

Pharmacy

PRIOR AUTHORIZATION FORM

Last Reviewed: March 2012

Last Updated: July 2011

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

 This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Immunoglobulin (IVIG, SCIG)

 URGENT (life threatening)

 Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

 Provider Signature

 Date

PRODUCT INFORMATION

Note: Not all currently available IVIG products are approved for each indication covered by this prior authorization form. Physicians should review specific product information.

- | | |
|---|--|
| <input type="checkbox"/> J1459 – Privigen | <input type="checkbox"/> J1569 – Gammagard Liquid |
| <input type="checkbox"/> J1559 – Hizentra | <input type="checkbox"/> J1572 – Flebogamma/Flebogamma Dif |
| <input type="checkbox"/> J1561 – Gamunex | <input type="checkbox"/> J1573 – Hepagam B |
| <input type="checkbox"/> J1562 – Vivaglobin | <input type="checkbox"/> J1599 – Non-lyophilized IVIG (liquid) |
| <input type="checkbox"/> J1566 – Lyophilized IVIG | <input type="checkbox"/> J2791 – Rhophylac |
| <input type="checkbox"/> J1568 – Octagam | <input type="checkbox"/> Other: _____ |

Dose (g/kg or mg/kg): _____

Frequency: _____ **Weeks:** _____

Duration: _____

Start Date: _____

Route of administration: intravenous subcutaneous

Patient's Weight: _____

Trough IgG level: _____ **Date of IgG Trough:** _____

Units: _____

Nursing visits (if applicable): _____

BILLING INFORMATION
Place of administration:

- Self-administered (Hizentra or Vivaglobin only)
 Provider's Office
 Outpatient Infusion Center
 Center Name: _____
 Home Infusion
 Agency Name: _____

Billing Options:

- Physician buy and bill
 Preferred Specialty Vendor
 Other: _____

Request:

- New
 Continuation/Renewal

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for immunoglobulin requires the following information to certify:

The following criteria are considered in assessing the medical necessity of IVIG:

1. Diagnosis of the disorder must be reasonably certain, and based on a thorough history and examination, and appropriate laboratory testing (e.g. electromyography (EMG), spinal fluid tests, serum tests and biopsy findings).
2. Documentation of previous treatment failures must be provided.
3. In some situations, IVIG may be used for medically necessary indications listed on this prior authorization form for a person that has rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents. In these situations, IVIG therapy would be given along with conventional treatment(s) and continued administration of IVIG is not considered medically necessary once conventional therapy takes effect.
4. Once treatment is initiated, there must be adequate documentation of progress. If there is initial improvement, and continued treatment is necessary, then some type of objective quantitative assessment to monitor the progress is required. Any accepted metric assessment may be used for objective monitoring of progress, such as the Medical Research Council (MRC) scale (most commonly used for muscle strength) and activities of daily living (ADL) measurements. Changes in these measures should be clearly documented. Subjective or experiential improvement alone is generally insufficient to either continue IVIG or to expect coverage.
5. Clinical monitoring takes clear precedence over laboratory monitoring. If clinical improvement is evident, then laboratory monitoring solely to guide IVIG therapy is *not* considered medically necessary.
6. There should be, depending on the diagnosis and clinical circumstances, an attempt made to decrease/wean the dosage when improvement has occurred. There should be, when clinically appropriate for the diagnosis, an attempt to stop the IVIG infusion if improvement is sustained with dosage reduction. If improvement does not occur with IVIG, continued infusion may not be considered medically necessary.
7. The use of intravenous immunoglobulin therapy is considered medically necessary by Priority Health for the conditions specified in the below diagnosis prior authorization criteria. Dosing recommendations are listed at the end of the form.

The Medical Research Council (MRC) scale is the most commonly used grading of muscle strength.

- Scale:
- 0 = no muscle improvement
 - 1 = flicker of muscle movement
 - 2 = trace movement but not able to fully overcome gravity
 - 3 = just able to overcome gravity
 - 4 = moves against resistance, but weak
 - 5 = full strength against resistance

DOCUMENTATION OF PREVIOUS THERAPY

Complete the following section to indicate previous therapy (*required* for authorization):

Drug or type of therapy	Trial Dates	Therapeutic Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Clinical progress:

Please provide clinical progress notes on the patient's response to therapy below (or attach copy of medical records):

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for immunoglobulin requires the following information to certify:

Quick Reference

- Primary Immunodeficiencies Section **A** (diagnoses 1-5)
- Hemotologic conditions Section **B** (diagnoses 6-13)
- Neurological conditions Section **C** (diagnoses 14-20)
- Autoimmune Disorders Section **D** (diagnoses 21-26)
- Dermatologic Conditions Section **E** (diagnoses 27-30)

A. PRIMARY IMMUNODEFICIENCIES

1. **Immunodeficiency Syndrome** (specify below)

- | | |
|---|-------------------------|
| i. <input type="checkbox"/> hypogammaglobulinemia, unspecified | ICD Code: <u>279.00</u> |
| ii. <input type="checkbox"/> selective IgM immunodeficiency | ICD Code: <u>279.02</u> |
| iii. <input type="checkbox"/> other selective immunoglobulin deficiencies | ICD Code: <u>279.03</u> |
| iv. <input type="checkbox"/> x-linked agammaglobulinemia | ICD Code: <u>279.04</u> |
| v. <input type="checkbox"/> x-linked immunodeficiency with hyper IGM | ICD Code: <u>279.05</u> |
| vi. <input type="checkbox"/> combined immunodeficiency | ICD Code: <u>279.2</u> |

Immunodeficiency Syndrome Note: A serum trough IgG level should be measured every 3 months before the infusion and the dose of intravenous immune globulin adjusted accordingly. Infusions are usually given every 4 weeks, but the interval should be adjusted, depending on the serum trough IgG concentrations and the patient's clinical condition. Serum trough levels should be maintained at 700-800 mg/dL (or average of low and high).

- vii. common variable hypoglobulinemia ICD Code: 279.06
Common Variable Immunodeficiency (CVID) Note: CVID is covered in patients with severe infection meeting the following criteria: Member has unexplained recurrent or persistent severe (i.e. sepsis, meningitis, osteomyelitis, not including sinus or middle ear) or opportunistic bacterial infections despite adequate treatment, including all of the following: 1. Aggressive management of other conditions predisposing to recurrent sinopulmonary infections (e.g. asthma, allergic rhinitis); 2. Prophylactic antibiotics; and 3. Increased vigilance and appropriate antibiotic therapy for infections. Serum trough levels should be maintained at 700-800 mg/dL (or average of low and high).

2. **Primary thrombocytopenia** (see requirements below) ICD Code: _____
Covered: 287.30-287.39
- a. **Acute ITP Requirements** (provide documentation)
 1. Covered when a rapid rise in platelet count is necessary (i.e. prior to surgery, acute bleeding or avoidance/deferral of splenectomy, persons at risk for intracerebral hemorrhage)
- b. **Chronic ITP Requirements** (provide documentation)
 1. Covered when platelet count is low (<30,000/uL in children and < 20,000/uL in adults) AND all of the following:
 a. Age of 10 years or older; and
 b. Duration of illness of greater than six months; and
 c. No concurrent illness/disease explaining thrombocytopenia; and
 d. Prior treatment with corticosteroids and splenectomy has failed or member is at high risk for post-splenectomy sepsis.
- c. **ITP in pregnancy** (provide documentation)
 1. Covered when patient refractory to steroids with platelets <10,000/uL in third trimester; **or** platelet counts <30,000/uL associated with bleeding prior to vaginal delivery or c-section; **or** pregnant women who have previously delivered infants with autoimmune thrombocytopenia; **or** pregnant women who have platelet counts < 75,000/uL during the current pregnancy; **or** pregnant women with a past history of splenectomy.

3. **Alloimmune thrombocytopenia refractory to platelet transfusion** (not for routine use) ICD Code: 287.49
May have a role in patients with severe thrombocytopenia of documented immune basis for whom other modalities are unsuccessful or contraindicated. Documentation of previous therapies must be submitted (complete documentation of previous therapy).

4. **Neonatal alloimmune thrombocytopenia** (not for routine use) ICD Code: 776.1
 i. Patient is severely thrombocytopenic and symptomatic
 ii. Patient is at high risk of developing intracranial hemorrhage despite other interventions
Documentation of previous therapies which have been unsuccessful, intolerable, or are contraindicated must be submitted (complete documentation of previous therapy).

