18 years and older

OCTAGAM 5% [IV]: PID: 6 years and older

PANZYGA [IV]: PID: 2 years and older; ITP, CIDP: 18 years and older

PRIVIGEN [IV]: PID: 3 years and older; ITP: 15 years and older, CIDP: 18 years and older

XEMBIFY [SC]: PID: 2 years and older

YIMMUGO [IV]: PID: 2 years and older

QUANTITY:

See Required Medical Information

PLACE OF ADMINISTRATION:

Intravenous Immunoglobulin:

The recommendation is that intravenously infused medications in this policy will be for pharmacy or medical benefit coverage administered in a place of service that is a non-hospital facility-based location as per the Molina Health Care Site of Care program.

Subcutaneous Immunoglobulin:

The recommendation is that subcutaneously infused medications in this policy will be for pharmacy or medical benefit coverage and the subcutaneously infused products administered in a place of service that is a non-hospital facility-based location as per the Molina Health Care Site of Care program.

Note: Site of Care Utilization Management Policy applies for Alyglo, Asceniv, Bivigam, Cutaquig, Cuvitru, Flebogamma, Gammagard (liquid and S/D), Gammaked, Gammaplex, Gamunex-C, Hizentra, Hyqvia,

DRUG INFORMATION

ROUTE OF ADMINISTRATION:

Subcutaneous, Intravenous

DRUG CLASS:

Immune Serums

FDA-APPROVED USES:

ALYGLO: Intravenous injection, indicated for the treatment of primary humoral immunodeficiency (PI) in adults

ASCENIV: Intravenous injection indicated for the treatment of primary humoral immunodeficiency (PI) in adults and adolescents (12 to 17 years of age).

BIVIGAM: Intravenous infusion indicated for the treatment of adults and pediatric patients 2 years of age and older with primary humoral immunodeficiency (PI)

CUTAQUIG: Subcutaneous infusion indicated for treatment of primary humoral immunodeficiency (PI) in adults and pediatric patients 2 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.

CUVITRU: Subcutaneous infusion indicated as 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.

FLEBOGAMMA DIF: Intravenous infusion 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.

GAMMAGARD LIQUID: Intravenous or subcutaneous infusion indicated as 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), X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies. Indicated as a maintenance therapy to improve muscle strength and disability in adult patients with Multifocal Motor Neuropathy (MMN). Indicated as therapy to improve neuromuscular disability and impairment in adult patients with Chronic Inflammatory Demyelinating Polyneuropathy (CIDP).

Limitations of Use: Safety and effectiveness of Gammagard Liquid has not been studied in immunoglobulin-naïve patients with CIDP. Gammagard Liquid maintenance therapy in CIDP has not been studied beyond 6 months.

GAMMAGARD S/D: Intravenous infusion indicated for the treatment of primary immunodeficiency (PI) associated with defects in humoral immunity, in adults and children two years and older. This includes, but is not limited to, congenital agammaglobulinemia, common variable immunodeficiency, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies; Indicated for prevention of bacterial infections in patients with hypogammaglobulinemia and/or recurrent bacterial infections associated with B-cell chronic lymphocytic leukemia (CLL); Indicated for the treatment of adult chronic idiopathic thrombocytopenic purpura to increase platelet count and to prevent and/or to control bleeding; Indicated for prevention of coronary artery aneurysms associated with Kawasaki syndrome in pediatric patients.

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GAMMAKED: Intravenous or subcutaneous infusion indicated for treatment of primary humoral immunodeficiency (PI) 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; Indicated for the treatment of adults and children with Idiopathic Thrombocytopenic Purpura to raise platelet counts to prevent bleeding or to allow a patient with ITP to undergo surgery; Indicated for the treatment of CIDP in adults to improve neuromuscular disability and impairment and for maintenance therapy to prevent relapse.

GAMMAPLEX 5%: Intravenous infusion indicated for replacement therapy in 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 common variable immunodeficiency, X-linked agammaglobulinemia (XLA), congenital agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies; Indicated for the treatment of chronic immune thrombocytopenic purpura (ITP) to raise platelet counts.

GAMMAPLEX 10%: Intravenous infusion indicated for replacement therapy in 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 common variable immunodeficiency, X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies; Indicated for the treatment of chronic immune thrombocytopenic purpura (ITP) in adults to raise platelet counts.

GAMUMEX-C: Intravenous or subcutaneous infusion indicated for treatment 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; Indicated for the treatment of adults and children with Idiopathic Thrombocytopenic Purpura to raise platelet counts to prevent bleeding or to allow a patient with ITP to undergo surgery; Indicated for the treatment of CIDP in adults to improve neuromuscular disability and impairment and for maintenance therapy to prevent relapse.

HIZENTRA: Subcutaneous infusion indicated 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, congenital agammaglobulinemia, common variable immunodeficiency, X-linked agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies; Indicated for the treatment of adult patients with chronic inflammatory demyelinating polyneuropathy (CIDP) as maintenance therapy to prevent relapse of neuromuscular disability and impairment.

Limitations of Use: Hizentra maintenance therapy in CIDP has been systematically studied for 6 months and for a further 12 months in a follow-up study. Maintenance therapy beyond these periods should be individualized based upon the patient's response and need for continued therapy.

HYQVIA: Subcutaneous infusion indicated for the treatment of Primary Immunodeficiency (PI) in adults 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; Indicated for the treatment of chronic inflammatory demyelinating polyneuropathy (CIDP) as maintenance therapy to prevent relapse of neuromuscular disability and impairment in adults.

OCTAGAM 10%: Intravenous infusion indicated for the treatment of chronic immune thrombocytopenic purpura to rapidly raise platelet counts to control or prevent bleeding in adults. Indicated for the treatment of dermatomyositis in adults.

