Premier Health Plan

POLICY AND PROCEDURE

POLICY TITLE:	**Intravenous Immune Globulin (IVIG) & Subcutaneous Immune Globulin (SCIG)**
DEPARTMENT:	**Clinical Pharmacy Services- Utilization Management**
ORIGINAL DATE:	***July 2007***

Last P & T Committee Approval Date: *February 2018*

Product Applicability: *mark all applicable products below:*

COMMERCIAL	[ ] HMO [ ] PPO *Products*: [ ] Small [ ] Indiv. [ ] Large *Exchange*: [ ] Shop [ ] Indiv. [x] All
OTHER	[x] Self-funded/ASO

PURPOSE

The purpose of this policy is to define the prior authorization process for all commercially-available, formulary IVIG and SCIG products.

DEFINITIONS

INCAT (Inflammatory Neuropathy Cause and Treatment Scale) – is used to assess functional disability of both upper and lower extremities in chronic inflammatory demyelinating polyradiculoneuropathy (CIDP).

Grade	**Arm Disability**
0	No upper limb problems
1	Symptoms, in one or both arms, not affecting the ability to perform any of the following functions: doing all zips and buttons; washing or brushing hair; using a knife and fork together; an handling small coins
2	Symptoms, in one arm or both arms, affecting but not preventing any of the above-mentioned functions
3	Symptoms, in one arm or both arms, preventing one or two of the above-mentioned functions
4	Symptoms, in one arm or both arms, preventing three or all of the functions listed, but some purposeful movements still possible
5	Inability to use either arm for any purposeful movement
Grade	**Leg Disability**

0	Walking not affected
1	Walking affected, but walks independently outdoors
2	Usually uses unilateral support (stick, single crutch, one arm) to walk outdoors
3	Usually uses bilateral support (stick, crutches, frame, two arms) to walk outdoors
4	Usually uses wheelchair to travel outdoors, but able to stand and walk a few steps with help
5	Restricted to wheelchair, unable to stand and walk a few steps with help

Refractory Myasthenia Gravis Disease- unchanged or worse disease after corticosteroids and at least 2 other immunosuppressants, used in adequate doses for an adequate duration, with persistent symptoms or side effects that limit functioning, as defined by patient and physician

POLICY

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, as defined in CRM.015-Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.003-Prior Authorization Process.

The drugs, intravenous immune globulin (IVIG) and subcutaneous immune globulin (SCIG), are subject to the prior authorization process.

PROCEDURE

IVIG and SCIG are used to increase circulating levels of gamma globulin in certain immunoglobulin deficiency states and in treatment of a limited number of specified diseases.

Must meet all of the criteria listed below:

FDA Approved Indications

1. For Primary Immunodeficiency

- Syndromes may include:
  - Common Variable Immunodeficiency (Hypogammaglobulinemia)
  - Congenital Agammaglobulinemia
  - Bruton's or X-linked Agammaglobulinemia
  - Severe Combined Immunodeficiency (SCID)
  - X-linked Hyper-IgM Syndrome
  - Wiskott-Aldrich Syndrome
  - Hypergammaglobulinemia Types
- Must be prescribed by or in consultation with an immunologist or hematologist
- Must have deficient antibody production, as evidenced through a documented IgG level ≤500mg/dL
  - Requests with IgG levels >500mg/dL require chart documentation that provides clinical rationale for the use of IVIG or SCIG.
- Must have history of at least 1 bacterial infection directly attributable to this deficiency
- Approve for 1 year initially

- Reauthorizations are granted for 1-year intervals based upon documentation from the prescriber of an updated IgG level and that the member's condition has improved as a result of treatment.

