Intravenous Immune Globulin (IVIG)

Asceniv, Bivigam, Carimune NF, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Octagam, Panzyga, and Privigen

Line(s) of Business: HMO; PPO; QUEST Integration

Original Effective Date: 10/01/2015

Current Effective Date: 12/20/2019

POLICY
A. INDICATIONS
The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-APPROVED INDICATIONS
- Primary immunodeficiency
- Idiopathic thrombocytopenic purpura
- Chronic inflammatory demyelinating polyneuropathy
- Multifocal motor neuropathy
- Kawasaki syndrome
- B-cell chronic lymphocytic leukemia

Note: subcutaneously administered immune globulin (Gammagard Liquid, Gamunex-C, or Gammaked) is covered only for the treatment of primary immunodeficiencies for members who are not able to tolerate intravenous immune globulin (IVIG).

COMPENDIAL USES
- Prevention of graft-versus-host disease and infections in bone marrow transplant (BMT)/hematopoietic stem cell transplant (HSCT) recipients
- Secondary immunodeficiency due to drugs/biologic agents, underlying disease, environmental exposure, or other causes
- Prevention of infections in pediatric human immunodeficiency virus (HIV) infection
- Dermatomyositis
- Guillain-Barre syndrome
- Fetal alloimmune thrombocytopenia
- Myasthenia gravis
- Autoimmune mucocutaneous blistering diseases: pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid, and epidermolysis bullosa acquisita
B. REQUIRED DOCUMENTATION

The following information is necessary to initiate the prior authorization review:

- Initial therapy
  - For subcutaneously administered immune globulin, documentation supporting the member’s inability to tolerate intravenously administered immune globulin
  - For primary or secondary immunodeficiency
    - Laboratory evidence of immunoglobulin deficiency (see Appendix)
    - Laboratory evidence of inability to mount an adequate response to inciting antigens (see Appendix)
  - For chronic inflammatory demyelinating polyneuropathy
    - Clinical notes documenting functional disability
    - Electromyography (EMG)/nerve conduction study (NCS) report
    - Spinal fluid protein and/or nerve biopsy report
  - For Guillain-Barre syndrome
    - Pulmonary function test, or
    - Clinical notes documenting the patient’s functional status and course of illness
  - Multifocal motor neuropathy
    - Anti-GM1 antibodies and conduction block
    - Conventional therapies that were tried and found to be ineffective, not tolerated or contraindicated

- Continuation of therapy
  - For primary or secondary immunodeficiency, continuation of therapy
    - Documentation supporting a clinical response to therapy (eg, reduction in bacterial infections)
  - For chronic inflammatory demyelinating polyneuropathy
    - Documentation that demonstrates significant improvement in clinical condition and, when relevant, a reduction in the level of sensory loss
    - For the long-term treatment of stable CIDP patients, documentation that the dose has been periodically reduced or withdrawn, and the effects measured

C. CRITERIA FOR APPROVAL

Note: Subcutaneously administered immune globulin (Gammagard Liquid, Gamunex-C, or Gammaked) is covered only for the treatment of primary immunodeficiencies.

1. Primary immunodeficiency (includes congenital agammaglobulinemia (X-linked agammaglobulinemia), hypogammaglobulinemia, common variable immunodeficiency, X-linked immunodeficiency with hyperimmunoglobulin M, severe combined immunodeficiency and Wiskott-Aldrich syndrome)

   Initial authorization for 12 months may be granted for members who meet the following criteria:
   a. Laboratory evidence of immunoglobulin deficiency (see Appendix)
   b. Documented inability to mount an adequate response to inciting antigens (see Appendix)
   c. Persistent and severe infections despite treatment with prophylactic antibiotics
   d. For subcutaneously administered immune globulin (Gammagard Liquid, Gamunex-C, or Gammaked), member is not able to tolerate intravenous immune globulin (IVIG)

2. Idiopathic thrombocytopenic purpura
Initial authorization for 6 months may be granted for members with idiopathic thrombocytopenic purpura.

3. **Secondary immunodeficiency due to drugs/biologic agents, underlying disease, environmental exposure, or other causes**
   Initial authorization for 12 months may be granted for members who meet the following criteria:
   a. Laboratory evidence of immunoglobulin deficiency (see Appendix)
   b. Documented inability to mount an adequate response to inciting antigens (see Appendix)
   c. Persistent and severe infections despite treatment with prophylactic antibiotics

4. **Chronic inflammatory demyelinating polyneuropathy (CIDP)**
   a. Initial authorization for 3 months may be granted for members who meet the following criteria:
      i. Significant functional disability
      ii. Slowing of nerve conduction velocity on EMG or NCS
      iii. Elevated spinal fluid protein on lumbar puncture or a nerve biopsy confirming the diagnosis
   b. For members receiving treatment with IVIG for 2 years or more, authorization of 6 months may be granted when IVIG dose reduction or withdrawal has been periodically attempted and the effects measured to validate continued use.

5. **Multifocal motor neuropathy**
   Initial authorization for 6 months may be granted for members who meet the following criteria:
   a. Conduction block on EMG/NCS
   b. Elevated anti-GM1 antibody titers
   c. Conventional therapy was ineffective or not tolerated.

