Cutaquig 16.5%
Cuvitru 20%
Gammagard Liquid 10%
Gammagard Liquid ERC 10%
Gammaked
Gamunex-C 10%
Hizentra 20%
HyQvia 10%
Xembify 20%

Place of Service
Home Infusion Administration
Infusion Center Administration
Outpatient Facility Infusion Administration

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:
J1551:Injection, immune globulin (cutaquig), 100 mg
J1555:Injection, immune globulin (cuvitru), 100 mg
J1558:Injection, immune globulin (xembify), 100 mg
J1559:Injection, immune globulin (hizentra), 100 mg
J1561:Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g., liquid), 500 mg
J1569:Injection, immune globulin, (gammagard liquid/gammagard liquid erc), 500 mg
J1575:Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immunoglobulin
How Supplied:
Cutaquig: 1 gm, 1.65 gm, 2 gm, 3.3 gm, 4 gm, 8 gm (single use vials)
Cuvitru: 1 gm, 2 gm, 4 gm, 8gm, 10 gm (single use vials)
Hizentra: 1 gm, 2 gm, 4 gm, 10 gm (single use vials)
Gamunex-C (10%): 1 gm, 2.5 gm, 5 gm, 10 gm, 20 gm, 40 gm (single use bottles)
Gammagard (10%): 1 gm, 2.5 gm, 5 gm, 10 gm, 20 gm, 30 gm (single use bottles)
Gammagard liquid ERC (10%): 5, 10 gm (single-use vial)
Gammaked (10%): 1 gm, 2.5 gm, 5 gm, 10 gm or 20 gm (single use vials)
HyQvia: 2.5 gm, 5 gm, 10 gm, 20 gm, 30 gm (dual vial unit of two single use vials containing the labeled amount of functionally active Immune Globulin Infusion 10% (Human) and

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Recombinant Human Hyaluronidase)
Xembify: 1 gm, 2 gm, 4 gm (single use vials)

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

- Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) and Variants
- Primary Immunodeficiency Disorders (PIDD)

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.

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) and Variants
Meets medical necessity if all the following are met:
Initial

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 at least one supportive testing to confirm the diagnosis: CSF examination, nerve biopsy, MRI, ultrasound
4. Patient has been stabilized with IVIG and is switching for maintenance therapy

Reauthorization

1. Patient is responding to therapy [e.g. control of symptoms (weakness, sensory loss, imbalance, pain), and/or improvement or maintenance of functional ability)]

Covered Doses:
Maintenance:
0.2 g/kg to 0.4 g/kg given by subcutaneous infusion weekly beginning one week after last IVIG infusion

Coverage Period:
Yearly

ICD-10:
G61.81

Primary Immunodeficiency Disorders (PIDD)
Meets medical necessity if all the following are met:
Initial
1. Meets ONE of the following (a) and (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

Reauthorization
1. Patient is responding to therapy

Covered Doses:
GAMUNEX-C, GAMMAGARD, GAMMAKED (10% immune globulin)
- Previous IVIG dose x 1.37, then divide this dose into weekly doses (e.g., if patient was administered IVIG every three weeks, divide dose by three).

CUVITRU (20% immune globulin)

- Switching from immune globulin intravenous (human) treatment (IVIG) or adult patients switching from HYQVIA:
  - Weekly: Start Cuvitru SC one week after the last IVIG or HyQvia SC infusion
  - Initial weekly dosing: 1.3 x previous IVIG or HyQvia SC dose (grams)/number of weeks between IVIG or HyQvia SC doses.
  - Frequent dosing (2 to 7 times per week): divide the calculated weekly dose by the desired number of times per week.
  - Biweekly: Multiply the calculated weekly dose by two.
- Switching from all other immune globulin subcutaneous (human) treatments (SCIG):
  - Weekly: weekly dose (grams) should be the same as the weekly dose of prior SCIG treatment (grams)
  - Frequent dosing (2 to 7 times per week): divide the calculated weekly dose by the desired number of times per week
  - Biweekly dosing: multiply the calculated weekly dose by two

HIZENTRA (20% immune globulin)

- Frequent dosing (2 to 7 times per week): Start Hizentra SC one week after the last IVIG or Hizentra/SCIG infusion. Divide the calculated weekly dose by the desired number of times per week.
- Weekly: Start Hizentra SC 1 week after last IVIG infusion.
- Initial weekly dosing: Cover up to 1.53 × previous IVIG dose (grams)/number of weeks between IVIG doses.
- Biweekly: Start Hizentra SC 1 or 2 weeks after the last IVIG infusion or 1 week after the last weekly Hizentra SC infusion. Administer twice the calculated weekly dose.
- Doses may be adjusted over time to achieve the desired clinical response and serum IgG levels.

HYQVIA (10% immune globulin with recombinant human hyaluronidase)

- Switching from IVIG treatment: Cover same dose and frequency as previous intravenous treatment after the initial dose ramp-up.
- Naïve to IgG treatment or switching from immune globulin subcutaneous (Human): Cover target dose 300 to 600 mg/kg at 3 to 4-week intervals, after initial ramp-up

Initial Treatment Interval/Dosage Ramp-Up Schedule:

- Week 1: Up to 7.5 grams SC
- Week 2: Up to 15 grams SC
- Week 3: No dose
- Week 4: Up to 22.5 grams SC
- Week 5: No dose
- Week 6: No dose
- Week 7: Up to 30 grams

CUTAQUIG (16.5% immune globulin)

Switching from IVIG or SCIG infusion: Ensure that patients have received IVIG or SCIG at regular intervals for at least 3 months. Start Cutaquig treatment one week after the last IVIG/SCIG infusion.