2. <u>For Idiopathic or Immune Thrombocytopenic Purpura (ITP)</u>

(Platelet counts expressed per mm3)

- Must be prescribed by a hematologist or oncologist
- For children with ITP:
  - Must have ONE of the following:
    - Platelet count <20,000 and significant mucous membrane bleeding
    - Platelet count <10,000 and minor purpura
    - Platelet count <20,000 and inaccessibility or noncompliance is a concern
    - Any surgery, dental extractions, or other procedures likely to cause blood loss are needed
- For adults with ITP:
  - Must have ONE of the following:
    - Platelet count <30,000 and documented previous inadequate response or intolerance to corticosteroids
    - Surgical procedures likely to cause blood loss are needed based upon the following platelet counts: dentistry ≤10,000, except teeth extractions or regional dental block ≤30,000
    - Minor surgery ≤50,000
    - Major surgery ≤80,000
- For pregnant women with ITP
  - Must be pregnant and have ONE of the following:
    - Platelet count is <100,000
    - History of splenectomy
    - Previously delivered infants with autoimmune thrombocytopenia
- Approve for 1 month
- Additional authorizations for treatment are made on a case-by-case basis, are subject to the above criteria, and require chart documentation describing the previous response and clinical rationale for re-treatment.

3. <u>For Kawasaki Disease</u>

- Must be receiving aspirin concomitantly
- Must be requesting treatment within the first 10 days of illness, or if >10 days, must have persistent fever (without other explanation), aneurysms, and ongoing systemic inflammation
- Approve for 1 dose
- May approve second dose in patients who fail to respond to initial therapy
- Additional authorizations for treatment are made on a case-by-case basis, are subject to the above criteria, and require chart documentation describing the previous response and clinical rationale for re-treatment.

4. <u>For Chronic B-cell Lymphocytic Leukemia</u>

- Must be prescribed by a hematologist, oncologist, or infectious disease specialist
- Must have Hypogammaglobulinemia (IgG <500mg/dl)
- Must have previous history of serious bacterial infection (requiring antibiotics)

- Approve for 1 year
- Reauthorizations are granted at 1-year intervals based upon documentation from the prescriber indicating that the member's condition has improved as a result of treatment.

5. <u>For HIV (Human Immunodeficiency Virus) in pediatric patients</u>

- Must be prescribed by an immunologist or infectious disease specialist
- Must be <13 years old
- Must have CD4 count ≥200/mm3
- Must have ONE of the following
    - Recurrent (2 or more) serious bacterial infections such as bacteremia, meningitis, or pneumonia during a 1-year period despite administration of highly active antiretroviral therapy (HAART) and prophylactic sulfamethoxazole/trimethoprim (TMP-SMZ)or other antimicrobials
    - Hypogammaglobulinemia with an IgG <400mg/dL
    - Absence of detectable antibodies to common antigens, (measles, pneumococcal, and/or haemophilus influnzae Type B)
    - Bronchiectasis not optimally responsive to antibiotics and pulmonary therapy
    - A need for passive immunization for measles if Intramuscular Immune Globulin (IMIG) is contraindicated. IM injection contraindicated with severe thrombocytopenia or any coagulation disorder
- Approve for 1 year
- Additional authorizations for treatment are made on a case-by-case basis, are subject to the above criteria, and require chart documentation describing previous response and clinical rationale for re-treatment.

6. <u>For Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)</u>

- Must be prescribed by a neurologist
- Must have a diagnosis of CIDP
- Must provide documentation of electrodiagnostic testing (an EMG report)
- Must have significant disability in upper and lower limb function as defined as having arm disability of INCAT grade 2 or higher OR leg disability of INCAT grade 1 or higher
- Approve for 3 months
- Reauthorizations are granted at 1-year intervals based upon documentation from the prescriber indicating the member's condition has improved as a result of treatment as evidenced by improvement or stability in INCAT disability scores.

7. For Multifocal Motor Neuropathy

- Must be prescribed by a neurologist
- Must provide documentation of electrodiagnostic testing (an EMG report)
- Must be used in patients with anti GM1 antibodies and conduction block
- Approve for 2 months
- Reauthorizations are granted for 1-year intervals based upon documentation from the prescriber indicating the member's condition has improved as a result of treatment

Off-label Uses

1. For Guillain-Barre Syndrome

- Must have been diagnosed within 4 weeks of onset of neuropathic symptoms
- Must be non-ambulating independently
- Approve for 1 month
- May approve 1 additional month
- Additional authorizations for treatment are made on a case-by-case basis, are subject to the above criteria, and require chart documentation describing previous response to treatment and clinical rationale for re-treatment.