5. **Wiskott-Aldrich Syndrome** ICD Code: 279.12

B. HEMATOLOGIC CONDITIONS

6. **Post-transfusion purpura** ICD Code: 287.41
Note: Covered in severely affected patients (platelets < 10,000/uL)
7. **Lymphoid Leukemia (CLL) with one of the following:** ICD Code: _____
Covered: 204.10, 204.12, 204.20, 204
 i. hypogammaglobulinemia
 ii. recurrent bacterial infections
8. **Autoimmune hemolytic anemia** (not for routine use) ICD Code: 283.0
 i. Patient has warm-type AIHA
 ii. Patient is not responsive to corticosteroids

9. **Immune-mediated neutropenia** (not for routine use) ICD Code: 288.09
May have a role in severe illness that does not respond to other modalities or when the latter are contraindicated. Documentation of previous therapies must be submitted (complete documentation of previous therapy).
10. **Multiple Myeloma** (not for routine use) ICD Code: _____
Covered: 203.00-203.02, 203.10-203.12, 203.80, 203.82
- i. Patient has stable (plateau phase) disease (> 3 months since diagnosis)
- ii. Patient has high risk of recurrent infections (2 or more significant infections in the last year or a single life-threatening infection)
- iii. Patient has an IgG level < 600 mg/dL
11. **Anemia due to pure red cell aplasia** ICD Code: _____
Covered: 284.81, 284.89
12. **Human Immunodeficiency Virus (HIV) infection** ICD Code: 042
- iii. IVIG will be covered for patients with HIV to reduce significant bacterial infection when all of the following coverage indicators are present:
- Age less than 13 years old
- Evidence of either qualitative or quantitative humoral immunologic defects
- a. T4 cell count is $\geq 200/\text{mm}^3$
- b. Child has received 2 doses of measles vaccine and lives in a region with a high prevalence of measles
- c. Child has bronchiectasis that is suboptimally responsive to antimicrobial and pulmonary therapy
- d. Child has HIV-associated thrombocytopenia despite antiretroviral therapy
- Current bacterial infections despite appropriate antimicrobial prophylaxis (2 or more bacterial infections in a 1 year period despite treatment)
13. **High-risk pregnancy** (covered for Medicare only) ICD Code: V23.89
with history of previously affected infant with fetal-neonatal thrombocytopenia

C. NEUROLOGICAL CONDITIONS

14. **Pediatric intractable epilepsy** (not for routine use) ICD Code: _____
Covered: 345.11, 345.3, 345.61
- i. Is the patient a candidate for surgical resection?
- Yes
- No, IVIG is being used as a last resort
- None of the above (not covered)
15. **Guillain-Barré syndrome** ICD Code: 357.0
16. **Myasthenia gravis (MG)** (not for routine use) ICD Code: _____
Covered: 358.00, 358.01
- May be considered in patients with severe MG to treat acute severe decompensation when other treatments have been unsuccessful or are contraindicated. Documentation of previous therapies must be submitted (complete documentation of previous therapy).*
17. **Eaton-Lambert Syndrome** ICD Code: 358.1
This is an immune-mediated, myasthenia-like syndrome. Treatment with IVIG is directed at decreasing the autoimmune response.
18. **Polyneuropathy (chronic inflammatory demyelinating)** ICD Code: 357.81

19. **Multifocal motor neuropathy** (not for routine use) ICD Code: 357.9
 ii. Patient has progressive, symptomatic multifocal motor neuropathy diagnosed by electrophysiologic findings that rule out other possible conditions that may not respond to IVIG. Objective evidence of improved EMG or improved muscle strength required for renewal.
20. **Stiff-man syndrome** ICD Code: 333.91
May be used for patients with severe active illness for whom other interventions have been unsuccessful or intolerable. Documentation of previous therapies must be submitted (complete documentation of previous therapy).

D. AUTOIMMUNE DISORDERS

21. **Dermatomyositis** (not for routine use) ICD Code: 710.3
May be used for patients with severe active illness for whom other interventions have been unsuccessful or intolerable (resistant to first and second line therapies). Documentation of previous therapies must be submitted (complete documentation of previous therapy).
22. **Polymyositis** (not for routine use) ICD Code: 710.4
May be used for patients with severe active illness for whom other interventions have been unsuccessful or intolerable (resistant to first and second line therapies). Documentation of previous therapies must be submitted (complete documentation of previous therapy).
23. **Systemic lupus erythematosus (SLE)** (not for routine use) ICD Code: 710.0
May be used for patients with severe active SLE for whom other interventions have been unsuccessful or intolerable. Documentation of previous therapies must be submitted (complete documentation of previous therapy).
24. **Systemic sclerosis dermatomyositis overlap syndrome** (not for routine use) ICD Code: 710.8
May be used for patients with severe active illness for whom other interventions have been unsuccessful or intolerable. Documentation of previous therapies must be submitted (complete documentation of previous therapy).
25. **Kawasaki disease** ICD Code: 446.1
 Number of days since diagnosis: _____
Note: Use of IVIG in Kawasaki disease should be used during the first 10 days of diagnosis to be effective.
26. **Severe Vasculitic Syndrome** (not for routine use)
 i. Specify which syndrome the patient has:
 systemic (polyarteritis nodosa) ICD Code: 446.0
 Churg-Strauss Vasculitis ICD Code: 446.4
 livedoid vasculitis (atrophie blanche) ICD Code: 703.1
 ii. *May be used for patients with severe active illness for whom other interventions have been unsuccessful or intolerable. Documentation of previous therapies must be submitted (complete documentation of previous therapy).*

