# Immune Globulin (Asceniv™, Bivigam®, Cutaquig®, Cuvitru®, Flebogamma DIF 5%, Flebogamma DIF 10%, GamaSTAN® S/D, Gammagard Liquid, Gammagard S/D, Gammaplex® 5%, Gammaplex® 10%, Gamunex®-C, Hizentra®, Hyqvia®, Octagam 10%, Panzyga®, Privigen®, Xembify®)

Prior Authorization Drug Coverage Policy

Effective Date: 3/1/2021
Revision Date: n/a
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Lines of Business: Commercial
Policy type: Prior Authorization

This Drug Coverage Policy provides parameters for the coverage of immune globulin (IVIG). Consideration of medically necessary indications are based upon U.S. Food and Drug Administration (FDA) indications, recommended uses within the Centers of Medicare & Medicaid Services (CMS) five recognized compendia, including the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium (Category 1 or 2A recommendations), and peer-reviewed scientific literature eligible for coverage according to the CMS, Medicare Benefit Policy Manual, Chapter 15, section 50.4.5 titled, "Off-Label Use of Anti-Cancer Drugs and Biologics." This policy evaluates whether the drug therapy is proven to be effective based on published evidence-based medicine.

## Drug Description[1-15]

Immune globulin supplies a broad spectrum of opsonizing and neutralizing IgG antibodies against a wide variety of bacterial and viral agents. Immune globulins also contain a spectrum of antibodies capable of interacting with and altering the activity of cells of the immune system as well as antibodies capable of reacting with cells such as erythrocytes. The mechanism of action has not been fully elucidated but may include immunomodulatory effects.

## FDA Indications[1-15]

Immune globulin is FDA indicated for the following:

- Treatment of Primary Immunodeficiency (PI) in adults and pediatric patients two years of age or older.
- Prevention of bacterial infections in hypogammaglobulinemia and/or recurrent bacterial infections associated with B-cell Chronic Lymphocytic Leukemia (CLL).

## NCCN Compendium Supported Indications

- Management of Immunotherapy-Related Toxicities - Immune Checkpoint Inhibitor-Related Toxicities

## Coverage Determinations[1-21]

Immune globulin will require prior authorization. This agent is considered medically necessary for the following oncology indications if all criteria below are met:

**Prophylactic Immune Globulin in B-cell Chronic Lymphocytic Leukemia**

- The member has a diagnosis of B-cell Chronic Leukemia with immune globulin therapy considered medically necessary if the following criteria are met:
  - Member has a documented secondary diagnosis of hypogammaglobulinemia defined as IgG <500mg/dL, **AND/OR**
  - Member has a history of bacterial infections associated with B-cell CLL diagnosis; **AND**
  - The dose of IVIG does not exceed 400 mg/kg every 3 to 4 weeks.

Recommended dose: 400 mg/kg every 3 to 4 weeks

**Prophylactic Immune Globulin in Multiple Myeloma**

- The member has a diagnosis of Multiple Myeloma (MM) with immune globulin therapy considered medically necessary if the following criteria are met:
  - Member has a documented hypogammaglobulinemia defined as IgG <500 mg/dL, **AND/OR**
  - Member has a history of bacterial infections associated with multiple myeloma diagnosis; **AND**
  - The dose of IVIG does not exceed 400 mg/kg every 3 to 4 weeks.

Recommended dose: 400 mg/kg every 3 to 4 weeks

## Management of Immunotherapy-Related Toxicities - Immune Checkpoint Inhibitor-Related Toxicities

- Used for management of the following immunotherapy-related toxicities
  - Consider for severe (G3) or life-threatening (G4) bullous dermatitis
  - Consider for Stevens-Johnson syndrome, or toxic epidermal necrolysis
  - Consider for severe (G3-4) pneumonitis if no improvement after 48 hours of methylprednisolone
  - As treatment for severe (G3-4) myasthenia gravis
  - As treatment for moderate (G2) or severe (G3-4) Guillain-Barré Syndrome or severe (G3-4) peripheral neuropathy in combination with pulse-dose methylprednisolone

- As treatment for encephalitis in combination with pulse-dose methylprednisolone if severe or progressing symptoms, or if oligoclonal bands present
- Strongly consider for transverse myelitis
- Consider as additional therapy for severe (G3) or life-threatening (G4) myocarditis, pericarditis, arrhythmias, impaired ventricular function, or conduction abnormalities if no improvement within 24 hours of starting pulse-dose methylprednisolone
- Consider as additional disease modifying antirheumatic therapy for severe inflammatory arthritis if symptoms do not improve within 2 weeks of starting high-dose corticosteroids
- Consider for moderate, severe, or life-threatening steroid-refractory myalgias or myositis

Recommended dose: Total dosing should be 2g/kg, administered in divided doses per package insert.

**All indications**:

- Immune globulin will be approved through clinical review for up to a 12-month duration

## Coverage Limitations

Treatment with immune globulin is not considered medically necessary for members with the following concomitant conditions:

- Indications not supported by NCCN category 2A or higher may not be considered medically necessary

## Contraindications/Warnings/Precautions[1-10]

- Anaphylactic or severe systemic hypersensitivity reactions to Immune Globulin.
- IgA deficient patients with antibodies against IgA and a history of hypersensitivity.
- Warnings/precautions:
  - IgA deficient patients
  - Renal dysfunction and acute renal failure
  - Thrombosis

For specific recommendations on contraindications, warnings and precautions, patient monitoring, and on dose adjustments and discontinuation, please refer to the current prescribing information.

## Billing

- Description: Immune Globulin
  - Bivigam®
    - HCPCS: J1556
  - Cuvitru®
    - HCPCS: J1555
  - Flebogamma®
    - HCPCS: J1572
  - Gammagard® **
    - HCPCS: J1569
  - Gammaked®
    - HCPCS: J1561
  - Gammaplex®
    - HCPCS: J1557
  - Gamunex-C®
    - HCPCS: J1561
  - Hizentra®
    - HCPCS: J1559
  - Hyqvia®
    - HCPCS: J1575
  - Octagam®
    - HCPCS: J1568
  - Privigen®
    - HCPCS: J1459
  - Xembify
    - HCPCS: J1558

** Gammagard-SD is the only product with treatment for B-cell CLL listed in the package insert with a FDA approved indication.[1,12]

## Disclaimer

Drug Coverage Policies are developed as needed, regularly reviewed, updated at least annually, and are subject to change. Other policies and coverage determination guidelines may apply. Federal and state regulatory requirements and member specific benefit plan documents, if applicable, must be reviewed prior to this Drug Coverage Policy. This Drug Coverage Policy is for informational purposes only and does not constitute medical advice or dictate how providers should practice medicine. This policy should not be reproduced, stored in a retrieval system, or altered from its original form without written permission from Oncology Analytics, Inc.

## References

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