blue california
Promise Health Plan

intravenous immune globulin (IVIG)

Medical Benefit Drug Policy

For oncology-related indications, coverage will be made based on medical necessity. Medical necessity determinations are made based on U.S. Food and Drug Administration (FDA) labeling, peer-reviewed medical literature, Medi-Cal coverage guidelines, and Centers for Medicare & Medicaid Services (CMS) approved compendia support (i.e., Clinical Pharmacology, National Comprehensive Cancer Network® (NCCN), American Hospital Formulary Service Drug Information, Thomson Micromedex DrugDex,® and Lexicomp®).

Alyglo 10%
Asceniv (10%)
Bivigam (10%)
Cytogam
Gammagard liquid (10%)
Gammagard S/D (5%)
Gamunex-C (10%)
Gammaked (10%)
Gammaplex (10%)
Gammaplex (5%)
Octagam (5%)
Octagam (10%)
Panzyga (10%)
Privigen (10%)
Yimmugo (10%)

Place of Service

Home Infusion Administration
Hospital Administration
Infusion Center Administration
Office Administration
Outpatient Facility Administration

Gammagard Liquid and Octagam will be the preferred IVIG products. Request for all other IVIG products for members newly initiating IVIG therapy will require treatment failure or intolerance to all the preferred drugs or contraindication to all the preferred drugs for certain indications.

Drug Details

USP Category: IMMUNOLOGICAL AGENTS
Mechanism of Action: Immune globulin is a sterile, nonpyrogenic solution of globulins containing many antibodies normally present in adult human blood.
HCPCS:

J1459:Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1552:Injection, immune globulin (alyglo), 500 mg
J1554:Injection, immune globulin (asceniv), 500 mg
J1556:Injection, immune globulin (bivigam), 500 mg
J1557:Injection, immune globulin, (gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1561:Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (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, non-lyophilized (e.g., liquid), 500 mg
J1569:Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg
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
J1599: Yimmugo, 500 mg (use as temporary code):
J3490:cytomegalovirus immune globulin intravenous (human), Cytogam, per vial:

How Supplied:

IVIG usual concentration: 5% = 5 gm/100ml, 10%= 10 gm/100ml, 20%, 20 gm/100ml
Alyglo 10%: 5, 10, 20 gm (single-use vial)
Asceniv (10%): 5 gm (single-use vial)
Bivigam (10%): 5, 10 gm (single-use vial)
Cytogam: 2500 mg/50 mL vials (single-use vial)
Gammagard liquid (10%): 1, 2.5, 5, 10, 20, 30 gm (single-use bottle)
Gammagard S/D (5%): 5, 10 gm (single-use bottle)
Gamunex-C (10%): 1, 2.5, 5, 10, 20, 40 gm (single-use bottle)
Gammaked (10%): 1, 2.5, 5, 10 ,20 gm (single-use bottle)
Gammaplex (10%): 5, 10, 20 gm (single-use bottle)
Gammaplex (5%): 5, 10, 20 gm (single-use bottle)
Octagam (5%): 1, 2.5, 5, 10, 25 gm (single-use bottle)
Octagam (10%): 2, 5, 10, 20 gm
Panzyga (10%): 1, 2.5, 5, 10, 20, 30 gm (single-use bottle)
Privigen (10%): 5, 10, 20, 40 gm (single-use vial)
Yimmugo (10%): 5, 10, 20 gm (single-use vial)

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

- Autoimmune Mucocutaneous Blistering Diseases (AMBDs)
- Chimeric Antigen Receptor T-Cell (CAR-T) Therapy - Related Toxicities

- Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) and Variants
- Guillain-Barre Syndrome
- Hematopoietic Stem Cell Transplant (Includes Bone Marrow Transplantation)
- Hemolytic Anemia - Autoimmune
- Hypogammaglobulinemia associated with Anti-CD20 Monoclonal Antibodies
- Immunotherapy-Related Toxicities Secondary to Immune-Checkpoint Inhibitor Therapy
- Kawasaki Disease
- Multifocal Motor Neuropathy (MMN)
- Myasthenia Gravis
- PANDAS / PANS
- Polymyositis and Dermatomyositis
- Prevention of Bacterial Infection in HIV-Pediatric
- Primary Immune Thrombocytopenia (ITP)
- Primary Immunodeficiency Disorders
- Solid Organ Transplant

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 California Code of Regulations (CCR), Title 22, Section 51303 and 51313 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.