E. DERMATOLOGIC CONDITIONS

27. **Toxic Epiderma Necrolysis** (not for routine use) ICD Code: 695.15
 Stevens-Johnson Syndrome (not for routine use) ICD Code: 695.13
 Stevens-Johnson Syndrome – Toxic Epidermal Necrolysis Overlap Syndrome (not for routine use) ICD Code: 695.14
Note: Will be covered if it is refractory to conventional therapy.
28. **Pemphigoid gestationis**
 i. Other specified antepartum complications ICD Code: 646.83
 ii. Other specified postpartum complications ICD Code: 646.84
Covered for pemphigoid gestationis that is refractory to conventional therapy. Documentation required.

29. **Pyoderma gangrenosum** ICD Code: 686.01
 iii. Refractory to conventional therapy (documentation required)
30. **Autoimmune mucocutaneous blistering disease** (biopsy-proven)
- | | |
|--|-------------------------|
| iv. <input type="checkbox"/> Pemphigus vulgaris and foliaceus | ICD Code: <u>694.4</u> |
| v. <input type="checkbox"/> Bullous pemphigoid | ICD Code: <u>694.5</u> |
| vi. <input type="checkbox"/> Mucous membrane pemphigoid without ocular involvement | ICD Code: <u>694.60</u> |
| vii. <input type="checkbox"/> Mucous membrane pemphigoid with ocular involvement | ICD Code: <u>694.61</u> |
| viii. <input type="checkbox"/> Epidermolysis bullosa | ICD Code: <u>694.8</u> |

Diagnoses not specified above may not be considered medically necessary by Priority Health. Provide the patient's diagnosis with appropriate rationale for use and documentation to support the use of IVIG for the condition being requested.

31. **Other:** _____ ICD Code: _____
Rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

ADDITIONAL INFORMATION

1. IVIG use in HLA-identical sibling transplants or autologous transplants is not considered medically necessary.
2. Additional diagnoses may be covered for members covered under a HMO/EPO, POS, PPO, ASO, Individual, or Medicaid policy, including:
 - a. (LCD 996.85) allogenic bone marrow transplant in adults up to 4 months following transplantation,
 - b. (LCD 771.81, 771.83, 790.7) patients with established bacterial sepsis.
3. A diagnosis of high-risk pregnancy with history of previously affected infant with fetal-neonatal thrombocytopenia is not covered for members with a HMO/EPO, POS, PPO, ASO, Individual, or Medicaid policy.
4. Priority Medicare covered diagnoses are limited to those listed by national determination criteria or local coverage determination criteria as required by CMS.

PRIORITY MEDICARE PLANS (PART B)

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

FOR MEDICARE ONLY (Part D Only)

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2. The number of doses available under a dose restriction for the prescription drug:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
 - c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4. None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

***** All fields must be complete and legible for Prior Authorization Review***
Please fax this request to: (877)974-4411 toll free or (616)942-8206
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**

ICD-9 Codes that Support Medical Necessity

Local Coverage Determination (LCD) for IMMUNE GLOBULINs (L30147)