OCTAGAM 5%: Intravenous infusion indicated for treatment of primary humoral immunodeficiency (PI), such as congenital agammaglobulinemia, common variable immunodeficiency, X-linked agammaglobulinemia, Wiskott-Aldrich syndrome and severe combined immunodeficiencies.

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PANZYGA: Intravenous infusion indicated for treatment of primary humoral immunodeficiency (PI) 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; Indicated for the treatment of adult patients with ITP to raise platelet counts to control or prevent bleeding; Indicated for the treatment of adults with chronic inflammatory demyelinating polyneuropathy (CIDP) to improve neuromuscular disability and impairment.

PRIVIGEN: Intravenous infusion indicated as 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; Indicated for the treatment of patients age 15 years and older with chronic immune thrombocytopenic purpura (ITP) to raise platelet counts; Indicated for the treatment of adults with chronic inflammatory demyelinating polyneuropathy (CIDP) to improve neuromuscular disability and impairment.

Limitations of Use: Privigen maintenance therapy in CIDP has not been studied for periods longer than 6 months. After responding during an initial treatment period, not all patients require indefinite maintenance therapy with Privigen in order to remain free of CIDP symptoms. Individualize the duration of any treatment beyond 6 months based upon the patient's response and demonstrated need for continued therapy.

XEMBIFY: Subcutaneous injection indicated for the treatment of primary humoral immunodeficiency (PI) 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.

YIMMUGO: Intravenous infusion indicated for the treatment of primary humoral immunodeficiency (PI) including but not limited to the humoral immune defect in congenital agammaglobulinemia, common variable immunodeficiency (CVID), X-linked agammaglobulinemia (XLA), Wiskott-Aldrich syndrome, and severe combined immunodeficiencies (SCID) in patients 2 years of age and older.

COMPENDIAL APPROVED OFF-LABELED USES:

Supported indications in Elsevier Gold Standard's Clinical Pharmacology, American Hospital Formulary Service-Drug Information (AHFS), or National Comprehensive Cancer Network Compendium (NCCN)

APPENDIX

APPENDIX:

Reserved for State specific information. Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.

State Specific Information

State Marketplace

Illinois (Source: [Illinois General Assembly](#))

“(215 ILCS 5/356z.24) Sec. 356z.24. Immune gamma globulin therapy. (a) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 99th General Assembly may not allow for the delay, discontinuation, or interruption of immune gamma globulin therapy for persons who are diagnosed with a primary immunodeficiency when prescribed as medically necessary by a physician licensed to practice medicine in all of its branches and if provided as a covered benefit under the plan. Nothing in this Section shall prevent an insurer from applying appropriate utilization review standards to the ongoing coverage of immune gamma globulin therapy for persons diagnosed with a primary immunodeficiency by a physician licensed to practice medicine in all of its branches. (b) Upon *diagnosis of primary immunodeficiency* by the prescribing physician, determination of an *initial authorization for immune gamma globulin therapy shall be no less than 3 months. Reauthorization for immune gamma globulin therapy for patients with a primary immunodeficiency diagnosis may occur every 6 months thereafter.* For patients with a diagnosis of primary immunodeficiency who have been *receiving immune gamma globulin therapy for at least 2 years with sustained beneficial response based on the treatment notes or*

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clinical narrative detailing progress to date, reauthorization shall be no less than 12 months unless a more frequent duration has been indicated by the prescribing physician. (Source: P.A. 99-788, eff. 8-12-16.)"

Illinois (Source: [Illinois General Assembly](#))

"(215 ILCS 5/356z.25) Sec. 356z.25. Coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome. A group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed after July 18, 2017 (the effective date of Public Act 100-24) *shall provide coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including, but not limited to, the use of intravenous immunoglobulin therapy.*"

Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections also known as **PANDAS**. Pediatric acute onset neuropsychiatric syndrome also known as **PANS**.

Kentucky (Source: [Kentucky Revised Statutes](#))

KY304.17A-167 Time span of authorizations

(Subsection 2) "Unless otherwise provided in subsection (3) of this section or prohibited by state or federal law, if a provider receives a prior authorization for a drug prescribed to a covered person with a condition that requires ongoing medication therapy, and the provider continues to prescribe the drug, and the drug is used for a condition that is within the scope of use approved by the United States Food and Drug Administration or has been proven to be a safe and effective form of treatment for the patient's specific underlying condition based on clinical practice guidelines that are developed from peer-reviewed publications, the prior authorization received shall: (a) Be valid for the lesser of: 1. One (1) year from the date the provider receives the prior authorization; or 2. Until the last day of coverage under the covered person's health benefit plan during a single plan year; and (b) Cover any change in dosage prescribed by the provider during the period of authorization." (Subsection 3) "Except as provided in paragraph (b) of this subsection, the provisions of subsection (2) of this section shall not apply to: 1. Medications that are prescribed for a non-maintenance condition; 2. Medications that have a typical treatment period of less than twelve (12) months; 3. Medications where there is medical or scientific evidence that does not support a twelve (12) month approval; or 4. Medications that are opioid analgesics or benzodiazepines. (b) Paragraph (a) of this subsection shall not apply to any medication that is prescribed to a patient in a community-based palliative care program."

Re-authorization (approved authorization previously issued by Molina Healthcare) for maintenance medications within this policy shall be approved for a 12 month duration when request meets policy requirements, unless exceptions noted above have been met.

Ohio (Source: [Ohio Revised Code](#))

Chapter 3923 Sickness And Accident Insurance Section 3923.041 Policies with prior authorization requirement provisions "(B)(6)(a) For policies issued on or after January 1, 2017, *for a prior approval related to a chronic condition*, the insurer or plan shall honor a prior authorization *approval for an approved drug for the lesser of the following from the date of the approval: (i) Twelve months; (ii) The last day of the covered person's eligibility under the policy or plan.* (b) The duration of all other prior authorization approvals shall be dictated by the policy or plan."

