Drug Coverage Policy

Effective Date 9/03/2026
Coverage Policy Number.....IP0776
Policy Title.....Immune Globulin - Intravenous

Immune Globulin - Intravenous

- Alyglo™ (immune globulin intravenous solution-stwk – GC Biopharma)
- Asceniv™ (immune globulin intravenous solution-sira – ADMA Biologics)
- Bivigam® (immune globulin intravenous solution – AMDA Biologics)
- Flebogamma® DIF (immune globulin intravenous solution – Grifols)
- Gammagard® Liquid (immune globulin solution – Baxalta [Takeda])
- Gammagard Liquid ERC® (immune globulin solution – Baxalta [Takeda])
- Gammagard® S/D < 1 mcg/mL in 5% solution (immune globulin intravenous solution – Baxalta [Takeda])
- Gammaked™ (immune globulin solution caprylate/chromatography purified – Kedrion)
- Gammaplex® (immune globulin intravenous solution – Bio Products Laboratory/Kedrion)
- Gamunex®-C (immune globulin solution caprylate/chromatography purified – Grifols)
- Octagam® (immune globulin intravenous solution – Octapharma/Pfizer)
- Panzyga® (immune globulin intravenous solution-ifas – Octapharma/Pfizer)
- Privigen® (immune globulin intravenous solution – CSL Behring)
- Qivigy® (immune globulin intravenous solution-kthm – Kedrion
- Yimmugo® (immune globulin intravenous solution-dira – Biotest (Grifols)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only

be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW

Immune globulin intravenous (IVIG) products are concentrated human immunoglobulins, primarily immunoglobulin G (IgG).

All of these products (except Octagam 10%) are FDA-approved for replacement therapy in patients with **primary immune deficiencies** due to defects in humoral immunity. The following indications are FDA approved:

- **B-cell chronic lymphocytic leukemia (CLL)**, for prevention of bacterial infections in patients with hypogammaglobulinemia and/or recurrent infections.[6,18,21]
- **Chronic inflammatory demyelinating polyneuropathy (CIDP)**, to improve neuromuscular disability and impairment and for maintenance therapy to prevent relapse.[5,7,9,12,15,67]
- **Dermatomyositis (or polymyositis)**. Octagam 10% is indicated for the treatment of dermatomyositis in adults.[11] Patients with dermatomyositis treated with Octagam were under treatment with corticosteroids and/or maximally two immune-suppressants OR patients had previous failure or intolerance with a corticosteroid and at least one additional immunosuppressive drug.[33]
- **Idiopathic (immune) thrombocytopenic purpura (ITP)**, acute and chronic, when a rapid rise in platelet count is needed to prevent and/or control bleeding or to allow a patient with ITP to undergo surgery.[2,6-9,11,12,15,23-25]
- **Kawasaki disease** in pediatric patients for the prevention of coronary artery aneurysm.[6,26] The American Heart Association and the American Academy of Pediatrics recommend initial therapy with 2 g of IVIG per kg as a single intravenous (IV) dose given over 10 to 12 hours.[26] The dose can be repeated if needed.
- **Multifocal motor neuropathy** in adults as maintenance therapy to improve muscle strength and disability.[5]
- **Primary humoral immune deficiency (PID)**, for replacement therapy, including but not limited to the humoral immune defect in the following conditions: common variable immunodeficiency, X-linked agammaglobulinemia [congenital agammaglobulinemia], Wiskott-Aldrich Syndrome, and severe combined immunodeficiencies.[1-3,5-10,12,15,16,25,53,80,84,85] Gammagard Liquid 10%, Gammaked, Gamunex-C, and Gammagard Liquid ERC may be administered via IV or subcutaneous infusion for primary immunodeficiency.[5,7,9,84] IVIG is also indicated for measles prophylaxis in individuals with PID who have been exposed to measles or who are at high risk of measles exposure.[3,7-10,12,13,17,25,45,80,84,85] Inborn errors of immunity includes all congenital disorders that primarily affect immune function, including primary immunodeficiencies.[99]

IVIG is prepared from pooled plasma collected from a large number of human donors.[1-3,5-12,15,16,25] The donors in a typical pool of plasma have a wide range of antibodies against infectious agents. These products have IgG subclasses similar to that found in normal humans. Asceniv contains not

only antibodies which satisfy the requirement to treat patients with PID, it also has elevated levels of respiratory syncytial virus (RSV) antibodies.[19]

IVIG also is used for many off-label indications. Much of the evidence for clinical effectiveness of IVIG is anecdotal (i.e., case reports, open series, or cohort studies). Some conditions have been studied in controlled trials. Usually, IVIG is indicated only if standard approaches have failed, become intolerable, or are contraindicated.

- **Antibody-mediated rejection (ABMR) in transplantation:** Current strategies for treatment of antibody-mediated rejection include plasmapheresis, IVIG, and T-cell or B-cell-depleting agents.[75] Although there are no controlled trials regarding the most appropriate treatments, the benefits of immune globulin have been well described and has been used as the standard-of-care (along with plasmapheresis) in multiple studies.[18,76] Clinical practice guidelines (2009 Kidney Disease: Improving Global Outcomes) recommends a combination of corticosteroids, plasmapheresis, IVIG, anti-CD20 antibody, and lymphocyte-depleting antibody for antibody-mediated rejection.[76,77] As in desensitization therapy, much of the information for IVIG use is in patients with kidney transplants, but the same principles apply to transplantation of other organs and tissues. Immune globulin has been used in lung transplant patients to treat ABMR[20,44,78] and a scientific statement from the American Heart Association states that primary therapy for ABMR in patients with heart transplants may include IVIG, plasmapheresis, high-dose corticosteroids, and anti-lymphocyte antibodies.[36]
- **Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid], and epidermolysis bullosa acquisita):** Conventional therapy (a systemic corticosteroid and an immunosuppressive agent) is started at the same time or before IVIG. Many case reports and uncontrolled case series suggest benefit of IVIG in patients with recalcitrant disease or in those with contraindications to conventional therapy.[28-30] International expert recommendations for the management of pemphigus note that first-line treatment includes corticosteroids and anti-CD20 monoclonal antibodies. First-line corticosteroid-sparing agents include azathioprine and mycophenolate mofetil, and other corticosteroid-sparing agents including IVIG.[2]
- **Aquaporin-4 Immunoglobulin Antibodies (AQP4-IgG)-positive Neuromyelitis Optica Spectrum Disorder (NMOSD):** NMOSD is an inflammatory disorder of the central nervous system characterized by severe, immune-mediated demyelination and axonal damage.[32] The range of NMOSD has expanded to include patients with aquaporin-4 (AQP4) antibody positivity who have single or recurrent attacks of optic neuritis, myelitis, or brainstem syndromes. Antibodies against AQP4 are present in the majority of NMOSD patients.[52] The loss of AQP4 expression leads to loss of nervous system cells and neuron damage. Products recommended for long-term management of the condition include rituximab, azathioprine, mycophenolate, and therapeutic antibodies, such as Soliris® (eculizumab intravenous infusion), Ultomiris® (ravulizumab-cwvz intravenous infusion), Uplizna® (inebilizumab-cdon intravenous infusion), and Enspryng® (satralizumab-mwge subcutaneous injection). IVIG is recommended in children or in case of contraindications to other long-term therapies.[52]
- **Coronavirus Disease-2019 (COVID-19)-Associated Multisystem Inflammatory Syndrome in Children (MIS-C):** MIS-C is a rare, but serious complication that may begin weeks after being infected with the virus that causes COVID-19. Patients diagnosed with MIS-C should be hospitalized. Treatment generally involves IVIG and steroids, both of which treat the overactive immune response.[94] American College of Rheumatology guidelines in MIS-C (2022) state that in select patients with mild disease or contraindications to glucocorticoids, IVIG alone may be appropriate as first-line treatment for MIS-C.[95]

- **Cytomegalovirus (CMV) pneumonitis or pneumonia in patients with cancer or transplant-related infection:** For CMV pneumonia, therapy generally consists of antivirals (e.g., ganciclovir, foscarnet). The National Comprehensive Cancer Network (NCCN) guidelines on prevention and treatment of cancer-related infections (version 1.2025 – June 20, 2025) lists IVIG as an adjunctive therapy for CMV pneumonitis.[31]
- **Desensitization therapy prior to and immediately after transplantation:** Most of the information on use of IVIG for desensitization is in patients with kidney transplantation but many of the same principles apply to transplantation of other organs and tissues.[34,35] Current protocols include using low-dose IVIG with plasma exchange or high-dose IVIG with or without B-cell depletions with rituximab.[18]
- **Evan's syndrome:** Is a rare autoimmune conditions generally characterized by simultaneous or sequential occurrence of ITP and autoimmune hemolytic anemia.[87] IVIG is not generally administered as chronic or maintenance therapy, it serves as a short-term adjunctive intervention to achieve rapid disease control. Treatment is extrapolated from dosing used for ITP.
- **Guillain Barré syndrome (GBS):** The American Academy of Neurology recommends IVIG in patients who require aid to walk within 2 or 4 weeks from the onset of neuropathic symptoms.[37] The European Academy of Neurology/Peripheral Nerve Society guideline on diagnosis and treatment of GBS (2023) recommends IVIG or plasma exchange in patients for up to 4 weeks after onset of weakness.[38] For patients who are > 4 weeks of onset and are still deteriorating, other diagnoses should be considered. The guidelines additionally note that observational data indicates that a repeated course of IVIG can be effective in case of treatment-related fluctuation.
- **Hematologic neoplasm-associated hypogammaglobulinemia or hypogammaglobulinemia after B-cell targeted therapies (secondary immunodeficiency):** Clinical guidelines for immunoglobulin use by the National Health Service-England note secondary antibody deficiency can be hypogammaglobinemia associated with therapeutic monoclonals targeted at B-cells and plasma cells, non-Hodgkin's lymphoma, CLL, multiple myeloma, or other relevant B-cell malignancies.[27] NCCN guidelines regarding management of chimeric antigen receptor (CAR)-T cell-related toxicities (version 2.2026 – November 11, 2025) recommends that after anti-CD19 CAR-T cell therapy, IVIG replacement should be considered for patients with serum IgG levels < 400 to 600 mg/dL and serious or recurrent infections.[73] NCCN drug compendia also notes IVIG should be administered during therapy with inotuzumab ozogamicin, blinatumomab, or tisagenlecluecel until B-cell recovery.[86] European guidelines note that IgG replacement in the first 3 months after CAR-T therapy is considered routine for children due to immunological maturity.[81]
- **Hematopoietic cell transplantation (HCT) to prevent infections:** HCT is defined as transplantation of any blood- or marrow-derived hematopoietic stem cells, regardless of transplant type (i.e., allogeneic or autologous) or cell source (i.e., bone marrow, peripheral blood, or umbilical cord blood). With regard to IVIG, guidelines recommend IVIG for prevention or preemptive treatment of specific infections in HCT recipients.[39] In adult or adolescent HCT recipients (allogeneic or autologous), IVIG is used to prevent infections in those with severe hypogammaglobulinemia (i.e., serum IgG < 400 mg/dL) during the first 100 days after HCT. In pediatric patients, IVIG is indicated in those with an allogeneic HCT if hypogammaglobulinemia is severe during the first 100 days after HCT. For prevention of infections beyond 100 days post-HCT (allogeneic or autologous), IVIG is recommended in recipients with severe hypogammaglobulinemia (i.e., serum IgG < 400 mg/dL). Guidelines from the American Society for Blood and Marrow Transplantation make recommendations for IVIG dosing in HCT recipients to prevent infectious complications.[39] During the first 100 days after HCT, the dose in adults and adolescents is 0.5 g/kg per week. The IVIG dose should be individualized to maintain trough (pre-dose) serum IgG > 400 to 500 mg/dL. The dose in allogeneic pediatric HCT patients is 0.4 g/kg per month, adjusted to keep IgG