6. **Guillain-Barre syndrome**
   Authorization for 6 months may be granted for members who meet the following criteria:
   a. Plasma exchange is not available or is not an appropriate treatment option
   b. Member has one of the following clinical features
      i. Deteriorating pulmonary function tests
      ii. Rapid deterioration with symptoms for less than 2 weeks
      iii. Rapidly deteriorating ability to ambulate
      iv. Frank inability to ambulate independently for 10 meters

7. **Fetal alloimmune thrombocytopenia**
   Initial authorization for 6 months may be granted for members with fetal alloimmune thrombocytopenia.

8. **Dermatomyositis**
   Initial authorization for 6 months may be granted for members whose condition has failed to respond to first-line treatment with corticosteroids.

9. **Myasthenia gravis**
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a. Authorization for 3 months may be granted for members who are experiencing a myasthenic crisis (ie, acute episode of respiratory muscle weakness) and plasma exchange is not available or is not an appropriate option.
b. Initial authorization for 6 months may be granted for members with chronic debilitating myasthenia gravis who have experienced an inadequate response or toxicity from treatment with cholinesterase inhibitors, corticosteroids, and/or azathioprine.

10. Autoimmune mucocutaneous blistering disease
Authorization for 6 months may be granted for members who meet both of the following criteria (a. and b.):
   a. Member has one of the following:
      i. Pemphigus vulgaris
      ii. Pemphigus foliaceus
      iii. Bullous pemphigoid
      iv. Mucous membrane pemphigoid (cicatrical pemphigoid, benign mucous membrane pemphigoid), with or without mention of ocular involvement
      v. Epidermolysis bullosa acquisita
   b. Member has severe progressive disease despite treatment with conventional therapy (eg, corticosteroids, azathioprine, or cyclophosphamide).

11. Kawasaki syndrome
Authorization for 6 months may be granted for members with Kawasaki syndrome and IVIG will be used in conjunction with aspirin.

12. Bone marrow/hematopoietic stem cell transplant recipients (BMT/HSCT)
Authorization for up to 100 days after BMT/HSCT may be granted for members who meet the following criteria:
   a. IVIG is prescribed for prevention of graft-versus-host disease after allogeneic BMT/HSCT, or for prevention of infection after BMT/HSCT
   b. Member is age 20 years or older
   c. IVIG is requested for use within 100 days after transplantation (the date of transplantation must be documented)

13. Pediatric HIV infection
Initial authorization for 6 months may be granted for members who meet the following criteria:
   a. IVIG is prescribed for prevention of infections associated with HIV infection
   b. Members is less than or equal to 12 years of age

14. Chronic lymphocytic leukemia (CLL)
Initial authorization for 6 months may be granted for members who meet the following criteria:
   a. IVIG is prescribed for prevention of infections associated with CLL
   b. Member has hypogammaglobulinemia prior to starting IVIG therapy
   c. Member has a history or recurrent bacterial infections prior to starting IVIG therapy

D. CONTINUATION OF THERAPY
1. No previous authorization/precertification:
   All members (including new members and members currently receiving treatment without prior authorization) must meet criteria for initial approval in section C.
2. Reauthorization:
   a. Primary/secondary immunodeficiency/CLL/pediatric HIV
      Authorization of an additional 12 months may be granted to members requesting authorization for continuation of therapy who are benefitting from IVIG therapy (eg, reduction in bacterial infections) and were previously authorized by HMSA/CVS.
   b. CIDP
      Authorization of an additional 12 months may be granted to members requesting authorization for continuation of therapy who demonstrate significant improvement in clinical condition and, when relevant, a reduction in the level of sensory loss and were previously authorized by HMSA/CVS. For members receiving treatment with IVIG for 2 years or more, authorization of 6 months may be granted when IVIG dose reduction or withdrawal has been periodically attempted and the effects measured to validate continued use.
   c. MMN/dermatomyositis/chronic myasthenia gravis
      Authorization of an additional 12 months may be granted to members requesting authorization for continuation of therapy who experience significant improvement in disability and maintenance of improvement with IVIG therapy and were previously authorized by HMSA/CVS.

E. APPENDIX - Primary Immunodeficiency Syndromes.
The diagnosis of immunodeficiency and post immunization titers must be taken in context with the clinical presentation of the patient and may vary dependent on the type of vaccine given and the prior immunization history of the patient. The following parameters are examples of criteria for diagnosis of the primary immunodeficiency syndromes.

1. Laboratory evidence of immunoglobulin deficiency may include the following definitions:
   a. Agammaglobulinemia (total IgG less than 200 mg/dL)
   b. Persistent hypogammaglobulinemia (total IgG less than 400 mg/dL, or at least two standard deviations below normal, on at least two occasions)
   c. Absence of B lymphocytes

2. Inability to mount an adequate antibody response to inciting antigens may include the following definitions:
   a. Lack of appropriate rise in antibody titer following provocation with a polysaccharide antigen. For example, an adequate response to the pneumococcal vaccine may be defined as at least a 4-fold increase in titers for at least 50% of serotypes tested.
   b. Lack of appropriate rise in antibody titer following provocation with a protein antigen. For example, an adequate response to tetanus/diphtheria vaccine may be defined as less than a 4-fold rise in titers 3-4 weeks after vaccine administration.

F. DOSAGE AND ADMINISTRATION
Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

G. ADMINISTRATIVE GUIDELINES
Precertification is required. Please refer to the HMSA medical policy web site for the fax form.

H. IMPORTANT REMINDER
The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA/CVS’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

I. REFERENCES


**Document History**

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