State Medicaid

Kentucky (Source: [Kentucky Revised Statutes](#))

KY304.17A-167 Time span of authorizations

(Subsection 2) "Unless otherwise provided in subsection (3) of this section or prohibited by state or federal law, if a provider receives a prior authorization for a drug prescribed to a covered person with a condition that requires ongoing medication therapy, and the provider continues to prescribe the drug, and the drug is used for a condition that is within the scope of use approved by the United States Food and Drug Administration or has been proven to be a safe and effective form of treatment for the patient's specific underlying condition based on clinical practice guidelines that are developed from peer-reviewed publications, the prior authorization received shall: (a) Be valid for the lesser of: 1. One (1) year from the date the provider receives the prior authorization; or 2. Until the last day of coverage under the covered person's health benefit plan during a single plan year; and

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(b) Cover any change in dosage prescribed by the provider during the period of authorization.” (Subsection 3) “Except as provided in paragraph (b) of this subsection, the provisions of subsection (2) of this section shall not apply to: 1. Medications that are prescribed for a non-maintenance condition; 2. Medications that have a typical treatment period of less than twelve (12) months; 3. Medications where there is medical or scientific evidence that does not support a twelve (12) month approval; or 4. Medications that are opioid analgesics or benzodiazepines. (b) Paragraph (a) of this subsection shall not apply to any medication that is prescribed to a patient in a community-based palliative care program.”

Re-authorization (approved authorization previously issued by Molina Healthcare) for maintenance medications within this policy shall be approved for a 12 month duration when request meets policy requirements, unless exceptions noted above have been met.

Appendix 1:

Products and FDA labeled indications

BRAND NAME	ROUTE	PID	ITP	CLL	CIDP	KD	MMN	DM
Intravenous								
Alyglo 10% Liquid	IV	X						
Asceniv 10%	IV	X						
Bivigam 10%	IV	X						
Flebogamma 5% DIF	IV	X						
Gammagard S/D 5% or 10%	IV	X	X	X		X		
Gammaplex 5% or 10%	IV	X	X					
Octagam 5%	IV	X						
Octagam 10%	IV		X					X
Panzyga 10%	IV	X	X		X			
Privigen 10%	IV	X	X		X			
Yimmugo 10%	IV	X						

Intravenous OR Subcutaneous								
*Gammagard Liquid 10%	IV/SC	X			X (IV only)		X (IV only)	
*Gammaked 10%	IV/SC	X	X (IV only)		X (IV only)			
*Gamunex-C 10%	IV/SC	X	X (IV only)		X (IV only)			
Subcutaneous Immune Globulin (SCIg)								
Cutaquig 16.5%	SQ	X						
Cuvitru 20%	SQ	X						
Hizentra 20%	SQ	X			X			
HyQvia 10%	SQ	X			X			
Xembify 20%	SQ	X						

PI: Primary Immunodeficiency; ITP: Immune Thrombocytopenia; CIDP: Chronic Inflammatory Demyelinating Polyneuropathy; CLL: Chronic Lymphocytic Leukemia; KD: Kawasaki Disease; MMN: Multifocal Motor Neuropathy; DM: Dermatomyositis

*Gammaked, Gamunex-C, and Gammagard Liquid are approved for both intravenous and subcutaneous use for treatment of PID and when administered subcutaneously, are FDA-approved for the treatment of PID only. NOTE: Gammagard Liquid, Gammaked and Gamunex-C are not approved for SQ use in patients with ITP or CIDP.

§The following products do not contain sucrose: Gammaplex, Bivigam, Octagam 10%, Gamunex-C, Gammagard Liquid, Gammagard S/D, Gammaked, Flebogamma 5% DIF, Flebogamma 10% DIF, Privigen, and Hizentra

Dosage Forms Considerations

- Cutaquig and Octagam contains maltose.
- Gammagard S/D may contain a significant amount of sodium and also contains glucose.
- Hyqvia Kit is supplied with a Hyaluronidase (Human Recombinant) component intended for injection prior to Immune Globulin administration to improve dispersion and absorption of the Immune

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Globulin.

Each product varies with FDA-approved indications.

- Currently there are seven indications that are FDA approved for specific Ig products:
 - Primary Immunodeficiency Diseases (PID) [includes, but are not limited to, the humoral immune defect in common variable immunodeficiency (CVID), X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies]; All available immune globulin replacement products are FDA-approved for use in primary immunodeficiency (PID).
 - Idiopathic thrombocytopenic purpura (ITP)
 - B-cell chronic lymphocytic leukemia (CLL)
 - Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
 - Kawasaki Disease (KD)
 - Multifocal Motor Neuropath (MMN)
 - Dermatomyositis (DM)
- SCIg products are currently only FDA approved for the treatment of PID and CIDP (Hizentra, Hyqvia only)
 - Hizentra is the first SCIg approved for the treatment of CIDP (March 2018)
- All conditions are FDA approved for the intravenous route
- IVIg products will not be approved for subcutaneous use unless FDA approved for that route of administration.

Subcutaneous immune globulin:

Subcutaneous immune globulin (SCIg) is a protein solution that contains at least 98% immunoglobulin G (IgG). It is used in the treatment of primary immunoglobulin deficiency (PID). For individuals with immunodeficiencies, both IVIg and SCIg are effective. Use of SCIg for the treatment of primary immunodeficiencies was approved by the FDA based on an open-label, nonrandomized, prospective, multicenter study.

SCIg products are indicated for replacement therapy in patients with PID, including but not limited to the humoral defect in the following conditions: common variable immunodeficiency (CVID), X-linked agammaglobulinemia (XLA), Wiskott-Aldrich syndrome, and severe combined immunodeficiencies (SCID). [Clinical Pharmacology, 2019]. The exact mechanism of SCIg in PID is not fully understood.