> 400 mg/dL. Higher and more frequent dosing may be necessary in patients for prevention of early disease after HCT because the half-life of IVIG is reduced to between 1 to 10 days in this population. Dosing for > 100 days post-HCT is 0.5 g/kg given every 3 to 4 weeks. The dose is not adjusted using serum IgG level in patients with multiple myeloma or malignant macroglobulinemia. NCCN guidelines on HCT (version 3.2025 – September 24, 2025) states there may be subsets of patients where prophylactic immune globulin replacement may be considered, such as recipients of an umbilical cord blood transplant, in patients undergoing transplantation for inherited or acquired disorders associated with B-cell deficiency, and in patients with chronic graft versus host disease with recurrent sinopulmonary infections.[82]

- **Human immunodeficiency virus (HIV)- or Hepatitis C-associated thrombocytopenia:** Secondary ITP can occur in patients with HIV infection.[23,24] It can also occur in patients with Hepatitis C. The American Society of Hematology (ASH) guidelines for ITP recommend initial treatment with corticosteroids, IVIG, or Rh0(D) immune globulin for patients with secondary ITP due to HIV. ASH also recommends IVIG for secondary ITP associated with Hepatitis C.[23,24]
- **HIV-infected infants and children to prevent recurrent infections:** IVIG is recommended to prevent serious bacterial infections in HIV-infected children who have hypogammaglobulinemia (IgG < 400 mg/dL).[40] Clinicians providing care for adolescents are advised to use the US Department of Health and Human Services Adult and Adolescent HIV-guideline for the care of post-pubertal adolescents (sexual maturity rating [SMR] four and five) and to use the pediatric guideline for guidance on the care of adolescents at SMR 3 or lower.[40]
- **Immune-Mediated Necrotizing Myopathy:** Muscle weakness is the predominant clinical feature and sometimes severely affects the lower limbs.[56] Pharyngeal muscles may also be affected and dysphagia is common. Serum creatine kinase (CK) is also high. The CK value can widely vary but is often well above 1,000 IU/L.[62] Myositis-specific antibodies are often detected (e.g., anti-HMGCR antibodies, anti-SRP antibodies). Muscle imaging and biopsy can also be useful to confirm the diagnosis. International consensus guidelines recommend IVIG as a second-line agent for anti-HMGCR to avoid long-term disability.[63] For patients with anti-HMGCR monotherapy with IVIG has also been used.[62]
- **Immunotherapy-related toxicities associated with checkpoint inhibitor therapy:** NCCN guidelines for the management of immunotherapy-related toxicities (version 2.2024 – October 25, 2024) recommends IVIG for the management of suspected myocarditis/pericarditis/large vessel vasculitis, severe pneumonitis after 48 hours of methylprednisolone therapy, severe myasthenia gravis, encephalitis, moderate or severe GBS, demyelinating disease, myositis, bullous dermatitis, and Stevens-Johnson syndrome/toxic epidermal necrolysis.[73] The American Society of Clinical Oncology also has practice guidelines on the management of immune-related adverse events in patients treated with checkpoint inhibitor therapy.[74] These practice guidelines note that corticosteroids may be administered for toxicities and refractory or severe cases may require other immunosuppressive therapies or IVIG.
- **Lambert-Eaton Myasthenic Syndrome:** Limited, but moderate- to high-quality evidence from randomized controlled trials have shown that 3,4-diaminopyridine or IVIG was associated with improved muscle strength score and compounded muscle action potential amplitudes. IVIG may be used as an alternative in patients who do not respond or do not tolerate other therapies.[18]
- **Multiple myeloma:** Patients with multiple myeloma are often functionally hypogammaglobulinemic with total immunoglobulin production being elevated, but the repertoire of antibody production restricted.[31] The NCCN guidelines on multiple myeloma (version 3.2026 – November 3, 2025) recommends immune globulin replacement with CAR-T cell and bispecific antibody therapies, based on clinical context.[42] NCCN also notes replacement can be considered for IgG < 400 mg/dL and recurrent life-threatening

infections, making sure to consider the portion of IgG that is clonal. NCCN guidelines on CAR-T cell therapy toxicities notes that immune globulin replacement during CAR-T cell therapy in patients with multiple myeloma is not guided by the presence of infections.[73]

- **Multiple sclerosis, acute severe exacerbation or relapses:** Medication options for relapse management include high dose corticosteroids, intramuscular adrenocorticotrophic hormone, plasmapheresis, and IVIG. IVIG is sometimes used to treat relapses that do not respond to corticosteroids.[43] During pregnancy, relapses severe enough to require treatment can be safely managed with a short-term course of corticosteroids after the first trimester. Methylprednisolone is the preferred agent because it is metabolized before crossing the placenta.[43]
- **Myasthenia gravis:** Recommendations from an international consensus guidance statement for management of adult or juvenile myasthenia gravis include the use of IVIG in some patients.[65] An update to these guidelines provides new recommendations for methotrexate, rituximab, and eculizumab intravenous infusion (Soliris®, biosimilars).[98] The international consensus guidance statement for myasthenia gravis[65] recommends an initial dose of 2 g/kg given in divided doses over 2 to 5 days. For maintenance therapy, the recommended dose is 0.4 to 1 g/kg given every 4 weeks; an attempt to decrease frequency can be made over time. If additional treatment is required, the dose should be adjusted based on the response.
- **Myelin Oligodendrocyte Glycoprotein Antibody-Associated Disease (MOGAD):** International MOGAD Panel proposed criteria reports the central nervous system demyelinating features of this condition include optic neuritis (most common feature), acute disseminated encephalomyelitis (with or without optic neuritis), transverse myelitis, and other less common presentations.[69] Serological evidence of myelin oligodendrocyte glycoprotein (MOG)-IgG is also seen. MOGAD can present as an acute attack and relapses of attacks; a diagnosis of multiple sclerosis should be excluded. Disease flares in MOGAD are generally treated with high dose corticosteroids.[70] A typical dose used for IVIG is 0.4 g/kg/day for 5 days. Maintenance therapy is generally offered in patients who have had two or more attacked; however, exceptions are noted in cases to prevent further disability.[70] For maintenance infusions, a loading dose of 0.4 g/kg/day for 5 days can be given, followed by treatment every 4 weeks with a dose of 0.4 g/kg to 2 g/kg.
- **Neonatal Isoimmune Hemolytic Disease (Hemolytic Disease of the Fetus and Newborn), Acute Treatment:** Neonatal isoimmune hemolytic disease occurs when maternal IgG antibodies cross the placenta and destroy fetal red blood cells, leading to fetal/neonatal anemia and hyperbilirubinemia.[88] IVIG (0.5 to 1 g/kg) may be provided when total serum bilirubin (TSB) reaches or exceeds escalation of care threshold. The use of IVIG during escalation of care may reduce hemolysis and stabilize or reduce TSB concentrations, preventing the need for exchange transfusion. IVIG may be considered in patients who have not initially responded to phototherapy when the TSB is rising or it is within 2 to 3 mg/dL of the exchange level.[89]
- **Opsoclonus-Myoclonus-Ataxia Syndrome (OMAS):** OMAS is a rare immune-mediated neurological disorder; it occurs in three main contexts: paraneoplastic (most commonly neuroblastoma in children), post-infectious, and idiopathic. Various regimens have been used including dexamethasone, adrenocorticotropic hormone, and IVIG.[96] IVIG may be given as a dose of 2 g/kg over 2 to 5 days followed by 1 to 2 g/kg every 4 weeks.
- **Passive immunization for measles (post-exposure prophylaxis):** When administered within 6 days of exposure, immune globulin (IG) can prevent or modify measles in patients who are nonimmune.[13] IG therapy is not indicated in persons who have received one dose of measles-containing vaccine at ≥ 12 months, unless the patient is severely immunocompromised. The Advisory Committee on Immunization Practices (ACIP) recommends the use of IG therapy for post-exposure prophylaxis of measles in the following patients who are at risk for severe disease and complication from measles: infants < 12 months of age, pregnant women without evidence of measles immunity, and

severely immunocompromised persons.[13] For infants < 12 months of age, intramuscular IG is used; infants 6 through 11 months of age can receive measles, mumps, and rubella vaccine instead of IG if given within 72 hours of exposure. IVIG is used for pregnant women and severely immunocompromised patients. ACIP recommends 400 mg/kg as an IV infusion.[13] The American College of Obstetricians and Gynecologists Practice Advisory on pregnant patients during a measles outbreak (2024, last updated May 2025) recommends pregnant patients with suspected measles exposure, but without immunity (or those who cannot readily show evidence of immunity), should receive IVIG 400 mg/kg within 6 days of exposure.[4] It additionally states that infants born to pregnant patients with suspected or confirmed measles should be given postexposure prophylaxis with IVIG, as the mother with measles can be infectious for up to days after the rash appears.