For services performed on or after 3/1/2011

ICD Code	Description of ICD Code Supporting Medical Necessity
42	HUMAN IMMUNODEFICIENCY VIRUS (HIV) DISEASE
070.20 - 070.23	VIRAL HEPATITIS B WITH HEPATIC COMA ACUTE OR UNSPECIFIED WITHOUT HEPATITIS DELTA - CHRONIC VIRAL HEPATITIS B WITH HEPATIC COMA WITH HEPATITIS DELTA
070.30 - 070.33	VIRAL HEPATITIS B WITHOUT HEPATIC COMA ACUTE OR UNSPECIFIED WITHOUT HEPATITIS DELTA - CHRONIC VIRAL HEPATITIS B WITHOUT HEPATIC COMA WITH HEPATITIS DELTA
70.42	HEPATITIS DELTA WITHOUT ACTIVE HEPATITIS B DISEASE WITH HEPATIC COMA HEPATITIS DELTA WITH HEPATITIS B CARRIER STATE
203.00 - 203.80	MULTIPLE MYELOMA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - OTHER IMMUNOPROLIFERATIVE NEOPLASMS, WITHOUT MENTION OF HAVING ACHIEVED REMISSION
203.82	OTHER IMMUNOPROLIFERATIVE NEOPLASMS, IN RELAPSE
204.1	CHRONIC LYMPHOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION
204.12	CHRONIC LYMPHOID LEUKEMIA, IN RELAPSE
204.2	SUBACUTE LYMPHOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION
204.22	SUBACUTE LYMPHOID LEUKEMIA, IN RELAPSE
279.00 - 279.06	HYPOGAMMAGLOBULINEMIA UNSPECIFIED - COMMON VARIABLE IMMUNODEFICIENCY
279.12	WISKOTT-ALDRICH SYNDROME
279.2	COMBINED IMMUNITY DEFICIENCY
283	AUTOIMMUNE HEMOLYTIC ANEMIAS
284.81	RED CELL APLASIA (ACQUIRED) (ADULT) (WITH THYMOMA)
284.89	OTHER SPECIFIED APLASTIC ANEMIAS
287.30 - 287.39	PRIMARY THROMBOCYTOPENIA, UNSPECIFIED - OTHER PRIMARY THROMBOCYTOPENIA
287.41	POSTTRANSFUSION PURPURA
287.49	OTHER SECONDARY THROMBOCYTOPENIA
288.09	OTHER NEUTROPENIA
333.91	STIFF-MAN SYNDROME
345.11	GENERALIZED CONVULSIVE EPILEPSY WITH INTRACTABLE EPILEPSY
345.3	GRAND MAL STATUS EPILEPTIC
345.61	INFANTILE SPASMS WITH INTRACTABLE EPILEPSY
357	ACUTE INFECTIVE POLYNEURITIS
357.81	CHRONIC INFLAMMATORY DEMYELINATING POLYNEURITIS
357.9	UNSPECIFIED INFLAMMATORY AND TOXIC NEUROPATHIES
358	MYASTHENIA GRAVIS WITHOUT (ACUTE) EXACERBATION
358.01	MYASTHENIA GRAVIS WITH (ACUTE) EXACERBATION
358.1	MYASTHENIC SYNDROMES IN DISEASES CLASSIFIED ELSEWHERE
446	POLYARTERITIS NODOSA
446.1	ACUTE FEBRILE MUCOCUTANEOUS LYMPH NODE SYNDROME (MCLS)
446.4	WEGENER'S GRANULOMATOSIS
646.83	OTHER SPECIFIED ANTEPARTUM COMPLICATIONS
646.84	OTHER SPECIFIED POSTPARTUM COMPLICATIONS
647.5	RUBELLA OF MOTHER COMPLICATING PREGNANCY CHILDBIRTH OR THE PUERPERIUM UNSPECIFIED AS TO EPISODE OF CARE
647.53	ANTEPARTUM RUBELLA
686.01	PYODERMA GANGRENOSUM