Immune globulin may be administered subcutaneously by three methods which differ in the frequency and how the SCIG is given: traditional, facilitated subcutaneous, and subcutaneous rapid push.

- Traditional: uses infusion pumps to give predominantly weekly infusions
- Rapid-push SC: administered using only a syringe and butterfly needle at frequencies from several times per week to daily
- Hyaluronidase-facilitated SCIg (fSCIg): A two-step delivery system of recombinant human hyaluronidase (rHuPH20) and a 10% immune globulin preparation, human hyaluronidase (rHuPH20) given immediately before the immune globulin, to allow up to a full monthly dose to be given in a single SC infusion. The hyaluronidase is drawn up into a separate single syringe and infused alone by manual push from the syringe before the SCIG is given. Generally administered every three to four weeks

SCIg has a lower bioavailability than IVIg, so must be given in higher doses to achieve the same serum IgG concentrations. However, subcutaneous delivery may result in higher steady-state IgG levels due to less variation in IgG levels.

Comparison of SCIg with IVIg:

Immune globulin products specifically intended for subcutaneous (SC) and intramuscular (IM) administration are generally more concentrated than those designed for intravenous (IV) use, allowing more immune globulin to be administered in lower volumes. Generally, many 10% IVIg solutions can be administered subcutaneously or intravenously, but more concentrated products (e.g., 20%) should not be given intravenously. The subcutaneous route is associated with fewer systemic adverse events

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and provides more stable serum IgG levels. In contrast, SCIG has not been studied as extensively in autoimmune and inflammatory disorders. IVIg infusions may be preferable for patients who require faster increase of trough level at initiation. SCIg is associated with more stable serum Ig concentrations and advantageous for patients with poor venous access due to no need for indwelling venous catheter, particularly in patients with poor venous access. There are no head-to-head studies comparing concentrated SCIg to IVIg in PID and no evidence-based reviews demonstrating that SCIg is more effective than IVIg to improve and maintain immunoglobulin levels. **Therefore, unless contraindicated, a trial of IVIg is required before SCIg products will be considered for authorization.**

APPENDIX 2:

Systemic corticosteroid immunosuppressive doses include:

≥ 14 days therapy with doses ≥ 80 mg per day of prednisone.

Equivalent doses include

- ≥ 400mg/day cortisone
- 320mg/day hydrocortisone
- 80mg/day prednisolone
- 64mg/day methylprednisolone
- 12mg/day dexamethasone

Objective Testing Information:

Cerebellar Functional System Score

The cerebellar functional system score was chosen to demonstrate initial disability and response.

Values of the cerebellar functional system score are:

0. Normal: no evidence of cerebellar dysfunction
1. Abnormal signs without disability
2. Mild ataxia
3. Moderate ataxia
4. Severe ataxia (all limbs or gait)
5. Unable to perform coordinated movements due to ataxia

Changes in opsoclonus symptoms will be rated as:

- i. Deterioration in symptoms
- ii. Symptoms stable
- iii. Mild improvement
- iv. Moderate improvement
- v. Significant improvement

Inflammatory Neuropathy Cause and Treatment (INCAT)

The Inflammatory Neuropathy Cause and Treatment (INCAT) scale is used to assess functional disability of both upper and lower extremity components in chronic inflammatory demyelinating polyneuropathy (CIDP). The INCAT scale has upper and lower extremity components, with a maximum of 5 points for the upper extremity (arm disability) and a maximum of 5 points for the lower extremity (leg disability), which add up to a maximum of 10 points (where 0 is normal and 10 is severely incapacitated). The INCAT scores may be used to evaluate the effectiveness and need for IVIG. IVIG may be discontinued when there is a lack of clear clinical improvement (i.e., a decline in INCAT disability score or failure to improve by 1 point at 6 weeks following the initial infusion or return to baseline at any time following initial improvement of 1 point).

Medical Research Council (MRC)

The Medical Research Council (MRC) scale is used to grade muscle strength. Scale: 0 = no muscle movement; 1 = flicker of muscle movement; 2 = trace movement but not able to fully overcome gravity; 3 = just able to overcome gravity, but not against resistance; 4 = moves against resistance, but weak; 5 = full strength against resistance.

Dosing Considerations

- If TBW is less than IBW, TBW should be used for calculating the dose.

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- If BMI is ≥ 30 kg/m² or if TBW is greater than 20%-30% over IBW, adjBW should be used for calculating the dose.

Suggested calculations for determining IBW and adjBW:

- IBW male: 50 kg + (2.3 x inches over 5 feet)
- IBW female: 45.5 kg + (2.3 x inches over 5 feet)
- AdjBW = IBW + 0.4 (TBW-IBW)

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:

Autoimmune Hemolytic Anemia (AIHA): AIHA is a relatively uncommon disorder caused by antibodies directed against autologous red blood cells. AIHA is classified as warm, cold (which includes cold hemagglutinin disease (CAD) and paroxysmal cold hemoglobinuria) or mixed, according to the thermal range of the autoantibody. AIHA due to the presence of warm agglutinins is almost always due to the presence of IgG antibodies that react with protein antigens on the RBC surface at body temperature.

Autoimmune Mucocutaneous Blistering Diseases (AMBDs): AMBDs are a group of rare, debilitating and possibly fatal disorders caused by antibodies directed against components of the skin. The diseases are characterized by the formation of extensive blisters evolving to painful erosions on the skin and mucous membranes.

B-Cell Chronic Lymphocytic Leukemia (CLL): CLL is a blood and marrow disorder characterized by increased numbers of CD5-positive B cells. The underlying cause of CLL is unknown, although it is thought to be genetically linked.