- **Parvovirus B19 infection and pure red blood cell aplasia, immunologic subtype:** In immunosuppressed patients lacking neutralizing antibodies, IVIG has been useful for the treatment of persistent B19 infection.[49] The guidelines from the American Society of Transplantation Infectious Diseases Community of Practice state that IVIG is frequently used for the treatment of solid organ transplant recipients with symptomatic parvovirus B19 infection.[66] A Canadian expert panel of hematologists recommend prednisone followed by cyclophosphamide or cyclosporine as first-line therapy for immunologic type pure red blood cell aplasia.[22] The panel considers IVIG a reasonable second-line option for this serious condition. Recent reviews note that 200 to 400 mg/kg/day for 5 to 10 days is considered the recommended treatment course.[79]
- **Post-exposure prophylaxis for varicella OR treatment or post-exposure prophylaxis for tetanus:** Children infected with HIV who lack evidence of immunity to varicella or who have severe immune suppression should receive VariZIG® (human varicella-zoster immune globulin for intramuscular administration)®.[40,41] An alternative to varicella-zoster immune globulin for passive immunization is oral valacyclovir or acyclovir beginning 7 days after exposure, and if this is not available, IVIG administered once within 10 days after exposure.[41] VariZIG is indicated for post-exposure prophylaxis in high risk individuals.[47] The dose is 400 mg/kg given once.[40,41,46] Per the Centers for Disease Control and Prevention, if tetanus immune globulin is not available, clinicians can use immune globulin at a dose of 200 to 400 mg/kg.[48]
- **Post-Transfusion Purpura, Acute Treatment:** Post-transfusion purpura is a rare but serious transfusion-associated complication. It is characterized by thrombocytopenia developing within 2 weeks of tranfusion.[91] IVIG is considered the treatment of choice for this condition. Recommended doses are 400 to 500 mg/kg/day for 1 to 10 days or 1-2 g/kg/day for 2 to 5 days.
- **Rasmussen Encephalitis:** Rasmussen encephalitis is a rare, progressive autoimmune disorder characterized by unilateral hemispheric inflammation that can lead to epilepsy, progressive hemiparesis, and cognitive decline. IVIG is commonly used as first-line therapy, although no universally standardized treatment exists.[97]
- **Red Blood Cell Alloantibodies During Pregnancy:** The clinical practice guidelines for the management of pregnancy alloimmunized to red blood cell antigens (2025) recommends the use of IVIG in patients with a documented antigen-positive fetus and a history of either fetal anemia or a fetal loss due to HDFN before 24 weeks' gestation age in a previous pregnancy.[90]
- **Stiff-Person Syndrome (Moersch-Woltman Syndrome):** Per the European Federation of Neurological Societies, IVIG should be reserved for patients who have no symptomatic relief after the use of diazepam and/or baclofen and have severe disability in carrying out daily activities.[83]

- **Thrombocytopenia, feto-neonatal alloimmune:** Antenatal therapy with IVIG administered to the mother is effective in increasing fetal platelet counts in neonatal alloimmune thrombocytopenia.[50,51] First-line therapy for newborns with fetal/neonatal alloimmune thrombocytopenia is antigen-negative compatible platelets; IVIG is adjunctive therapy.
- **Toxic Shock Syndrome, Acute Treatment:** Per the Red Book® (2026), IVIG can be strongly considered for toxic shock syndrome if the patient is moderately to severely ill, although its use is supported by limited data.[93]
- **Warm Type Autoimmune Hemolytic Anemia:** First-line therapy for warm autoimmune hemolytic anemia is prednisone or rituximab.[92] Patients with severe hemolysis may not maintain satisfactory hemoglobulin. IVIG and plasma exchange can be a bridging therapy and alternatives such as immunosuppression can also be considered.

Coverage Policy

POLICY STATEMENT

Prior Authorization is required for benefit coverage of IVIG products. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indications. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with IVIG products as well as the monitoring required for adverse events and long-term efficacy, some approvals require IVIG products to be prescribed by or in consultation with a physician who specializes in the condition being treated.

If the prescriber is switching between IVIG products and a case has already been approved by a clinician, a new approval may be entered without another clinical review. The new approval should only be extended for the remaining doses and duration which were granted on the original review. The indication (or diagnosis code) and dosing need to be the same as the original review. If the indication or dosing is different, a new clinical review would need to be completed

Documentation: Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, prescription receipts and/or other information. All documentation must include patient-specific identifying information.

Immune globulin intravenous products are considered medically necessary when ONE of the following is met:

FDA-Approved Indications

1. **Primary Immunodeficiencies.** Approve for 1 year if the patient meets ONE of the following (A or B):
   A) Initial Therapy. Approve if the patient meets ALL of the following (i, ii and iii):
      i. Patient meets ONE of the following (a, b, or c):
      Note: An exception can be made for the impaired antibody response if, according to the prescriber, the delay caused by pre-vaccination and post-vaccination antibody measurement would be deleterious to the patient's health.

a) Patient has a diagnosis of congenital agammaglobulinemia, X-linked agammaglobulinemia, other agammaglobulinemia due to the absence of B-cells, Wiskott-Aldrich syndrome, ataxia telangiectasia, DiGeorge syndrome, severe combined immunodeficiency, Hyper-Immunoglobulin M (IgM) syndromes, an IgG level lower than 250 mg/dL, or a primary immune deficiency which has been confirmed by genetic or molecular testing **[documentation required]**; OR
Note: Molecular testing is a type of genetic testing.

b) Patient has a diagnosis of common variable immunodeficiency or other immunodeficiencies with significant hypogammaglobulinemia **[documentation required]** and meets ALL of the following [(1), (2), and (3)]:

(1) Patient's pretreatment IgG level is below the normal range (age-adjusted and according to the normal reference range for the reporting laboratory) **[documentation required]**; AND

(2) Patient has an impaired antibody response (e.g., failure to produce antibodies to specific antigens) **[documentation required]**; AND

(3) Patient has recurrent infections; OR

c) Patient has an IgG subclass deficiency, selective antibody deficiency (SAD), or another confirmed primary immunodeficiency **[documentation required]** and meets the following criteria [(1) and (2)]:

(1) Patient has an impaired antibody response (e.g., failure to produce antibodies to specific antigens) **[documentation required]**; AND

(2) Patient has recurrent infections; AND

ii. The medication is prescribed by or in consultation with one of the following physician specialists: an allergist, immunologist, otolaryngologist (ear nose and throat [ENT] physician), pulmonologist, or infectious diseases physician who treats patients with primary immune deficiencies; AND

iii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Patient is Currently Receiving Immune Globulin. Approve if the patient has been diagnosed with a primary immunodeficiency and according to the prescriber, is continuing to receive benefit from the product.
Note: Examples of continued benefit with the product includes increased IgG levels or prevention and/or controlling of infections.

Dosing. Approve ONE of the following dosing regimens (A, B, C, or D):

A) An initial loading dose of 1 g/kg given intravenously one time; OR

B) 0.2 g/kg to 0.8 g/kg given intravenously once every 3 to 4 weeks; OR

C) The dose and interval between doses have been adjusted based on clinical response as determined by the prescriber; OR

D) Patients with primary immune deficiency and exposure to measles (previous exposure or risk of future measles exposure), the minimum dose has been determined by the prescriber.

2. B-Cell Chronic Lymphocytic Leukemia for Prevention of Infections. Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 4 months if the patient meets ALL of the following (i, ii, and iii):

i. Patient meets ONE of the following (a or b):

a) Patient has an immunoglobulin G (IgG) level <600 mg/dL (6.0 g/L) **[documentation required]**; OR

b) Patient has a history of recurrent infections **[documentation required]**; AND

ii. The medication is prescribed by or in consultation with an oncologist, hematologist, immunologist, or infectious diseases physician; AND

iii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Patient is Currently Receiving Immune Globulin. Approve for 1 year if the patient has a positive response to therapy according to the prescriber.
Note: Examples of a positive response to therapy include maintaining an increased IgG trough level or a decrease in the number of infections.

Dosing. Approve ONE of the following dosing regimens (A or B):

A) 0.2 g/kg to 0.8 g/kg given intravenously every 3 to 4 weeks; OR

B) The dose and interval have been adjusted to maintain a trough (pre-dose) IgG level of greater than 500 mg/dL.

3. Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) or Polyradiculoneuropathy. Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 3 months if the patient meets ALL of the following (i, ii and iii):

i. Electrodiagnostic studies support the diagnosis of CIDP **[documentation required]**; AND

ii. The medication is prescribed by or in consultation with a neurologist; AND

iii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Patient is Currently Receiving Immune Globulin. Approve for 1 year if the patient has a clinically significant improvement in neurologic symptoms, as determined by the prescriber.
Note: Examples of improvement in neurologic symptoms include improvement in disability; nerve conduction study results improved or stabilized; physical examination show improvement in neurological symptoms, strength (e.g., grip strength), and sensation.

Dosing. Approve ONE of the following dosing regimens (A, B, or C):

A) An initial loading dose of 2 g/kg given intravenously in divided doses over 2 to 5 consecutive days; OR

B) A maintenance dose of 1 g/kg given intravenously in divided doses over 1 to 4 consecutive days given every 3 weeks; OR

C) The dose and interval are adjusted according to clinical response with a maximum dose per treatment course of 2 g/kg.

4. Dermatomyositis or Polymyositis. Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii, iii, iv, and v):

i. Prior to starting any therapy for this condition, the patient meets ONE of the following (a or b):

a) According to the prescriber, Patient has or had an elevated creatine kinase (CK) level; OR

b) Other measures support the diagnosis, according to the prescriber, including, but not limited to, skin manifestations, myositis autoantibody testing, muscle biopsy results, electromyographic (EMG) findings; AND

ii. Patient has tried a systemic corticosteroid OR a corticosteroid is contraindicated according to the prescriber; AND

iii. Patient has tried a nonsteroidal immunosuppressive agent OR a nonsteroidal immunosuppressive agent is contraindicated according to the prescriber; AND
Note: Examples of nonsteroidal immunosuppressive agents include azathioprine, methotrexate, cyclosporine, cyclophosphamide, and mycophenolate mofetil.

iv. The medication is prescribed by or in consultation with a neurologist or a rheumatologist; AND

v. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Patient is Currently Receiving Immune Globulin. Approve for 1 year if the patient has responded to therapy according to the prescriber.
Note: Examples of a response to therapy includes improved muscle strength, improved neuromuscular symptoms, and improved functional ability.

Dosing. Approve ONE of the following dosing regimens (A or B):

A) 2 g/kg given intravenously in divided doses over 2 to 5 consecutive days every 4 weeks; OR

B) 2 g/kg given intravenously in divided doses over 2 to 5 consecutive days every 2 to 3 weeks.

5. Immune Thrombocytopenia (ITP). Approve for the duration noted if the patient meets ONE of the following (A, B, C, D, or E):
Note: The diagnosis of ITP encompasses previous nomenclature, such as idiopathic thrombocytopenia, idiopathic thrombocytopenic purpura, immune thrombocytopenic purpura.

A) Initial Therapy – Adult ≥ 18 Years of Age: Approve for 3 months if the patient meets ALL of the following (i, ii and iii):

i. Patient meets ONE of the following (a, b, or c):

a) Patient has tried a systemic corticosteroid (e.g., prednisone) **[documentation required]**; OR

b) There is an urgent need to increase the platelet count quickly **[documentation required]**; OR

c) According to the prescriber, a systemic corticosteroid is contraindicated; AND

ii. The medication is prescribed by or in consultation with a hematologist; AND

iii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Initial Therapy – Patient is < 18 Years of Age. Approve for 3 months if BOTH of the following (i and ii) are met:

i. The medication is prescribed by or in consultation with a hematologist; AND

ii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

C) Initial Therapy – To Increase Platelet Count Before Surgical or Dental Procedures. Approve for 1 month if BOTH of the following (i and ii) are met:

i. The medication is prescribed by or in consultation with a hematologist; AND

ii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

D) Initial Therapy – Pregnant Patient. Approve for 6 months if BOTH of the following (i and ii) are met:

i. The medication is prescribed by or in consultation with a hematologist; AND

ii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

E) Patient is Currently Receiving Immune Globulin OR Requires Retreatment with Immune Globulin. Approve for 1 year if the patient is responding to therapy OR if the patient has previously responded to therapy, according to the prescriber.
Note: Examples of responding to therapy include increased platelet counts, absence of significant bleeding, or preventing hemorrhage/ensuring an adequate platelet count in order for delivery in pregnant patients.