ICD Code	Description of ICD Code Supporting Medical Necessity
694.4	PEMPHIGUS
694.5	PEMPHIGOID
694.6	BENIGN MUCOUS MEMBRANE PEMPHIGOID WITHOUT OCULAR INVOLVEMENT
694.61	BENIGN MUCOUS MEMBRANE PEMPHIGOID WITH OCULAR INVOLVEMENT
694.8	OTHER SPECIFIED BULLOUS DERMATOSES
695.13 - 695.15	STEVENS-JOHNSON SYNDROME - TOXIC EPIDERMAL NECROLYSIS
701.3	STRIAE ATROPHICAE
710	SYSTEMIC LUPUS ERYTHEMATOSUS
710.3	DERMATOMYOSITIS
710.4	POLYMYOSITIS
710.8	OTHER SPECIFIED DIFFUSE DISEASES OF CONNECTIVE TISSUE
776.1	TRANSIENT NEONATAL THROMBOCYTOPENIA
V01.4	CONTACT WITH OR EXPOSURE TO RUBELLA
V01.5	CONTACT WITH OR EXPOSURE TO RABIES
V01.71	CONTACT OR EXPOSURE TO VARICELLA
V01.79	CONTACT OR EXPOSURE TO OTHER VIRAL DISEASES
V02.61	CARRIER OR SUSPECTED CARRIER OF HEPATITIS B
V03.7	NEED FOR PROPHYLACTIC VACCINATION WITH TETANUS TOXOID ALONE
V04.2	NEED FOR PROPHYLACTIC VACCINATION AND INOCULATION AGAINST MEASLES ALONE
V05.4	NEED FOR PROPHYLACTIC VACCINATION AND INOCULATION AGAINST VARICELLA
V15.85	PERSONAL HISTORY OF CONTACT WITH AND (SUSPECTED) EXPOSURE TO POTENTIALLY HAZARDOUS BODY FLUIDS
V22.2	PREGNANT STATE INCIDENTAL
V23.89	SUPERVISION OF OTHER HIGH-RISK PREGNANCY
V42.0	KIDNEY REPLACED BY TRANSPLANT
V42.1	HEART REPLACED BY TRANSPLANT
V42.6	LUNG REPLACED BY TRANSPLANT
V42.7	LIVER REPLACED BY TRANSPLANT
V42.83	PANCREAS REPLACED BY TRANSPLANT

DOSING INFORMATION

If approved, authorization will be limited to the following standard dosing recommendations.

Indication	Initial dose (mg/kg)	Maintenance dose (mg/kg)	Frequency	Trough target (mg/dL)
Infectious diseases				
Kawasaki	400 mg/kg for 4 days or a single dose of 1-2 g/kg			
Pediatric HIV infection	400 mg/kg		every 28 days	
Autoimmune disorders				
Dermatomyositis & Polymyositis		1-2 g/kg	monthly	
Autoimmune mucocutaneous blistering diseases	up to 2 g/kg	up to 2 g/kg per course of therapy	Administered in divided doses over 3 to 5 days every 3 to 4 weeks, monthly up to 6 months	

Indication	Initial dose (mg/kg)	Maintenance dose (mg/kg)	Frequency	Trough target (mg/dL)
Neurological disorders				
Acute & demyelinating polyneuropathies, Guillain-Barre syndrome CIDP ¹	400 mg/kg per day for 5 days	250-400 mg/kg	3 weeks	
Multifocal motor neuropathy	400 mg/kg per day for 5 days	1 g/kg	3 weeks	NA- Objective evidence of improved EMG or improved muscle strength
		2 g/kg	6 weeks	
		1 g/kg	3 weeks	
Multiple sclerosis (relapsing remitting)				
Myasthenia gravis & Lambert-eaton myasthenia	400 mg/kg per day for 5 days	not covered	not covered	
Stiff person syndrome				
Cancer-related Treatments				
Allogenic bone marrow transplant	100-500 mg/kg		monthly	400-600 mg/dL
Chronic B-cell lymphocytic leukemia (CLL) – <i>not covered for Medicare</i>				
Multiple myeloma				
Primary immunodeficiency disorders:				
1. X-linked agammaglobulinemia 2. X-linked agammaglobulinemia with hyper-IgM 3. Hypogammaglobulinemia 4. Combined immunodeficiency syndromes (including Wiskott-aldrich syndrome, SCID)	400 mg/kg intravenous or 100 mg/kg subcutaneous	400 mg/kg intravenous or 100 mg/kg subcutaneous	monthly intravenous or weekly subcutaneous	700-800 mg/dL <i>or</i> average of low and high
Common variable immunodeficiency (CVID)	400 mg/kg intravenous or 100 mg/kg subcutaneous	400 mg/kg intravenous or 100 mg/kg subcutaneous	monthly intravenous or weekly subcutaneous	700-800 mg/dL <i>or</i> average of low and high
IgG subclass deficiency	400 mg/kg intravenous or 100 mg/kg subcutaneous	400 mg/kg intravenous or 100 mg/kg subcutaneous	monthly intravenous or weekly subcutaneous	700-800 mg/dL <i>or</i> average of low and high
Acute idiopathic thrombocytopenia purpura (ITP)	1 g/kg over 1 or 2 consecutive days or 400 mg/kg over 2 to 5 consecutive days			
Chronic ITP	1 or 2 g/kg total over 2 to 5 days	800-1,000 mg/kg	every 2 to 6 weeks based on platelet counts	