Chronic Inflammatory Demyelinating Polyneuropathy (CIPD) or Polyradiculoneuropathy: CIPD is a neurological disorder characterized by progressive weakness and impaired sensory function in the legs and arms. Chronic Inflammatory Demyelinating Polyneuropathy (CIPD) is an immune mediated disorder which affects the peripheral nervous system. The classical presentation has symmetric proximal and distal sensory and motor involvement which develops over 8 weeks. This 8 week development time and persistence greater than 8 weeks helps to distinguish CIPD from Guillain-Barre. For CIPD the typically IVIg is administered as an initial induction dose of 2 g/kg over 2 to 5 days, followed by a maintenance dose of 0.4 g/kg (0.2 to 1 g/kg) every 3 to 4 weeks.^{18,19}

Dermatomyositis; Polymyositis: Dermatomyositis is an idiopathic inflammatory myopathy that most commonly affects the skin and muscles and may impact joints. Polymyositis is an idiopathic inflammatory myopathy causing muscle weakness, elevated muscle enzyme levels and is similar to dermatomyositis.

Fetal or Natal Alloimmune Thrombocytopenia (FAIT/ NAIT): FAIT/ NAIT is the most common cause of severe thrombocytopenia in the fetus and in otherwise healthy newborn. The mother produces antibodies (IgG) against fetal HPA antigens inherited from the father. These alloantibodies (IgG) can cross the placenta, destroy fetal thrombocytes and may induce severe thrombocytopenia. It is most commonly caused by the HPA-1a antigen (80%).

Guillain-Barré Syndrome (GBS) [also referred to as Acute Inflammatory Demyelinating Polyneuropathy (AIDP)]: GBS is an acquired acute peripheral neuropathy causing limb weakness that progresses over a period of days to weeks. The syndrome typically presents with rapidly progressive, relatively symmetrical ascending limb weakness consistent with a polyradiculoneuropathy and often with associated cranial nerve involvement. Motor signs and symptoms usually predominate over sensory signs and symptoms. Major complications include respiratory failure and autonomic dysfunction. The disease is monophasic, reaching its nadir usually within two weeks, although arbitrary definition accepts a limit of four weeks. A plateau phase of variable duration follows the nadir before gradual recovery.

Immune or Idiopathic Thrombocytopenic Purpura (ITP): ITP is a reduction in platelet count (thrombocytopenia) resulting from shortened platelet survival due to anti-platelet antibodies. ITP is divided into chronic and acute forms. The goal of medical care for ITP is to increase the platelet count to a safe level, permitting patients to live normal lives while awaiting spontaneous or treatment-induced remission. Chronic ITP may relapse and remit spontaneously and the course may be difficult to predict. The goal is to maintain platelet count at a level that prevents spontaneous bleeding or bruising.

Neonatal hemochromatosis, prophylaxis: Neonatal hemochromatosis is a rare gestational condition in which iron accumulates in the fetal tissues in a distribution like that seen in hereditary hemochromatosis. Extensive liver damage is the dominant clinical feature, with late fetal loss or early neonatal death.

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Kawasaki Disease (Mucocutaneous Lymph Node Syndrome): Kawasaki disease is an acute, febrile, multi-system disease of children and young infants often involving the coronary arteries. Coronary artery aneurysms may occur from the second week of illness during the convalescent stage. The cause of the condition is unknown but there is evidence that the characteristic vasculitis results from an immune reaction characterized by T-cell and macrophage activation to an unknown antigen, secretion of cytokines, polyclonal B-cell hyperactivity, and the formation of autoantibodies to endothelial cells and smooth muscle cells. It is likely that in genetically susceptible individuals, one or more uncharacterized common infectious agents, possibly with super-antigen activity, may trigger the disease.

Lambert-Eaton Myasthenia Syndrome (LEMS): LEMS is a rare acquired autoimmune disorder characterized by proximal weakness of extremities, decreased reflexes, and dryness of mouth and eyes. The primary goal of treatment for LEMS is to identify and treat any tumors or other underlying disorders.

Multiple Myeloma (MM): MM is a malignant tumor of plasma cells associated with impaired function of immunoglobulins, which are an essential component of the immune system. Patients with MM are at increased risk of infection, due to a combination of several factors, including immunoparesis and physical factors.

Myasthenia Gravis: Myasthenia gravis is an autoimmune disease characterized by autoantibodies directed against the acetylcholine receptors of the muscle end plate that induce muscle weakness and pronounced fatigability. Initial treatment focuses on the use of cholinesterase inhibitors to overcome the post-synaptic blockade.

Multifocal Motor Neuropathy (MMN): MMN is a rare neurological disorder characterized by slowly progressive, asymmetric, predominately distal limb weakness without sensory impairment. Weakness often begins in the arms and the combination of weakness, wasting, cramps and fasciculations may suggest a diagnosis of motor neuron disease. However, clinical examination may demonstrate that the pattern of weakness follows the distribution of individual nerves rather than a spinal segmental pattern.

Post-Transfusion Purpura (PTP) [Hemolytic Transfusion Reaction]: PTP is a rare bleeding disorder caused by alloantibodies specific to platelet antigens. PTP is characterized by the development of severe, sudden and self-limiting thrombocytopenia occurring 5-10 days after a blood transfusion.

Pure Red Blood Cell Aplasia (PRCA) Secondary to Chronic (Persistent) Parvovirus B19 Infection: Parvovirus B19 infects and lyses red cell precursors, which can cause pure red cell aplasia. IVIg therapy is usually reserved for patients with chronic parvovirus infection and chronic anemia.

Opsoclonus Myoclonus Syndrome (OMS): Opsoclonus myoclonus is a rare neurological disorder that may occur in association with tumors (paraneoplastic) or viral infections and is characterized by an unsteady, trembling gait, myoclonus and opsoclonus (irregular, rapid eye movements). It is more common in children.

Rasmussen Syndrome (RS) [also known as Rasmussen Encephalitis (RE) or Chronic Focal Encephalitis]: RS/RE is a rare neurological, progressive, focal encephalitis that is commonly accompanied by focal seizures, hemiparesis and cognitive decline. It is generally considered to be a disease of childhood, with most cases occurring in children younger than 10 years, although adult onset cases do occur. The precise etiology of RE remains unknown, but immune-mediated injury is considered central in the pathogenesis.