Dosing. Approve ONE of the following dosing regimens (A or B):

A) Up to 1 g/kg on 2 consecutive days OR up to 0.4 g/kg on 5 consecutive days (up to a total of 2 g per kg per treatment course); OR

B) The dose and interval between doses have been adjusted according to the platelet count and/or to prevent significant bleeding as determined by the prescriber.

6. Kawasaki Disease. Approve for 3 months if BOTH of the following are met (A and B):
- **A)** The medication is prescribed by or in consultation with a pediatric cardiologist, a pediatric infectious diseases physician, or a pediatric rheumatologist; AND
- **B)** Preferred product criteria is met for the product(s) as listed in the below table(s).

Dosing. Approve up to 2 g/kg given intravenously as a single dose or over multiple consecutive days. The dose may be repeated if needed.

7. Multifocal Motor Neuropathy, Approve for the duration noted if the patient meets ONE of the following (A or B):
- **A)** Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii and iii):
  - **i.** The diagnosis is supported by weakness without sensory abnormalities, upper motor neuron signs, or marked bulbar involvement and meets ONE of the following (a, b, or c):
    - **a)** The diagnosis is supported by nerve conduction studies that demonstrate motor conduction block or probable motor conduction block **[documentation required]**; OR
    - **b)** The prescriber has determined the patient has multifocal motor neuropathy without conduction block **[documentation required]**; OR
    - **c)** The diagnosis is supported by a motor nerve biopsy or by a magnetic resonance imaging (MRI) neurography **[documentation required]**; AND
  - **ii.** The medication is prescribed by or in consultation with a neurologist; AND
  - **iii.** Preferred product criteria is met for the product(s) as listed in the below table(s); OR
- **B)** Patient is Currently Receiving Immune Globulin. Approve for 1 year if the patient has improvement in neurologic symptoms as determined by the prescriber.
  Note: Examples of improvement in neurologic symptoms include improvement in disability, grip strength improvement (measured with dynamometer), physical examination show improvement in neurological symptoms and strength.

Dosing. Approve ONE of the following dosing regimens (A or B):
- **A)** Therapy is initiated with 2 g/kg given intravenously in divided doses over 2 to 5 consecutive days; OR
- **B)** ONE of the following maintenance dosing regimens is used (i, ii, or iii):
  - **i.** 0.5 g/kg to 2.4 g/kg given intravenously every month; OR
  - **ii.** 1 g/kg given intravenously every 2 to 4 weeks; OR
  - **iii.** 2 g/kg given intravenously every 1 to 2 months.

Other Uses with Supportive Evidence

8. Antibody-Mediated Rejection in Transplantation. Approve for 1 year if the patient meets BOTH of the following (A and B):
- **A)** The medication is prescribed by or in consultation with a physician affiliated with a transplant center; AND
- **B)** Preferred product criteria is met for the product(s) as listed in the below table(s).

Dosing. Approve ONE of the following dosing regimens (A or B):

A) Up to 2 g/kg as an intravenous infusion (as a single dose or divided in smaller doses [e.g., 400 mg per kg daily for 5 days]); OR
B) The dosage is based on a transplant center's protocol.

9. Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatricial Pemphigoid], and Epidermolysis Bullosa Acquisita).
Approve for the duration noted if the patient meets ONE of the following (A or B):
A) Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii and iii):
i. Patient meets ONE of the following (a, b, or c):
a) Patient meets BOTH of the following [(1) and (2)]:
(1) Patient has tried a systemic corticosteroid OR a corticosteroid is contraindicated according to the prescriber; AND
(2) Patient has tried a nonsteroidal immunosuppressive agent OR a nonsteroidal immunosuppressive agent is contraindicated according to the prescriber; OR
Note: Examples of nonsteroidal immunosuppressive agents include azathioprine, cyclophosphamide, dapsone, methotrexate, cyclosporine, mycophenolate mofetil, and tacrolimus.
b) Patient has rapid, debilitating, progressive disease that cannot be controlled with a systemic corticosteroid and a nonsteroidal immunosuppressive agent **[documentation required]**; OR
c) The disease is so serious that there is inadequate time for therapy with a systemic corticosteroid and a nonsteroidal immunosuppressive agent to have a rapid enough effect **[documentation required]**; AND
ii. The medication is prescribed by or in consultation with a dermatologist; AND
iii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR
B) Patient is Currently Receiving Immune Globulin. Approve for 1 year if the patient has responded to therapy according to the prescriber.
Note: Examples of response to therapy can include healing of previous lesions or fewer new lesions.

Dosing. Approve ONE of the following dosing regimens (A, B, or C):
A) 2 g/kg per cycle given intravenously every 3 to 4 weeks. This dose is divided over 2, 3, or 5 consecutive days; OR
B) In patient with aggressive ocular disease, such as ocular cicatricial pemphigoid, 2 g/kg given intravenously may be given every 2 weeks in divided doses over 2, 3, or 5 consecutive days; OR
C) The frequency is gradually being slowly decreased as the lesions resolve and heal.

10. Aquaporin-4 Immunoglobulin Antibodies (AQP4-IgG)-Positive Neuromyelitis Optica Spectrum Disorder (NMOSD). Approve for the duration noted if the patient meets ONE of the following (A or B):
A) Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii, iii, iv, and v):
i. Patient has the presence of at least one core clinical feature of NMOSD, according to the prescriber; AND
Note: Examples of core clinical features of NMOSD include optic neuritis, acute myelitis, acute brainstem syndrome.
ii. The diagnosis was confirmed by a positive blood serum test for AQP4-IgG **[documentation required]**; AND

Note: Detection in cerebral spinal fluid would also satisfy this requirement.

iii. Patient is using the requested medication for attack prevention AND meets ONE of the following (a or b):

a) Patient is < 18 years of age; OR

b) According to the prescriber, the patient has tried or has a contraindication to one other therapy for this condition; AND

Note: Examples of other therapies for this condition include azathioprine, mycophenolate mofetil, rituximab, Enspryng (satralizumab subcutaneous injection), Soliris (eculizumab intravenous injection), Ultomiris (ravulizumab intravenous injection), Uplizna (inebilizumab intravenous injection).

iv. The medication is prescribed by or in consultation with a neurologist; AND

v. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Patient is Currently Receiving Immune Globulin. Approve for 1 year if the patient has responded to therapy, according to the prescriber.

Note: Examples of a response to therapy includes reduction in relapse rate, reduction in symptoms, slowing in the progression of symptoms.

Dosing. Approve up to 2 g/kg per month administered intravenously (as a single dose or divided in smaller doses [e.g., 400 mg per kg daily for 5 days]).

11. Coronavirus Disease-2019 (COVID-19)-Associated Multisystem Inflammatory Syndrome in Children (MIS-C). Approve for 1 month if the patient meets ALL of the following (A, B, C, D, and E):

A) Patient is < 21 years of age; AND

B) Patient meets ONE of the following (i or ii):

i. Positive for current or recent COVID infection by molecular (PCR), antigen (ELISA) laboratory methods or serology results **[documentation required]**; OR

ii. COVID exposure within 60 days prior to hospitalization **[documentation required]**; AND

C) Patient has ALL of the following symptoms and laboratory findings (i, ii, and iii):

i. Fever (> 100.4°F for ≥ 24 hours, or report of subjective fever lasting ≥ 24 hours); AND

ii. Laboratory evidence of inflammation including, but not limited to, at least ONE of the following: elevated C-reactive protein, erythrocyte sedimentation rate, fibrinogen, procalcitonin, D-dimer, ferritin, lactate dehydrogenase, interleukin-6, or neutrophils, or reduced lymphocytes or albumin levels **[documentation required]**; AND

iii. Evidence of clinically severe illness that requires hospitalization with multisystem (i.e., > 2 organ involvement (cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic, or neurological) **[documentation required]**; AND

D) Other causes have been excluded; AND

E) Preferred product criteria is met for the product(s) as listed in the below table(s).

Dosing. Approve ONE of the following dosing regimens (A or B):

A) Up to 2 g/kg administered intravenously given one time; OR

B) Up to 1 g/kg administered intravenously per day for 2 doses.

12. Cytomegalovirus Pneumonitis or Pneumonia in a Patient with Cancer or Transplant-Related Infection. Approve for 2 months if the patient meets BOTH of the following (A and B):

A) The medication is prescribed by or in consultation with an oncologist, hematologist, or an infectious diseases physician; AND
B) Preferred product criteria is met for the product(s) as listed in the below table(s).

Dosing. Approve 400 mg/kg given intravenously every other day for 3 to 5 doses.

13. Desensitization Therapy Prior to and Immediately after Transplantation. Approve for 1 year if the patient meets BOTH of the following (A and B):
A) The medication is prescribed by or in consultation with a physician affiliated with a transplant center; AND
B) Preferred product criteria is met for the product(s) as listed in the below table(s).

Dosing. Approve ONE of the following dosing regimens (A or B):
A) Up to 2 g/kg per month administered intravenously (as a single dose or divided in smaller doses [e.g., 400 mg per kg daily for 5 days]); OR
B) The dosage is based on a transplant center's protocol.

14. Evan's Syndrome Approve for 3 months if the patient meets ONE of the following (A or B):
A) Adult ≥ 18 years of age: Patient meets ALL of the following (i ii, and iii):
i. Patient meets ONE of the following (a, b, or c):
a) Patient has tried or is currently receiving a systemic corticosteroid; OR
Note: Examples of systemic corticosteroids include prednisone or prednisolone.
b) There is an urgent need to increase blood counts quickly (e.g., severe bleeding) **[documentation required]**; OR
c) A systemic corticosteroid is contraindicated according to the prescriber; AND
ii. The medication is prescribed by or in consultation with an oncologist or hematologist; AND
iii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR
B) Patient is < 18 Years of Age. Patient meets BOTH of the following (i and ii):
i. The medication is prescribed by or in consultation with an oncologist or hematologist; AND
ii. Preferred product criteria is met for the product(s) as listed in the below table(s).

Dosing. Approve ONE of the following dosing regimens (A or B):
A) Up to 500 mg/kg/day administered intravenously for 4 days; OR
B) Up to 1 g/kg/day administered intravenously for 2 days.

15. Guillain-Barré Syndrome. Approve for the duration noted if the patient meets ONE of the following (A or B):
A) Initial Therapy. Approve for 1 month (this is to provide one course of therapy) if the patient meets ALL of the following (i, ii and iii):
i. Patient meets ONE of the following (a or b):
a) The medication is initiated within 2 weeks and no longer than 4 weeks after onset of neuropathic symptoms **[documentation required]**; OR
Note: Examples of neuropathic symptoms include weakness, inability to stand or walk without assistance, and respiratory or bulbar weakness.
b) Patient has had a relapse (treatment-related fluctuation), but had an initial response to IVIG **[documentation required]**; AND
ii. The medication is prescribed by or in consultation with a neurologist or a specialist with experience in diagnosing and treating patients with Guillain Barré syndrome; AND

iii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Patient is Currently Receiving Immune Globulin. Approve for 1 month to allow for one additional course of therapy.
Note: Guillain-Barré Syndrome cases that have progressed to chronic inflammatory demyelinating polyneuropathy (CIDP) should be reviewed under the CIDP indication.