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

<u>Autoimmune Mucocutaneous Blistering Diseases (AMBDs)</u>

Meets medical necessity if all the following are met:

1. Diagnosis of ONE of the following:
   a. pemphigus foliaceus
   b. pemphigus vulgaris
   c. bullous pemphigoid
   d. cicatricial pemphigoid
   e. epidermolysis bullosa acquisita
2. Diagnosis is confirmed by lesional tissue biopsy or serology

3. Inadequate response to an immunosuppressant and a systemic corticosteroid, or contraindication or intolerance to immunosuppressants and systemic corticosteroids
4. Request for a non-preferred product requires an inadequate response, intolerable side effect, or contraindication to two preferred products (e.g. Gammagard Liquid 10%, Octagam 5%, Octagam 10%)

Covered Doses:
Up to 2 g/kg given intravenously over 3-5 days per month

Coverage Period:
Initial:
Up to 6 months
First Reauthorization:
Cover for another 12 months if patient has had clinical response (i.e., a reduction in lesions and/or ability to reduce concomitant steroids or immunosuppressants.)
Subsequent authorizations:
Cover yearly based on continued response

ICD-10:
L10.0, L10.2, L12.0, L12.1, L13.8

Chimeric Antigen Receptor T-Cell (CAR-T) Therapy - Related Toxicities
Meets medical necessity if all the following are met:
1. Prescribed by an oncologist or immunologist
2. Meets ONE of the following:
   a. Diagnosis of CAR-T induced hypogammaglobulinemia
   b. Being used for the management of grade 4 cytokine release syndrome that is refractory to high-dose corticosteroids and anti-IL-6 therapy
   c. Being used for acute inflammatory demyelinating polyneuropathy (AIDP)-type picture

Covered Doses:
Given intravenously. Dose is highly variable

Coverage Period:
Yearly based upon continued response to treatment

ICD-10:
D80.0-D83.3

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) and Variants

Meets medical necessity if all the following are met:

1. Diagnosis of ONE of the following:
   a. Typical chronic inflammatory demyelinating polyneuropathy (CIDP)
   b. Multifocal acquired demyelinating polyneuropathy
   c. Pure sensory chronic inflammatory demyelinating polyneuropathy
   d. Distal chronic inflammatory demyelinating polyneuropathy
   e. Focal chronic inflammatory demyelinating polyneuropathy
   f. Motor chronic inflammatory demyelinating polyneuropathy
2. Diagnosis by a neurologist
3. Meets ONE of the following:
   a. Electrodiagnostic testing (nerve conduction studies) shows definite CIDP
   b. Nerve conduction studies show possible CIDP AND 2 of the following to confirm the diagnosis: CSF examination, nerve biopsy, MRI, ultrasound
4. Request for a non-preferred product requires an inadequate response, intolerable side effect, or contraindication to two preferred products (e.g. Gammagard Liquid 10%, Octagam 5%, Octagam 10%)

Covered Doses:

Initial:
Up to 2 g/kg given intravenously by IV over up to a 5-day period
Maintenance:
Up to 2 g/kg given intravenously as often as every 2 weeks. For requests more frequent than every 2 weeks, total dose given over a two week period should not exceed 2 g/kg.

Coverage Period:

Initial:
Up to 5 days depending on dose (See initial dosing)
Maintenance:
Cover yearly as long as patient continues to respond to treatment e.g. control of symptoms (e.g., weakness, sensory loss, imbalance, pain), and/or improvement or maintenance of functional ability.

ICD-10:

G61.81

Guillain-Barre Syndrome

Meets medical necessity if all the following are met:

1. Treatment with IVIG will begin within 4 weeks of onset of neuropathic symptoms
2. Request for a non-preferred product requires an inadequate response, intolerable side effect, or contraindication to two preferred products (e.g. Gammagard Liquid 10%,

Octagam 5%, Octagam 10%)

Covered Doses:
Up to 400 mg/kg given intravenously daily for 5 days

Coverage Period:
Initial: 5 days
Retreatment with IVIG has not been studied for Guillain-Barre syndrome

ICD-10:
G61.0

Hematopoietic Stem Cell Transplant (Includes Bone Marrow Transplantation)
Meets medical necessity if all the following are met:

1. Being used for prevention of bacterial infections among allogenic hematopoietic stem cell transplant (HSCT) recipients
2. Meets ONE of the following:
   a. Patient is within 100 days post-allogenic hematopoietic cell transplantation or planned allogenic hematopoietic cell transplantation within 7 days of the first dose
   b. Patient has severe hypogammaglobulinemia (serum immunoglobulin G level less than 400 mg/dl)
   c. Patient has chronic GVHD on steroids or has chronic GVHD with pulmonary infection AND IgG level is below normal as defined by the testing laboratory
   d. Patient has positive CMV serology

Covered Doses:
Up to 500 mg/kg given intravenously weekly
Increased doses or frequency are covered, as needed to maintain serum IgG levels > 400 mg/dL.