Stiff-Person Syndrome (Moersch-Woltmann Syndrome): Stiff-person syndrome is a chronic disorder with features of an autoimmune disease involving painful muscle spasms and rigidity. SPS treatments are aimed at symptom relief and/or modulation of the underlying aberrant immune process.

Staphylococcal or Streptococcal Toxic Shock Syndrome (TSS): TSS is an acute, multi-system, toxin-mediated illness which may typically result in shock and multi-organ failure early in its clinical course.

Causes include toxin-producing strains of *Staphylococcus aureus* and Invasive Group A *Streptococcus* (e.g. *Streptococcus pyogenes*). IVIg is recommended as an adjunctive therapy in children with severe toxin-related infection showing failure to improve despite best standard care. **Solid Organ Transplantation:** Acute rejection after transplant can be broadly divided into two categories, the more common acute cellular rejection (ACR) related to activation of T cells and the less common antibody-mediated rejection reaction (AbMR) related to the presence of anti-donor antibodies. While ACR typically responds to immunologic therapy directed at T cells, AbMR does not, and, as such, has also been referred to as “steroid-resistant rejection.”

- The risk of AbMR is related to the presence of preformed allo-antibodies in the recipient due to prior blood transfusions, transplants, or pregnancies. The presence of allo- antibodies is assessed by

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using a panel reactive antibody (PRA) screen, which combines the recipient's serum with samples of antigen containing cells taken from 60 individuals, representative of the potential donor pool.

- The percentage of PRA is the percentage of positive reactions. Those with a PRA greater than 20% are referred to as "sensitized," and these patients often have prolonged waiting times to identify a compatible donor. Living donor kidney transplants have also been performed using ABO mismatched donor organs. These recipients are also at risk of ABMR.
- As an immunomodulatory agent, IVIg has been widely used in the prevention and management of AbMR, often in conjunction with plasma exchange. For instance, in patients at high risk for AbMR, IVIg may be given prior to transplant to reduce the numbers of allo- antibodies and the risk of AbMR, thus reducing the wait time for a compatible organ. IVIg may be one component of therapy after transplant if AbMR develops.

Treatment

- The aim of immunosuppression in clinical practice is to control an undesirable immune response while avoiding, if possible, the complications of immunodeficiency. The effect can be achieved by ablation (i.e., irreversibly damaging immune tissue); by altering lymphocyte location and traffic; by altering lymphocyte or dendritic cell function; or by affecting lymphokines. These interventions may be physical (i.e., by irradiation, plasmapheresis, photopheresis) or pharmacological (i.e., IVIg).
- Patients with high levels of "anti-donor" antibodies often have very high rejection rates after transplant, especially in kidney transplant. Rejection risks are very high for a patient whose immune system has been exposed to "non-self" human leukocyte antigens (HLA). Exposure to HLAs may occur in a number of ways, including prior organ transplant or blood transfusions.
- IVIg increases a highly sensitized patient's chance of successful transplant. IVIg is a new immune-modulating therapy that can reduce high antibody levels and improve transplant rates. IVIg helps by modifying the immune system rather than suppressing it.
- IVIg is given while a highly sensitized patient waits for transplant, with the goal of decreasing their overall level of sensitization and therefore increasing the possibility that a donor kidney would be acceptable to their immune system.

POSITION STATEMENTS

A position statement from the American Academy of Asthma, Allergy and Immunology (Orange, et al., 2005) states that "the decision to administer IVIg to patients with primary deficiencies in antibody production should be based on: 1) abnormalities of serum immunoglobulin concentrations; 2) clinical history of infections; and, when appropriate, 3) the demonstrated inability to produce antibody normally following antigenic stimulation."

Guidelines from the American Academy of Asthma, Allergy & Immunology (Orange, et al., 2006) state; "Reduced levels of serum immunoglobulin in patients with recurrent bacterial infections coupled with a lack of response to protein or polysaccharide vaccine challenges (i.e., patients who cannot make IgG antibody against diphtheria and tetanus toxoids, pneumococcal polysaccharide vaccine, or both) is a clear indication for IgG replacement.

CLINICAL PRACTICE GUIDELINES

American Academy of Neurology

Evidence-based guideline: intravenous immunoglobulin in the treatment of neuromuscular disorders: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology (AAN 2012). AAN's evidence-based guidelines on "intravenous immunoglobulin treatment of neuromuscular disorders" (Patwa et al, 2012) states the following:

- IVIg is as efficacious as plasmapheresis and should be offered for treating Guillain-Barré syndrome (GBS) in adults (Level A)
- IVIg is effective and should be offered in the long-term treatment of chronic inflammatory demyelinating polyneuropathy (Level A)
- IVIg is probably effective and should be considered for treating moderate-to-severe myasthenia gravis and multifocal motor neuropathy (Level B)

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- IVIg is possibly effective and may be considered for treating non-responsive dermatomyositis in adults and Lambert-Eaton myasthenic syndrome (Level C)
- Evidence is insufficient to support or refute use of IVIG in the treatment of immunoglobulin M paraprotein-associated neuropathy, inclusion body myositis, polymyositis, diabetic radiculoplexoneuropathy, or Miller Fisher syndrome, or in the routine treatment of post-polio syndrome or in children with GBS (Level U)
- IVIg combined with plasmapheresis should not be considered for treating GBS (Level B). More data are needed regarding IVIG efficacy as compared with other treatments/treatment combinations.

The Immune Deficiency Foundation (IDF) Guidelines

In 2011, the Immune Deficiency Foundation (IDF) published guidelines on diagnosis and clinical care for primary immunodeficiency diseases. The guidelines support clinicians determine the possible type of PI and the screening diagnostic tests that should be ordered based on the site of infection.