Dosing. Approve 2 g/kg administered intravenously in divided doses over 2 to 5 days.

16. Hematologic Neoplasm-Associated Hypogammaglobulinemia or treatment after B-cell Targeted Therapies (Secondary Immunodeficiency [SID]). Approve for 6 months if the patient meets ONE of the following (A or B):
Note: Some examples of B-cell targeted therapy are chimeric antigen receptor (CAR)-T cell therapy (e.g., Kymriah [tisagenlecleucel intravenous infusion], Abecma [idecabtagene vicleucel intravenous infusion], Breyanzi [lisocabtagene maraleucel intravenous infusion], Tecartus [brexucabtagene autoleucel intravenous infusion], Yescarta [axicabtagene ciloleucel intravenous infusion]), a rituximab product, Besponsa (inotuzumab ozogamicin intravenous infusion), Blincyto (blinatumomab intravenous infusion).
Note: Refer to B-Cell Chronic Lymphocytic Leukemia (CLL) for Prevention of Infections and Multiple Myeloma for diagnosis-specific criteria.

A) Initial Therapy. Approve if the patient meets ONE of the following (i or ii):

i. Patient meets ALL of the following (a, b, c, and d):

a) Patient has an immunoglobulin G (IgG) level of < 600 mg/dL (6.0 g/L) [excluding paraprotein] **[documentation required]**; AND

b) Patient has recurrent or severe infections or there is a high risk of infection according to the prescriber; AND

c) The medication is being prescribed by or in consultation with an oncologist, hematologist, infectious disease physician, or immunologist; AND

d) Preferred product criteria is met for the product(s) as listed in the below table(s); OR

ii. Patient meets ALL of the following (a, b and c):

a) Patient is < 18 years of age; AND

b) Patient will be starting, has taken, or is currently receiving chimeric antigen receptor (CAR)-T cell therapy or other B-Cell targeted therapy **[documentation required]**; AND
Note: Examples of CAR-T cell therapy includes: Abecma (idecabtagene vicleucel intravenous infusion), Carvykti (ciltacabtagene autoleucel intravenous infusion).
Note: Examples of other B-Cell targeted therapy includes: Besponsa (inotuzumab ozogamicin intravenous infusion), Blincyto (blinatumomab intravenous infusion).

c) Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Patient is Currently Receiving Immune Globulin. Approve if the patient is having a positive response to therapy according to the prescriber.
Note: Examples of a positive response to therapy include maintaining an increased IgG trough level or a decrease in the number of infections.

Dosing. Approve ONE of the following dosing regimens (A or B):

A) 0.2 g/kg to 0.8 g/kg given intravenously once every 3 to 4 weeks; OR

B) The dose and interval between doses have been adjusted based on clinical response as determined by the prescriber.

17. Hematopoietic Cell Transplant (HCT) to Prevent Infection. Approve for the duration noted if the patient meets ONE of the following (A, B, or C):

A) Initial Therapy. Approve for 3 months if the patient meets ALL of the following (i, ii, iii, iv, and v):
- **i.** Patient has had HCT within the previous year **[documentation required]**; AND
- **ii.** Patient has an immunoglobulin G (IgG) level < 600 mg/dL (6.0 g/L) OR the patient has multiple myeloma or malignant macroglobulinemia **[documentation required]**; AND
- **iii.** According to the prescriber, the patient has a significant risk of having frequent and/or severe infections; AND
- **iv.** The medication is prescribed by or in consultation with a hematologist, oncologist, or infectious diseases physician; AND
- **v.** Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Initial Therapy. Approve for 3 months if the patient meets BOTH of the following (i and ii):
- **i.** Patient meets ONE of the following (a, b, or c):
  - **a)** Patient is a recipient of an umbilical cord blood transplant **[documentation required]**; OR
  - **b)** Patient is undergoing transplantation for inherited or acquired disorders associated with B-cell deficiency **[documentation required]**; OR
  - **c)** Patient with chronic graft-versus-host-disease with recurrent sinopulmonary infections **[documentation required]**; AND
- **ii.** Preferred product criteria is met for the product(s) as listed in the below table(s); OR

C) Patient is Currently Receiving Immune Globulin. Approve for 6 months if the patient is having a positive response to therapy according to the prescriber.
Note: Examples of a positive response to therapy include maintaining an increased IgG trough level, controlling the number of infections, or a decrease in the number of infections.

Dosing. Approve ONE of the following dosing regimens (A, B, C, or D):

A) During the first 100 days after HCT, the patient meets ONE of the following (i or ii):
- **i.** Adults and adolescents: 0.5 g/kg per week given intravenously and the dose is adjusted to maintain trough (pre-dose) serum IgG greater than 400 mg/dL; OR
- **ii.** Pediatric patient with allogeneic HCT: 0.4 g/kg per month given intravenously and the dose is adjusted to keep IgG greater than 400 mg/dL; OR

B) Greater than 100 days post-HCT, the dose is 0.5 g/kg given intravenously every 3 to 4 weeks, and the dose is adjusted to keep IgG greater than 400 mg/dL; OR

C) 0.2 g/kg to 0.8 g/kg given intravenously every 3 to 4 weeks; OR

D) The dosage is based on a transplant center's protocol.

18. Human Immunodeficiency Virus (HIV)- or Hepatitis C-Associated Thrombocytopenia. Approve for 1 month if the patient meets ALL of the following (A, B and C):

A) Patient is receiving antiviral therapy; AND

B) The medication is prescribed by or in consultation with an infectious diseases specialist, a physician who specializes in the treatment of HIV infection, a gastroenterologist, hepatologist, or a liver transplant physician; AND

C) Preferred product criteria is met for the product(s) as listed in the below table(s).

Dosing. Approve ONE of the following dosing regimens (A or B):

A) Up to 2 g/kg given intravenously in divided doses over 2 to 5 days; OR

B) Up to 1 g/kg one time given intravenously up to once weekly.

19. Human Immunodeficiency Virus (HIV), to Prevent Infections
Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii, iii, iv, and v):
- **i.** Patient is < 18 years of age; AND
- **ii.** Patient is receiving combination antiretroviral therapy; AND
- **iii.** Patient has ONE of the following (a, b, or c):
  - **a)** Hypogammaglobulinemia (i.e. IgG < 400 mg/dL) [4.0 g/L]) **[documentation required]**; OR
  - **b)** Functional antibody deficiency is demonstrated by poor specific antibody titers (that is, the patient does not develop specific antibody responses against protein and polysaccharide antigens) **[documentation required]**; OR
  - **c)** Functional antibody deficiency is demonstrated by the patient having recurrent (two or more per year) serious infections (e.g., bacteremia, meningitis, pneumonia) despite administration of combination antiretroviral therapy and appropriate antimicrobial prophylaxis **[documentation required]**; AND
- **iv.** The medication is prescribed by or in consultation with an infectious diseases specialist or an immunologist; AND
- **v.** Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Patient is Currently Receiving Immune Globulin. Approve for 1 year if the frequency and/or severity of infections have decreased according to the prescriber.

Dosing. Approve ONE of the following dosing regimens (A or B):

A) The dose is 0.4 g/kg given by intravenous infusion every 2 to 4 weeks; OR

B) The dose and interval are adjusted according to clinical effectiveness.
Note: Examples of adjusting according to clinical effectiveness may include the need to increase the dose or frequency based on frequency or severity of infections, hospitalizations, days of school or work missed, failure to thrive.

20. Immune-Mediated Necrotizing Myopathy. Approve for the duration noted if the patient meets ONE of the following (A or B):
Note: Also known as necrotizing autoimmune myopathy.

A) Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii, iii, iv, v, and vi):
- **i.** Patient has muscle weakness; AND
- **ii.** Patient has or had an elevated creatine kinase (CK) level above 1,000 IU/L **[documentation required]**; AND
- **iii.** Patient meets ONE of the following (a or b):
  - **a)** Patient has myositis-associated autoantibodies **[documentation required]**; OR
    Note: Examples of myositis-associated autoantibodies include anti-SRP autoantibodies, anti-HMGCR autoantibodies.
  - **b)** Patient has an electromyography, muscle magnetic resonance imaging, or muscle biopsy which, according to the prescriber, supports the given diagnosis **[documentation required]**; AND
- **iv.** Patient meets ONE of the following (a, b, c, or d):
  - **a)** Patient has tried a systemic corticosteroid; OR
  - **b)** Corticosteroids are contraindicated, according to the prescriber; OR
  - **c)** Patient has tried one of rituximab, methotrexate, mycophenolate, or tacrolimus; OR
  - **d)** Patient has anti-HMGCR autoantibodies; AND
- **v.** The medication is prescribed by or in consultation with a neurologist or rheumatologist; AND
- **vi.** Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Patient is Currently Receiving Immune Globulin. Approve for 1 year if the patient has responded to therapy, according to the prescriber.
Note: Examples of a response to therapy includes improved muscle strength, improved functional ability, and CK decrease.

Dosing. Approve up to 2 g/kg per month administered intravenously (as a single dose or divided in smaller doses [e.g., 400 mg per kg daily for 5 days]).

21. Immunotherapy-Related Toxicities Associated with Checkpoint Inhibitor Therapy Approve for the duration noted if the patient meets ONE of the following (A or B):
Note: Examples of checkpoint inhibitors are Keytruda (pembrolizumab intravenous infusion), Opdivo (nivolumab intravenous infusion), Yervoy (ipilimumab intravenous infusion), Tecentriq (atezolizumab intravenous infusion), Bavencio (avelumab intravenous infusion), Imfinzi (durvalumab intravenous infusion), Libtayo (cemiplimab intravenous infusion), Jemperli (dostarlimab intravenous infusion).

A. Initial Therapy. Approve for 1 month if the patient meets BOTH of the following (i and ii):
- **i.** Patient meets ONE of the following (a, b, or c):
  - **a.** Patient has tried a systemic corticosteroid and has not adequately responded to therapy; OR
    Note: Examples of systemic corticosteroids include prednisone, methylprednisolone.
  - **b.** The medication is being started with a systemic corticosteroid; OR
  - **c.** A corticosteroid is contraindicated per the prescriber; AND
- **ii.** Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B. Patient is Currently Receiving Immune Globulin. Approve for 6 months if the patient is having a positive response to therapy, as determined by the prescriber, and the prescriber has determined extended therapy is required.

Dosing. Approve ONE of the following dosing regimens (A, B, or C):
A) Up to 0.4 g/kg given intravenously daily for 5 days; OR
B) Up to 2 g/kg given intravenously over 2 to 5 days; OR
C) The dose and interval between doses have been adjusted based on clinical response as determined by the prescriber.