Coverage Period:

- For patients within 100 days of HSCT: Cover up to 100 days post HSCT
- For hypogammaglobulinemia, chronic GVHD, or positive CMV serology: Cover for 1 year or up to 24 months post-transplant (whichever is less)
- Reauthorization:
  - For patients who are less than 24 months post-transplant: Cover for remaining time that adds up to 24 months total if patient is responding to therapy
  - For patients who are more than 24 months post-transplant: Cover yearly if there is documented current IgG level < 400mg/dl OR patient has chronic GVHD with IgG level that is less than normal as defined by the testing laboratory

CPT:
38240

ICD 10:
30233Y1

Hemolytic Anemia - Autoimmune

Meets medical necessity if all the following are met:

1. Diagnosis of warm-type autoimmune hemolytic anemia
2. Patient has experienced an inadequate response to high dose steroids
3. Request for a non-preferred product requires an inadequate response, intolerable side effect, or contraindication to two preferred products (e.g. Gammagard Liquid 10%, Octagam 5%, Octagam 10%)

Covered Doses:
Up to 1 g/kg given intravenously per day for up to 7 days

Coverage Period:
Up to 7 days
The efficacy and safety of retreatment with IVIG has not been established.

ICD-10:
D59.11

Hypogammaglobulinemia associated with Anti-CD20 Monoclonal Antibodies

Meets medical necessity if all the following are met:

1. Patient with recurrent bacterial infections
2. Patient has received treatment with an anti-CD20 monoclonal antibody (e.g., rituximab, Arzerra, Gazyva)
3. Request for a non-preferred product requires an inadequate response, intolerable side effect, or contraindication to two preferred products (e.g. Gammagard Liquid 10%, Octagam 5%, Octagam 10%)

Covered Doses:
Up to 400 mg/kg given intravenously as often as every 3 weeks, or up to 500 mg/kg given intravenously every 4 weeks

Coverage Period:
1 year

ICD-10:

D59.0, D59.2, D61.1, D69.59, D89.834, D89.839, J70.2, J70.4, G70.00, G70.01, G61.0, G61.1, G61.81, G61.82, G61.89, G61.9, G62.0, G03.8, G03.9, G04.81, G04.89, G04.90-G04.91, G56.80-G56.83, G56.90-G56.93, G57.80-G57.83, G57.90-G57.93, I30.8, I30.9, I40.8, I40.9, L13.8, L13.9, L51.1, L51.2, M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839, M60.841, M60.842, M60.849, M60.851, M60.852, M60.859, M60.861, M60.862,, M60.869, M60.871, M60.872, M60.879, M60.88, M60.89, M79.10, M79.11, M79.12, M79.18, H46.9, T80.82XA,T80.82XS, T80.89XA, T80.89XS

Immunotherapy-Related Toxicities Secondary to Immune-Checkpoint Inhibitor Therapy
Meets medical necessity if all the following are met:

1. Being treated with an immune-checkpoint inhibitor
2. Treatment of ONE of the following immunotherapy-related toxicities secondary to immune-checkpoint inhibitor therapy:
   a. Severe pneumonitis refractory to methylprednisolone
   b. Severe myasthenia gravis
   c. Moderate or severe Guillain-Barré Syndrome or severe peripheral neuropathy in combination with pulse-dose methylprednisolone
   d. Encephalitis in combination with pulse-dose methylprednisolone
   e. Transverse myelitis
   f. Severe bullous dermatitis
   g. Stevens-Johnson syndrome or toxic epidermal necrolysis
   h. Severe myocarditis, pericarditis, arrhythmias, impaired ventricular function, or conduction abnormalities refractory to pulse-dose methylprednisolone
   j. Moderate or severe myalgias or myositis refractory to corticosteroids

