SPECIALTY GUIDELINE MANAGEMENT

Subcutaneous Immune Globulin (SCIG):
Hizentra® and HyQvia®

POLICY

A. INDICATIONS
The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Hizentra (Immune Globulin Subcutaneous [Human], 20% Liquid)
Hizentra is indicated for the treatment of primary immunodeficiency in adults and pediatric patients 2 years of age and older.

HyQvia (Immune Globulin Infusion 10% [Human] with Recombinant Human Hyaluronidase)
HyQvia is indicated for the treatment of primary immunodeficiency in adults.

Limitation of use: Safety and efficacy of chronic use of recombinant human hyaluronidase in HyQvia have not been established in conditions other than primary immunodeficiency.

All other indications are considered experimental/investigational and are not a covered benefit.

B. EXCLUSIONS

1. Immunoglobulin A (IgA) deficiency with antibodies to IgA and a history of hypersensitivity
2. History of anaphylaxis or severe systemic reaction to the administration of human immune globulin or product components
3. Known systemic hypersensitivity to hyaluronidase or recombinant human hyaluronidase in those prescribed HyQvia
4. Age less than 18 years in those prescribed HyQvia
5. Hyperprolinemia in those prescribed Hizentra (contains the stabilizer L-proline)

C. REQUIRED DOCUMENTATION

1. Primary Immunodeficiency
   a. Diagnostic test results
      i. Copy of laboratory report with serum immunoglobulin levels: IgG, IgA, IgM, and IgG subclasses
      ii. Vaccine response to pneumococcal polysaccharide vaccine (post-vaccination Streptococcus pneumoniae antibody titers)
      iii. Pertinent genetic or molecular testing in members with a known genetic disorder
   b. IgG trough level for those continuing with SCIG therapy

D. CRITERIA FOR APPROVAL

1. Primary Immunodeficiency
   Initial authorization of 12 months may be granted for members with any of the following diagnoses:
   a. Severe combined immunodeficiency (SCID) or congenital agammaglobulinemia (eg, X-linked or autosomal recessive agammaglobulinemia):
      i. Diagnosis confirmed by genetic or molecular testing, or
      ii. Pretreatment IgG level < 200 mg/dL
   b. Wiskott-Aldrich syndrome, DiGeorge syndrome, or ataxia-telangiectasia (or other non-SCID combined immunodeficiency):
      i. Diagnosis confirmed by genetic or molecular testing (if applicable), and

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ii. History of recurrent bacterial infections (eg, pneumonia, otitis media, sinusitis, sepsis, gastrointestinal), and
iii. Impaired antibody response to pneumococcal polysaccharide vaccine (see Appendix)

c. Common variable immunodeficiency (CVID):
   i. Age 4 years or older
   ii. Other causes of immune deficiency have been excluded (eg, drug induced, genetic disorders, infectious diseases such as HIV, malignancy)
   iii. Pretreatment IgG level < 500 mg/dL or ≥ 2 SD below the mean for age
   iv. History of recurrent bacterial infections
   v. Impaired antibody response to pneumococcal polysaccharide vaccine (see Appendix)

d. Hypogammaglobulinemia (unspecified), IgG subclass deficiency, selective IgA deficiency, selective IgM deficiency, or specific antibody deficiency:
   i. History of recurrent bacterial infections
   ii. Impaired antibody response to pneumococcal polysaccharide vaccine (see Appendix)
   iii. Any of the following pre-treatment laboratory findings:
      a) Hypogammaglobulinemia: IgG < 500 mg/dL or ≥ 2 SD below the mean for age
      b) Selective IgA deficiency: IgA level < 7 mg/dL with normal IgG and IgM levels
      c) Selective IgM deficiency: IgM level < 30 mg/dL with normal IgG and IgA levels
      d) IgG subclass deficiency: IgG1, IgG2, or IgG3 ≥ 2 SD below mean for age assessed on at least 2 occasions; normal IgG (total) and IgM levels, normal/low IgA levels
      e) Specific antibody deficiency: normal IgG, IgA and IgM levels

e. Other predominant antibody deficiency disorders must meet i., ii., and iii. in section d. above.
f. Other combined immunodeficiency must meet criteria in section b. above.

E. CONTINUATION OF THERAPY
The following criteria apply to members who are currently receiving SCIG therapy through a paid pharmacy or medical benefit. All other members (including new members) must meet initial authorization criteria.

Primary Immunodeficiency
Authorization of 12 months may be granted when the following criteria are met:
   a. A reduction in the frequency of bacterial infections has been demonstrated since initiation of SCIG therapy, AND
   b. IgG trough levels are monitored at least yearly and maintained at or above the lower range of normal for age (when applicable for indication), OR
   c. The prescriber will re-evaluate the dose of SCIG and consider a dose adjustment (when appropriate).

F. DOSAGE AND ADMINISTRATION
Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

G. APPENDIX
Impaired Antibody Response to Pneumococcal Polysaccharide Vaccine:
- Age 6 years and older: antibody levels are not ≥ 1.3 mcg/mL for at least 70% of serotypes in the vaccine
- Age 2 to 5 years: antibody levels are not ≥ 1.3 mcg/mL for at least 50% of serotypes in the vaccine
- Not established for children less than 2 years of age

REFERENCES