22. Lambert-Eaton Myasthenic Syndrome (LEMS) Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 1 month (to allow for one course of therapy) if the patient meets ALL of the following (i, ii, iii, and iv):
- **i.** Patient is having refractory weakness after symptomatic treatment of LEMS with an amifampridine product (e.g., Firdapse, Ruzurgi), guanidine, or pyridostigmine **[documentation required]**; AND
- **ii.** Patient meets ONE of the following (a or b):
  - **a)** Patient has paraneoplastic LEMS **[documentation required]**; OR
  - **b)** Patient has non-paraneoplastic LEMS AND has tried a systemic corticosteroid (e.g., prednisone) or another nonsteroidal immunosuppressive agent (e.g., azathioprine), or has a contraindication to corticosteroids and/or nonsteroidal immunosuppressive agents, according to the prescriber **[documentation required]**; AND
- **iii.** The medication is prescribed by or in consultation with a neurologist; AND
- **iv.** Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Patient is Currently Receiving Immune Globulin. Approve for 1 year if the patient has a response or continued effectiveness, according to the prescriber.

Note: Examples of a response to therapy include improved muscle strength or other clinical response.

Dosing. Approve ONE of the following dosing regimens (A or B):
A) Up to 2 g/kg given intravenously in divided doses over 2 to 5 consecutive days; OR
B) Maintenance therapy every 4 weeks with up to 2 g/kg with the dose being adjusted based on clinical symptoms.

23. Multiple Myeloma. Approve for the duration noted if the patient meets ONE of the following (A or B)
A. Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i ii, and iii):
i. Patient meets ONE of the following (a or b):
a) Patient has or is at risk of severe, recurrent infections according to the prescriber; OR
b) Patient will be starting, has taken, or is currently receiving chimeric antigen receptor (CAR)-T cell therapy, bispecific antibody therapy, or other B-Cell targeted therapy **[documentation required]**; AND
Note: Examples of CAR-T cell therapy includes: Abecma (idecabtagene vicleucel intravenous infusion), Carvykti (ciltacabtagene autoleucel intravenous infusion).
Note: Examples of bispecific antibody therapy or other B-Cell targeted therapy includes: Elrexfio (elranatamab-bcmm subcutaneous injection), Tecvayli (teclistamab-cqyv subcutaneous injection), Talvey (talquetamab-tgvs subcutaneous injection).
ii. The medication is prescribed by or in consultation with a hematologist, oncologist, or infectious disease specialist; AND
iii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR
B. Patient is Currently Receiving Immune Globulin. Approve for 1 year.

Dosing. Approve 0.2 g/kg to 0.8 g/kg given intravenously every 3 to 4 weeks.

24. Multiple Sclerosis (MS), Acute Severe Exacerbation or Relapses. Approve for 1 month (this is to provide one course of therapy) if the patient meets ALL of the following (A, B, C, and D):
A) Patient meets ONE of the following (i or ii):
i. Patient has either not responded to OR has had a significant adverse reaction with systemic corticosteroids (e.g., methylprednisolone sodium succinate injection) OR plasma exchange **[documentation required]**; OR
ii. A systemic corticosteroid is contraindicated, according to the prescriber; AND
B) Patient meets ONE of the following (i or ii):
i. Patient is already on maintenance therapy for MS or will be starting maintenance therapy for MS; OR
Note: Maintenance therapy does NOT include IVIG. Examples of maintenance therapy for MS would include: Avonex (interferon beta-1a subcutaneous injection), Plegridy (peginterferon beta-1a subcutaneous injection), Rebif (interferon beta-1a subcutaneous injection), Betaseron (interferon beta-1b subcutaneous injection)/Extavia (interferon beta-1b subcutaneous injection), Copaxone (glatiramer subcutaneous injection)/Glatopa (glatiramer subcutaneous injection), Gilenya (fingolimod capsule), Lemtrada (alemtuzumab intravenous infusion), Aubagio (teriflunomide tablet), Mavenclad (cladribine tablet), Mayzent (siponimod tablet), Tecfidera (dimethyl fumarate capsule), Vumerity (diroximel fumarate capsule), Zeposia (ozanimod capsule), Tysabri (natalizumab intravenous infusion), Novantrone (mitoxantrone

intravenous infusion), Bafiertam (monomethyl fumarate capsule), Kesimpta (ofatumumab subcutaneous injection), Ocrevus (ocrelizumab intravenous infusion), Ponvory (penesimod tablet).

ii. Patient is pregnant or post-partum and the prescriber has determined maintenance therapy is not clinically appropriate; AND

C) The medication is prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of MS; AND

D) Preferred product criteria is met for the product(s) as listed in the below table(s).

Dosing. Approve ONE of the following dosing regimens (A or B):

A) A single 1 g/kg given intravenously; OR

B) 0.4 g/kg per day IV infusion for 5 consecutive days.

25. Myasthenia Gravis. Approve for the duration noted if the patient meets ONE of the following (A, B, C, D, or E):

A) Patient with myasthenic crisis or impending myasthenic crisis: Approve for 30 days if preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Initial Therapy for Short-Term (Acute) Use. Approve for 5 days (to allow for one course of therapy) if the patient meets ALL of the following (i, ii, and iii):

i. Patient meets ONE of the following conditions (a, b, c, or d):

a) Patient has an exacerbation of myasthenia gravis **[documentation required]**; OR

b) Patient requires stabilization of myasthenia gravis before surgery **[documentation required]**; OR

c) Patient has been started on a nonsteroidal immunosuppressive drug and is waiting for full effect **[documentation required]**; OR
Note: Examples of nonsteroidal immunosuppressive drugs include azathioprine, cyclosporine, cyclophosphamide, mycophenolate mofetil, methotrexate, or tacrolimus.

d) Patient is starting therapy with a corticosteroid and IVIG is being given to prevent or minimize exacerbations **[documentation required]**; AND

ii. The medication is prescribed by or in consultation with a neurologist; AND

iii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

C) Patient is Currently Receiving Immune Globulin Short-Term (Acute) Use. Approve for 5 days (to allow for one course of therapy); OR

D) Initial Therapy for Maintenance. Approve for 1 year if the patient meets ALL of the following (i, ii, and iii):

i. Patient meets at least ONE of the following (a or b):

a) Patient has tried at least one of the following medications for myasthenia gravis AND has had an inadequate response: a complement inhibitor, a neonatal Fc receptor blocker, or a CD19-directed monoclonal antibody; OR
Note: Examples of complement inhibitors include eculizumab intravenous infusion (Soliris, biosimilars), Ultomiris (ravulizumab-cwvz intravenous infusion), Zilbrysq (zilucoplan subcutaneous injection). Examples of neonatal Fc receptor blockers include Imaavy (nipocalimab-aahu intravenous infusion), Rystiggo (rozanolixizumab-noli subcutaneous infusion), Vyvgart (efgartigimod alfa intravenous infusion), Vyvgart Hytrulo (efgartigimod alfa-fcab and hyaluronidase-qvfc subcutaneous injection). An example of CD19-directed monoclonal antibody is Uplizna (inebilizumab-cdon intravenous infusion).

b) According to the prescriber, complement inhibitors, neonatal Fc receptor blockers, and CD19-directed monoclonal antibodies are NOT clinically appropriate for the patient; AND

ii. The medication is prescribed by or in consultation with a neurologist; AND

iii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

E) Patient is Currently Receiving Immune Globulin for Maintenance Therapy. Approve for 1 year if the patient is responding according to the prescriber.
Note: Examples of responding to therapy include improvement in weakness (bulbar, limb, or respiratory), improvement with ocular symptoms.

Dosing. Approve ONE of the following dosing regimens (A, B, or C):

A) Crisis or Short-term use: 2 g/kg given intravenously in divided doses over 2 to 5 consecutive days; OR

B) Maintenance therapy: 0.4 g/kg to 1 g/kg given intravenously every 4 weeks; OR

C) The dose and interval between doses have been adjusted based on clinical response as determined by the prescriber.

26. Myelin Oligodendrocyte Glycoprotein Antibody-Associated Disease (MOGAD).
Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii, iii, iv, and v):

i. Patient has a clinical demyelinating event, according to the prescriber; AND
Note: Examples of a clinical demyelinating event includes, but is not limited to, optic neuritis, acute disseminated encephalomyelitis, traverse myelitis.

ii. The diagnosis was confirmed by a positive blood serum test which was positive for myelin oligodendrocyte glycoprotein (MOG)-Immune globulin G (IgG) **[documentation required]**; AND
Note: Detection in cerebral spinal fluid would also satisfy this requirement.

iii. Patient meets ONE of the following (a or b):

a) Patient is using the requested medication for the treatment of acute attacks AND meets ONE of the following [(1) or (2)]:
(1) Patient has tried a systemic corticosteroid; OR
(2) Corticosteroids are contraindicated, according to the prescriber; OR

b) Patient is using the requested medication for attack prevention AND meets ONE of the following [(1) or (2)]:
(1) Patient has tried a nonsteroidal immunosuppressant; OR
(2) Nonsteroidal immunosuppressants are contraindicated, according to the prescriber; AND

iv. The medication is prescribed by or in consultation with a neurologist; AND

v. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Patient is Currently Receiving Immune Globulin. Approve for 1 year if the patient has responded to therapy, according to the prescriber.
Note: Examples of a response to therapy includes a reduction in relapse rate, slowing of disability, slowing in the progression of symptoms.

Dosing. Approve up to 2 g/kg per month administered intravenously (as a single dose or divided in smaller doses [e.g., 400 mg per kg daily for 5 days]).

27. Neonatal Isoimmune Hemolytic Disease (Hemolytic Disease of the Fetus and Newborn), Acute treatment. Approve for 1 month if the patient meets ALL of the following (A, B and C):
Note: Also could see the diagnosis Red Blood Cell Alloantibodies During Pregnancy.

A) Patient's total serum bilirubin is rising despite intensive phototherapy OR is within 3 mg/dL of the exchange transfusion threshold **[documentation required]**; AND

B) The medication is prescribed by or in consultation with a neonatologist, pediatrician, hematologist, or obstetrician; AND
C) Preferred product criteria is met for the product(s) as listed in the below table(s).

Dosing. Approve 0.5 g/kg/dose to 1 g/kg/dose administered intravenously; may repeat dose if necessary.

28. Opsoclonus-Myoclonus-Ataxia Syndrome.. Approve for the duration noted if the patient meets ONE of the following (A or B):
A) Initial Therapy: Approve for 6 months if the patient meets BOTH of the following (i and ii):
  i. The requested medication is prescribed by or in consultation with an immunologist, oncologist, or neurologist; AND
  ii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR
B) Patient is Currently Receiving Immune Globulin. Approve for 1 year if the patient has responded to therapy, according to the prescriber.
  Note: Examples of response to therapy can include improvement of stance and gait, arm or hand function, opsoclonus, mood or behavior, or speech.

Dosing. Approve the following dosing regimen: Up to 2 g/kg over 2 to 5 days followed by 1 to 2 g/kg every 4 weeks.