Covered Doses:
Up to 2 gm/kg total dose given intravenously

Coverage Period:
Once per treatment course

ICD-10:
J70.2, J70.4, G70.00, G70.01, G61.0, G61.1, G61.81, G61.82, G61.89, G61.9, G03.8, G03.9, G04.81, G04.89, G04.90-G04.91, G56.80-G56.83, G56.90-G56.93, G57.80-G57.83, G57.90-G57.93, G90.09, I44.0, I44.1-I44.3, I44.30, I44.39, I47.0, I45.0, I45.10, I45.19, I45.2-I45.6, I45.81, I45.89, I45.9, I49.9, L13.8, L13.9, L51.1, L51.2, M06.4, M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839, M60.841, M60.842, M60.849, M6

Kawasaki Disease
Meets medical necessity if all the following are met:

1. Patient is now on or will be on combination treatment with high dose aspirin (80-100 mg/kg per day)
2. Request for a non-preferred product requires an inadequate response, intolerable side effect, or contraindication to two preferred products (e.g. Gammagard Liquid 10%, Octagam 5%, Octagam 10%)

Covered Doses:
Up to 2 g/kg given intravenously as a single dose
OR
Up to 400 mg/kg given intravenously once daily for 4 consecutive days

Coverage Period:
Initial:
- If giving as a single dose, authorize for 2 doses (one initial and one for possible retreatment)
- If giving as a multiple dose regimen, authorize for 8 doses (4 initial and 4 for possible retreatment).

Reauthorization beyond the first retreatment: Subsequent retreatments after the first retreatment have not been evaluated for efficacy or safety.

ICD-10:
M30.3

Multifocal Motor Neuropathy (MMN)
Meets medical necessity if all the following are met:
1. Diagnosis by a neurologist, confirmed by electrodiagnostic testing (nerve conduction studies)
2. Asymmetric weakness and/or atrophy without sensory dysfunction for at least one month
3. Request for a non-preferred product requires an inadequate response, intolerable side effect, or contraindication to two preferred products (e.g. Gammagard Liquid 10%, Octagam 5%, Octagam 10%)

Covered Doses:
Up to 2.4 gm/kg given intravenously every 4 weeks

Coverage Period:
Yearly, based on continued response

ICD-10:
G61.82

Myasthenia Gravis

Meets medical necessity if all the following are met:

1. Prescribed by a neurologist
2. Patient has experienced an inadequate response or has an intolerance or contraindication to at least one of the following: a corticosteroid, mycophenolate, azathioprine, cyclosporine, or cyclophosphamide
3. Effective 1/1/2026 and after: Request for a non-preferred product requires an inadequate response, intolerable side effect, or contraindication to two preferred products (e.g. Gammagard Liquid 10%, Octagam 5%, Octagam 10%)

Covered Doses:
Up to 2 g/kg given intravenously per month

Coverage Period:
Initial: 3 months
Reauthorization: Yearly, based on continued response to therapy

ICD-10:
G70.00, G70.01

PANDAS / PANS
Meets medical necessity if all the following are met:

1. Moderate-to-severe disease (e.g., symptoms interfere with daily activities, occupying 50%-70% of waking hours)
2. Patient has a history of antibiotic use or is currently taking prophylactic antibiotics
3. Inadequate response, intolerable side effect, or contraindication to glucocorticoids or NSAIDS
4. Effective 1/1/2026 and after: Request for a non-preferred product requires an inadequate response, intolerable side effect, or contraindication to two preferred products (e.g. Gammagard Liquid 10%, Octagam 5%, Octagam 10%)

Covered Doses:
Up to 2 gm/kg total given intravenously monthly

Coverage Period:
Yearly, based on continued response to therapy

ICD-10:
G04.81

Polymyositis and Dermatomyositis
Meets medical necessity if all the following are met:

1. Inadequate response to treatment with high dose corticosteroids (equivalent to prednisone 40-60 mg/d or highest tolerated dose)
2. Inadequate response, intolerable side effect, or contraindication to an immunosuppressant (i.e., azathioprine, methotrexate, tacrolimus, cyclosporin A, mycophenolate, cyclophosphamide)
3. Effective 1/1/2026 and after: Request for a non-preferred product requires an inadequate response, intolerable side effect, or contraindication to two preferred products (e.g. Gammagard Liquid 10%, Octagam 5%, Octagam 10%)

