SCIG: Hizentra®, Gammagard Liquid®, Gamunex®-C, Gammaked®, HyQvia®, Cuvitru®, Xembify® (immune globulin SQ)

Last Review Date: Janurary 18, 2022 | **Number: MG.MM.PH.107**

Authorization

- Initial coverage will be provided for 6 months and may be renewed annually thereafter.

Dosing Limits

A. Max Units (per dose and over time) [Medical Benefit]:

Drug Name	Billable units/28 days
Hizentra	960 (PID)
	1840 (CIDP)
Gamunex-C & Gammaked	192
Gammagard liquid	192
HyQvia	690
Cuvitru	920
Xembify	N/A (96gm)

***Xembify** -Prior to switching to Xembify, obtain patient's serum IgG trough level to guide subsequent dose adjustment. Switching from immune globulin intravenous (human), 10% (IVIG) to XEMBIFY: calculate the dose by using a dose adjustment factor. Xembify is to be given one week after the last IVIG infusion.

Guideline

Initial Approval Criteria

- Baseline values for BUN and serum creatinine obtained within 30 days of request; **AND**
- Coverage is provided in the following conditions:

Primary immunodeficiencies (PI) †

Such as: x-linked agammaglobulinemia, Wiskott -Aldrich syndrome, common variable immunodeficiency, transient hypogammaglobulinemia of infancy, IgG subclass deficiency with or without IgA deficiency, antibody deficiency with near normal immunoglobulin levels) and combined deficiencies (severe combined immunodeficiencies, ataxia-telangiectasia, x-linked lymphoproliferative syndrome) [**list not all inclusive**]

- For HyQvia ONLY: Patient must be ≥ 18 years old;
- For Gammagard Liquid, Gamunex-C, Gammaked, Hizentra, Cuvitru, Xembify: Patient must be ≥ 2 years old;

  AND
- Patient's IgG level is <200 mg/dL **OR <u>both</u>** of the following
  - Patient has a history of multiple hard to treat infections as indicated by at least **<u>one</u>** of the following:
    - Four or more ear infections within 1 year
    - Two or more serious sinus infections within 1 year
    - Two or more months of antibiotics with little effect
    - Two or more pneumonias within 1 year
    - Recurrent or deep skin abscesses
    - Need for intravenous antibiotics to clear infections
    - Two or more deep-seated infections including septicemia; **AND**
  - The patient has a deficiency in producing antibodies in response to vaccination; **AND**
    - Titers were drawn before challenging with vaccination; **AND**
    - Titers were drawn between 4 and 8 weeks of vaccination

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) [Hizentra ONLY] †

- Patient must be ≥ 18 years old; **AND**
- Physician has assessed baseline disease severity utilizing an objective measure/tool; **AND**
  - Used as initial maintenance therapy for prevention of disease relapses after treatment and stabilization with intravenous immunoglobulin (IVIG)§; **OR**

- Used for re-initiation of maintenance therapy after experiencing a relapse and requiring re-induction therapy with IVIG (see Hizentra Renewal Criteria)

PANDAS/PANS

As per Massachusetts DOI Bulletin 2021-06, coverage for the following indication will be covered for Massachusetts residents under the Commercial line of business, starting 1/1/2022:

• Treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS)

§ Initial IVIG criteria used for determination of coverage: *(Reference Use Only)*

- Patient's disease course is progressive or relapsing and remitting for 2 months or longer; AND
- Patient has abnormal or absent deep tendon reflexes in upper or lower limbs; AND
- Electrodiagnostic testing indicating demyelination:
  - Partial motor conduction block in at least two motor nerves or in 1 nerve plus one other demyelination criterion listed here in at least 1 other nerve; OR
  - Distal CMAP duration increase in at least 1 nerve plus one other demyelination criterion listed here in at least 1 other nerve; OR
  - Abnormal temporal dispersion conduction must be present in at least 2 motor nerves; OR
  - Reduced conduction velocity in at least 2 motor nerves; OR
  - Prolonged distal motor latency in at least 2 motor nerves; OR
  - Absent F wave in at least two motor nerves plus one other demyelination criterion listed here in at least 1 other nerve; OR
  - Prolonged F wave latency in at least 2 motor nerves; AND
- Cerebrospinal fluid analysis indicates the following:
  - CSF white cell count of <10 cells/mm^3; AND
  - CSF protein is elevated; AND
- Patient is refractory or intolerant to corticosteroids (e.g., prednisolone, prednisone, etc.) given in therapeutic doses over at least three months; AND
- Baseline in strength/weakness has been documented using an objective clinical measuring tool (e.g., INCAT, Medical Research Council (MRC) muscle strength, 6-MWT, Rankin, Modified Rankin, etc.)

† FDA Approved Indication(s)

Renewal Criteria

Coverage can be renewed for 1 year based upon the following criteria:

- Absence of unacceptable toxicity from the drug; **AND**
- BUN and serum creatinine obtained within the last 6 months and the concentration and rate of infusion have been adjusted accordingly; **AND**

Primary immunodeficiencies (PI)

- Disease response as evidenced by one or more of the following:
    - Decrease in the frequency of infection
    - Decrease in the severity of infection

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

- Renewals will be authorized for patients who have demonstrated a beneficial clinical response to maintenance therapy with subcutaneous immune globulin therapy.

  OR

  Renewals for re-initiation of Hizentra (for the treatment of CIPD) only:
- Patient is re-initiating maintenance therapy; **AND**
- Patient has improved and stabilized on IVIG treatment before re-initiating Hizentra.