29. Passive Immunization for Measles (Post-Exposure Prophylaxis). Approve for 1 day (to allow for a single dose) if the patient meets BOTH of the following (A and B):
Note: For patients with primary immune deficiency (PID), see criteria for PID.
A) Patient meets ONE of the following (i, ii, or iii):
  i. Patient is pregnant and meets BOTH of the following (a and b):
    a) Patient has been exposed to measles **[documentation required]**; AND
    b) Patient cannot readily show they have evidence of immunity against measles (e.g., the patient does not have a history of the disease or age-appropriate vaccination); OR
  ii. Infants born to pregnant patients with suspected or confirmed measles **[documentation required]**; OR
  iii. Patient meets BOTH of the following (a and b):
    a) Patient is immunocompromised **[documentation required]**; AND
    b) Patient has been exposed to measles **[documentation required];** AND
B) Preferred product criteria is met for the product(s) as listed in the below table(s); OR

Dosing. Approve the following dosing regimen: 0.4 g/kg intravenously administered one time.

30. Parvovirus B19 Infection. Approve for the duration noted if the patient meets ONE of the following (A or B):
A) Initial Therapy. Approve for 2 months if the patient meets ALL of the following (i, ii, and iii):
  i. Patient has an immunodeficiency condition **[documentation required]**; AND
  Note: Examples of an immunodeficiency condition include patients with HIV infection, solid organ transplants (e.g., renal, liver), chemotherapy for hematologic malignancy.
  ii. The medication is prescribed by or in consultation with an infectious diseases specialist, immunologist, hematologist, or transplant specialist; AND
  iii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR
B) Patient is Currently Receiving Immune Globulin. Approve for 6 months.

Dosing. Approve ONE of the following dosing regimens (A, B, C, or D):
A) 2 g/kg given intravenously over a period of 2 to 5 consecutive days; OR
B) 0.4 g/kg to 0.5 g/kg given intravenously daily for 5 days; OR
C) 0.4 g/kg given intravenously once every 4 weeks; OR
D) 0.2 g/kg to 0.4 g/kg given intravenously daily for 5 to 10 days

31. Post-Exposure Prophylaxis for Varicella OR Post-Exposure Prophylaxis or treatment for Tetanus. Approve for 1 day (to allow for a single dose) if the patient meets BOTH of the following (A and B):
A) Patient meets ONE of the following (i or ii):
  i. For Varicella post-exposure. Varicella Immune Globulin is not available or cannot be administered **[documentation required]**; OR
  ii. For Tetanus treatment or post-exposure, Tetanus Immune Globulin is not available**[documentation required]**; AND
B) Preferred product criteria is met for the product(s) as listed in the below table(s).

Dosing. Approve ONE of the following dosing regimens (A or B):
A) 0.4 g/kg given intravenously one time; OR
B) 0.2 to 0.4 g/kg given intravenously one time.

32. Post-Transfusion Purpura, Acute Treatment. Approve for 1 month if the patient meets BOTH of the following (A and B):
A) The medication is prescribed by or in consultation with a hematologist or a transfusion medicine specialist; AND
B) Preferred product criteria is met for the product(s) as listed in the below table(s).

Dosing. Approve ONE of the following dosing regimens (A or B):
A) Up to 2 g/kg/day administered intravenously over either 2 or 5 days; OR
B) Up to 500 mg/kg/day administered intravenously for 1 to 10 days.

33. Pure Red Blood Cell Aplasia (PRCA), Immunologic Subtype. Approve for the duration noted if the patient meets ONE of the following (A or B):
A) Initial Therapy. Approve for 1 month if the patient meets ALL of the following (i, ii, iii, and iv):
  i. Patient has tried a systemic corticosteroid (e.g., prednisone); AND
  ii. Patient has tried either cyclophosphamide OR cyclosporine; AND
  iii. The medication is prescribed by or in consultation with an infectious diseases specialist, immunologist, hematologist, or transplant specialist; AND
  iv. Preferred product criteria is met for the product(s) as listed in the below table(s); OR
B) Patient is Currently Receiving Immune Globulin. Approve for 1 month if the patient has responded with an increase in hemoglobin and reticulocytosis according to the prescriber.

Dosing. Approve 0.5 g/kg given intravenously for 4 weeks.

34. Rasmussen Encephalitis. Approve for the duration noted if the patient meets ONE of the following (A or B):
A) Initial Therapy: Approve for 6 months if the patient meets ALL of the following (i, ii and iii):
  i. Patient meets ONE of the following (a or b):

a) As determined by the prescriber, clinical features, an electroencephalogram, AND magnetic resonance imaging support the diagnosis of Rasmussen encephalitis, OR

b) As determined by the prescriber, two of the following: 1) clinical features, 2) magnetic resonance imaging, or 3) histopathology support the diagnosis of Rasmussen encephalitis; AND

ii. The requested medication is prescribed by or in consultation with a neurologist; AND

iii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Patient is Currently Receiving Immune Globulin. Approve for 1 year if the patient has responded to therapy, according to the prescriber.

Note: Examples of response to therapy can include improvement or stabilization of seizure frequency or motor deficits.

Dosing. Approve the following dosing regimen: Up to 2 g/kg administered intravenously over 2 to 5 days per treatment cycle.

35. Red Blood Cell Alloantibodies During Pregnancy. Approve for the duration of the pregnancy if the patient meets ONE of the following (A or B):

A) Patient meets ALL of the following (i, ii, and iii):

i. Patient meets BOTH of the following (a and b):

a) Patient has a clinically significant maternal red blood cell alloantibody (e.g., anti-D, anti-Kell, anti-c, or other clinically significant antigen) **[documentation required]**; AND

b) Patient meets BOTH of the following (1 and 2):

(1) Patient has an antigen-positive fetus or a fetus presumed to be antigen-positive **[documentation required]**: AND

(2) Patient meets ONE of the following (a or b):

(a) Patient has a history of a pregnancy or child with fetal anemia requiring intrauterine transfusion **[documentation required]**; OR

(b) Patient experienced hydrops fetalis or fetal loss due to hemolytic disease of the fetus and newborn in a previous pregnancy **[documentation required]**; AND

ii. The medication is prescribed by or in consultation with a hematologist or obstetrician; AND

iii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Patient meets BOTH of the following (i and ii):

i. Patient has already been started on immune globulin therapy for the condition; AND

ii. The medication is prescribed by or in consultation with a hematologist or obstetrician.

Dosing. Approve ONE of the following dosing regimens (A or B):

A) Up to 2 g/kg administered intravenously once weekly; OR

B) Up to 2 g/kg per cycle administered intravenously over two consecutive days every 3 weeks

36. Stiff Person Syndrome (Moersch-Woltman Syndrome) Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 3 months if the patient meets ALL of the following (i, ii and iii):

i. Patient meets ONE of the following (a or b):

a) Patient has tried a benzodiazepine (e.g., diazepam) OR baclofen; OR

b) Patient has contraindications to both a benzodiazepine AND baclofen according to the prescriber; AND

ii. The medication is prescribed by or in consultation with a neurologist; AND

iii. Preferred product criteria is met for the product(s) as listed in the below table(s); OR

B) Patient is Currently Receiving Immune Globulin. Approve for 1 year if the patient has responded to therapy according to the prescriber.
Note: Examples of response to therapy includes reduced stiffness or frequency of spasms, ability to walk unassisted.

Dosing. Approve ONE of the following dosing regimens (A or B):

A) 2 g/kg given intravenously over a period of 2 to 5 consecutive days every month; OR

B) For maintenance therapy, the dose is adjusted to provide the minimum effective dosage of IVIG. Maximum dose is 2 g/kg given intravenously.

37. Thrombocytopenia Feto-neonatal Alloimmune.
Approve for 6 months if the patient meets BOTH of the following (A and B):

A) Pregnant mother or newborn patient is prescribed the medication by or in consultation with a hematologist or an obstetrician; AND

B) Preferred product criteria is met for the product(s) as listed in the below table(s); OR

Dosing. Approve ONE of the following dosing regimens (A, B, C, or D):

A) For the mother: 1 g/kg given intravenously every week; OR

B) For the mother: 2 g/kg given intravenously every week; OR

C) For the mother: 1 g/kg given intravenously twice weekly; OR

D) For the newborn: 1 g/kg to 2 g/kg given intravenously dosed per the prescriber.

38. Toxic Shock Syndrome Acute Treatment. Approve for 1 month if preferred product criteria is met for the product(s) as listed in the below table(s).

Dosing. Approve the following dosing regimen: Up to 1 g/kg on day 1, followed by up to 500 mg/kg once daily on days 2 and 3.

39. Warm Type Autoimmune Hemolytic Anemia. Approve for 1 month if the patient meets ALL of the following (A, B, and C):

A) Patient meets ONE of the following (i or ii):

i. Patient has tried at least one systemic corticosteroid; OR
Note: Examples of systemic corticosteroids include prednisone, methylprednisolone.

ii. Patient has severe or rapidly progressive hemolysis requiring urgent intervention (e.g., symptomatic anemia, significant hemoglobulin decline, or hemodynamic instability); AND

B) The medication is prescribed by or in consultation with a hematologist, oncologist, rheumatologist, or immunologist; AND

C) Preferred product criteria is met for the product(s) as listed in the below table(s).

Dosing. Approve ONE of the following dosing regimens (A or B):

A) Up to 500 mg/kg/day administered intravenously for 4 days; OR

B) Up to 1 g/kg/day administered intravenously for 2 days.

Employer Plans:

Product	Criteria
Alyglo (immune globulin intravenous, human-stwk, 10% solution)	Patient meets **ONE** of the following (A or B): **A.** Patient has tried **THREE** of the following products (i, ii, iii, iv, v, vi, vii, viii, ix, x) **[documentation required]**: i. Bivigam ii. Flebogamma DIF iii. Gammagard Liquid iv. Gammagard Liquid ERC v. Gammaked vi. Gammaplex vii. Gamunex-C viii. Octagam ix. Panzyga x. Privigen **B.** According to the prescriber, a product with minimal content of coagulation factor XIa is needed based on a comorbidity of the patient.
Asceniv (immune globulin intravenous, human - slra, 10% liquid)	Patient meets **ONE** of the following (A or B): **A.** Patient has tried **THREE** of the following products (i, ii, iii, iv, v, vi, vii, viii, ix, x) **[documentation required]**: i. Bivigam ii. Flebogamma DIF iii. Gammagard Liquid iv. Gammagard Liquid ERC v. Gammaked vi. Gammaplex vii. Gamunex-C viii. Octagam ix. Panzyga x. Privigen **B.** According to the prescriber, the patient requires an immune globulin product with elevated levels of respiratory syncytial virus (RSV) antibodies (e.g., if the patient has repeated RSV infections despite adequate IVIG dosing in a compliant patient)
Gammagard S/D IgA ≤ 1 mcg/mL (immune globulin intravenous [IVIG])	Patient meets **ONE** of the following (A or B): **A.** Patient has tried **THREE** of the following products (i, ii, iii, iv, v, vi, vii, viii, ix, x) **[documentation required]**: i. Bivigam ii. Flebogamma DIF iii. Gammagard Liquid iv. Gammagard Liquid ERC v. Gammaked vi. Gammaplex vii. Gamunex-C viii. Octagam ix. Panzyga x. Privigen **B.** Patient requires an IVIG product with the lowest IgA content.