Although there are several different types of PI, the types that result in antibody production defects are those that are eligible for IgG therapy.

- The IDF recommends regular IgG therapy for patients with identified antibody deficiency disorders.
- The guidelines state the IVIG product should be dosed every 2-4 weeks and SCIG should be given every 1-14 days.
- It is recommended that an immunologist should participate in the determination of the proper dose and interval for IgG therapy in each patient.
- Should IgG treatment be required IV or SC administration are both recommended, and one product is not preferentially recommended over any other product.

Canadian Blood Services and Canada's National Advisory Committee Guidelines

The Canadian Blood Services and Canada's National Advisory Committee on Blood and Blood Products led a joint initiative to create guidelines for treatment of PI with immunoglobulin therapy. While the guidelines are primarily intended for health care professionals in Canada, many of their recommendations may be applied in other parts of the world, including the United States.

The National Advisory Committee on Blood and Blood Products and Canadian Blood Services issued practice guidelines on the use of IVIg in primary immune deficiency in 2010. The recommendations were based on interpretation of available evidence and where evidence was lacking, consensus of expert clinical opinion. The guidelines were constructed from an expert panel consisting of physicians from large pediatric and adult tertiary care centers who frequently cared for patients with primary immune deficiency, methodology experts, and members from the National Advisory Committee on Blood and Blood Products. The levels of evidence and grades used for each recommendation were adapted from the Canadian Task Force on Preventative Health Care. The levels of evidence describe the methodological rigor of the study, and the grades of recommendation comprise the level of evidence and clinical expertise. Relevant recommendations include the following:

- Give immunoglobulin to patients with primary antibody deficiency to reduce infections. (Level of evidence: I, Grade of recommendation: A)
- Give immunoglobulin to reduce hospitalization and organ damage. (I, A)
- Give immunoglobulin to improve survival and quality of life. (III, A)
- With respect to clinical efficacy and adverse events, there is insufficient evidence to recommend one manufacturer of IG over another for currently available products. (I to II-2, I)
- With respect to clinical efficacy for reducing infections, IVIG and SCIG preparations should be considered equivalent. (I and II, B)
- Do not give IMIG for replacement therapy for primary immune deficiency. (I, D)
- Start IVIG at a dose of 400 to 600 mg/kg per 4 weeks or SCIG at a dose of 100 to 150 mg/kg per week in most patients. (III, B)
- Patient and practitioners should be aware that patients with primary immune deficiency may require immunoglobulin replacement therapy indefinitely. (II-3, A)

DOSING CONSIDERATIONS

Although there is no clearly defined standard approach to dosing of immune globulin in obese patients, there is substantial evidence to support dosing using adjusted or ideal body weight. According to published data, both options provide comparable drug exposure without altering the clinical outcomes of immune globulin treatment. Immune globulin is a relatively polar molecule with a small volume of distribution – it does not distribute into fat tissue and is only present in the intravascular space and extracellular fluids. The use of adjBW, rather than IBW or lean body weight (LBW) is based on the presumption that extracellular fluid is increased in patients with increased adipose tissue. Dosing immune globulin using a patient's adjBW or IBW rather than TBW has been demonstrated to have similar clinical outcomes as using TBW. Ultimately, regardless of dosing, immune globulin efficacy should be monitored by clinical outcome. Also consider, If TBW is less than IBW, TBW should be used for calculating the dose. If BMI is ≥ 30 kg/m² or if TBW is greater than 20%-30% over IBW, adjBW should be used for calculating the dose.

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:

All other uses of immune globulin are considered experimental/investigational and therefore, will follow Molina's Off- Label policy. Contraindications to Aylglo, Asceniv, Bivigam, Cutaquig, Cuvitru, Flebogamma, Gammagard, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Octagam, Panzyga, Yimmugo (immune globulin) include: History of anaphylactic or severe systemic reactions to human immunoglobulin, IgA deficient patients with antibodies against IgA and a history of hypersensitivity. Contraindications to Hizentra (immune globulin) include: Anaphylactic or severe systemic reaction to human immune globulin or inactive ingredients of Hizentra, such as polysorbate 80; Hyperprolinemia Type I or II (HIZENTRA contains stabilizer L-proline); IgA-deficient patients with antibodies against IgA and a history of hypersensitivity. Contraindications to Hyqvia (immune globulin) include: History of anaphylactic or severe systemic hypersensitivity reactions to Immune Globulin (Human); IgA deficient patients with antibodies against IgA and a history of hypersensitivity; Known systemic hypersensitivity to hyaluronidase including Recombinant Human Hyaluronidase of HYQVIA; Known systemic hypersensitivity to human albumin (in the hyaluronidase solution). Contraindications to Privigen (immune globulin) include: History of anaphylactic or severe systemic reaction to human immune globulin; Hyperprolinemia (Privigen contains the stabilizer L-proline); IgA-deficient patients with antibodies to IgA and a history of hypersensitivity. Contraindications to Xembify (immune globulin) include: Anaphylactic or severe systemic reaction to human immunoglobulin or inactive ingredients of Xembify, such as polysorbate 80, IgA deficient patients with antibodies against IgA and a history of hypersensitivity.

Applications of Subcutaneous Immune Globulin (SCIg) for conditions other than primary immunodeficiencies and Chronic Inflammatory Demyelinating Polyneuropathy and B-cell Chronic Lymphocytic Leukemia are considered investigational.

OTHER SPECIAL CONSIDERATIONS:

Black Box Warnings

Thrombosis may occur with immune globulin products. Risk factors may include: advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling central vascular catheters, hyperviscosity, and cardiovascular risk factors. Thrombosis may occur in the absence of known risk factors. For patients at risk of thrombosis, administer at the minimum dose and infusion rate practicable. Ensure adequate hydration in patients before administration. Monitor for signs and symptoms of thrombosis and assess blood viscosity in patients at risk for hyperviscosity.