- Switching from IVIG to CUTAQUIG: Establish the initial weekly dose by converting the monthly IVIG dose into an equivalent weekly dose and increasing it using a dose adjustment factor. To calculate the initial weekly dose, divide the monthly IVIG dose in grams by the number of weeks between IVIG infusions and then multiply this value with a Dose Adjustment Factor of 1.40. To convert the dose (in grams) to milliliters (mL), multiply the calculated dose (in grams) by 6.

  Weekly: Start Cutaquig one week after last IVIG infusion

  $$\text{Initial weekly dose} = \frac{\text{Previous IVIG dose (in grams)} \times 1.40}{\text{Number of weeks between IVIG doses}}$$

- Switching from other SCIG: Dosing should be the same as for previous SCIG. To convert the dose (in grams) to milliliters (mL), multiply the calculated dose (in grams) by 6.

XEMBIFY (20% immune globulin)

- Switching from immune globulin intravenous (human), 10% (IVIG) to XEMBIFY: calculate the dose by using a dose adjustment factor (1.37)
- Weekly: Begin Xembify one week after last IVIG infusion.
- Establish initial weekly dose by converting the monthly (or every 3 weeks) IVIG dose into an equivalent weekly dose and increasing it using a dose adjustment factor (1.37).

  $$\text{Initial weekly dose (grams)} = \frac{\text{Prior IVIG dose (in grams)} \times 1.37}{\text{Number of weeks between IVIG doses}}$$

- Frequent dosing (2-7 times per week): Divide the calculated weekly dose by the desired number of times per week.
- Switching from immune globulin subcutaneous (human) treatment (SCIG): Weekly dose (grams) should be the same as the weekly dose of prior SCIG treatment (grams).

Coverage Period:

Initial: 6 months

Reauthorization: yearly

ICD-10:

D80.0, D80.1, D80.3, D80.5, D80.6, D80.7, D81.0, D81.1, 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

References

1. AHFS. Available by subscription at http://www.lexi.com
2. Bonilla FA, Khan DA, Ballas ZK et al. Practice parameter for the diagnosis and management of primary immunodeficiency. Allergy Clin Immunol 2015; 136(5): 1186-1205.
3. Cutaquig (immune globulin subcutaneous, human) Prescribing Information. Octapharma USA, Inc., Paramus, NJ: 03/2025.
4. Cuvitru (immune globulin subcutaneous, human) Prescribing Information. Takeda Pharmaceuticals U.S.A. Inc, Lexington, MA: 2/2025.
5. DrugDex. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
6. Hizentra (immune globulin subcutaneous, human) Prescribing Information. CSL Behring LLC, Kankakee, IL: 4/2023.
7. Gammagard (immune globulin, human) Prescribing Information. Takeda Pharmaceuticals U.S.A., Inc., Cambridge, MA: 9/2024.
8. Gammagard liquid ERC (immune globulin, human) Prescribing Information. Takeda Pharmaceuticals U.S.A., Inc.; Cambridge, MA: 6/2025.
9. Gammaked (immune globulin, human) Prescribing Information. Kedrion Biopharma, Inc., Fort Lee, NJ: 1/2020.
10. Gamunex-C (immune globulin, human) Prescribing Information. Grifols Therapeutics LLC, Research Triangle Park, NC: 1/2020.
11. HyQvia (immune globulin 10% subcutaneous with recombinant human hyaluronidase) Prescribing Information. Takeda Pharmaceuticals U.S.A. Inc., Cambridge, MA: 7/2025.
12. LCD L33794: External Infusion Pumps
13. Immune Deficiency Foundation. Types of Primary Immunodeficiencies. Available at: http://primaryimmune.org/understanding-primary-immunodeficiency/types-of-pi. Accessed in June 2026.
    Impact of 2021 European Academy of Neurology/Peripheral Nerve Society diagnostic criteria on diagnosis and therapy of chronic inflammatory demyelinating polyradiculoneuropathy variants. Eur J Neurol. 2024 Jan 2;31(4)
14. Tangye SG, et al. Human Inborn Errors of Immunity: 2019 Update on the Classification from the International Union of Immunological Societies Expert Committee. J Clin Immunol. 2020 Jan;40(1):24-64.
15. Van den Bergh PYK, et al. European Academy of Neurology/Peripheral Nerve Society guideline on diagnosis and treatment of chronic inflammatory demyelinating polyradiculoneuropathy: Report of a joint Task Force-Second revision. J Peripher Nerv Syst. 2021 Sep;26(3):242-268.
16. Xembify (immune globulin subcutaneous, human) Prescribing Information. Grifols Therapeutics LLC, Research Triangle Park, NC: 7/2024.

Review History

Date of Last Annual Review: 2Q2026
Changes from previous policy version:

- Clarify one supportive testing to confirm possible CIDP. Rationale: 2021 EAN/PNS guidelines on diagnosis and treatment of CIDP: report of a joint task force- second version

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