Product	Criteria
Qivigy (immune globulin intravenous solution-kthm)	Patient has tried **THREE** of the following products (i, ii, iii, iv, v, vi, vii, viii, ix, x) **[documentation required]**: i. Bivigam ii. Flebogamma DIF iii. Gammagard Liquid iv. Gammagard Liquid ERC v. Gammaked vi. Gammaplex vii. Gamunex-C viii. Octagam ix. Panzyga x. Privigen
Yimmugo (immune globulin intravenous, human-dira, 10% liquid)	Patient has tried **THREE** of the following products (i, ii, iii, iv, v, vi, vii, viii, ix, x) **[documentation required]**: i. Bivigam ii. Flebogamma DIF iii. Gammagard Liquid iv. Gammagard Liquid ERC v. Gammaked vi. Gammaplex vii. Gamunex-C viii. Octagam ix. Panzyga x. Privigen

Individual and Family Plans:

Product	Criteria
Alyglo (immune globulin intravenous, human-stwk, 10% solution)	Patient meets **ONE** of the following (A or B): **A.** Patient has tried **THREE** of the following products (i, ii, iii, iv, v, vi, vii, viii, ix, x) **[documentation required]**: i. Bivigam ii. Flebogamma DIF iii. Gammagard Liquid iv. Gammagard Liquid ERC v. Gammaked vi. Gammaplex vii. Gamunex-C viii. Octagam ix. Panzyga x. Privigen **B.** According to the prescriber, a product with minimal content of coagulation factor XIa is needed based on a comorbidity of the patient.
Asceniv (immune globulin intravenous, human - slra, 10% liquid)	Patient meets **ONE** of the following (A or B): **A.** Patient has tried **THREE** of the following products (i, ii, iii, iv, v, vi, vii, viii, ix, x) **[documentation required]**: i. Bivigam ii. Flebogamma DIF iii. Gammagard Liquid

Product	Criteria
	iv. Gammagard Liquid ERC v. Gammaked vi. Gammaplex vii. Gamunex-C viii. Octagam ix. Panzyga x. Privigen **B.** According to the prescriber, the patient requires an immune globulin product with elevated levels of respiratory syncytial virus (RSV) antibodies (e.g., if the patient has repeated RSV infections despite adequate IVIG dosing in a compliant patient)
Gammagard S/D IgA ≤ 1 mcg/mL (immune globulin intravenous [IVIG])	Patient meets **ONE** of the following (A or B): **A.** Patient has tried **THREE** of the following products (i, ii, iii, iv, v, vi, vii, viii, ix, x) **[documentation required]**: i. Bivigam ii. Flebogamma DIF iii. Gammagard Liquid iv. Gammagard Liquid ERC v. Gammaked vi. Gammaplex vii. Gamunex-C viii. Octagam ix. Panzyga x. Privigen **B.** Patient requires an IVIG product with the lowest IgA content.
Qivigy (immune globulin intravenous solution-kthm)	Patient has tried **THREE** of the following products (i, ii, iii, iv, v, vi, vii, viii, ix, x) **[documentation required]**: i. Bivigam ii. Flebogamma DIF iii. Gammagard Liquid iv. Gammagard Liquid ERC v. Gammaked vi. Gammaplex vii. Gamunex-C viii. Octagam ix. Panzyga x. Privigen
Yimmugo (immune globulin intravenous, human-dira, 10% liquid)	Patient has tried **THREE** of the following products (i, ii, iii, iv, v, vi, vii, viii, ix, x) **[documentation required]**: i. Bivigam ii. Flebogamma DIF iii. Gammagard Liquid iv. Gammagard Liquid ERC v. Gammaked vi. Gammaplex vii. Gamunex-C viii. Octagam

Product	Criteria
	ix. Panzyga x. Privigen

Conditions Not Covered

Immune globulin intravenous products for any other use is considered not medically necessary, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Adrenoleukodystrophy.** Evidence does not support IVIG use.[18]

2. **Alzheimer's Disease (AD).** In one multicenter, double-blind, Phase III, placebo-controlled trial, 390 patients with mild to moderate AD were randomized to therapy with IVIG 400 mg/kg or 200 mg/kg, or to placebo given every 2 weeks for 18 months.[61] There was no statistically significant difference in the rate of cognitive decline when compared with placebo. Also, there was not a statistically significant change in functional ability when compared to placebo.

3. **Amyotrophic Lateral Sclerosis.** There is insufficient evidence to recommend IVIG.[18]

4. **Asthma.** Global Initiative for Asthma (GINA) guidelines for asthma management and prevention do not include recommendations for use of IVIG.[54]

5. **Atopic Dermatitis.** Limited data exist to determine the utility of IVIG in the management of atopic dermatitis.[55]

6. **Autism.** Evidence does not support IVIG use.[18] Well controlled, double-blind trials are needed.

7. **Complex Regional Pain Syndrome (Reflex Sympathetic Dystrophy).** There is insufficient evidence to recommend IVIG. In one single center study a single dose of 0.5 g/kg of IVIG produced a decrease in pain intensity by 50% or more compared to placebo in 3 of 12 patients.[57] In a randomized, placebo-controlled, multicenter trial, low-dose immunoglobulin treatment for 6 weeks was not effective in relieving pain in patients with moderate-to-severe complex regional pain syndrome.[58] Well-controlled large-scale trials are needed.

8. **Crohn's Disease.** There is insufficient evidence to recommend IVIG. In one single center case collection report, 19 patients with acute Crohn's disease (Crohn's Disease Activity Index [CDAI] 284.1 ± 149.8) who were resistant to steroids received IVIG daily for 7 to 10 days.[59] Four weeks after completing therapy, 14 patients were in clinical remission (CDAI < 150). Prospective, randomized, placebo-controlled trials are needed to determine if IVIG has a role in the treatment of Crohn's disease.

9. **Cystic Fibrosis.** There is insufficient evidence to recommend IVIG. In one single-center retrospective case review of 16 children with cystic fibrosis, IVIG was reportedly effective.[60] Well-designed, controlled trials are needed.[18]

10. **Diabetes Mellitus, Immunotherapy.** Evidence does not support IVIG use.[18]

11. **Fibromyalgia Syndrome.** There is insufficient evidence to recommend IVIG. In one open-label single center study, 15 patients with fibromyalgia syndrome and distal demyelinating polyneuropathy received IVIG 400 mg/kg given daily for 5 days.[64] Pain, tenderness, and

strength reportedly improved. Double-blind, placebo-controlled trials are needed to determine if IVIG is effective in fibromyalgia syndrome.

12. **In Vitro Fertilization (IVF).** There is insufficient evidence to recommend IVIG administration as part of IVF outcomes.[68]

13. **Pediatric acute-onset neuropsychiatric syndrome (PANS) and Pediatric autoimmune neuropsychiatric disorder associated with group A streptococci (PANDAS).**

14. **Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal Gammopathy, and Skin Changes (POEMS) Syndrome.** Evidence does not support IVIG use.[18]

15. **Recurrent Spontaneous Pregnancy Loss (RSPL) [Including a Patient with Antiphospholipid Antibody-Positive].** The American Society for Reproductive Medicine practice committee states that several trials and meta-analyses concluded that IVIG is ineffective for primary recurrent pregnancy loss and this treatment is not recommended.[72] According to the European Society of Human Reproduction and Embryology guideline on recurrent pregnancy loss (RPL) [2022], IVIG may improve live birth rates in women with four or more unexplained RPLs.[71] The recommendation is conditional and high-quality evidence is lacking. Data is also limited in antiphospholipid syndrome in pregnancy and further study is needed on the role of IVIG.

16. **Selective Immune Globulin A (IgA) Deficiency as the Sole Immunologic Abnormality.** Evidence does not support use of IVIG.[14,18] Selective IgA deficiency is defined as a serum IgA level less than 0.07 g/L, but normal serum IgG and IgM levels in a patient greater than 4 years of age in whom other causes of hypogammaglobulinemia have been excluded.[14] Selective IgA deficiency may co-exist in some patients with poor specific IgG antibody production, with or without IgG2 subclass deficiency.[14,18] Some of these patients with a concomitant specific antibody defect might benefit from therapy with IVIG.

Coding Information

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
90283	Immune globulin (IgIV), human, for intravenous use

HCPCS Codes	Description
J1459	Injection, immune globulin (Privigen), intravenous, non–lyophilized (e.g., liquid), 500 mg
J1552	Injection, immune globulin (Alyglo), 500 mg
J1553	Injection, immune globulin (yimmugo), 100 mg (effective date 4/1/2026)
J1554	Injection, immune globulin (Asceniv), 500 mg
J1556	Injection, immune globulin (Bivigam), 500 mg

HCPCS Codes	Description
J1557	Injection, immune globulin, (Gammaplex), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1561	Injection, immune globulin, (Gamunex/Gamunex-C/Gammaked), nonlyophilized (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, nonlyophilized (e.g., liquid), 500 mg
J1569	Injection, immune globulin, (Gammagard liquid), nonlyophilized, (e.g., liquid), 500 mg
J1572	Injection, immune globulin, (Flebogamma/Flebogamma Dif), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1576	Injection, immune globulin (Panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1577	Injection, immune globulin (qivigy), 100 mg

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Revision Details

Summary of Changes	Review Date	Effective Date
New Policy.	6/25/2026	8/15/2026
Primary Immunodeficiencies: Removed 'unspecified hypogammaglobulinemia' from the criteria. For a diagnosis of common variable immunodeficiency or other immunodeficiencies with significant hypogammaglobulinemia, both an impaired antibody response and recurrent infections are required to be met; previously only one was required. For the criterion, patient has an impaired antibody response (i.e., failure to produce antibodies to specific antigens), 'that is' (i.e.) was replaced with 'for example' (e.g.). **Myasthenia Gravis:** Added "if preferred product criteria is met for the product(s) as listed in the below table(s)" for patient with myasthenic crisis or impending myasthenic crisis criteria. The Initial Therapy for Maintenance criteria was updated. The following criteria were removed: patient has refractory myasthenia gravis, patient has tried pyridostigmine, and patient has tried an immunosuppressive therapy with at least one of the following agents: azathioprine, cyclosporine, cyclophosphamide, mycophenolate mofetil, methotrexate, tacrolimus AND has had an inadequate response. The following criteria were added: Patient has tried at least one of the following medications for myasthenia gravis AND has had an inadequate response: a complement inhibitor, a neonatal Fc receptor blocker, or a CD19-directed monoclonal antibody OR according to the prescriber, these therapies are not clinically appropriate for the patient. Examples of each class of medication were also added in a note.	8/20/2026	9/03/2026

The policy effective date is in force until updated or retired.

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