Covered Doses:
Up to 2 gm/kg total given intravenously each month

Coverage Period:
Yearly, based on continued response to therapy

ICD-10:
M33.00-M33.02, M33.09-M33.12, M33.19, M33.20-M33.22, M33.29, M33.90-M33.92, M33.99, M36.0

Prevention of Bacterial Infection in HIV-Pediatric
Meets medical necessity if all the following are met:
1. Age is less than 13 years
2. Symptomatic HIV or history of recurrent infections
3. Effective 11/1/2025 and after: Will require IgG < 400 mg/dL
4. Effective 1/1/2026 and after: Request for a non-preferred product requires an inadequate response, intolerable side effect, or contraindication to two preferred products (e.g. Gammagard Liquid 10%, Octagam 5%, Octagam 10%)

Covered Doses:
Up to 400 mg/kg given intravenously every 4 weeks

Coverage Period:
Yearly, based on continued response to therapy

ICD-10:
B20

Primary Immune Thrombocytopenia (ITP)
Meets medical necessity if all the following are met:
1. Meets ONE of the following:
   a. Acute primary ITP and a rapid increase in platelets is required for surgery, invasive procedure, or acute bleeding episode
   b. Chronic primary ITP and platelet count is less than 30 X 10^9/L (<30,000/mm^3)

2. Request for a non-preferred product requires an inadequate response, intolerable side effect, or contraindication to two preferred products (e.g. Gammagard Liquid 10%, Octagam 5%, Octagam 10%)

Covered Doses:
Acute ITP: Up to 2 g/kg given intravenously over 2-5 days for 5 doses total
Chronic ITP: Up to 2 g/kg given intravenously per month for up to 12 doses over up to 12 months

Subsequent reauthorization for acute or chronic ITP requires the following:
1. Meets ALL of the following:
   a. Patient had a prior response to IVIG, defined as platelet count >30 x 10^9/L
   b. Either of the following: Patient has continued thrombocytopenia (defined as platelet count <30 x 10^9/L) or patient is scheduled for surgery or invasive procedure

Coverage Period:
See above

ICD-10:
D69.3

Primary Immunodeficiency Disorders
Meets medical necessity if all the following are met:
1. Meets ONE of the following (a) or (b):
   a. Diagnosis of primary immunodeficiency (There are over 500 Primary immunodeficiency diseases which can be found at the Immune Deficiency Foundation website) and meets ONE of the following:
      i. IgG <200 mg/dL
      ii. Meets ALL of the following:
         1. Member has a history of recurrent bacterial infections
         2. Inability to respond to IgG antibody production after antigenic challenge against diphtheria and tetanus toxoids or pneumococcal polysaccharide vaccine
         3. Decreased IgG concentrations (<500mg/dL or below normal as defined by testing laboratory) documented on two or more occasions OR diagnosed by an allergist or immunologist if IgG concentrations are not decreased (>500mg/d or normal as defined by the testing laboratory)
   b. Diagnosis of IgG Subclass Deficiency, and meets ALL of the following:
      i. History of recurrent infections requiring antibiotic therapy
      ii. Pre-treatment levels of one or more serum IgG subclasses are below the lower limit of the age-adjusted laboratory reference range

iii. Inability to respond to IgG antibody production after antigenic challenge against diphtheria and tetanus toxoids or pneumococcal polysaccharide

2. Request for a non-preferred product requires an inadequate response, intolerable side effect, or contraindication to two preferred products (e.g. Gammagard Liquid 10%, Octagam 5%, Octagam 10%)

Covered Doses:
Up to 800 mg/kg given intravenously every 3-4 weeks, and not to exceed 2 doses per month

Coverage Period:
Yearly, based on continued response to therapy

ICD-10:
D80.0, D80.1, D80.3, D80.5, D80.6, D80.7, D81.0-D81.2, D81.6, D81.7, D81.89, D81.9, D82.0, D82.1, D82.3, D82.4, D83.0, D83.1, D83.2, D83.8, D83.9

Solid Organ Transplant

Meets medical necessity if all the following are met:

1. Documented solid organ transplant (e.g., pre/perioperative prevention or for treatment of antibody-mediated rejection of allograft)
2. Request for a non-preferred product requires an inadequate response, intolerable side effect, or contraindication to two preferred products (e.g. Gammagard Liquid 10%, Octagam 5%, Octagam 10%)

Covered Doses:
Given intravenously. Dose is highly variable

Coverage Period:
16 weeks per treatment course

ICD-10:
Z94.0, Z94.1, Z94.4

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Review History

Date of Last Annual Review: 2Q2025

Changes from previous policy version:

- For oncology-related indications, coverage will be made based on medical necessity

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