Hizentra
(Immune Globulin Subcutaneous [Human], 20% Liquid)

Line(s) of Business: HMO; PPO; QUEST Integration

Original Effective Date: 05/21/1999
Current Effective Date: 12/01/2017

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 is indicated as replacement therapy for the treatment of primary humoral immunodeficiency (PI) in adults and pediatric patients 2 years of age and older. This includes, but is not limited to, the humoral immune defect in congenital agammaglobulinemia, common variable immunodeficiency, X-linked agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.\textsuperscript{4}

Hizentra is indicated for the treatment of adult patients with chronic inflammatory demyelinating polyneuropathy (CIDP) as maintenance therapy to prevent relapse of neuromuscular disability and impairment.

Limitations of Use: Hizentra maintenance therapy in CIDP has been systematically studied for 6 months and for a further 12 months in a follow-up study. Maintenance therapy beyond these periods should be individualized based upon the patient’s response and need for continued therapy.

B. REQUIRED DOCUMENTATION
The following information is necessary to initiate the prior authorization review:

- Initial therapy
  - Documentation supporting the member’s inability to tolerate intravenously administered immune globulin
  - For primary immunodeficiency, initial authorization
    - Laboratory evidence of immunoglobulin deficiency (see Appendix)
    - Laboratory evidence of inability to mount an adequate response to inciting antigens (see Appendix)
  - For chronic inflammatory demyelinating polyneuropathy
    - Clinical notes documenting functional disability
    - Electromyography (EMG)/nerve conduction study (NCS) report
- Spinal fluid protein and/or nerve biopsy report
- Continuation of therapy
  - For primary immunodeficiency, continuation of therapy
    - Documentation supporting a clinical response to therapy (e.g., reduction in bacterial infections)
  - For chronic inflammatory demyelinating polyneuropathy
    - Documentation that demonstrates significant improvement in clinical condition and, when relevant, a reduction in the level of sensory loss
    - For the long-term treatment of stable CIDP patients, documentation that the dose has been periodically reduced or withdrawn, and the effects measured

C. CRITERIA FOR APPROVAL
1. Primary immunodeficiency (includes congenital agammaglobulinemia (X-linked agammaglobulinemia), hypogammaglobulinemia, common variable immunodeficiency, X-linked immunodeficiency with hyperimmunoglobulin M, severe combined immunodeficiency and Wiskott-Aldrich syndrome)
   Initial authorization for 12 months may be granted for members who meet the following criteria:
   a. Member is unable to tolerate intravenously administered immune globulin
   b. Laboratory evidence of immunoglobulin deficiency (see Appendix)
   c. Documented inability to mount an adequate response to inciting antigens (see Appendix)
   d. Persistent and severe infections despite treatment with prophylactic antibiotics

2. Chronic inflammatory demyelinating polyneuropathy (CIDP)
   Initial authorization for 3 months may be granted for members who meet the following criteria:
   a. Member is unable to tolerate intravenously administered immune globulin
   b. Significant functional disability
   c. Slowing of nerve conduction velocity on EMG or NCS
   d. Elevated spinal fluid protein on lumbar puncture or a nerve biopsy confirming the diagnosis

D. CONTINUATION OF THERAPY
1. No previous authorization/precertification:
   All members (including new members and members currently receiving treatment without prior authorization) must meet criteria for initial approval in section C.
2. Reauthorization:
   a. Primary immunodeficiency
      Authorization of an additional 12 months may be granted to members requesting authorization for continuation of therapy who are benefitting from Hizentra therapy (e.g., reduction in bacterial infections) and were previously authorized by HMSA/CVS and member demonstrated a clinical response to therapy (e.g., reduction in bacterial infections).
   b. Chronic inflammatory demyelinating polyneuropathy
      Authorization of an additional 12 months may be granted to members requesting authorization for continuation of therapy who demonstrate significant improvement in clinical condition and, when relevant, a reduction in the level of sensory loss and were previously authorized by HMSA/CVS. For members receiving treatment with Hizentra for 18 months or more, authorization of 6 months may be granted when Hizentra dose reduction or withdrawal has been periodically attempted and the effects measured to validate continued use.
E. **APPENDIX - Primary Immunodeficiency Syndromes.**

The diagnosis of immunodeficiency and post immunization titers must be taken in context with the clinical presentation of the patient and may vary dependent on the type of vaccine given and the prior immunization history of the patient. The following parameters are examples of criteria for diagnosis of the primary immunodeficiency syndromes.

1. Laboratory evidence of immunoglobulin deficiency may include the following definitions:
   a. Agammaglobulinemia (total IgG less than 200 mg/dL)
   b. Persistent hypogammaglobulinemia (total IgG less than 400 mg/dL, or at least two standard deviations below normal, on at least two occasions)
   c. Absence of B lymphocytes

2. Inability to mount an adequate antibody response to inciting antigens may include the following definitions:
   a. Lack of appropriate rise in antibody titer following provocation with a polysaccharide antigen. For example, an adequate response to the pneumococcal vaccine may be defined as at least a 4-fold increase in titers for at least 50% of serotypes tested.
   b. Lack of appropriate rise in antibody titer following provocation with a protein antigen. For example, an adequate response to tetanus/diphtheria vaccine may be defined as less than a 4-fold rise in titers 3-4 weeks after vaccine administration.

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. **ADMINISTRATIVE GUIDELINES**

Precertification is required. Please refer to the [HMSA medical policy web site](#) for the fax form.

H. **IMPORTANT REMINDER**

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA/CVS’s determination as to medical necessity in a given case, the physician may request that CVS/caremark/HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.
I. REFERENCES


Document History

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