## anti-thymocyte globulin (Atgam)

## Commercial Medical Benefit Drug Policy

**Place of Service**

Home Infusion Administration
Infusion Center Administration
Office Administration
Outpatient Facility Administration

### Drug Details

**USP Category:** IMMUNOLOGICAL AGENTS
**Mechanism of Action:** Immunosuppressant Agent
**HCPCS:**
J7504:Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg
**How Supplied:**
250 mg/5 mL (50 mg/mL) 5 ampoules

### Condition(s) listed in policy *(see coverage criteria for details)*

- Allograft Rejection in Renal Transplant
- Aplastic Anemia, moderate to severe
- Hematopoietic Cell Transplantation
- Management of Immunotherapy-Related Toxicities
- Myelodysplastic syndrome (MDS)

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the Health and Safety Code section 1367.21 must be met.

### Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

For billing purposes, drugs must be submitted with the drug's assigned HCPCS code (as listed in the drug policy) and the corresponding NDC (national drug code). An unlisted, unspecified, or miscellaneous code should not be used if there is a specific code assigned to the drug.

### Coverage Criteria
**The following condition(s) require Prior Authorization/Preservice.**

**Allograft Rejection in Renal Transplant**
**Meets medical necessity if all the following are met:**
1. For prevention or treatment of allograft rejection episodes from a renal transplant
2. Being used in combination with other immunosuppressant therapy

**Covered Doses:**
15 mg/kg given as an IV infusion per day

**Coverage Period:**
To allow for up to 21 doses

**ICD-10:**
T86.11

**Aplastic Anemia, moderate to severe**
**Meets medical necessity if all the following are met:**
1. Patient is not a candidate for bone marrow transplantation
2. Condition is not caused by secondary causes (e.g., Neoplastic disease, storage disease, myelofibrosis, Fanconi syndrome, exposure to myelotoxic agents or radiation)

**Covered Doses:**
20 mg/kg given as an IV infusion per day

**Coverage Period:**
To allow for up to 21 doses

**ICD-10:**
D61.9

**Hematopoietic Cell Transplantation**
**Meets medical necessity if all the following are met:**
1. Meets either of the following:
    a. For graft-versus-host disease and all the following:
        i. Used for steroid refractory disease
        ii. Being used in combination with immunosuppressant
    b. For conditioning as part of a reduced-intensity regimen in combination with cladribine and busulfan

**Covered Doses:**
Up to 15 mg/kg given as an intravenous infusion twice per day

**Coverage Period:**
Up to 44 days

**ICD-10:**
D89.810, D89.812, D89.813, T86.09, Z94.81, Z94.89, Z94.9

**Management of Immunotherapy-Related Toxicities**
**Meets medical necessity if all the following are met:**
1. Either of the following:
    a. For cytokine release syndrome secondary to CAR-T use: refractory to high-dose steroid therapy and tocilizumab
    b. For immunotherapy-related myocarditis secondary to immune checkpoint inhibitor use: refractory to high-dose methylprednisolone: Refractory to high-dose methylprednisolone

**Covered Doses:**
20 mg/kg given as an IV infusion once daily

**Coverage Period:**
To allow for up to 21 doses

**ICD-10:**
D89.834, D89.839, I30.8, I30.9, I40.8, I40.9, T80.82XA, T80.82XS, T80.89XA

**Myelodysplastic syndrome (MDS)**
**Meets medical necessity if all the following are met:**
1. Patient is not a candidate for bone marrow transplantation
2. For treatment of lower risk disease associated with anemia, thrombocytopenia or neutropenia
3. One of the following:
   a. Being used in combination with cyclosporine and/or Promacta (eltrombopag)
   b. Being used as a single agent (for thrombocytopenia or neutropenia only)

**Covered Doses:**
40 mg/kg given as an IV infusion once daily, or
15 mg/kg given as an IV infusion once daily

**Coverage Period:**
40 mg/kg dose for 4 days, or
15 mg/kg dose for 5 days

**ICD-10:**
C93.10, D46.0, D46.1, D46.20, D46.21, D46.4, D46.9, D46.A, D46.B, D46.Z

## References


1. AHFS. Available by subscription at http://www.lexi.com
2. Atgam (anti-thymocyte globulin) Prescribing information. Pfizer Inc.; New York, NY: 9/2023.
3. DrugDex. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
4. National Comprehensive Cancer Network Drugs & Biologics Compendium. Atgam (2025). Available by subscription at: https://www.nccn.org/.
5. National Comprehensive Cancer Network. Hematopoietic Cell Transplantation (Version 2.2025). Available at: https://www.nccn.org/.
6. National Comprehensive Cancer Network. Management of Immunotherapy-Related Toxicities (Version 1.2025). Available at: https://www.nccn.org/.
7. National Comprehensive Cancer Network. Myelodysplastic Syndromes (Version 2.2025). Available at: Available at: https://www.nccn.org/.


## Review History

Date of Last Annual Review: 3Q2025
Changes from previous policy version:

- No clinical change following annual review.

*Blue Shield of California Medication Policy to Determine Medical Necessity*
*Reviewed by P&T Committee*