Renal dysfunction and acute renal failure (excluding Cutaquig, Cuvitru, Hizentra, HyQvia, and Xembify) may occur in predisposed patients with immune globulin intravenous IV products. Patients predisposed to renal dysfunction include those with any degree of preexisting renal insufficiency, diabetes mellitus, age greater than 65 years, volume depletion, sepsis, paraproteinemia, or patients receiving known nephrotoxic drugs. Renal dysfunction and acute renal failure occur more commonly in patients receiving immune globulin IV products containing sucrose. (Note: The following products do not contain sucrose: Bivigam, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Octagam 5%, Octagam 10%, Panzyga, and Privigen) For patients at risk of renal dysfunction or acute renal failure, administer immune globulin IV products at the minimum concentration dose and infusion rate practicable. Ensure adequate hydration in patients before administration.

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Drug shortages: In August 2019, FDA released a statement addressing the issues of product shortages along with a list of the products with limited availability. IG products with a supply that is not able to keep pace as the reason for the shortages. Its recommendations for healthcare providers are to develop a system to determine which patients should receive priority treatment and to consider adding additional products to their formularies to use during times of shortages.

One or more forms of this drug may be in short supply or unavailable. As recently as February 2025, some shortages are still ongoing.

CODING/BILLING INFORMATION

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive or applicable for every state or line of business. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry-standard coding practices for all submissions. Molina has the right to reject/deny the claim and recover claim payment(s) if it is determined it is not billed appropriately or not a covered benefit. Molina reserves the right to revise this policy as needed.

HCP/CS CODE	DESCRIPTION
J1459	Injection, immune globulin (privigen), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1551	Injection, immune globulin (cutaquin), 100 mg
J1554	Injection, immune globulin (asceniv), 500 mg
J1555	Injection, immune globulin (cuvitru), 100 mg
J1556	Injection, Immune Globulin (bivigam) Intravenous, Non-Lyophilized (e.g., Liquid), 500mg
J1557	Injection, immune globulin, (gammagard), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1558	Injection, immune globulin (xembify), 100 mg
J1559	Injection, immune globulin (hizentra), 100 mg
J1561	Injection, immune globulin, (gamunex-hyphenc/gammagard), nonlyophilized (e.g. liquid), 500 mg
J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg
J1568	Injection, immune globulin, (octagam), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1569	Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg
J1572	Injection, immune globulin, (flebogamma/flebogamma dif), intravenous, non-lyophilized (e.g., liquid), 500 mg

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J1575	Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immunoglobulin
J1576	Injection, immune globulin (Panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1599	Injection, immune globulin, intravenous, non-lyophilized (e.g., liquid), not otherwise specified, 500 mg

AVAILABLE DOSAGE FORMS:

Alyglo SOLN 5GM/50ML, 10GM/100ML, 20GM/200ML
 Asceniv SOLN 5GM/50ML
 Bivigam SOLN 5GM/50ML, 10GM/100ML
 Cutaquig SOLN 1GM/6ML, 1.65GM/10ML, 2GM/12ML, 3.3GM/20ML, 4GM/24ML, 8GM/48ML
 Cuvitru SOLN 1GM/5ML, 2GM/10ML, 4GM/20ML, 8GM/40ML, 10GM/50ML
 Flebogamma DIF SOLN 0.5GM/10ML, 2.5GM/50ML, 5GM/50ML, 5GM/100ML, 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML
 Gammagard S/D Less IgA SOLR 5GM, 10GM
 Gammagard SOLN 1GM/10ML, 2.5GM/25ML, 5GM/50ML, 10GM/100ML, 20GM/200ML
 Gammaked SOLN 1GM/10ML, 5GM/50ML, 10GM/100ML, 20GM/200ML
 Gammaplex SOLN 5GM/50ML, 5GM/100ML, 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML
 Gamunex-C SOLN 1GM/10ML, 2.5GM/25ML, 5GM/50ML, 10GM/100ML, 20GM/200ML, 40GM/400ML
 Hizentra SOLN 1GM/5ML, 2GM/10ML, 4GM/20ML, 10GM/50ML
 Hizentra SOSY 1GM/5ML, 2GM/10ML, 4GM/20ML, 10GM/50ML
 Hyqvia KIT 2.5GM/25ML, 5GM/50ML, 10GM/100ML, 20GM/200ML, 30GM/300ML
 Octagam SOLN 1GM/20ML, 2GM/20ML, 2.5GM/50ML, 5GM/50ML, 5GM/100ML, 10GM/100ML, 10GM/200ML, 20GM/200ML, 25GM/500ML, 30GM/300ML
 Panzyga SOLN 1GM/10ML, 2.5GM/25ML, 5GM/50ML, 10GM/100ML, 20GM/200ML, 30GM/300ML
 Privigen SOLN 5GM/50ML, 10GM/100ML, 20GM/200ML, 40GM/400ML
 Xembify SOLN 1GM/5ML, 2GM/10ML, 4GM/20ML, 10GM/50ML

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SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Duration of Approval Prescriber Requirements Quantity FDA Approved Uses Appendix Coding/Billing Information Available Dosage Forms References	Q3 2025

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REVISION- Notable revisions: Products Affected Required Medical Information Continuation of Therapy Duration of Approval Age Restrictions Quantity FDA-Approved Uses Contraindications/Exclusions/Dis continuation Coding/Billing Information References	Q3 2024
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Quantity FDA-Approved Uses Compendial Approved Off-Label Uses Appendix Other Special Considerations References	Q3 2023
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Duration of Approval Age Restrictions Quantity Appendix Background Coding/Billing Information Available Dosage Forms References	Q3 2022
Q2 2022 Established tracking in new format	Historical changes on file