2. For Dermatomyositis and Polymyositis (including juvenile)

- Must have dermatomyositis and polymyositis confirmed by biopsy
- Must have tried and failed or have a contraindication to both of the following:
  - Corticosteroids for 3 months
  - Concomitant adjuvant therapy (azathioprine, methotrexate, cyclosporine)
- Approve for 2 months for either diagnosis
- Reauthorizations are granted upon documentation from the prescriber indicating the member's condition has improved as a result of treatment for:
  - Dermatomyositis: 1 year
  - Polymyositis: 2 months

3. For Systemic Lupus Erythematosus (SLE)

- Must have severe active SLE
- Must have tried and failed or have contraindications to ALL of the following:
  - Corticosteroids
  - Antimalarials
  - 1 additional immunosuppressant (azathioprine, cyclophosphamide, cyclosporine, methotrexate)
- Approve for 3 months
- Reauthorizations are granted for 1-year intervals based upon documentation from the prescriber indicating the member's condition has improved as a result of treatment.

4. For Multiple Sclerosis (MS)

- Must be prescribed by a neurologist
- For acute exacerbations of MS:
  - Must have a trial and failure or have contraindications to corticosteroids or plasma exchange
  - Approve for 1 month
  - Additional authorizations for treatment are made on a case-by-case basis, are subject to the above criteria, and require chart documentation describing previous response to treatment and clinical rationale for re-treatment if IVIG did not provide a sufficient response.
- For chronic maintenance treatment of MS:
  - Must have relapsing, remitting type of MS

- Must have a trial and failure (duration of at least 3 months) or have contraindications to ALL of the following:
  - At least one interferon [interferon beta-1a (Rebif®) or interferon beta-1b (Betaseron®)]
  - Glatiramer (Copaxone®)
  - Fingolimod (Gilenya®)
- No previous trials are required if:
  - Member is pregnant
  - Member is immunosuppressed or is having recurrent infections
- Approve for 6 months
- Additional authorizations for treatment are made on a case-by-case basis, are subject to the above criteria, and require chart documentation describing previous response to treatment and clinical rationale for re-treatment.

5. <u>For Autoimmune Mucocutaneous Blistering Disease (AMBD)</u>

- Must have biopsy-proven pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphoid (a.k.a., cictrical pemphigoid), and epidermolysis bullosa acquisita
- Must have a trial and failure or have contraindications to corticosteroids or immunosuppressive agents
- In rapidly progressive, extensive, or debilitating cases (i.e. Stevens Johnson Syndrome), IVIG may be approved along with corticosteroids or immunosuppressive agents
- Approve for 4 months
- Additional authorizations for treatment are made on a case-by-case basis, are subject to the above criteria, and require chart documentation describing previous response to treatment and clinical rationale for re-treatment.

6. <u>For Myasthenia Gravis Syndrome</u>

- Must have a diagnosis of Myasthenia Gravis
- Must be prescribed by a neurologist
- For acute use:
  - Chart documentation of acute exacerbation and impaired function is required (e.g. respiratory insufficiency, inability to swallow)
  - Approve for 1 month
  - Reauthorizations are granted on a case by case basis with chart documentation describing previous response to treatment and clinical rationale for re-treatment
- For temporary use as a bridge to immunotherapy:
  - Must have a history of myasthenia gravis exacerbation
  - Must be recently started (within 3 months) on immunosuppressant therapy (e.g. azathioprine, mycophenolate, cyclosporine, or tacrolimus)
  - Chart documentation of use as bridge therapy is required
  - Approve for 6 months
  - Reauthorizations are granted on a case by case basis with chart documentation describing previous response to treatment and clinical rationale for re-treatment
- For stabilization prior to surgery:
  - Must have a history of myasthenia gravis with current or previous difficulty with swallowing, speech, or respiratory involvement (e.g. shortness of breath or reduce force

vital capacity on pre-op pulmonary function test). Chart documentation of symptoms is required.
    - IVIG infusion must be scheduled within 14 days of anticipated surgery date
    - Approve for 1 month
    - Reauthorizations are granted on a case by case basis with chart documentation describing previous response to treatment and clinical rationale for re-treatment
- For chronic use in refractory disease:
    - Must have an adequate trial with inadequate response, significant side effects/toxicity, or have a contraindication to both of the following:
        - Cholinesterase inhibitors- pyridostigmine or neostigmine
        - Coricosteroids
    - Must have an adequate trial of at least 3 months each with inadequate response, significant side effects/toxicity, or have a contraindication to TWO of the following:
        - Azathioprine
        - Mycophenolate mofetil
        - Cyclosporine
        - Tacrolimus
        - Methotrexate
    - Approve for 6 months
    - Reauthorizations for patients with refractory disease are granted for 1 year intervals on a case by case basis and require chart documentation describing previous response to treatment, including improvement in symptoms that limit daily function