Limitations/Exclusions

SCIG: Hizentra, Gammagard Liquid, Gamunex-C, Gammaked, HyQvia, Cuvitru, Xembify is considered investigational when used for any indication not listed above.

Applicable Procedure Codes

J1559	Injection, immune globulin (Hizentra), 100 mg
J1561	Injection, immune globulin, (Gamunex-C/Gammaked), non-lyophilized (e.g. liquid), 500 mg
J1569	Injection, immune globulin, (Gammagard liquid), non-lyophilized, (e.g. liquid), 500 mg
J1575	Injection, immune globulin/hyaluronidase, (HyQvia), 100 mg immune globulin
J1555	Injection, immune globulin (Cuvitru), 100 mg
J1558	Injection, immune globulin, 100 mg (Xembify). J-Code effective date: 07/01/2020
J3590	Unclassified biologics
90284	Immune globulin (SCIg), human, for use in subcutaneous infusions

Applicable NDCs

Drug Name	NDC	IgG (grams)	Volume (mL)
Hizentra 20%	44206-0451-01	1	5
	44206-0452-02	2	10
	44206-0454-04	4	20
	44206-0455-10	10	50
Gammaked 10%	76125-0900-01	1	10
	76125-0900-25	2.5	25
	76125-0900-50	5	50
	76125-0900-10	10	100
	76125-0900-20	20	200

Gamunex-C 10%	13533-0800-12	1	10
	13533-0800-15	2.5	25
	13533-0800-20	5	50
	13533-0800-71	10	100
	13533-0800-24	20	200
	13533-0800-40	40	400
Gammagard Liquid 10%	00944-2700-02	1	10
	00944-2700-03	2.5	25
	00944-2700-04	5	50
	00944-2700-05	10	100
	00944-2700-06	20	200
	00944-2700-07	30	300
HyQvia 10% (with Recombinant Human Hyaluronidase 160 U/mL)	00944-2510-02	2.5	25
	00944-2511-02	5	50
	00944-2512-02	10	100
	00944-2513-02	20	200
	00944-2514-02	30	300
Cuvitru 20%	00944-2850-01	1	5
	00944-2850-03	2	10
	00944-2850-05	4	20
	00944-2850-07	8	40
Xembify	13533-0810-05	1	5
	13533-0810-06	1	5
	13533-0810-10	2	10
	13533-0810-11	2	10
	13533-0810-20	4	20
	13533-0810-21	4	20
	13533-0810-50	10	50
	13533-0810-51	10	50

Applicable Diagnosis Codes

B20	Human immunodeficiency virus [HIV] disease
D80.0	Hereditary hypogammaglobulinemia
D80.1	Nonfamilial hypogammaglobulinemia
D80.2	Selective deficiency of immunoglobulin A [IgA]
D80.3	Selective deficiency of immunoglobulin G [IgG] subclasses
D80.4	Selective deficiency of immunoglobulin M [IgM]
D80.5	Immunodeficiency with increased immunoglobulin M [IgM]

D80.7	Transient hypogammaglobulinemia of infancy
D81.0	Severe combined immunodeficiency [SCID] with reticular dysgenesis
D81.1	Severe combined immunodeficiency [SCID] with low T- and B-cell numbers
D81.2	Severe combined immunodeficiency [SCID] with low or normal B-cell numbers
D81.6	Major histocompatibility complex class I deficiency
D81.7	Major histocompatibility complex class II deficiency
D81.89	Other combined immunodeficiencies
D81.9	Combined immunodeficiency, unspecified
D82.0	Wiskott-Aldrich syndrome
D83.0	Common variable immunodeficiency with predominant abnormalities of B-cell numbers and function
D83.2	Common variable immunodeficiency with autoantibodies to B- or T-cells
D83.8	Other common variable immunodeficiencies
D83.9	Common variable immunodeficiency, unspecified
G61.81	Chronic inflammatory demyelinating polyneuritis
G61.89	Other inflammatory polyneuropathies
G62.89	Other specified polyneuropathies

Revision History

1/18/2022	Updated Primary immunodeficiency (PID)/Wiskott -Aldrich syndrome indication to Primary immunodeficiencies (PI) and moved Wiskott-Aldrich below as an example for clarification Added coverage of Hizentra to Primary immunodeficiencies to capture FDA approval
11/29/2021	Added PANDAS/PANS coverage as per Massachusetts DOI Bulletin 2021-06 for Massachusetts residents under the Commercial line of business, starting 1/1/2022
2/1/2021	Removed the following from Renewal Criteria: • "Patient continues to meet criteria identified in section III; " Clarified Hizentra renewal criteria.
06/10/2020	Added J-Code (J1558): Injection, immune globulin, 100 mg (Xembify). J-Code effective date: 07/01/2020
11/01/2019	-Added Xembify to this MP, included drug in title -Added under Dosing Limits: Prior to switching to Xembify, obtain patient's serum IgG trough level to guide subsequent dose adjustment. Switching from immune globulin intravenous (human), 10% (IVIG) to XEMBIFY: calculate the dose by using a dose adjustment factor. Xembify is to be given one week after the last IVIG infusion. - Xembify NDC's, Pkg sizes and Gm strength added to chart -Updated age restrictions for PID indication for Gammagard Liquid, Gamunex-C, Gammaked, HyQvia, Cuvitru, Xembify

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