7. <u>For Parvovirus B19 Infection</u>

- Must have documentation (e.g. Polymerase Chain Reaction test result) confirming presence of HPV-B19 infection
- Must have severe anemia defined as hemoglobin level <8ng/dL
- Must have low reticulocyte count defined as <8x109/L
- Must have history of immunodeficiency due to suppressive medications or HIV
- Approve for 1 month
- Additional authorizations for treatment made on a case-by-case basis, are subject to the above criteria, and require chart documentation describing previous response to treatment and clinical rationale for re-treatment.

8. <u>For Renal and/or Pancreatic Transplant Desensitization in Combination with Rituxan</u>

- Must be prescribed by a transplant specialist
- Must be age 18 or older
- Must be awaiting kidney and/or pancreas transplant requiring desensitization as defined by the following criteria:
    - For deceased donor transplants:
        - Panel reactive antibody (PRA) level >30% **OR**
        - PRA <30% with previous kidney and/or pancreas transplant
    - For living donor transplants:
        - Positive crossmatch **OR**
        - Positive donor-specific antibody using Luminex® assay
- Approve for 1 course of treatment (2 doses)

- Additional authorizations for treatment are subject to the above criteria and are not granted until 6 months have passed since the initial treatment.

9. For Renal Transplant Desensitization

- Must be prescribed by a transplant specialist
- Must be awaiting kidney transplant (either from a living or deceased donor) and requiring desensitization
- Approve for 4 months
- Additional authorizations for treatment are subject to the above criteria and are not granted until 12 months have passed since the initial treatment.

10. For Renal Post-Transplant Rejection

- Must have received a renal transplant from a living donor with post-transplant rejection
- Approve for 1 month
- Additional authorizations for treatment are made on a case-by-case basis, are subject to the above criteria, and require chart documentation describing previous response to treatment and clinical rationale for re-treatment.

11. For Allogenic or Hematopoietic Stem Cell Transplantation (HSCT) (or Bone Marrow Transplant)

- Must have severe hypogammaglobulinemia (IgG <400 mg/dL)
- Must have history of recurrent infections
- Approve for 6 months
- Additional authorizations for treatment are made on a case-by-case basis, are subject to the above criteria, and require chart documentation describing the previous response to treatment and clinical rationale for re-treatment.

12. For Autoimmune Hemolytic Anemia

- Must have warm-type diagnosis
- Must have a trial and failure or have contraindications to corticosteroids
- Approve for 1 month
- Additional authorizations for treatment are made on a case-by-case basis, are subject to the above criteria, and require chart documentation describing the previous response to treatment and clinical rationale for re-treatment.

13. For Stiff-Person Syndrome

- Must have a diagnosis of Stiff-Person Syndrome confirmed by electromyography (EMG) or elevated levels of glutamic acid decarboxylase (GAD)
- Must be prescribed by a neurologist
- Must have an adequate trial with inadequate responses, significant side effects/toxicity, or have contraindications to THREE of the following:
    - Corticosteroids
    - Antiepileptics
    - Benzodiazepines
    - Muscle relaxants

  - Gabapentin
- Approve for 4 months
- Reauthorization for an additional 2 months of treatment may be made on a case-by-case basis, is subject to the above criteria, and require chart documentation describing the previous response to treatment and clinical rationale for re-treatment. Continued use beyond 6 months of therapy is not authorized.

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Case-by-Case bases (see criteria above)
Reauthorization	Same as initial

If the established criteria are not met, the request is referred to a Medical Director for review.

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REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Annual Review	*02/16, 02/17, 02/18*
Criteria Update	*08/17, 12/17*